

EXPANDING SENIORS RECEIVING DIALYSIS CHOICE ACT
 OF 2016

SEPTEMBER 19, 2016.—Committed to the Committee of the Whole House on the
 State of the Union and ordered to be printed

Mr. BRADY of Texas, from the Committee on Ways and Means,
 submitted the following

R E P O R T

[To accompany H.R. 5659]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 5659) to amend title XVIII of the Social Security Act with respect to expanding Medicare Advantage coverage for individuals with end-stage renal disease (ESRD), 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 “Expanding Seniors Receiving Dialysis Choice Act of 2016” or as the “ESRD Choice Act of 2016”.

SEC. 2. EXPANDING MEDICARE ADVANTAGE COVERAGE FOR INDIVIDUALS WITH END-STAGE RENAL DISEASE (ESRD).

(a) EXPANDED MA ELIGIBILITY.—

(1) IN GENERAL.—Section 1851(a)(3) of the Social Security Act (42 U.S.C. 1395w–21(a)(3)) is amended—

(A) by striking subparagraph (B); and

(B) by striking “ELIGIBLE INDIVIDUAL” and all that follows through “In this title, subject to subparagraph (B),” and inserting “ELIGIBLE INDIVIDUAL.—In this title.”.

(2) CONFORMING AMENDMENTS.—

(A) Section 1852(b)(1) of the Social Security Act (42 U.S.C. 1395w–22(b)(1)) is amended—

(i) by striking subparagraph (B); and

(ii) by striking “BENEFICIARIES” and all that follows through “A Medicare+Choice organization” and inserting “BENEFICIARIES.—A Medicare Advantage organization”.

(B) Section 1859(b)(6) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)) is amended by striking “may waive” and all that follows through “subparagraph and”.

(b) EXCLUDING COSTS FOR KIDNEY ACQUISITIONS FROM MA BENCHMARK.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended—

(1) in subsection (k)—

(A) in paragraph (1)—

(i) in the matter preceding subparagraph (A), by striking “paragraphs (2) and (4)” and inserting “paragraphs (2), (4), and (5)”; and

(ii) in subparagraph (B)(i), by striking “paragraphs (2) and (4)” and inserting “paragraphs (2), (4), and (5)”; and

(B) by adding at the end the following new paragraph:

“(5) EXCLUSION OF COSTS FOR KIDNEY ACQUISITIONS FROM CAPITATION RATES.—After determining the applicable amount for an area for a year under paragraph (1) (beginning with 2019), the Secretary shall adjust such applicable amount to exclude from such applicable amount the Secretary’s estimate of the standardized costs for payments for organ acquisitions for kidney transplants covered under this title (including expenses covered under section 1881(d)) in the area for the year.”; and

(2) in subsection (n)(2)—

(A) in subparagraph (A)(i), by inserting “and, for 2019 and subsequent years, the exclusion of payments for organ acquisitions for kidney transplants from the capitation rate as described in subsection (k)(5)” before the semicolon at the end;

(B) in subparagraph (E), in the matter preceding clause (i), by striking “subparagraph (F)” and inserting “subparagraphs (F) and (G)”; and

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

“(G) APPLICATION OF KIDNEY ACQUISITIONS ADJUSTMENT.—The base payment amount specified in subparagraph (E) for a year (beginning with 2019) shall be adjusted in the same manner under paragraph (5) of subsection (k) as the applicable amount is adjusted under such subsection.”.

(c) FFS COVERAGE OF KIDNEY ACQUISITIONS.—

(1) IN GENERAL.—Section 1852(a)(1)(B)(i) of the Social Security Act (42 U.S.C. 1395w–22(a)(1)(B)(i)) is amended by inserting “or coverage for organ acquisitions for kidney transplants, including as covered under section 1881(d)” after “hospice care”.

(2) CONFORMING AMENDMENT.—Section 1851(i) of the Social Security Act (42 U.S.C. 1395w–21(i)) is amended by adding at the end the following new paragraph:

“(3) FFS PAYMENT FOR EXPENSES FOR KIDNEY ACQUISITIONS.—Paragraphs (1) and (2) do not apply with respect to expenses for organ acquisitions for kidney transplants described in section 1852(a)(1)(B)(i).”.

(d) **SENSE OF CONGRESS REGARDING APPLICATION OF APPROPRIATE MEDICARE ADVANTAGE RISK ADJUSTMENT FOR PAYMENT FOR INCREASED ESRD ENROLLEES.**—It is the sense of Congress that in implementing the policies under this section, the Centers for Medicare & Medicaid Services should provide, in an accurate and transparent manner, for risk adjustment to payment under the Medicare Advantage program to account for the increased enrollment in Medicare Advantage plans of individuals with end-stage renal disease.

(e) **EXPANDED MA EDUCATION.**—Section 1851(d)(2)(A)(iii) of the Social Security Act (42 U.S.C. 1395w–21(d)(2)(A)(iii)) is amended by inserting before the period at the end the following: “, including any additional information that individuals determined to have end-stage renal disease may need to make informed decisions with respect to such an election”.

(f) **REPORT.**—Not later than April 1, 2022, the Administrator of the Centers for Medicare & Medicaid Services shall submit to Congress a report on the impact of the amendments made by this section on spending under the traditional Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act as well as on spending under parts C and D of such title. The report shall include an assessment of the risk adjustment payment methodologies under such parts C and D and their adequacy with respect to individuals with end-stage renal disease and such recommendations as the Administrator deems appropriate.

(g) **EFFECTIVE DATE.**—The amendments made by this section shall apply to plans years beginning on or after January 1, 2020.

I. SUMMARY AND BACKGROUND

A. PURPOSE AND SUMMARY

The bill, H.R. 5659, the “Expanding Senior Receiving Dialysis (ESRD) Choice Act of 2016” as ordered reported by the Committee on Ways and Means on July 13, 2016, amends title XVIII of the Social Security Act with respect to expanding Medicare Advantage (MA) coverage for individuals with end-stage renal disease (ESRD).

B. BACKGROUND AND NEED FOR LEGISLATION

On July 7, 2016, Representative Smith (R–MO), Representative Lewis (D–GA), Representative Bilirakis (R–FL), Representative Marino (R–PA), and Representative Schrader (D–OR) introduced H.R. 5659, the ESRD Choice Act of 2016. More than 640,000 Americans live with kidney failure and are among the most vulnerable Medicare beneficiaries. The only real treatments available are kidney transplants, or renal dialysis. Most individuals with ESRD receive dialysis due to the limited number of kidneys available for transplantation. The majority of people with kidney failure rely on Medicare for their dialysis treatments. This legislation will allow beneficiaries receiving dialysis access to an MA plan, which has proven valuable for patients that suffer from multiple chronic conditions.

Since 2000, the Medicare Payment Advisory Commission has regularly advised Congress to eliminate the unfair MA enrollment prohibition. The Committee believes that the expansion of MA to be a whole benefit is an important step towards achieving a high quality sustainable Medicare program.

C. LEGISLATIVE HISTORY

Background

H.R. 5659 was introduced on July 7, 2016, and was referred to the Committee on Ways and Means and additionally 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 MA program.

On March 16, 2016, the Committee on Ways and Means Subcommittee on Health held a hearing on Preserving and Strengthening Medicare, including the MA program.

Committee Action

The Committee on Ways and Means marked up H.R. 5659, the ESRD Choice Act of 2016, on July 13, 2016, 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**“EXPANDING SENIORS RECEIVING DIALYSIS (ESRD) CHOICE ACT OF 2016”**

PRESENT LAW

Current law does not allow beneficiaries that suffer from kidney failure prior to choosing a managed care plan under the MA program to leave fee-for-service and choose an MA plan.

EXPLANATION OF PROVISIONS

This legislation would remove the current restrictions on ESRD beneficiaries that prevent them from switching into a managed care MA plan by lifting the statutory restriction on Medicare beneficiaries who suffer from end-stage renal disease from enrolling in an MA plan.

The legislation removes the current financial add-on that MA plans receive per member per month in the benchmark that currently exists to account for costs associated with kidney acquisition in the case of a kidney transplant. Consequently, the legislation removes the kidney acquisition costs from MA altogether, streamlining the transplant process across Medicare. Additionally, it requires the Centers for Medicare and Medicaid Services (CMS) to provide a report to Congress by 2022 regarding the effects of this legislation on spending and the risk adjusted payments to MA plans, including recommendations as deemed appropriate by the Administrator.

The amendment in the nature of a substitute added a sense of Congress that CMS properly risk adjust payments to plans, in an accurate and transparent manner, for the additional beneficiaries through the implementation of this legislation.

REASONS FOR CHANGE

Currently, more than 640,000 Americans live with kidney failure, known as ESRD. ESRD beneficiaries are among the most vulnerable and kidney failure affects Americans of all ages. The only real treatments available are kidney transplants or renal dialysis, with most individuals receiving dialysis. The overwhelming majority of people with kidney failure, regardless of their age, rely on Medicare for their life sustaining dialysis treatments.

MA offers better coordinated and integrated care, flexibility, and financial protections for beneficiaries, but ESRD patients are the only group of beneficiaries specifically denied enrollment in MA plans. MA includes integrated care models that allow plans the flexibility to distribute clinical resources to address unique patient needs. Integrated managed care models have shown to be valuable tools for patients that suffer from multiple chronic conditions. Low-income Medicare beneficiaries also enjoy the benefits of MA's maximum out-of-pocket cost that protects beneficiaries from catastrophic health care costs.

EFFECTIVE DATE

The bill would take effect beginning in 2020.

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. 5659, the "Expanding Seniors Receiving Dialysis Choice Act of 2016," on July 13, 2016.

The bill, H.R. 5659, was ordered favorably reported 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. 5659, 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 or increased 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, July 21, 2016.

Hon. KEVIN BRADY,
*Chairman, Committee on Ways and Means,
House of Representatives, Washington, DC.*

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for H.R. 5659, the Expanding Seniors Receiving Dialysis Choice Act of 2016.

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. 5659—Expanding Seniors Receiving Dialysis Choice Act of 2016

Under current law, beneficiaries who develop End-Stage Renal Disease (ESRD) while enrolled in a Medicare Advantage (MA) plan may remain in that plan. However, Medicare beneficiaries are prohibited from enrolling in an MA plan after they have developed ESRD, and must stay in the fee-for-service portion of the Medicare program. H.R. 5659 would eliminate that prohibition, beginning in January 2020.

For beneficiaries with ESRD, Medicare currently pays MA plans an amount equal to the statewide average cost of treating such beneficiaries in the fee-for-service portion of Medicare, and would continue to do so under H.R. 5659. That methodology is designed to pay similar amounts regardless of whether beneficiaries are in fee-for-service or an MA plan. In CBO's judgement, that system, on average, is effective at achieving parity in payment between the two sectors. For beneficiaries who would newly enroll in MA plans under H.R. 5659, CBO estimates that, on average, payments to MA plans would be equal to the spending that otherwise would have occurred for those beneficiaries in the fee-for-service portion of Medicare. Thus, the budgetary effect of enacting this provision would be negligible.

The bill would also transfer responsibility for the costs of acquiring organs for kidney transplants from MA plans to the fee-for-service portion of Medicare. Payments to MA plans would be adjusted to reflect that shift. Thus, CBO estimates that this provision would not have a significant effect on federal spending.

Because enacting H.R. 5659 would affect direct spending, pay-as-you-go procedures apply; however CBO estimates that effects would be negligible over the 2017–2026 period. CBO estimates that enacting H.R. 5659 would not increase net direct spending or on-budget deficits in any of the four consecutive 10-year periods beginning in 2027.

H.R. 5659 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act.

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 RECOMMENDATION

With respect to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the Committee advises that the findings and recommendations of the Committee, based on oversight activities under clause 2(b)(1) of rule X of the Rules of the House of Representatives, are incorporated in the descriptive portions of this report.

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 contains 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:

CHANGES IN EXISTING LAW MADE 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

ELIGIBILITY, ELECTION, AND ENROLLMENT

SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS THROUGH MEDICARE+CHOICE PLANS.—

(1) **IN GENERAL.**—Subject to the provisions of this section, each Medicare+Choice eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits (other than qualified prescription drug benefits) under this title—

(A) through the original medicare fee-for-service program under parts A and B, or

(B) through enrollment in a Medicare+Choice plan under this part, and may elect qualified prescription drug coverage in accordance with section 1860D–1.

(2) **TYPES OF MEDICARE+CHOICE PLANS THAT MAY BE AVAILABLE.**—A Medicare+Choice plan may be any of the following types of plans of health insurance:

(A) **COORDINATED CARE PLANS (INCLUDING REGIONAL PLANS).**—

(i) **IN GENERAL.**—Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without point of service options), plans offered by provider-sponsored organizations (as defined in section 1855(d)), and regional or local preferred provider organization plans (including MA regional plans).

(ii) **SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.**—Specialized MA plans for special needs individuals (as defined in section 1859(b)(6)) may be any type of coordinated care plan.

(B) COMBINATION OF MSA PLAN AND CONTRIBUTIONS TO MEDICARE+CHOICE MSA.—An MSA plan, as defined in section 1859(b)(3), and a contribution into a Medicare+Choice medical savings account (MSA).

(C) PRIVATE FEE-FOR-SERVICE PLANS.—A Medicare+Choice private fee-for-service plan, as defined in section 1859(b)(2).

(3) MEDICARE+CHOICE ELIGIBLE INDIVIDUAL.—

(A) IN GENERAL.—In this title, subject to subparagraph (B), the term “Medicare+Choice eligible individual” means an individual who is entitled to benefits under part A and enrolled under part B.

(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—Such term shall not include an individual medically determined to have end-stage renal disease, except that—

(i) an individual who develops end-stage renal disease while enrolled in a Medicare+Choice plan may continue to be enrolled in that plan; and

(ii) in the case of such an individual who is enrolled in a Medicare+Choice plan under clause (i) (or subsequently under this clause), if the enrollment is discontinued under circumstances described in subsection (e)(4)(A), then the individual will be treated as a “Medicare+Choice eligible individual” for purposes of electing to continue enrollment in another Medicare+Choice plan.

An individual who develops end-stage renal disease while enrolled in a reasonable cost reimbursement contract under section 1876(h) shall be treated as an MA eligible individual for purposes of applying the deemed enrollment under subsection (c)(4).

(b) SPECIAL RULES.—

(1) RESIDENCE REQUIREMENT.—

(A) IN GENERAL.—Except as the Secretary may otherwise provide and except as provided in subparagraph (C), an individual is eligible to elect a Medicare+Choice plan offered by a Medicare+Choice organization only if the plan serves the geographic area in which the individual resides.

(B) CONTINUATION OF ENROLLMENT PERMITTED.—Pursuant to rules specified by the Secretary, the Secretary shall provide that an MA local plan may offer to all individuals residing in a geographic area the option to continue enrollment in the plan, notwithstanding that the individual no longer resides in the service area of the plan, so long as the plan provides that individuals exercising this option have, as part of the benefits under the original medicare fee-for-service program option, reasonable access within that geographic area to the full range of basic benefits, subject to reasonable cost sharing liability in obtaining such benefits.

(C) CONTINUATION OF ENROLLMENT PERMITTED WHERE SERVICE CHANGED.—Notwithstanding subparagraph (A) and in addition to subparagraph (B), if a Medicare+Choice organization eliminates from its service area a Medicare+Choice payment area that was previously within

its service area, the organization may elect to offer individuals residing in all or portions of the affected area who would otherwise be ineligible to continue enrollment the option to continue enrollment in an MA local plan it offers so long as—

(i) the enrollee agrees to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively at facilities designated by the organization within the plan service area; and

(ii) there is no other Medicare+Choice plan offered in the area in which the enrollee resides at the time of the organization's election.

(2) SPECIAL RULE FOR CERTAIN INDIVIDUALS COVERED UNDER FEHBP OR ELIGIBLE FOR VETERANS OR MILITARY HEALTH BENEFITS, VETERANS.—

(A) FEHBP.—An individual who is enrolled in a health benefit plan under chapter 89 of title 5, United States Code, is not eligible to enroll in an MSA plan until such time as the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in such plans will not result in increased expenditures for the Federal Government for health benefit plans under such chapter.

(B) VA AND DOD.—The Secretary may apply rules similar to the rules described in subparagraph (A) in the case of individuals who are eligible for health care benefits under chapter 55 of title 10, United States Code, or under chapter 17 of title 38 of such Code.

(3) LIMITATION ON ELIGIBILITY OF QUALIFIED MEDICARE BENEFICIARIES AND OTHER MEDICAID BENEFICIARIES TO ENROLL IN AN MSA PLAN.—An individual who is a qualified medicare beneficiary (as defined in section 1905(p)(1)), a qualified disabled and working individual (described in section 1905(s)), an individual described in section 1902(a)(10)(E)(iii), or otherwise entitled to medicare cost-sharing under a State plan under title XIX is not eligible to enroll in an MSA plan.

(4) COVERAGE UNDER MSA PLANS.—

(A) IN GENERAL.—Under rules established by the Secretary, an individual is not eligible to enroll (or continue enrollment) in an MSA plan for a year unless the individual provides assurances satisfactory to the Secretary that the individual will reside in the United States for at least 183 days during the year.

(B) EVALUATION.—The Secretary shall regularly evaluate the impact of permitting enrollment in MSA plans under this part on selection (including adverse selection), use of preventive care, access to care, and the financial status of the Trust Funds under this title.

(C) REPORTS.—The Secretary shall submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the evaluation being conducted under subparagraph (B).

(c) PROCESS FOR EXERCISING CHOICE.—

(1) IN GENERAL.—The Secretary shall establish a process through which elections described in subsection (a) are made and changed, including the form and manner in which such elections are made and changed. Subject to paragraph (4), such elections shall be made or changed only during coverage election periods specified under subsection (e) and shall become effective as provided in subsection (f).

(2) COORDINATION THROUGH MEDICARE+CHOICE ORGANIZATIONS.—

(A) ENROLLMENT.—Such process shall permit an individual who wishes to elect a Medicare+Choice plan offered by a Medicare+Choice organization to make such election through the filing of an appropriate election form with the organization.

(B) DISENROLLMENT.—Such process shall permit an individual, who has elected a Medicare+Choice plan offered by a Medicare+Choice organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

(3) DEFAULT.—

(A) INITIAL ELECTION.—

(i) IN GENERAL.—Subject to clause (ii), an individual who fails to make an election during an initial election period under subsection (e)(1) is deemed to have chosen the original medicare fee-for-service program option.

(ii) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary may establish procedures under which an individual who is enrolled in a health plan (other than Medicare+Choice plan) offered by a Medicare+Choice organization at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the Medicare+Choice plan offered by the organization (or, if the organization offers more than one such plan, such plan or plans as the Secretary identifies under such procedures).

(B) CONTINUING PERIODS.—An individual who has made (or is deemed to have made) an election under this section is considered to have continued to make such election until such time as—

(i) the individual changes the election under this section, or

(ii) the Medicare+Choice plan with respect to which such election is in effect is discontinued or, subject to subsection (b)(1)(B), no longer serves the area in which the individual resides.

(4) DEEMED ENROLLMENT RELATING TO CONVERTED REASONABLE COST REIMBURSEMENT CONTRACTS.—

(A) IN GENERAL.—On the first day of the annual, coordinated election period under subsection (e)(3) for plan years beginning on or after January 1, 2017, an MA eligible individual described in clause (i) or (ii) of subparagraph (B) is deemed, unless the individual elects otherwise, to have

elected to receive benefits under this title through an applicable MA plan (and shall be enrolled in such plan) beginning with such plan year, if—

(i) the individual is enrolled in a reasonable cost reimbursement contract under section 1876(h) in the previous plan year;

(ii) such reasonable cost reimbursement contract was extended or renewed for the last reasonable cost reimbursement contract year of the contract (as described in subclause (I) of section 1876(h)(5)(C)(iv)) pursuant to such section;

(iii) the eligible organization that is offering such reasonable cost reimbursement contract provided the notice described in subclause (III) of such section that the contract was to be converted;

(iv) the applicable MA plan—

(I) is the plan that was converted from the reasonable cost reimbursement contract described in clause (iii);

(II) is offered by the same entity (or an organization affiliated with such entity that has a common ownership interest of control) that entered into such contract; and

(III) is offered in the service area where the individual resides;

(v) in the case of reasonable cost reimbursement contracts that provide coverage under parts A and B (and, to the extent the Secretary determines it to be feasible, contracts that provide only part B coverage), the difference between the estimated individual costs (as determined applicable by the Secretary) for the applicable MA plan and such costs for the predecessor cost plan does not exceed a threshold established by the Secretary; and

(vi) the applicable MA plan—

(I) provides coverage for enrollees transitioning from the converted reasonable cost reimbursement contract to such plan to maintain current providers of services and suppliers and course of treatment at the time of enrollment for a period of at least 90 days after enrollment; and

(II) during such period, pays such providers of services and suppliers for items and services furnished to the enrollee an amount that is not less than the amount of payment applicable for such items and services under the original Medicare fee-for-service program under parts A and B.

(B) MA ELIGIBLE INDIVIDUALS DESCRIBED.—

(i) WITHOUT PRESCRIPTION DRUG COVERAGE.—An MA eligible individual described in this clause, with respect to a plan year, is an MA eligible individual who is enrolled in a reasonable cost reimbursement contract under section 1876(h) in the previous plan year and who is not, for such previous plan year, enrolled

in a prescription drug plan under part D, including coverage under section 1860D-22.

(ii) WITH PRESCRIPTION DRUG COVERAGE.—An MA eligible individual described in this clause, with respect to a plan year, is an MA eligible individual who is enrolled in a reasonable cost reimbursement contract under section 1876(h) in the previous plan year and who, for such previous plan year, is enrolled in a prescription drug plan under part D—

(I) through such contract; or

(II) through a prescription drug plan, if the sponsor of such plan is the same entity (or an organization affiliated with such entity) that entered into such contract.

(C) APPLICABLE MA PLAN DEFINED.—In this paragraph, the term “applicable MA plan” means, in the case of an individual described in—

(i) subparagraph (B)(i), an MA plan that is not an MA-PD plan; and

(ii) subparagraph (B)(ii), an MA-PD plan.

(D) IDENTIFICATION AND NOTIFICATION OF DEEMED INDIVIDUALS.—Not later than 45 days before the first day of the annual, coordinated election period under subsection (e)(3) for plan years beginning on or after January 1, 2017, the Secretary shall identify and notify the individuals who will be subject to deemed elections under subparagraph (A) on the first day of such period.

(d) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—

(1) IN GENERAL.—The Secretary shall provide for activities under this subsection to broadly disseminate information to medicare beneficiaries (and prospective medicare beneficiaries) on the coverage options provided under this section in order to promote an active, informed selection among such options.

(2) PROVISION OF NOTICE.—

(A) OPEN SEASON NOTIFICATION.—At least 15 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each Medicare+Choice eligible individual residing in an area the following:

(i) GENERAL INFORMATION.—The general information described in paragraph (3).

(ii) LIST OF PLANS AND COMPARISON OF PLAN OPTIONS.—A list identifying the Medicare+Choice plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans. Such information shall be presented in a comparative form.

(iii) ADDITIONAL INFORMATION.—Any other information that the Secretary determines will assist the individual in making the election under this section.

The mailing of such information shall be coordinated, to the extent practicable, with the mailing of any annual notice under section 1804.

(B) NOTIFICATION TO NEWLY ELIGIBLE MEDICARE+CHOICE ELIGIBLE INDIVIDUALS.—To the extent practicable, the Sec-

retary shall, not later than 30 days before the beginning of the initial Medicare+Choice enrollment period for an individual described in subsection (e)(1), mail to the individual the information described in subparagraph (A).

(ii) NOTIFICATION RELATED TO CERTAIN DEEMED ELECTIONS.—The Secretary shall require a Medicare Advantage organization that is offering a Medicare Advantage plan that has been converted from a reasonable cost reimbursement contract pursuant to section 1876(h)(5)(C)(iv) to mail, not later than 30 days prior to the first day of the annual, coordinated election period under subsection (e)(3) of a year, to any individual enrolled under such contract and identified by the Secretary under subsection (c)(4)(D) for such year—

(I) a notification that such individual will, on such day, be deemed to have made an election with respect to such plan to receive benefits under this title through an MA plan or MA–PD plan (and shall be enrolled in such plan) for the next plan year under subsection (c)(4)(A), but that the individual may make a different election during the annual, coordinated election period for such year;

(II) the information described in subparagraph (A);

(III) a description of the differences between such MA plan or MA–PD plan and the reasonable cost reimbursement contract in which the individual was most recently enrolled with respect to benefits covered under such plans, including cost-sharing, premiums, drug coverage, and provider networks;

(IV) information about the special period for elections under subsection (e)(2)(F); and

(V) other information the Secretary may specify.

(C) FORM.—The information disseminated under this paragraph shall be written and formatted using language that is easily understandable by medicare beneficiaries.

(D) PERIODIC UPDATING.—The information described in subparagraph (A) shall be updated on at least an annual basis to reflect changes in the availability of Medicare+Choice plans and the benefits and Medicare+Choice monthly basic and supplemental beneficiary premiums for such plans.

(3) GENERAL INFORMATION.—General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

(A) BENEFITS UNDER ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—A general description of the benefits covered under the original medicare fee-for-service program under parts A and B, including—

(i) covered items and services,

(ii) beneficiary cost sharing, such as deductibles, co-insurance, and copayment amounts, and

(iii) any beneficiary liability for balance billing.

(B) ELECTION PROCEDURES.—Information and instructions on how to exercise election options under this section.

(C) RIGHTS.—A general description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program and the Medicare+Choice program and the right to be protected against discrimination based on health status-related factors under section 1852(b).

(D) INFORMATION ON MEDIGAP AND MEDICARE SELECT.—A general description of the benefits, enrollment rights, and other requirements applicable to medicare supplemental policies under section 1882 and provisions relating to medicare select policies described in section 1882(t).

(E) POTENTIAL FOR CONTRACT TERMINATION.—The fact that a Medicare+Choice organization may terminate its contract, refuse to renew its contract, or reduce the service area included in its contract, under this part, and the effect of such a termination, nonrenewal, or service area reduction may have on individuals enrolled with the Medicare+Choice plan under this part.

(F) CATASTROPHIC COVERAGE AND SINGLE DEDUCTIBLE.—In the case of an MA regional plan, a description of the catastrophic coverage and single deductible applicable under the plan.

(4) INFORMATION COMPARING PLAN OPTIONS.—Information under this paragraph, with respect to a Medicare+Choice plan for a year, shall include the following:

(A) BENEFITS.—The benefits covered under the plan, including the following:

(i) Covered items and services beyond those provided under the original medicare fee-for-service program.

(ii) Any beneficiary cost sharing, including information on the single deductible (if applicable) under section 1858(b)(1).

(iii) Any maximum limitations on out-of-pocket expenses.

(iv) In the case of an MSA plan, differences in cost sharing, premiums, and balance billing under such a plan compared to under other Medicare+Choice plans.

(v) In the case of a Medicare+Choice private fee-for-service plan, differences in cost sharing, premiums, and balance billing under such a plan compared to under other Medicare+Choice plans.

(vi) The extent to which an enrollee may obtain benefits through out-of-network health care providers.

(vii) The extent to which an enrollee may select among in-network providers and the types of providers participating in the plan's network.

(viii) The organization's coverage of emergency and urgently needed care.

(B) PREMIUMS.—

(i) IN GENERAL.—The monthly amount of the premium charged to an individual.

(ii) REDUCTIONS.—The reduction in part B premiums, if any.

(C) SERVICE AREA.—The service area of the plan.

(D) QUALITY AND PERFORMANCE.—To the extent available, plan quality and performance indicators for the benefits under the plan (and how they compare to such indicators under the original medicare fee-for-service program under parts A and B in the area involved), including—

(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for the previous 2 years (excluding disenrollment due to death or moving outside the plan's service area),

(ii) information on medicare enrollee satisfaction,

(iii) information on health outcomes, and

(iv) the recent record regarding compliance of the plan with requirements of this part (as determined by the Secretary).

(E) SUPPLEMENTAL BENEFITS.—Supplemental health care benefits, including any reductions in cost-sharing under section 1852(a)(3) and the terms and conditions (including premiums) for such benefits.

(5) MAINTAINING A TOLL-FREE NUMBER AND INTERNET SITE.—The Secretary shall maintain a toll-free number for inquiries regarding Medicare+Choice options and the operation of this part in all areas in which Medicare+Choice plans are offered and an Internet site through which individuals may electronically obtain information on such options and Medicare+Choice plans.

(6) USE OF NON-FEDERAL ENTITIES.—The Secretary may enter into contracts with non-Federal entities to carry out activities under this subsection.

(7) PROVISION OF INFORMATION.—A Medicare+Choice organization shall provide the Secretary with such information on the organization and each Medicare+Choice plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

(e) COVERAGE ELECTION PERIODS.—

(1) INITIAL CHOICE UPON ELIGIBILITY TO MAKE ELECTION IF MEDICARE+CHOICE PLANS AVAILABLE TO INDIVIDUAL.—If, at the time an individual first becomes entitled to benefits under part A and enrolled under part B, there is one or more Medicare+Choice plans offered in the area in which the individual resides, the individual shall make the election under this section during a period specified by the Secretary such that if the individual elects a Medicare+Choice plan during the period, coverage under the plan becomes effective as of the first date on which the individual may receive such coverage. If any portion of an individual's initial enrollment period under part B occurs after the end of the annual, coordinated election period described in paragraph (3)(B)(iii), the initial enrollment period under this part shall further extend through the end of the individual's initial enrollment period under part B.

(2) OPEN ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—Subject to paragraph (5)—

(A) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT THROUGH 2005.—At any time during the period beginning January 1, 1998, and ending on December 31, 2005, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

(B) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 6 MONTHS DURING 2006.—

(i) IN GENERAL.—Subject to clause (ii), subparagraph(C)(iii), and subparagraph (D), at any time during the first 6 months of 2006, or, if the individual first becomes a Medicare+Choice eligible individual during 2006, during the first 6 months during 2006 in which the individual is a Medicare+Choice eligible individual, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

(ii) LIMITATION OF ONE CHANGE.—An individual may exercise the right under clause (i) only once. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under the first sentence of paragraph (4).

(C) ANNUAL 45-DAY PERIOD FOR DISENROLLMENT FROM MA PLANS TO ELECT TO RECEIVE BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—Subject to subparagraph (D), at any time during the first 45 days of a year (beginning with 2011), an individual who is enrolled in a Medicare Advantage plan may change the election under subsection (a)(1), but only with respect to coverage under the original medicare fee-for-service program under parts A and B, and may elect qualified prescription drug coverage in accordance with section 1860D-1.

(D) CONTINUOUS OPEN ENROLLMENT FOR INSTITUTIONALIZED INDIVIDUALS.—At any time after 2005 in the case of a Medicare+Choice eligible individual who is institutionalized (as defined by the Secretary), the individual may elect under subsection (a)(1)—

(i) to enroll in a Medicare+Choice plan; or

(ii) to change the Medicare+Choice plan in which the individual is enrolled.

(E) LIMITED CONTINUOUS OPEN ENROLLMENT OF ORIGINAL FEE-FOR-SERVICE ENROLLEES IN MEDICARE ADVANTAGE NON-PRESCRIPTION DRUG PLANS.—

(i) IN GENERAL.—On any date during the period beginning on January 1, 2007, and ending on July 31, 2007, on which a Medicare Advantage eligible individual is an unenrolled fee-for-service individual (as defined in clause (ii)), the individual may elect under subsection (a)(1) to enroll in a Medicare Advantage plan that is not an MA-PD plan.

(ii) UNENROLLED FEE-FOR-SERVICE INDIVIDUAL DEFINED.—In this subparagraph, the term “unenrolled fee-for-service individual” means, with respect to a date, a Medicare Advantage eligible individual who—

(I) is receiving benefits under this title through enrollment in the original medicare fee-for-service program under parts A and B;

(II) is not enrolled in an MA plan on such date; and

(III) as of such date is not otherwise eligible to elect to enroll in an MA plan.

(iii) LIMITATION OF ONE CHANGE DURING THE APPLICABLE PERIOD.—An individual may exercise the right under clause (i) only once during the period described in such clause.

(iv) NO EFFECT ON COVERAGE UNDER A PRESCRIPTION DRUG PLAN.—Nothing in this subparagraph shall be construed as permitting an individual exercising the right under clause (i)—

(I) who is enrolled in a prescription drug plan under part D, to disenroll from such plan or to enroll in a different prescription drug plan; or

(II) who is not enrolled in a prescription drug plan, to enroll in such a plan.

(F) SPECIAL PERIOD FOR CERTAIN DEEMED ELECTIONS.—

(i) IN GENERAL.—At any time during the period beginning after the last day of the annual, coordinated election period under paragraph (3) in which an individual is deemed to have elected to enroll in an MA plan or MA-PD plan under subsection (c)(4) and ending on the last day of February of the first plan year for which the individual is enrolled in such plan, such individual may change the election under subsection (a)(1) (including changing the MA plan or MA-PD plan in which the individual is enrolled).

(ii) LIMITATION OF ONE CHANGE.—An individual may exercise the right under clause (i) only once during the applicable period described in such clause. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

(3) ANNUAL, COORDINATED ELECTION PERIOD.—

(A) IN GENERAL.—Subject to paragraph (5), each individual who is eligible to make an election under this section may change such election during an annual, coordinated election period.

(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term “annual, coordinated election period” means—

(i) with respect to a year before 2002, the month of November before such year;

(ii) with respect to 2002, 2003, 2004, and 2005, the period beginning on November 15 and ending on December 31 of the year before such year;

(iii) with respect to 2006, the period beginning on November 15, 2005, and ending on May 15, 2006;

(iv) with respect to 2007, 2008, 2009, and 2010, the period beginning on November 15 and ending on December 31 of the year before such year; and

(v) with respect to 2012 and succeeding years, the period beginning on October 15 and ending on December 7 of the year before such year.

(C) **MEDICARE+CHOICE HEALTH INFORMATION FAIRS.**—During the fall season of each year (beginning with 1999) and during the period described in subparagraph (B)(iii), in conjunction with the annual coordinated election period defined in subparagraph (B), the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform Medicare+Choice eligible individuals about Medicare+Choice plans and the election process provided under this section.

(D) **SPECIAL INFORMATION CAMPAIGNS.**—During November 1998 the Secretary shall provide for an educational and publicity campaign to inform Medicare+Choice eligible individuals about the availability of Medicare+Choice plans, and eligible organizations with risk-sharing contracts under section 1876, offered in different areas and the election process provided under this section. During the period described in subparagraph (B)(iii), the Secretary shall provide for an educational and publicity campaign to inform MA eligible individuals about the availability of MA plans (including MA–PD plans) offered in different areas and the election process provided under this section.

(4) **SPECIAL ELECTION PERIODS.**—Effective as of January 1, 2006, an individual may discontinue an election of a Medicare+Choice plan offered by a Medicare+Choice organization other than during an annual, coordinated election period and make a new election under this section if—

(A)(i) the certification of the organization or plan under this part has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or

(ii) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuation of such plan;

(B) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances (specified by the Secretary, but not including termination of the individual's enrollment on the basis described in clause (i) or (ii) of subsection (g)(3)(B));

(C) the individual demonstrates (in accordance with guidelines established by the Secretary) that—

(i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual (including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such

covered care in accordance with applicable quality standards); or

(ii) the organization (or an agent or other entity acting on the organization's behalf) materially misrepresented the plan's provisions in marketing the plan to the individual; or

(D) the individual meets such other exceptional conditions as the Secretary may provide.

Effective as of January 1, 2006, an individual who, upon first becoming eligible for benefits under part A at age 65, enrolls in a Medicare+Choice plan under this part, the individual may discontinue the election of such plan, and elect coverage under the original fee-for-service plan, at any time during the 12-month period beginning on the effective date of such enrollment.

(5) SPECIAL RULES FOR MSA PLANS.—Notwithstanding the preceding provisions of this subsection, an individual—

(A) may elect an MSA plan only during—

(i) an initial open enrollment period described in paragraph (1), or

(ii) an annual, coordinated election period described in paragraph (3)(B);

(B) subject to subparagraph (C), may not discontinue an election of an MSA plan except during the periods described in clause (ii) or (iii) of subparagraph (A) and under the first sentence of paragraph (4); and

(C) who elects an MSA plan during an annual, coordinated election period, and who never previously had elected such a plan, may revoke such election, in a manner determined by the Secretary, by not later than December 15 following the date of the election.

(6) OPEN ENROLLMENT PERIODS.—Subject to paragraph (5), a Medicare+Choice organization—

(A) shall accept elections or changes to elections during the initial enrollment periods described in paragraph (1), during the period described in paragraph (2)(F), during the month of November 1998 and during the annual, coordinated election period under paragraph (3) for each subsequent year, and during special election periods described in the first sentence of paragraph (4); and

(B) may accept other changes to elections at such other times as the organization provides.

(f) EFFECTIVENESS OF ELECTIONS AND CHANGES OF ELECTIONS.—

(1) DURING INITIAL COVERAGE ELECTION PERIOD.—An election of coverage made during the initial coverage election period under subsection (e)(1) shall take effect upon the date the individual becomes entitled to benefits under part A and enrolled under part B, except as the Secretary may provide (consistent with section 1838) in order to prevent retroactive coverage.

(2) DURING CONTINUOUS OPEN ENROLLMENT PERIODS.—An election or change of coverage made under subsection (e)(2) shall take effect with the first day of the first calendar month following the date on which the election or change is made.

(3) ANNUAL, COORDINATED ELECTION PERIOD.—An election or change of coverage made during an annual, coordinated election period (as defined in subsection (e)(3)(B), other than the period described in clause (iii) of such subsection) in a year shall take effect as of the first day of the following year.

(4) OTHER PERIODS.—An election or change of coverage made during any other period under subsection (e)(4) shall take effect in such manner as the Secretary provides in a manner consistent (to the extent practicable) with protecting continuity of health benefit coverage.

(g) GUARANTEED ISSUE AND RENEWAL.—

(1) IN GENERAL.—Except as provided in this subsection, a Medicare+Choice organization shall provide that at any time during which elections are accepted under this section with respect to a Medicare+Choice plan offered by the organization, the organization will accept without restrictions individuals who are eligible to make such election.

(2) PRIORITY.—If the Secretary determines that a Medicare+Choice organization, in relation to a Medicare+Choice plan it offers, has a capacity limit and the number of Medicare+Choice eligible individuals who elect the plan under this section exceeds the capacity limit, the organization may limit the election of individuals of the plan under this section but only if priority in election is provided—

(A) first to such individuals as have elected the plan at the time of the determination, and

(B) then to other such individuals in such a manner that does not discriminate, on a basis described in section 1852(b), among the individuals (who seek to elect the plan).

The preceding sentence shall not apply if it would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the medicare population in the service area of the plan.

(3) LIMITATION ON TERMINATION OF ELECTION.—

(A) IN GENERAL.—Subject to subparagraph (B), a Medicare+Choice organization may not for any reason terminate the election of any individual under this section for a Medicare+Choice plan it offers.

(B) BASIS FOR TERMINATION OF ELECTION.—A Medicare+Choice organization may terminate an individual's election under this section with respect to a Medicare+Choice plan it offers if—

(i) any Medicare+Choice monthly basic and supplemental beneficiary premiums required with respect to such plan are not paid on a timely basis (consistent with standards under section 1856 that provide for a grace period for late payment of such premiums),

(ii) the individual has engaged in disruptive behavior (as specified in such standards), or

(iii) the plan is terminated with respect to all individuals under this part in the area in which the individual resides.

(C) CONSEQUENCE OF TERMINATION.—

(i) **TERMINATIONS FOR CAUSE.**—Any individual whose election is terminated under clause (i) or (ii) of subparagraph (B) is deemed to have elected the original medicare fee-for-service program option described in subsection (a)(1)(A).

(ii) **TERMINATION BASED ON PLAN TERMINATION OR SERVICE AREA REDUCTION.**—Any individual whose election is terminated under subparagraph (B)(iii) shall have a special election period under subsection (e)(4)(A) in which to change coverage to coverage under another Medicare+Choice plan. Such an individual who fails to make an election during such period is deemed to have chosen to change coverage to the original medicare fee-for-service program option described in subsection (a)(1)(A).

(D) **ORGANIZATION OBLIGATION WITH RESPECT TO ELECTION FORMS.**—Pursuant to a contract under section 1857, each Medicare+Choice organization receiving an election form under subsection (c)(2) shall transmit to the Secretary (at such time and in such manner as the Secretary may specify) a copy of such form or such other information respecting the election as the Secretary may specify.

(h) **APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.**—

(1) **SUBMISSION.**—No marketing material or application form may be distributed by a Medicare+Choice organization to (or for the use of) Medicare+Choice eligible individuals unless—

(A) at least 45 days (or 10 days in the case described in paragraph (5)) before the date of distribution the organization has submitted the material or form to the Secretary for review, and

(B) the Secretary has not disapproved the distribution of such material or form.

(2) **REVIEW.**—The standards established under section 1856 shall include guidelines for the review of any material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.

(3) **DEEMED APPROVAL (1-STOP SHOPPING).**—In the case of material or form that is submitted under paragraph (1)(A) to the Secretary or a regional office of the Department of Health and Human Services and the Secretary or the office has not disapproved the distribution of marketing material or form under paragraph (1)(B) with respect to a Medicare+Choice plan in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the plan and organization except with regard to that portion of such material or form that is specific only to an area involved.

(4) **PROHIBITION OF CERTAIN MARKETING PRACTICES.**—Each Medicare+Choice organization shall conform to fair marketing standards, in relation to Medicare+Choice plans offered under this part, included in the standards established under section 1856. Such standards—

(A) shall not permit a Medicare+Choice organization to provide for, subject to subsection (j)(2)(C), cash, gifts, prizes, or other monetary rebates as an inducement for enrollment or otherwise;

(B) may include a prohibition against a Medicare+Choice organization (or agent of such an organization) completing any portion of any election form used to carry out elections under this section on behalf of any individual;

(C) shall not permit a Medicare Advantage organization (or the agents, brokers, and other third parties representing such organization) to conduct the prohibited activities described in subsection (j)(1); and

(D) shall only permit a Medicare Advantage organization (and the agents, brokers, and other third parties representing such organization) to conduct the activities described in subsection (j)(2) in accordance with the limitations established under such subsection.

(5) SPECIAL TREATMENT OF MARKETING MATERIAL FOLLOWING MODEL MARKETING LANGUAGE.—In the case of marketing material of an organization that uses, without modification, proposed model language specified by the Secretary, the period specified in paragraph (1)(A) shall be reduced from 45 days to 10 days.

(6) REQUIRED INCLUSION OF PLAN TYPE IN PLAN NAME.—For plan years beginning on or after January 1, 2010, a Medicare Advantage organization must ensure that the name of each Medicare Advantage plan offered by the Medicare Advantage organization includes the plan type of the plan (using standard terminology developed by the Secretary).

(7) STRENGTHENING THE ABILITY OF STATES TO ACT IN COLLABORATION WITH THE SECRETARY TO ADDRESS FRAUDULENT OR INAPPROPRIATE MARKETING PRACTICES.—

(A) APPOINTMENT OF AGENTS AND BROKERS.—Each Medicare Advantage organization shall—

(i) only use agents and brokers who have been licensed under State law to sell Medicare Advantage plans offered by the Medicare Advantage organization;

(ii) in the case where a State has a State appointment law, abide by such law; and

(iii) report to the applicable State the termination of any such agent or broker, including the reasons for such termination (as required under applicable State law).

(B) COMPLIANCE WITH STATE INFORMATION REQUESTS.—Each Medicare Advantage organization shall comply in a timely manner with any request by a State for information regarding the performance of a licensed agent, broker, or other third party representing the Medicare Advantage organization as part of an investigation by the State into the conduct of the agent, broker, or other third party.

(i) EFFECT OF ELECTION OF MEDICARE+CHOICE PLAN OPTION.—

(1) PAYMENTS TO ORGANIZATIONS.—Subject to sections 1852(a)(5), 1853(a)(4), 1853(g), 1853(h), 1886(d)(11), 1886(h)(3)(D), and 1853(m), payments under a contract with a Medicare+Choice organization under section 1853(a) with re-

spect to an individual electing a Medicare+Choice plan offered by the organization shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A and B for items and services furnished to the individual.

(2) ONLY ORGANIZATION ENTITLED TO PAYMENT.—Subject to sections 1853(a)(4), 1853(e), 1853(g), 1853(h), 1857(f)(2), 1858(h), 1886(d)(11), and 1886(h)(3)(D), only the Medicare+Choice organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.

(j) PROHIBITED ACTIVITIES DESCRIBED AND LIMITATIONS ON THE CONDUCT OF CERTAIN OTHER ACTIVITIES.—

(1) PROHIBITED ACTIVITIES DESCRIBED.—The following prohibited activities are described in this paragraph:

(A) UNSOLICITED MEANS OF DIRECT CONTACT.—Any unsolicited means of direct contact of prospective enrollees, including soliciting door-to-door or any outbound telemarketing without the prospective enrollee initiating contact.

(B) CROSS-SELLING.—The sale of other non-health related products (such as annuities and life insurance) during any sales or marketing activity or presentation conducted with respect to a Medicare Advantage plan.

(C) MEALS.—The provision of meals of any sort, regardless of value, to prospective enrollees at promotional and sales activities.

(D) SALES AND MARKETING IN HEALTH CARE SETTINGS AND AT EDUCATIONAL EVENTS.—Sales and marketing activities for the enrollment of individuals in Medicare Advantage plans that are conducted—

(i) in health care settings in areas where health care is delivered to individuals (such as physician offices and pharmacies), except in the case where such activities are conducted in common areas in health care settings; and

(ii) at educational events.

(2) LIMITATIONS.—The Secretary shall establish limitations with respect to at least the following:

(A) SCOPE OF MARKETING APPOINTMENTS.—The scope of any appointment with respect to the marketing of a Medicare Advantage plan. Such limitation shall require advance agreement with a prospective enrollee on the scope of the marketing appointment and documentation of such agreement by the Medicare Advantage organization. In the case where the marketing appointment is in person, such documentation shall be in writing.

(B) CO-BRANDING.—The use of the name or logo of a co-branded network provider on Medicare Advantage plan membership and marketing materials.

(C) LIMITATION OF GIFTS TO NOMINAL DOLLAR VALUE.—The offering of gifts and other promotional items other than those that are of nominal value (as determined by the Secretary) to prospective enrollees at promotional activities.

(D) COMPENSATION.—The use of compensation other than as provided under guidelines established by the Secretary. Such guidelines shall ensure that the use of compensation creates incentives for agents and brokers to enroll individuals in the Medicare Advantage plan that is intended to best meet their health care needs.

(E) REQUIRED TRAINING, ANNUAL RETRAINING, AND TESTING OF AGENTS, BROKERS, AND OTHER THIRD PARTIES.—The use by a Medicare Advantage organization of any individual as an agent, broker, or other third party representing the organization that has not completed an initial training and testing program and does not complete an annual retraining and testing program.

BENEFITS AND BENEFICIARY PROTECTIONS

SEC. 1852. (a) BASIC BENEFITS.—

(1) REQUIREMENT.—

(A) IN GENERAL.—Except as provided in section 1859(b)(3) for MSA plans and except as provided in paragraph (6) for MA regional plans, each Medicare+Choice plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI, benefits under the original medicare fee-for-service program option (and, for plan years before 2006, additional benefits required under section 1854(f)(1)(A)).

(B) BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION DEFINED.—

(i) IN GENERAL.—For purposes of this part, the term “benefits under the original medicare fee-for-service program option” means those items and services (other than hospice care) for which benefits are available under parts A and B to individuals entitled to benefits under part A and enrolled under part B, with cost-sharing for those services as required under parts A and B or, subject to clause (iii), an actuarially equivalent level of cost-sharing as determined in this part.

(ii) SPECIAL RULE FOR REGIONAL PLANS.—In the case of an MA regional plan in determining an actuarially equivalent level of cost-sharing with respect to benefits under the original medicare fee-for-service program option, there shall only be taken into account, with respect to the application of section 1858(b)(2), such expenses only with respect to subparagraph (A) of such section.

(iii) LIMITATION ON VARIATION OF COST SHARING FOR CERTAIN BENEFITS.—Subject to clause (v), cost-sharing for services described in clause (iv) shall not exceed the cost-sharing required for those services under parts A and B.

(iv) SERVICES DESCRIBED.—The following services are described in this clause:

(I) Chemotherapy administration services.

(II) Renal dialysis services (as defined in section 1881(b)(14)(B)).

(III) Skilled nursing care.

(IV) Such other services that the Secretary determines appropriate (including services that the Secretary determines require a high level of predictability and transparency for beneficiaries).

(v) EXCEPTION.—In the case of services described in clause (iv) for which there is no cost-sharing required under parts A and B, cost-sharing may be required for those services in accordance with clause (i).

(2) SATISFACTION OF REQUIREMENT.—

(A) IN GENERAL.—A Medicare+Choice plan (other than an MSA plan) offered by a Medicare+Choice organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider or other person that has a contract with the organization offering the plan, if the plan provides payment in an amount so that—

(i) the sum of such payment amount and any cost sharing provided for under the plan, is equal to at least

(ii) the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing permitted under such parts).

(B) REFERENCE TO RELATED PROVISIONS.—For provision relating to—

(i) limitations on balance billing against Medicare+Choice organizations for non-contract providers, see sections 1852(k) and 1866(a)(1)(O), and

(ii) limiting actuarial value of enrollee liability for covered benefits, see section 1854(e).

(C) ELECTION OF UNIFORM COVERAGE DETERMINATION.—

In the case of a Medicare+Choice organization that offers a Medicare+Choice plan in an area in which more than one local coverage determination is applied with respect to different parts of the area, the organization may elect to have the local coverage determination for the part of the area that is most beneficial to Medicare+Choice enrollees (as identified by the Secretary) apply with respect to all Medicare+Choice enrollees enrolled in the plan.

(3) SUPPLEMENTAL BENEFITS.—

(A) BENEFITS INCLUDED SUBJECT TO SECRETARY'S APPROVAL.—Each Medicare+Choice organization may provide to individuals enrolled under this part, other than under an MSA plan (without affording those individuals an option to decline the coverage), supplemental health care benefits that the Secretary may approve. The Secretary shall approve any such supplemental benefits unless the Secretary determines that including such supplemental benefits would substantially discourage enrollment by Medicare+Choice eligible individuals with the organization.

(B) AT ENROLLEES' OPTION.—

(i) IN GENERAL.—Subject to clause (ii), a Medicare+Choice organization may provide to individ-

uals enrolled under this part supplemental health care benefits that the individuals may elect, at their option, to have covered.

(ii) SPECIAL RULE FOR MSA PLANS.—A Medicare+Choice organization may not provide, under an MSA plan, supplemental health care benefits that cover the deductible described in section 1859(b)(2)(B). In applying the previous sentence, health benefits described in section 1882(u)(2)(B) shall not be treated as covering such deductible.

(C) APPLICATION TO MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLANS.—Nothing in this paragraph shall be construed as preventing a Medicare+Choice private fee-for-service plan from offering supplemental benefits that include payment for some or all of the balance billing amounts permitted consistent with section 1852(k) and coverage of additional services that the plan finds to be medically necessary. Such benefits may include reductions in cost-sharing below the actuarial value specified in section 1854(e)(4)(B).

(4) ORGANIZATION AS SECONDARY PAYER.—Notwithstanding any other provision of law, a Medicare+Choice organization may (in the case of the provision of items and services to an individual under a Medicare+Choice plan under circumstances in which payment under this title is made secondary pursuant to section 1862(b)(2)) charge or authorize the provider of such services to charge, in accordance with the charges allowed under a law, plan, or policy described in such section—

(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

(B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

(5) NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If there is a national coverage determination or legislative change in benefits required to be provided under this part made in the period beginning on the date of an announcement under section 1853(b) and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a Medicare+Choice organization of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the annual Medicare+Choice capitation rate under section 1853 included in the announcement made at the beginning of such period, then, unless otherwise required by law—

(A) such determination or legislative change in benefits shall not apply to contracts under this part until the first contract year that begins after the end of such period, and

(B) if such coverage determination or legislative change provides for coverage of additional benefits or coverage under additional circumstances, section 1851(i)(1) shall not apply to payment for such additional benefits or benefits

provided under such additional circumstances until the first contract year that begins after the end of such period. The projection under the previous sentence shall be based on an analysis by the Chief Actuary of the Centers for Medicare & Medicaid Services of the actuarial costs associated with the coverage determination or legislative change in benefits.

(6) SPECIAL BENEFIT RULES FOR REGIONAL PLANS.—In the case of an MA plan that is an MA regional plan, benefits under the plan shall include the benefits described in paragraphs (1) and (2) of section 1858(b).

(7) LIMITATION ON COST-SHARING FOR DUAL ELIGIBLES AND QUALIFIED MEDICARE BENEFICIARIES.—In the case of an individual who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)) or a qualified medicare beneficiary (as defined in section 1905(p)(1)) and who is enrolled in a specialized Medicare Advantage plan for special needs individuals described in section 1859(b)(6)(B)(ii), the plan may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such plan.

(b) ANTIDISCRIMINATION.—

(1) BENEFICIARIES.—

(A) IN GENERAL.— A Medicare+Choice organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act. The Secretary shall not approve a plan of an organization if the Secretary determines that the design of the plan and its benefits are likely to substantially discourage enrollment by certain MA eligible individuals with the organization.

(B) CONSTRUCTION.—Subparagraph (A) shall not be construed as requiring a Medicare+Choice organization to enroll individuals who are determined to have end-stage renal disease, except as provided under section 1851(a)(3)(B).

(2) PROVIDERS.—A Medicare+Choice organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

(c) DISCLOSURE REQUIREMENTS.—

(1) DETAILED DESCRIPTION OF PLAN PROVISIONS.—A Medicare+Choice organization shall disclose, in clear, accurate, and standardized form to each enrollee with a Medicare+Choice plan offered by the organization under this part at the time of enrollment and at least annually thereafter, the following information regarding such plan:

(A) SERVICE AREA.—The plan's service area.

(B) BENEFITS.—Benefits offered under the plan, including information described in section 1851(d)(3)(A) and exclusions from coverage and, if it is an MSA plan, a comparison of benefits under such a plan with benefits under other Medicare+Choice plans.

(C) ACCESS.—The number, mix, and distribution of plan providers, out-of-network coverage (if any) provided by the plan, and any point-of-service option (including the supplemental premium for such option).

(D) OUT-OF-AREA COVERAGE.—Out-of-area coverage provided by the plan.

(E) EMERGENCY COVERAGE.—Coverage of emergency services, including—

(i) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

(ii) the process and procedures of the plan for obtaining emergency services; and

(iii) the locations of (I) emergency departments, and (II) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

(F) SUPPLEMENTAL BENEFITS.—Supplemental benefits available from the organization offering the plan, including—

(i) whether the supplemental benefits are optional,

(ii) the supplemental benefits covered, and

(iii) the Medicare+Choice monthly supplemental beneficiary premium for the supplemental benefits.

(G) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in nonpayment.

(H) PLAN GRIEVANCE AND APPEALS PROCEDURES.—All plan appeal or grievance rights and procedures.

(I) QUALITY IMPROVEMENT PROGRAM.—A description of the organization's quality improvement program under subsection (e).

(2) DISCLOSURE UPON REQUEST.—Upon request of a Medicare+Choice eligible individual, a Medicare+Choice organization must provide the following information to such individual:

(A) The general coverage information and general comparative plan information made available under clauses (i) and (ii) of section 1851(d)(2)(A).

(B) Information on procedures used by the organization to control utilization of services and expenditures.

(C) Information on the number of grievances, redeterminations, and appeals and on the disposition in the aggregate of such matters.

(D) An overall summary description as to the method of compensation of participating physicians.

(d) ACCESS TO SERVICES.—

(1) IN GENERAL.—A Medicare+Choice organization offering a Medicare+Choice plan may select the providers from whom the benefits under the plan are provided so long as—

(A) the organization makes such benefits available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits;

(B) when medically necessary the organization makes such benefits available and accessible 24 hours a day and 7 days a week;

(C) the plan provides for reimbursement with respect to services which are covered under subparagraphs (A) and (B) and which are provided to such an individual other than through the organization, if—

(i) the services were not emergency services (as defined in paragraph (3)), but (I) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition, and (II) it was not reasonable given the circumstances to obtain the services through the organization,

(ii) the services were renal dialysis services and were provided other than through the organization because the individual was temporarily out of the plan's service area, or

(iii) the services are maintenance care or post-stabilization care covered under the guidelines established under paragraph (2);

(D) the organization provides access to appropriate providers, including credentialed specialists, for medically necessary treatment and services; and

(E) coverage is provided for emergency services (as defined in paragraph (3)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization.

(2) GUIDELINES RESPECTING COORDINATION OF POST-STABILIZATION CARE.—A Medicare+Choice plan shall comply with such guidelines as the Secretary may prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1867.

(3) DEFINITION OF EMERGENCY SERVICES.—In this subsection—

(A) IN GENERAL.—The term “emergency services” means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

(i) are furnished by a provider that is qualified to furnish such services under this title, and

(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (B)).

(B) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.—The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average

knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

- (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- (ii) serious impairment to bodily functions, or
- (iii) serious dysfunction of any bodily organ or part.

(4) ASSURING ACCESS TO SERVICES IN MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLANS.—In addition to any other requirements under this part, in the case of a Medicare+Choice private fee-for-service plan, the organization offering the plan must demonstrate to the Secretary that the organization has sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan. Subject to paragraphs (5) and (6), the Secretary shall find that an organization has met such requirement with respect to any category of health care professional or provider if, with respect to that category of provider—

(A) the plan has established payment rates for covered services furnished by that category of provider that are not less than the payment rates provided for under part A, part B, or both, for such services, or

(B) the plan has contracts or agreements (other than deemed contracts or agreements under subsection (j)(6)) with a sufficient number and range of providers within such category to meet the access standards in subparagraphs (A) through (E) of paragraph (1),

or a combination of both. The previous sentence shall not be construed as restricting the persons from whom enrollees under such a plan may obtain covered benefits, except that, if a plan entirely meets such requirement with respect to a category of health care professional or provider on the basis of subparagraph (B), it may provide for a higher beneficiary copayment in the case of health care professionals and providers of that category who do not have contracts or agreements (other than deemed contracts or agreements under subsection (j)(6)) to provide covered services under the terms of the plan.

(5) REQUIREMENT OF CERTAIN NONEMPLOYER MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS TO USE CONTRACTS WITH PROVIDERS.—

(A) IN GENERAL.—For plan year 2011 and subsequent plan years, in the case of a Medicare Advantage private fee-for-service plan not described in paragraph (1) or (2) of section 1857(i) operating in a network area (as defined in subparagraph (B)), the plan shall meet the access standards under paragraph (4) in that area only through entering into written contracts as provided for under subparagraph (B) of such paragraph and not, in whole or in part, through the establishment of payment rates meeting the requirements under subparagraph (A) of such paragraph.

(B) NETWORK AREA DEFINED.—For purposes of subparagraph (A), the term “network area” means, for a plan year, an area which the Secretary identifies (in the Secretary’s

announcement of the proposed payment rates for the previous plan year under section 1853(b)(1)(B)) as having at least 2 network-based plans (as defined in subparagraph (C)) with enrollment under this part as of the first day of the year in which such announcement is made.

(C) NETWORK-BASED PLAN DEFINED.—

(i) IN GENERAL.—For purposes of subparagraph (B), the term “network-based plan” means—

(I) except as provided in clause (ii), a Medicare Advantage plan that is a coordinated care plan described in section 1851(a)(2)(A)(i);

(II) a network-based MSA plan; and

(III) a reasonable cost reimbursement plan under section 1876.

(ii) EXCLUSION OF NON-NETWORK REGIONAL PPOS.—The term “network-based plan” shall not include an MA regional plan that, with respect to the area, meets access adequacy standards under this part substantially through the authority of section 422.112(a)(1)(ii) of title 42, Code of Federal Regulations, rather than through written contracts.

(6) REQUIREMENT OF ALL EMPLOYER MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS TO USE CONTRACTS WITH PROVIDERS.—For plan year 2011 and subsequent plan years, in the case of a Medicare Advantage private fee-for-service plan that is described in paragraph (1) or (2) of section 1857(i), the plan shall meet the access standards under paragraph (4) only through entering into written contracts as provided for under subparagraph (B) of such paragraph and not, in whole or in part, through the establishment of payment rates meeting the requirements under subparagraph (A) of such paragraph.

(e) QUALITY IMPROVEMENT PROGRAM.—

(1) IN GENERAL.—Each MA organization shall have an ongoing quality improvement program for the purpose of improving the quality of care provided to enrollees in each MA plan offered by such organization.

(2) CHRONIC CARE IMPROVEMENT PROGRAMS.—As part of the quality improvement program under paragraph (1), each MA organization shall have a chronic care improvement program. Each chronic care improvement program shall have a method for monitoring and identifying enrollees with multiple or sufficiently severe chronic conditions that meet criteria established by the organization for participation under the program.

(3) DATA.—

(A) COLLECTION, ANALYSIS, AND REPORTING.—

(i) IN GENERAL.—Except as provided in clauses (ii) and (iii) with respect to plans described in such clauses and subject to subparagraph (B), as part of the quality improvement program under paragraph (1), each MA organization shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality. With respect to MA private fee-for-service plans and MSA plans, the requirements under the preceding sentence may not exceed the requirements under this

subparagraph with respect to MA local plans that are preferred provider organization plans, except that, for plan year 2010, the limitation under clause (iii) shall not apply and such requirements shall apply only with respect to administrative claims data.

(ii) SPECIAL REQUIREMENTS FOR SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—In addition to the data required to be collected, analyzed, and reported under clause (i) and notwithstanding the limitations under subparagraph (B), as part of the quality improvement program under paragraph (1), each MA organization offering a specialized Medicare Advantage plan for special needs individuals shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality with respect to the requirements described in paragraphs (2) through (5) of subsection (f). Such data may be based on claims data and shall be at the plan level.

(iii) APPLICATION TO LOCAL PREFERRED PROVIDER ORGANIZATIONS AND MA REGIONAL PLANS.—Clause (i) shall apply to MA organizations with respect to MA local plans that are preferred provider organization plans and to MA regional plans only insofar as services are furnished by providers or services, physicians, and other health care practitioners and suppliers that have contracts with such organization to furnish services under such plans.

(iv) DEFINITION OF PREFERRED PROVIDER ORGANIZATION PLAN.—In this subparagraph, the term “preferred provider organization plan” means an MA plan that—

(I) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

(II) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

(III) is offered by an organization that is not licensed or organized under State law as a health maintenance organization.

(B) LIMITATIONS.—

(i) TYPES OF DATA.—The Secretary shall not collect under subparagraph (A) data on quality, outcomes, and beneficiary satisfaction to facilitate consumer choice and program administration other than the types of data that were collected by the Secretary as of November 1, 2003.

(ii) CHANGES IN TYPES OF DATA.—Subject to subclause (iii), the Secretary may only change the types of data that are required to be submitted under subparagraph (A) after submitting to Congress a report on the reasons for such changes that was prepared in consultation with MA organizations and private accrediting bodies.

(iii) CONSTRUCTION.—Nothing in the subsection shall be construed as restricting the ability of the Secretary to carry out the duties under section 1851(d)(4)(D).

(4) TREATMENT OF ACCREDITATION.—

(A) IN GENERAL.—The Secretary shall provide that a Medicare+Choice organization is deemed to meet all the requirements described in any specific clause of subparagraph (B) if the organization is accredited (and periodically reaccredited) by a private accrediting organization under a process that the Secretary has determined assures that the accrediting organization applies and enforces standards that meet or exceed the standards established under section 1856 to carry out the requirements in such clause.

(B) REQUIREMENTS DESCRIBED.—The provisions described in this subparagraph are the following:

(i) Paragraphs (1) through (3) of this subsection (relating to quality improvement programs).

(ii) Subsection (b) (relating to antidiscrimination).

(iii) Subsection (d) (relating to access to services).

(iv) Subsection (h) (relating to confidentiality and accuracy of enrollee records).

(v) Subsection (i) (relating to information on advance directives).

(vi) Subsection (j) (relating to provider participation rules).

(vii) The requirements described in section 1860D-4(j), to the extent such requirements apply under section 1860D-21(c).

(C) TIMELY ACTION ON APPLICATIONS.—The Secretary shall determine, within 210 days after the date the Secretary receives an application by a private accrediting organization and using the criteria specified in section 1865(a)(2), whether the process of the private accrediting organization meets the requirements with respect to any specific clause in subparagraph (B) with respect to which the application is made. The Secretary may not deny such an application on the basis that it seeks to meet the requirements with respect to only one, or more than one, such specific clause.

(D) CONSTRUCTION.—Nothing in this paragraph shall be construed as limiting the authority of the Secretary under section 1857, including the authority to terminate contracts with Medicare+Choice organizations under subsection (c)(2) of such section.

(f) GRIEVANCE MECHANISM.—Each Medicare+Choice organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and enrollees with Medicare+Choice plans of the organization under this part.

(g) COVERAGE DETERMINATIONS, RECONSIDERATIONS, AND APPEALS.—

(1) DETERMINATIONS BY ORGANIZATION.—

(A) IN GENERAL.—A Medicare+Choice organization shall have a procedure for making determinations regarding whether an individual enrolled with the plan of the organization under this part is entitled to receive a health service under this section and the amount (if any) that the individual is required to pay with respect to such service. Subject to paragraph (3), such procedures shall provide for such determination to be made on a timely basis.

(B) EXPLANATION OF DETERMINATION.—Such a determination that denies coverage, in whole or in part, shall be in writing and shall include a statement in understandable language of the reasons for the denial and a description of the reconsideration and appeals processes.

(2) RECONSIDERATIONS.—

(A) IN GENERAL.—The organization shall provide for reconsideration of a determination described in paragraph (1)(B) upon request by the enrollee involved. The reconsideration shall be within a time period specified by the Secretary, but shall be made, subject to paragraph (3), not later than 60 days after the date of the receipt of the request for reconsideration.

(B) PHYSICIAN DECISION ON CERTAIN RECONSIDERATIONS.—A reconsideration relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician with appropriate expertise in the field of medicine which necessitates treatment who is other than a physician involved in the initial determination.

(3) EXPEDITED DETERMINATIONS AND RECONSIDERATIONS.—

(A) RECEIPT OF REQUESTS.—

(i) ENROLLEE REQUESTS.—An enrollee in a Medicare+Choice plan may request, either in writing or orally, an expedited determination under paragraph (1) or an expedited reconsideration under paragraph (2) by the Medicare+Choice organization.

(ii) PHYSICIAN REQUESTS.—A physician, regardless whether the physician is affiliated with the organization or not, may request, either in writing or orally, such an expedited determination or reconsideration.

(B) ORGANIZATION PROCEDURES.—

(i) IN GENERAL.—The Medicare+Choice organization shall maintain procedures for expediting organization determinations and reconsiderations when, upon request of an enrollee, the organization determines that the application of the normal time frame for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(ii) EXPEDITION REQUIRED FOR PHYSICIAN REQUESTS.—In the case of a request for an expedited determination or reconsideration made under subparagraph (A)(ii), the organization shall expedite the determination or reconsideration if the request indicates that the application of the normal time frame for mak-

ing a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(iii) **TIMELY RESPONSE.**—In cases described in clauses (i) and (ii), the organization shall notify the enrollee (and the physician involved, as appropriate) of the determination or reconsideration under time limitations established by the Secretary, but not later than 72 hours of the time of receipt of the request for the determination or reconsideration (or receipt of the information necessary to make the determination or reconsideration), or such longer period as the Secretary may permit in specified cases.

(4) **INDEPENDENT REVIEW OF CERTAIN COVERAGE DENIALS.**—The Secretary shall contract with an independent, outside entity to review and resolve in a timely manner reconsiderations that affirm denial of coverage, in whole or in part. The provisions of section 1869(c)(5) shall apply to independent outside entities under contract with the Secretary under this paragraph.

(5) **APPEALS.**—An enrollee with a Medicare+Choice plan of a Medicare+Choice organization under this part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is \$100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is \$1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the organization shall be entitled to be parties to that judicial review. In applying subsections (b) and (g) of section 205 as provided in this paragraph, and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively. The provisions of section 1869(b)(1)(E)(iii) shall apply with respect to dollar amounts specified in the first 2 sentences of this paragraph in the same manner as they apply to the dollar amounts specified in section 1869(b)(1)(E)(i).

(h) **CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.**—Insofar as a Medicare+Choice organization maintains medical records or other health information regarding enrollees under this part, the Medicare+Choice organization shall establish procedures—

(1) to safeguard the privacy of any individually identifiable enrollee information;

(2) to maintain such records and information in a manner that is accurate and timely; and

(3) to assure timely access of enrollees to such records and information.

(i) INFORMATION ON ADVANCE DIRECTIVES.—Each Medicare+Choice organization shall meet the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

(j) RULES REGARDING PROVIDER PARTICIPATION.—

(1) PROCEDURES.—Insofar as a Medicare+Choice organization offers benefits under a Medicare+Choice plan through agreements with physicians, the organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under such a plan. Such procedures shall include—

(A) providing notice of the rules regarding participation,

(B) providing written notice of participation decisions that are adverse to physicians, and

(C) providing a process within the organization for appealing such adverse decisions, including the presentation of information and views of the physician regarding such decision.

(2) CONSULTATION IN MEDICAL POLICIES.—A Medicare+Choice organization shall consult with physicians who have entered into participation agreements with the organization regarding the organization's medical policy, quality, and medical management procedures.

(3) PROHIBITING INTERFERENCE WITH PROVIDER ADVICE TO ENROLLEES.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), a Medicare+Choice organization (in relation to an individual enrolled under a Medicare+Choice plan offered by the organization under this part) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

(B) CONSCIENCE PROTECTION.—Subparagraph (A) shall not be construed as requiring a Medicare+Choice plan to provide, reimburse for, or provide coverage of a counseling or referral service if the Medicare+Choice organization offering the plan—

(i) objects to the provision of such service on moral or religious grounds; and

(ii) in the manner and through the written instrumentalities such Medicare+Choice organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization or plan adopts a change in policy regarding such a counseling or referral service.

(C) CONSTRUCTION.—Nothing in subparagraph (B) shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

(D) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this paragraph, the term “health care professional” means a physician (as defined in section 1861(r)) or other health care professional if coverage for the professional’s services is provided under the Medicare+Choice plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

(4) LIMITATIONS ON PHYSICIAN INCENTIVE PLANS.—

(A) IN GENERAL.—No Medicare+Choice organization may operate any physician incentive plan (as defined in subparagraph (B)) unless the organization provides assurances satisfactory to the Secretary that the following requirements are met:

(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or group.

(B) PHYSICIAN INCENTIVE PLAN DEFINED.—In this paragraph, the term “physician incentive plan” means any compensation arrangement between a Medicare+Choice organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization under this part.

(5) LIMITATION ON PROVIDER INDEMNIFICATION.—A Medicare+Choice organization may not provide (directly or indirectly) for a health care professional, provider of services, or other entity providing health care services (or group of such professionals, providers, or entities) to indemnify the organization against any liability resulting from a civil action brought for any damage caused to an enrollee with a Medicare+Choice

plan of the organization under this part by the organization's denial of medically necessary care.

(6) SPECIAL RULES FOR MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLANS.—For purposes of applying this part (including subsection (k)(1)) and section 1866(a)(1)(O), a hospital (or other provider of services), a physician or other health care professional, or other entity furnishing health care services is treated as having an agreement or contract in effect with a Medicare+Choice organization (with respect to an individual enrolled in a Medicare+Choice private fee-for-service plan it offers), if—

(A) the provider, professional, or other entity furnishes services that are covered under the plan to such an enrollee; and

(B) before providing such services, the provider, professional, or other entity —

(i) has been informed of the individual's enrollment under the plan, and

(ii) either—

(I) has been informed of the terms and conditions of payment for such services under the plan, or

(II) is given a reasonable opportunity to obtain information concerning such terms and conditions, in a manner reasonably designed to effect informed agreement by a provider.

The previous sentence shall only apply in the absence of an explicit agreement between such a provider, professional, or other entity and the Medicare+Choice organization.

(7) PROMOTION OF E-PRESCRIBING BY MA PLANS.—

(A) IN GENERAL.—An MA-PD plan may provide for a separate payment or otherwise provide for a differential payment for a participating physician that prescribes covered part D drugs in accordance with an electronic prescription drug program that meets standards established under section 1860D-4(e).

(B) CONSIDERATIONS.—Such payment may take into consideration the costs of the physician in implementing such a program and may also be increased for those participating physicians who significantly increase—

(i) formulary compliance;

(ii) lower cost, therapeutically equivalent alternatives;

(iii) reductions in adverse drug interactions; and

(iv) efficiencies in filing prescriptions through reduced administrative costs.

(C) STRUCTURE.—Additional or increased payments under this subsection may be structured in the same manner as medication therapy management fees are structured under section 1860D-4(c)(2)(E).

(k) TREATMENT OF SERVICES FURNISHED BY CERTAIN PROVIDERS.—

(1) IN GENERAL.—Except as provided in paragraph (2), a physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for

services furnished to an individual enrolled under this part with a Medicare+Choice organization described in section 1851(a)(2)(A) or with an organization offering an MSA plan shall accept as payment in full for covered services under this title that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but not enrolled with a Medicare+Choice organization under this part) also applies with respect to an individual so enrolled.

(2) APPLICATION TO MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLANS.—

(A) BALANCE BILLING LIMITS UNDER MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLANS IN CASE OF CONTRACT PROVIDERS.—

(i) IN GENERAL.—In the case of an individual enrolled in a Medicare+Choice private fee-for-service plan under this part, a physician, provider of services, or other entity that has a contract (including through the operation of subsection (j)(6)) establishing a payment rate for services furnished to the enrollee shall accept as payment in full for covered services under this title that are furnished to such an individual an amount not to exceed (including any deductibles, coinsurance, copayments, or balance billing otherwise permitted under the plan) an amount equal to 115 percent of such payment rate.

(ii) PROCEDURES TO ENFORCE LIMITS.—The Medicare+Choice organization that offers such a plan shall establish procedures, similar to the procedures described in section 1848(g)(1)(A), in order to carry out the previous sentence.

(iii) ASSURING ENFORCEMENT.—If the Medicare+Choice organization fails to establish and enforce procedures required under clause (ii), the organization is subject to intermediate sanctions under section 1857(g).

(B) ENROLLEE LIABILITY FOR NONCONTRACT PROVIDERS.—
For provision—

(i) establishing minimum payment rate in the case of noncontract providers under a Medicare+Choice private fee-for-service plan, see section 1852(a)(2); or

(ii) limiting enrollee liability in the case of covered services furnished by such providers, see paragraph (1) and section 1866(a)(1)(O).

(C) INFORMATION ON BENEFICIARY LIABILITY.—

(i) IN GENERAL.—Each Medicare+Choice organization that offers a Medicare+Choice private fee-for-service plan shall provide that enrollees under the plan who are furnished services for which payment is sought under the plan are provided an appropriate explanation of benefits (consistent with that provided under parts A and B and, if applicable, under medicare supplemental policies) that includes a clear state-

ment of the amount of the enrollee's liability (including any liability for balance billing consistent with this subsection) with respect to payments for such services.

(ii) ADVANCE NOTICE BEFORE RECEIPT OF INPATIENT HOSPITAL SERVICES AND CERTAIN OTHER SERVICES.—In addition, such organization shall, in its terms and conditions of payments to hospitals for inpatient hospital services and for other services identified by the Secretary for which the amount of the balance billing under subparagraph (A) could be substantial, require the hospital to provide to the enrollee, before furnishing such services and if the hospital imposes balance billing under subparagraph (A)—

(I) notice of the fact that balance billing is permitted under such subparagraph for such services, and

(II) a good faith estimate of the likely amount of such balance billing (if any), with respect to such services, based upon the presenting condition of the enrollee.

(1) RETURN TO HOME SKILLED NURSING FACILITIES FOR COVERED POST-HOSPITAL EXTENDED CARE SERVICES.—

(1) ENSURING RETURN TO HOME SNF.—

(A) IN GENERAL.—In providing coverage of post-hospital extended care services, a Medicare+Choice plan shall provide for such coverage through a home skilled nursing facility if the following conditions are met:

(i) ENROLLEE ELECTION.—The enrollee elects to receive such coverage through such facility.

(ii) SNF AGREEMENT.—The facility has a contract with the Medicare+Choice organization for the provision of such services, or the facility agrees to accept substantially similar payment under the same terms and conditions that apply to similarly situated skilled nursing facilities that are under contract with the Medicare+Choice organization for the provision of such services and through which the enrollee would otherwise receive such services.

(B) MANNER OF PAYMENT TO HOME SNF.—The organization shall provide payment to the home skilled nursing facility consistent with the contract or the agreement described in subparagraph (A)(ii), as the case may be.

(2) NO LESS FAVORABLE COVERAGE.—The coverage provided under paragraph (1) (including scope of services, cost-sharing, and other criteria of coverage) shall be no less favorable to the enrollee than the coverage that would be provided to the enrollee with respect to a skilled nursing facility the post-hospital extended care services of which are otherwise covered under the Medicare+Choice plan.

(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to do the following:

(A) To require coverage through a skilled nursing facility that is not otherwise qualified to provide benefits under part A for medicare beneficiaries not enrolled in a Medicare+Choice plan.

(B) To prevent a skilled nursing facility from refusing to accept, or imposing conditions upon the acceptance of, an enrollee for the receipt of post-hospital extended care services.

(4) DEFINITIONS.—In this subsection:

(A) HOME SKILLED NURSING FACILITY.—The term “home skilled nursing facility” means, with respect to an enrollee who is entitled to receive post-hospital extended care services under a Medicare+Choice plan, any of the following skilled nursing facilities:

(i) SNF RESIDENCE AT TIME OF ADMISSION.—The skilled nursing facility in which the enrollee resided at the time of admission to the hospital preceding the receipt of such post-hospital extended care services.

(ii) SNF IN CONTINUING CARE RETIREMENT COMMUNITY.—A skilled nursing facility that is providing such services through a continuing care retirement community (as defined in subparagraph (B)) which provided residence to the enrollee at the time of such admission.

(iii) SNF RESIDENCE OF SPOUSE AT TIME OF DISCHARGE.—The skilled nursing facility in which the spouse of the enrollee is residing at the time of discharge from such hospital.

(B) CONTINUING CARE RETIREMENT COMMUNITY.—The term “continuing care retirement community” means, with respect to an enrollee in a Medicare+Choice plan, an arrangement under which housing and health-related services are provided (or arranged) through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period.

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 ad-

justment 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 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 (or, in 2017 and each subsequent year, at least 60 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 (in 2017 and each subsequent year, of no less than 30 days) 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 serv-

ices, 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 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 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 appro-

priate (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 (ex-

pressed 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)(B)) 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)(B)) 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, for 2019 and subsequent years, the exclusion of payments for organ acquisitions for kidney transplants from the capitation rate as described in subsection (k)(5); 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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DEFINITIONS; MISCELLANEOUS PROVISIONS

SEC. 1859. (a) DEFINITIONS RELATING TO MEDICARE+CHOICE ORGANIZATIONS.—In this part—

(1) MEDICARE+CHOICE ORGANIZATION.—The term “Medicare+Choice organization” means a public or private entity that is certified under section 1856 as meeting the requirements and standards of this part for such an organization.

(2) PROVIDER-SPONSORED ORGANIZATION.—The term “provider-sponsored organization” is defined in section 1855(d)(1).

(b) DEFINITIONS RELATING TO MEDICARE+CHOICE PLANS.—

(1) MEDICARE+CHOICE PLAN.—The term “Medicare+Choice plan” means health benefits coverage offered under a policy, contract, or plan by a Medicare+Choice organization pursuant to and in accordance with a contract under section 1857.

(2) MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLAN.—The term “Medicare+Choice private fee-for-service plan” means a Medicare+Choice plan that—

(A) reimburses hospitals, physicians, and other providers at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk;

(B) does not vary such rates for such a provider based on utilization relating to such provider; and

(C) does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established by the plan.

Nothing in subparagraph (B) shall be construed to preclude a plan from varying rates for such a provider based on the specialty of the provider, the location of the provider, or other factors related to such provider that are not related to utilization, or to preclude a plan from increasing rates for such a provider based on increased utilization of specified preventive or screening services.

(3) MSA PLAN.—

(A) IN GENERAL.—The term “MSA plan” means a Medicare+Choice plan that—

(i) provides reimbursement for at least the items and services described in section 1852(a)(1) in a year but only after the enrollee incurs countable expenses (as specified under the plan) equal to the amount of an annual deductible (described in subparagraph (B));

(ii) counts as such expenses (for purposes of such deductible) at least all amounts that would have been payable under parts A and B, and that would have been payable by the enrollee as deductibles, coinsurance, or copayments, if the enrollee had elected to receive benefits through the provisions of such parts; and

(iii) provides, after such deductible is met for a year and for all subsequent expenses for items and services referred to in clause (i) in the year, for a level of reimbursement that is not less than—

(I) 100 percent of such expenses, or

(II) 100 percent of the amounts that would have been paid (without regard to any deductibles or coinsurance) under parts A and B with respect to such expenses,

whichever is less.

(B) DEDUCTIBLE.—The amount of annual deductible under an MSA plan—

(i) for contract year 1999 shall be not more than \$6,000; and

(ii) for a subsequent contract year shall be not more than the maximum amount of such deductible for the previous contract year under this subparagraph increased by the national per capita Medicare+Choice growth percentage under section 1853(c)(6) for the year.

If the amount of the deductible under clause (ii) is not a multiple of \$50, the amount shall be rounded to the nearest multiple of \$50.

(4) MA REGIONAL PLAN.—The term “MA regional plan” means an MA plan described in section 1851(a)(2)(A)(i)—

(A) that has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

(B) that provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

(C) the service area of which is one or more entire MA regions.

(5) MA LOCAL PLAN.—The term “MA local plan” means an MA plan that is not an MA regional plan.

(6) SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—

(A) IN GENERAL.—The term “specialized MA plan for special needs individuals” means an MA plan that exclusively serves special needs individuals (as defined in subparagraph (B)) and that, as of January 1, 2010, meets the applicable requirements of paragraph (2), (3), or (4) of subsection (f), as the case may be.

(B) SPECIAL NEEDS INDIVIDUAL.—The term “special needs individual” means an MA eligible individual who—

(i) is institutionalized (as defined by the Secretary);

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

(iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized MA plan described in subparagraph (A) for individuals with severe or disabling chronic conditions who have one or more comorbid and medically complex chronic conditions that are substantially disabling or life threatening, have a high risk of hospitalization or

other significant adverse health outcomes, and require specialized delivery systems across domains of care.

The Secretary may waive application of section 1851(a)(3)(B) in the case of an individual described in clause (i), (ii), or (iii) of this subparagraph and may apply rules similar to the rules of section 1894(c)(4) for continued eligibility of special needs individuals.

(c) OTHER REFERENCES TO OTHER TERMS.—

(1) MEDICARE+CHOICE ELIGIBLE INDIVIDUAL.—The term “Medicare+Choice eligible individual” is defined in section 1851(a)(3).

(2) MEDICARE+CHOICE PAYMENT AREA.—The term “Medicare+Choice payment area” is defined in section 1853(d).

(3) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE.—The “national per capita Medicare+Choice growth percentage” is defined in section 1853(c)(6).

(4) MEDICARE+CHOICE MONTHLY BASIC BENEFICIARY PREMIUM; MEDICARE+CHOICE MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The terms “Medicare+Choice monthly basic beneficiary premium” and “Medicare+Choice monthly supplemental beneficiary premium” are defined in section 1854(a)(2).

(5) MA LOCAL AREA.—The term “MA local area” is defined in section 1853(d)(2).

(d) COORDINATED ACUTE AND LONG-TERM CARE BENEFITS UNDER A MEDICARE+CHOICE PLAN.—Nothing in this part shall be construed as preventing a State from coordinating benefits under a medicaid plan under title XIX with those provided under a Medicare+Choice plan in a manner that assures continuity of a full-range of acute care and long-term care services to poor elderly or disabled individuals eligible for benefits under this title and under such plan.

(e) RESTRICTION ON ENROLLMENT FOR CERTAIN MEDICARE+CHOICE PLANS.—

(1) IN GENERAL.—In the case of a Medicare+Choice religious fraternal benefit society plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the society offering the plan may restrict the enrollment of individuals under this part to individuals who are members of the church, convention, or group described in paragraph (3)(B) with which the society is affiliated.

(2) MEDICARE+CHOICE RELIGIOUS FRATERNAL BENEFIT SOCIETY PLAN DESCRIBED.—For purposes of this subsection, a Medicare+Choice religious fraternal benefit society plan described in this paragraph is a Medicare+Choice plan described in section 1851(a)(2) that—

(A) is offered by a religious fraternal benefit society described in paragraph (3) only to members of the church, convention, or group described in paragraph (3)(B); and

(B) permits all such members to enroll under the plan without regard to health status-related factors.

Nothing in this subsection shall be construed as waiving any plan requirements relating to financial solvency.

(3) RELIGIOUS FRATERNAL BENEFIT SOCIETY DEFINED.—For purposes of paragraph (2)(A), a “religious fraternal benefit society” described in this section is an organization that—

(A) is described in section 501(c)(8) of the Internal Revenue Code of 1986 and is exempt from taxation under section 501(a) of such Act;

(B) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches;

(C) offers, in addition to a Medicare+Choice religious fraternal benefit society plan, health coverage to individuals not entitled to benefits under this title who are members of such church, convention, or group; and

(D) does not impose any limitation on membership in the society based on any health status-related factor.

(4) PAYMENT ADJUSTMENT.—Under regulations of the Secretary, in the case of individuals enrolled under this part under a Medicare+Choice religious fraternal benefit society plan described in paragraph (2), the Secretary shall provide for such adjustment to the payment amounts otherwise established under section 1854 as may be appropriate to assure an appropriate payment level, taking into account the actuarial characteristics and experience of such individuals.

(f) REQUIREMENTS REGARDING ENROLLMENT IN SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—

(1) REQUIREMENTS FOR ENROLLMENT.—In the case of a specialized MA plan for special needs individuals (as defined in subsection (b)(6)), notwithstanding any other provision of this part and in accordance with regulations of the Secretary and for periods before January 1, 2019, the plan may restrict the enrollment of individuals under the plan to individuals who are within one or more classes of special needs individuals.

(2) ADDITIONAL REQUIREMENTS FOR INSTITUTIONAL SNPS.—In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(i), the applicable requirements described in this paragraph are as follows:

(A) Each individual that enrolls in the plan on or after January 1, 2010, is a special needs individuals described in subsection (b)(6)(B)(i). In the case of an individual who is living in the community but requires an institutional level of care, such individual shall not be considered a special needs individual described in subsection (b)(6)(B)(i) unless the determination that the individual requires an institutional level of care was made—

(i) using a State assessment tool of the State in which the individual resides; and

(ii) by an entity other than the organization offering the plan.

(B) The plan meets the requirements described in paragraph (5).

(C) If applicable, the plan meets the requirement described in paragraph (7).

(3) ADDITIONAL REQUIREMENTS FOR DUAL SNPS.—In the case of a specialized MA plan for special needs individuals described

in subsection (b)(6)(B)(ii), the applicable requirements described in this paragraph are as follows:

(A) Each individual that enrolls in the plan on or after January 1, 2010, is a special needs individual described in subsection (b)(6)(B)(ii).

(B) The plan meets the requirements described in paragraph (5).

(C) The plan provides each prospective enrollee, prior to enrollment, with a comprehensive written statement (using standardized content and format established by the Secretary) that describes—

(i) the benefits and cost-sharing protections that the individual is entitled to under the State Medicaid program under title XIX; and

(ii) which of such benefits and cost-sharing protections are covered under the plan.

Such statement shall be included with any description of benefits offered by the plan.

(D) The plan has a contract with the State Medicaid agency to provide benefits, or arrange for benefits to be provided, for which such individual is entitled to receive as medical assistance under title XIX. Such benefits may include long-term care services consistent with State policy.

(E) If applicable, the plan meets the requirement described in paragraph (7).

(4) **ADDITIONAL REQUIREMENTS FOR SEVERE OR DISABLING CHRONIC CONDITION SNPS.**—In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(iii), the applicable requirements described in this paragraph are as follows:

(A) Each individual that enrolls in the plan on or after January 1, 2010, is a special needs individual described in subsection (b)(6)(B)(iii).

(B) The plan meets the requirements described in paragraph (5).

(C) If applicable, the plan meets the requirement described in paragraph (7).

(5) **CARE MANAGEMENT REQUIREMENTS FOR ALL SNPS.**—The requirements described in this paragraph are that the organization offering a specialized MA plan for special needs individuals—

(A) have in place an evidenced-based model of care with appropriate networks of providers and specialists; and

(B) with respect to each individual enrolled in the plan—

(i) conduct an initial assessment and an annual reassessment of the individual's physical, psychosocial, and functional needs;

(ii) develop a plan, in consultation with the individual as feasible, that identifies goals and objectives, including measurable outcomes as well as specific services and benefits to be provided; and

(iii) use an interdisciplinary team in the management of care.

(6) **TRANSITION AND EXCEPTION REGARDING RESTRICTION ON ENROLLMENT.**—

(A) IN GENERAL.—Subject to subparagraph (C), the Secretary shall establish procedures for the transition of applicable individuals to—

- (i) a Medicare Advantage plan that is not a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); or
- (ii) the original medicare fee-for-service program under parts A and B.

(B) APPLICABLE INDIVIDUALS.—For purposes of clause (i), the term “applicable individual” means an individual who—

- (i) is enrolled under a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); and
- (ii) is not within the 1 or more of the classes of special needs individuals to which enrollment under the plan is restricted to.

(C) EXCEPTION.—The Secretary shall provide for an exception to the transition described in subparagraph (A) for a limited period of time for individuals enrolled under a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) who are no longer eligible for medical assistance under title XIX.

(D) TIMELINE FOR INITIAL TRANSITION.—The Secretary shall ensure that applicable individuals enrolled in a specialized MA plan for special needs individuals (as defined in subsection (b)(6)) prior to January 1, 2010, are transitioned to a plan or the program described in subparagraph (A) by not later than January 1, 2013.

(7) AUTHORITY TO REQUIRE SPECIAL NEEDS PLANS BE NCQA APPROVED.—For 2012 and subsequent years, the Secretary shall require that a Medicare Advantage organization offering a specialized MA plan for special needs individuals be approved by the National Committee for Quality Assurance (based on standards established by the Secretary).

(g) SPECIAL RULES FOR SENIOR HOUSING FACILITY PLANS.—

(1) IN GENERAL.—In the case of a Medicare Advantage senior housing facility plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the service area of such plan may be limited to a senior housing facility in a geographic area.

(2) MEDICARE ADVANTAGE SENIOR HOUSING FACILITY PLAN DESCRIBED.—For purposes of this subsection, a Medicare Advantage senior housing facility plan is a Medicare Advantage plan that—

(A) restricts enrollment of individuals under this part to individuals who reside in a continuing care retirement community (as defined in section 1852(l)(4)(B));

(B) provides primary care services onsite and has a ratio of accessible physicians to beneficiaries that the Secretary determines is adequate;

(C) provides transportation services for beneficiaries to specialty providers outside of the facility; and

(D) has participated (as of December 31, 2009) in a demonstration project established by the Secretary under which such a plan was offered for not less than 1 year.

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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):

CHANGES IN EXISTING LAW MADE 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 (new matter is printed in italics and 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

ELIGIBILITY, ELECTION, AND ENROLLMENT

SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS THROUGH MEDICARE+CHOICE PLANS.—

(1) IN GENERAL.—Subject to the provisions of this section, each Medicare+Choice eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits (other than qualified prescription drug benefits) under this title—

(A) through the original medicare fee-for-service program under parts A and B, or

(B) through enrollment in a Medicare+Choice plan under this part, and may elect qualified prescription drug coverage in accordance with section 1860D–1.

(2) TYPES OF MEDICARE+CHOICE PLANS THAT MAY BE AVAILABLE.—A Medicare+Choice plan may be any of the following types of plans of health insurance:

(A) COORDINATED CARE PLANS (INCLUDING REGIONAL PLANS).—

(i) IN GENERAL.—Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without point of service options), plans offered by provider-sponsored organizations (as defined in section

1855(d)), and regional or local preferred provider organization plans (including MA regional plans).

(ii) SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—Specialized MA plans for special needs individuals (as defined in section 1859(b)(6)) may be any type of coordinated care plan.

(B) COMBINATION OF MSA PLAN AND CONTRIBUTIONS TO MEDICARE+CHOICE MSA.—An MSA plan, as defined in section 1859(b)(3), and a contribution into a Medicare+Choice medical savings account (MSA).

(C) PRIVATE FEE-FOR-SERVICE PLANS.—A Medicare+Choice private fee-for-service plan, as defined in section 1859(b)(2).

(3) MEDICARE+CHOICE [ELIGIBLE INDIVIDUAL.—]

[(A) IN GENERAL.—In this title, subject to subparagraph (B),] *ELIGIBLE INDIVIDUAL.*—*In this title,* the term “Medicare+Choice eligible individual” means an individual who is entitled to benefits under part A and enrolled under part B.

[(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—Such term shall not include an individual medically determined to have end-stage renal disease, except that—

[(i) an individual who develops end-stage renal disease while enrolled in a Medicare+Choice plan may continue to be enrolled in that plan; and

[(ii) in the case of such an individual who is enrolled in a Medicare+Choice plan under clause (i) (or subsequently under this clause), if the enrollment is discontinued under circumstances described in subsection (e)(4)(A), then the individual will be treated as a “Medicare+Choice eligible individual” for purposes of electing to continue enrollment in another Medicare+Choice plan.

An individual who develops end-stage renal disease while enrolled in a reasonable cost reimbursement contract under section 1876(h) shall be treated as an MA eligible individual for purposes of applying the deemed enrollment under subsection (c)(4).]

(b) SPECIAL RULES.—

(1) RESIDENCE REQUIREMENT.—

(A) IN GENERAL.—Except as the Secretary may otherwise provide and except as provided in subparagraph (C), an individual is eligible to elect a Medicare+Choice plan offered by a Medicare+Choice organization only if the plan serves the geographic area in which the individual resides.

(B) CONTINUATION OF ENROLLMENT PERMITTED.—Pursuant to rules specified by the Secretary, the Secretary shall provide that an MA local plan may offer to all individuals residing in a geographic area the option to continue enrollment in the plan, notwithstanding that the individual no longer resides in the service area of the plan, so long as the plan provides that individuals exercising this option have, as part of the benefits under the original Medicare fee-for-service program option, reasonable access within that geographic area to the full range of basic benefits,

subject to reasonable cost sharing liability in obtaining such benefits.

(C) CONTINUATION OF ENROLLMENT PERMITTED WHERE SERVICE CHANGED.—Notwithstanding subparagraph (A) and in addition to subparagraph (B), if a Medicare+Choice organization eliminates from its service area a Medicare+Choice payment area that was previously within its service area, the organization may elect to offer individuals residing in all or portions of the affected area who would otherwise be ineligible to continue enrollment the option to continue enrollment in an MA local plan it offers so long as—

(i) the enrollee agrees to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively at facilities designated by the organization within the plan service area; and

(ii) there is no other Medicare+Choice plan offered in the area in which the enrollee resides at the time of the organization's election.

(2) SPECIAL RULE FOR CERTAIN INDIVIDUALS COVERED UNDER FEHBP OR ELIGIBLE FOR VETERANS OR MILITARY HEALTH BENEFITS, VETERANS.—

(A) FEHBP.—An individual who is enrolled in a health benefit plan under chapter 89 of title 5, United States Code, is not eligible to enroll in an MSA plan until such time as the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in such plans will not result in increased expenditures for the Federal Government for health benefit plans under such chapter.

(B) VA AND DOD.—The Secretary may apply rules similar to the rules described in subparagraph (A) in the case of individuals who are eligible for health care benefits under chapter 55 of title 10, United States Code, or under chapter 17 of title 38 of such Code.

(3) LIMITATION ON ELIGIBILITY OF QUALIFIED MEDICARE BENEFICIARIES AND OTHER MEDICAID BENEFICIARIES TO ENROLL IN AN MSA PLAN.—An individual who is a qualified medicare beneficiary (as defined in section 1905(p)(1)), a qualified disabled and working individual (described in section 1905(s)), an individual described in section 1902(a)(10)(E)(iii), or otherwise entitled to medicare cost-sharing under a State plan under title XIX is not eligible to enroll in an MSA plan.

(4) COVERAGE UNDER MSA PLANS.—

(A) IN GENERAL.—Under rules established by the Secretary, an individual is not eligible to enroll (or continue enrollment) in an MSA plan for a year unless the individual provides assurances satisfactory to the Secretary that the individual will reside in the United States for at least 183 days during the year.

(B) EVALUATION.—The Secretary shall regularly evaluate the impact of permitting enrollment in MSA plans under this part on selection (including adverse selection), use of

preventive care, access to care, and the financial status of the Trust Funds under this title.

(C) REPORTS.—The Secretary shall submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the evaluation being conducted under subparagraph (B).

(c) PROCESS FOR EXERCISING CHOICE.—

(1) IN GENERAL.—The Secretary shall establish a process through which elections described in subsection (a) are made and changed, including the form and manner in which such elections are made and changed. Subject to paragraph (4), such elections shall be made or changed only during coverage election periods specified under subsection (e) and shall become effective as provided in subsection (f).

(2) COORDINATION THROUGH MEDICARE+CHOICE ORGANIZATIONS.—

(A) ENROLLMENT.—Such process shall permit an individual who wishes to elect a Medicare+Choice plan offered by a Medicare+Choice organization to make such election through the filing of an appropriate election form with the organization.

(B) DISENROLLMENT.—Such process shall permit an individual, who has elected a Medicare+Choice plan offered by a Medicare+Choice organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

(3) DEFAULT.—

(A) INITIAL ELECTION.—

(i) IN GENERAL.—Subject to clause (ii), an individual who fails to make an election during an initial election period under subsection (e)(1) is deemed to have chosen the original medicare fee-for-service program option.

(ii) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary may establish procedures under which an individual who is enrolled in a health plan (other than Medicare+Choice plan) offered by a Medicare+Choice organization at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the Medicare+Choice plan offered by the organization (or, if the organization offers more than one such plan, such plan or plans as the Secretary identifies under such procedures).

(B) CONTINUING PERIODS.—An individual who has made (or is deemed to have made) an election under this section is considered to have continued to make such election until such time as—

(i) the individual changes the election under this section, or

(ii) the Medicare+Choice plan with respect to which such election is in effect is discontinued or, subject to subsection (b)(1)(B), no longer serves the area in which the individual resides.

(4) DEEMED ENROLLMENT RELATING TO CONVERTED REASONABLE COST REIMBURSEMENT CONTRACTS.—

(A) IN GENERAL.—On the first day of the annual, coordinated election period under subsection (e)(3) for plan years beginning on or after January 1, 2017, an MA eligible individual described in clause (i) or (ii) of subparagraph (B) is deemed, unless the individual elects otherwise, to have elected to receive benefits under this title through an applicable MA plan (and shall be enrolled in such plan) beginning with such plan year, if—

(i) the individual is enrolled in a reasonable cost reimbursement contract under section 1876(h) in the previous plan year;

(ii) such reasonable cost reimbursement contract was extended or renewed for the last reasonable cost reimbursement contract year of the contract (as described in subclause (I) of section 1876(h)(5)(C)(iv)) pursuant to such section;

(iii) the eligible organization that is offering such reasonable cost reimbursement contract provided the notice described in subclause (III) of such section that the contract was to be converted;

(iv) the applicable MA plan—

(I) is the plan that was converted from the reasonable cost reimbursement contract described in clause (iii);

(II) is offered by the same entity (or an organization affiliated with such entity that has a common ownership interest of control) that entered into such contract; and

(III) is offered in the service area where the individual resides;

(v) in the case of reasonable cost reimbursement contracts that provide coverage under parts A and B (and, to the extent the Secretary determines it to be feasible, contracts that provide only part B coverage), the difference between the estimated individual costs (as determined applicable by the Secretary) for the applicable MA plan and such costs for the predecessor cost plan does not exceed a threshold established by the Secretary; and

(vi) the applicable MA plan—

(I) provides coverage for enrollees transitioning from the converted reasonable cost reimbursement contract to such plan to maintain current providers of services and suppliers and course of treatment at the time of enrollment for a period of at least 90 days after enrollment; and

(II) during such period, pays such providers of services and suppliers for items and services furnished to the enrollee an amount that is not less than the amount of payment applicable for such items and services under the original Medicare fee-for-service program under parts A and B.

(B) MA ELIGIBLE INDIVIDUALS DESCRIBED.—

(i) **WITHOUT PRESCRIPTION DRUG COVERAGE.**—An MA eligible individual described in this clause, with respect to a plan year, is an MA eligible individual who is enrolled in a reasonable cost reimbursement contract under section 1876(h) in the previous plan year and who is not, for such previous plan year, enrolled in a prescription drug plan under part D, including coverage under section 1860D-22.

(ii) **WITH PRESCRIPTION DRUG COVERAGE.**—An MA eligible individual described in this clause, with respect to a plan year, is an MA eligible individual who is enrolled in a reasonable cost reimbursement contract under section 1876(h) in the previous plan year and who, for such previous plan year, is enrolled in a prescription drug plan under part D—

(I) through such contract; or

(II) through a prescription drug plan, if the sponsor of such plan is the same entity (or an organization affiliated with such entity) that entered into such contract.

(C) **APPLICABLE MA PLAN DEFINED.**—In this paragraph, the term “applicable MA plan” means, in the case of an individual described in—

(i) subparagraph (B)(i), an MA plan that is not an MA-PD plan; and

(ii) subparagraph (B)(ii), an MA-PD plan.

(D) **IDENTIFICATION AND NOTIFICATION OF DEEMED INDIVIDUALS.**—Not later than 45 days before the first day of the annual, coordinated election period under subsection (e)(3) for plan years beginning on or after January 1, 2017, the Secretary shall identify and notify the individuals who will be subject to deemed elections under subparagraph (A) on the first day of such period.

(d) **PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.**—

(1) **IN GENERAL.**—The Secretary shall provide for activities under this subsection to broadly disseminate information to medicare beneficiaries (and prospective medicare beneficiaries) on the coverage options provided under this section in order to promote an active, informed selection among such options.

(2) **PROVISION OF NOTICE.**—

(A) **OPEN SEASON NOTIFICATION.**—At least 15 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each Medicare+Choice eligible individual residing in an area the following:

(i) **GENERAL INFORMATION.**—The general information described in paragraph (3).

(ii) **LIST OF PLANS AND COMPARISON OF PLAN OPTIONS.**—A list identifying the Medicare+Choice plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans. Such information shall be presented in a comparative form.

(iii) **ADDITIONAL INFORMATION.**—Any other information that the Secretary determines will assist the indi-

vidual in making the election under this section, *including any additional information that individuals determined to have end-stage renal disease may need to make informed decisions with respect to such an election.*

The mailing of such information shall be coordinated, to the extent practicable, with the mailing of any annual notice under section 1804.

(B) NOTIFICATION TO NEWLY ELIGIBLE MEDICARE+CHOICE ELIGIBLE INDIVIDUALS.—To the extent practicable, the Secretary shall, not later than 30 days before the beginning of the initial Medicare+Choice enrollment period for an individual described in subsection (e)(1), mail to the individual the information described in subparagraph (A).

(ii) NOTIFICATION RELATED TO CERTAIN DEEMED ELECTIONS.—The Secretary shall require a Medicare Advantage organization that is offering a Medicare Advantage plan that has been converted from a reasonable cost reimbursement contract pursuant to section 1876(h)(5)(C)(iv) to mail, not later than 30 days prior to the first day of the annual, coordinated election period under subsection (e)(3) of a year, to any individual enrolled under such contract and identified by the Secretary under subsection (c)(4)(D) for such year—

(I) a notification that such individual will, on such day, be deemed to have made an election with respect to such plan to receive benefits under this title through an MA plan or MA–PD plan (and shall be enrolled in such plan) for the next plan year under subsection (c)(4)(A), but that the individual may make a different election during the annual, coordinated election period for such year;

(II) the information described in subparagraph (A);

(III) a description of the differences between such MA plan or MA–PD plan and the reasonable cost reimbursement contract in which the individual was most recently enrolled with respect to benefits covered under such plans, including cost-sharing, premiums, drug coverage, and provider networks;

(IV) information about the special period for elections under subsection (e)(2)(F); and

(V) other information the Secretary may specify.

(C) FORM.—The information disseminated under this paragraph shall be written and formatted using language that is easily understandable by medicare beneficiaries.

(D) PERIODIC UPDATING.—The information described in subparagraph (A) shall be updated on at least an annual basis to reflect changes in the availability of Medicare+Choice plans and the benefits and Medicare+Choice monthly basic and supplemental beneficiary premiums for such plans.

(3) GENERAL INFORMATION.—General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

(A) BENEFITS UNDER ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—A general description of the benefits covered under the original medicare fee-for-service program under parts A and B, including—

- (i) covered items and services,
- (ii) beneficiary cost sharing, such as deductibles, co-insurance, and copayment amounts, and
- (iii) any beneficiary liability for balance billing.

(B) ELECTION PROCEDURES.—Information and instructions on how to exercise election options under this section.

(C) RIGHTS.—A general description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program and the Medicare+Choice program and the right to be protected against discrimination based on health status-related factors under section 1852(b).

(D) INFORMATION ON MEDIGAP AND MEDICARE SELECT.—A general description of the benefits, enrollment rights, and other requirements applicable to medicare supplemental policies under section 1882 and provisions relating to medicare select policies described in section 1882(t).

(E) POTENTIAL FOR CONTRACT TERMINATION.—The fact that a Medicare+Choice organization may terminate its contract, refuse to renew its contract, or reduce the service area included in its contract, under this part, and the effect of such a termination, nonrenewal, or service area reduction may have on individuals enrolled with the Medicare+Choice plan under this part.

(F) CATASTROPHIC COVERAGE AND SINGLE DEDUCTIBLE.—In the case of an MA regional plan, a description of the catastrophic coverage and single deductible applicable under the plan.

(4) INFORMATION COMPARING PLAN OPTIONS.—Information under this paragraph, with respect to a Medicare+Choice plan for a year, shall include the following:

(A) BENEFITS.—The benefits covered under the plan, including the following:

(i) Covered items and services beyond those provided under the original medicare fee-for-service program.

(ii) Any beneficiary cost sharing, including information on the single deductible (if applicable) under section 1858(b)(1).

(iii) Any maximum limitations on out-of-pocket expenses.

(iv) In the case of an MSA plan, differences in cost sharing, premiums, and balance billing under such a plan compared to under other Medicare+Choice plans.

(v) In the case of a Medicare+Choice private fee-for-service plan, differences in cost sharing, premiums, and balance billing under such a plan compared to under other Medicare+Choice plans.

(vi) The extent to which an enrollee may obtain benefits through out-of-network health care providers.

(vii) The extent to which an enrollee may select among in-network providers and the types of providers participating in the plan's network.

(viii) The organization's coverage of emergency and urgently needed care.

(B) PREMIUMS.—

(i) IN GENERAL.—The monthly amount of the premium charged to an individual.

(ii) REDUCTIONS.—The reduction in part B premiums, if any.

(C) SERVICE AREA.—The service area of the plan.

(D) QUALITY AND PERFORMANCE.—To the extent available, plan quality and performance indicators for the benefits under the plan (and how they compare to such indicators under the original medicare fee-for-service program under parts A and B in the area involved), including—

(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for the previous 2 years (excluding disenrollment due to death or moving outside the plan's service area),

(ii) information on medicare enrollee satisfaction,

(iii) information on health outcomes, and

(iv) the recent record regarding compliance of the plan with requirements of this part (as determined by the Secretary).

(E) SUPPLEMENTAL BENEFITS.—Supplemental health care benefits, including any reductions in cost-sharing under section 1852(a)(3) and the terms and conditions (including premiums) for such benefits.

(5) MAINTAINING A TOLL-FREE NUMBER AND INTERNET SITE.—The Secretary shall maintain a toll-free number for inquiries regarding Medicare+Choice options and the operation of this part in all areas in which Medicare+Choice plans are offered and an Internet site through which individuals may electronically obtain information on such options and Medicare+Choice plans.

(6) USE OF NON-FEDERAL ENTITIES.—The Secretary may enter into contracts with non-Federal entities to carry out activities under this subsection.

(7) PROVISION OF INFORMATION.—A Medicare+Choice organization shall provide the Secretary with such information on the organization and each Medicare+Choice plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

(e) COVERAGE ELECTION PERIODS.—

(1) INITIAL CHOICE UPON ELIGIBILITY TO MAKE ELECTION IF MEDICARE+CHOICE PLANS AVAILABLE TO INDIVIDUAL.—If, at the time an individual first becomes entitled to benefits under part A and enrolled under part B, there is one or more Medicare+Choice plans offered in the area in which the individual resides, the individual shall make the election under this section during a period specified by the Secretary such that if the individual elects a Medicare+Choice plan during the

period, coverage under the plan becomes effective as of the first date on which the individual may receive such coverage. If any portion of an individual's initial enrollment period under part B occurs after the end of the annual, coordinated election period described in paragraph (3)(B)(iii), the initial enrollment period under this part shall further extend through the end of the individual's initial enrollment period under part B.

(2) OPEN ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—Subject to paragraph (5)—

(A) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT THROUGH 2005.—At any time during the period beginning January 1, 1998, and ending on December 31, 2005, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

(B) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 6 MONTHS DURING 2006.—

(i) IN GENERAL.—Subject to clause (ii), subparagraph(C)(iii), and subparagraph (D), at any time during the first 6 months of 2006, or, if the individual first becomes a Medicare+Choice eligible individual during 2006, during the first 6 months during 2006 in which the individual is a Medicare+Choice eligible individual, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

(ii) LIMITATION OF ONE CHANGE.—An individual may exercise the right under clause (i) only once. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under the first sentence of paragraph (4).

(C) ANNUAL 45-DAY PERIOD FOR DISENROLLMENT FROM MA PLANS TO ELECT TO RECEIVE BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—Subject to subparagraph (D), at any time during the first 45 days of a year (beginning with 2011), an individual who is enrolled in a Medicare Advantage plan may change the election under subsection (a)(1), but only with respect to coverage under the original medicare fee-for-service program under parts A and B, and may elect qualified prescription drug coverage in accordance with section 1860D-1.

(D) CONTINUOUS OPEN ENROLLMENT FOR INSTITUTIONALIZED INDIVIDUALS.—At any time after 2005 in the case of a Medicare+Choice eligible individual who is institutionalized (as defined by the Secretary), the individual may elect under subsection (a)(1)—

(i) to enroll in a Medicare+Choice plan; or
(ii) to change the Medicare+Choice plan in which the individual is enrolled.

(E) LIMITED CONTINUOUS OPEN ENROLLMENT OF ORIGINAL FEE-FOR-SERVICE ENROLLEES IN MEDICARE ADVANTAGE NON-PRESCRIPTION DRUG PLANS.—

(i) IN GENERAL.—On any date during the period beginning on January 1, 2007, and ending on July 31, 2007, on which a Medicare Advantage eligible indi-

vidual is an unenrolled fee-for-service individual (as defined in clause (ii)), the individual may elect under subsection (a)(1) to enroll in a Medicare Advantage plan that is not an MA–PD plan.

(ii) UNENROLLED FEE-FOR-SERVICE INDIVIDUAL DEFINED.—In this subparagraph, the term “unenrolled fee-for-service individual” means, with respect to a date, a Medicare Advantage eligible individual who—

(I) is receiving benefits under this title through enrollment in the original medicare fee-for-service program under parts A and B;

(II) is not enrolled in an MA plan on such date; and

(III) as of such date is not otherwise eligible to elect to enroll in an MA plan.

(iii) LIMITATION OF ONE CHANGE DURING THE APPLICABLE PERIOD.—An individual may exercise the right under clause (i) only once during the period described in such clause.

(iv) NO EFFECT ON COVERAGE UNDER A PRESCRIPTION DRUG PLAN.—Nothing in this subparagraph shall be construed as permitting an individual exercising the right under clause (i)—

(I) who is enrolled in a prescription drug plan under part D, to disenroll from such plan or to enroll in a different prescription drug plan; or

(II) who is not enrolled in a prescription drug plan, to enroll in such a plan.

(F) SPECIAL PERIOD FOR CERTAIN DEEMED ELECTIONS.—

(i) IN GENERAL.—At any time during the period beginning after the last day of the annual, coordinated election period under paragraph (3) in which an individual is deemed to have elected to enroll in an MA plan or MA–PD plan under subsection (c)(4) and ending on the last day of February of the first plan year for which the individual is enrolled in such plan, such individual may change the election under subsection (a)(1) (including changing the MA plan or MA–PD plan in which the individual is enrolled).

(ii) LIMITATION OF ONE CHANGE.—An individual may exercise the right under clause (i) only once during the applicable period described in such clause. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

(3) ANNUAL, COORDINATED ELECTION PERIOD.—

(A) IN GENERAL.—Subject to paragraph (5), each individual who is eligible to make an election under this section may change such election during an annual, coordinated election period.

(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term “annual, coordinated election period” means—

(i) with respect to a year before 2002, the month of November before such year;

(ii) with respect to 2002, 2003, 2004, and 2005, the period beginning on November 15 and ending on December 31 of the year before such year;

(iii) with respect to 2006, the period beginning on November 15, 2005, and ending on May 15, 2006;

(iv) with respect to 2007, 2008, 2009, and 2010, the period beginning on November 15 and ending on December 31 of the year before such year; and

(v) with respect to 2012 and succeeding years, the period beginning on October 15 and ending on December 7 of the year before such year.

(C) **MEDICARE+CHOICE HEALTH INFORMATION FAIRS.**—During the fall season of each year (beginning with 1999) and during the period described in subparagraph (B)(iii), in conjunction with the annual coordinated election period defined in subparagraph (B), the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform Medicare+Choice eligible individuals about Medicare+Choice plans and the election process provided under this section.

(D) **SPECIAL INFORMATION CAMPAIGNS.**—During November 1998 the Secretary shall provide for an educational and publicity campaign to inform Medicare+Choice eligible individuals about the availability of Medicare+Choice plans, and eligible organizations with risk-sharing contracts under section 1876, offered in different areas and the election process provided under this section. During the period described in subparagraph (B)(iii), the Secretary shall provide for an educational and publicity campaign to inform MA eligible individuals about the availability of MA plans (including MA–PD plans) offered in different areas and the election process provided under this section.

(4) **SPECIAL ELECTION PERIODS.**—Effective as of January 1, 2006, an individual may discontinue an election of a Medicare+Choice plan offered by a Medicare+Choice organization other than during an annual, coordinated election period and make a new election under this section if—

(A)(i) the certification of the organization or plan under this part has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or

(ii) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuation of such plan;

(B) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances (specified by the Secretary, but not including termination of the individual's enrollment on the basis described in clause (i) or (ii) of subsection (g)(3)(B));

(C) the individual demonstrates (in accordance with guidelines established by the Secretary) that—

(i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual (including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards); or

(ii) the organization (or an agent or other entity acting on the organization's behalf) materially misrepresented the plan's provisions in marketing the plan to the individual; or

(D) the individual meets such other exceptional conditions as the Secretary may provide.

Effective as of January 1, 2006, an individual who, upon first becoming eligible for benefits under part A at age 65, enrolls in a Medicare+Choice plan under this part, the individual may discontinue the election of such plan, and elect coverage under the original fee-for-service plan, at any time during the 12-month period beginning on the effective date of such enrollment.

(5) SPECIAL RULES FOR MSA PLANS.—Notwithstanding the preceding provisions of this subsection, an individual—

(A) may elect an MSA plan only during—

(i) an initial open enrollment period described in paragraph (1), or

(ii) an annual, coordinated election period described in paragraph (3)(B);

(B) subject to subparagraph (C), may not discontinue an election of an MSA plan except during the periods described in clause (ii) or (iii) of subparagraph (A) and under the first sentence of paragraph (4); and

(C) who elects an MSA plan during an annual, coordinated election period, and who never previously had elected such a plan, may revoke such election, in a manner determined by the Secretary, by not later than December 15 following the date of the election.

(6) OPEN ENROLLMENT PERIODS.—Subject to paragraph (5), a Medicare+Choice organization—

(A) shall accept elections or changes to elections during the initial enrollment periods described in paragraph (1), during the period described in paragraph (2)(F), during the month of November 1998 and during the annual, coordinated election period under paragraph (3) for each subsequent year, and during special election periods described in the first sentence of paragraph (4); and

(B) may accept other changes to elections at such other times as the organization provides.

(f) EFFECTIVENESS OF ELECTIONS AND CHANGES OF ELECTIONS.—

(1) DURING INITIAL COVERAGE ELECTION PERIOD.—An election of coverage made during the initial coverage election period under subsection (e)(1) shall take effect upon the date the individual becomes entitled to benefits under part A and enrolled under part B, except as the Secretary may pro-

vide (consistent with section 1838) in order to prevent retroactive coverage.

(2) DURING CONTINUOUS OPEN ENROLLMENT PERIODS.—An election or change of coverage made under subsection (e)(2) shall take effect with the first day of the first calendar month following the date on which the election or change is made.

(3) ANNUAL, COORDINATED ELECTION PERIOD.—An election or change of coverage made during an annual, coordinated election period (as defined in subsection (e)(3)(B), other than the period described in clause (iii) of such subsection) in a year shall take effect as of the first day of the following year.

(4) OTHER PERIODS.—An election or change of coverage made during any other period under subsection (e)(4) shall take effect in such manner as the Secretary provides in a manner consistent (to the extent practicable) with protecting continuity of health benefit coverage.

(g) GUARANTEED ISSUE AND RENEWAL.—

(1) IN GENERAL.—Except as provided in this subsection, a Medicare+Choice organization shall provide that at any time during which elections are accepted under this section with respect to a Medicare+Choice plan offered by the organization, the organization will accept without restrictions individuals who are eligible to make such election.

(2) PRIORITY.—If the Secretary determines that a Medicare+Choice organization, in relation to a Medicare+Choice plan it offers, has a capacity limit and the number of Medicare+Choice eligible individuals who elect the plan under this section exceeds the capacity limit, the organization may limit the election of individuals of the plan under this section but only if priority in election is provided—

(A) first to such individuals as have elected the plan at the time of the determination, and

(B) then to other such individuals in such a manner that does not discriminate, on a basis described in section 1852(b), among the individuals (who seek to elect the plan).

The preceding sentence shall not apply if it would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the medicare population in the service area of the plan.

(3) LIMITATION ON TERMINATION OF ELECTION.—

(A) IN GENERAL.—Subject to subparagraph (B), a Medicare+Choice organization may not for any reason terminate the election of any individual under this section for a Medicare+Choice plan it offers.

(B) BASIS FOR TERMINATION OF ELECTION.—A Medicare+Choice organization may terminate an individual's election under this section with respect to a Medicare+Choice plan it offers if—

(i) any Medicare+Choice monthly basic and supplemental beneficiary premiums required with respect to such plan are not paid on a timely basis (consistent with standards under section 1856 that provide for a grace period for late payment of such premiums),

(ii) the individual has engaged in disruptive behavior (as specified in such standards), or

(iii) the plan is terminated with respect to all individuals under this part in the area in which the individual resides.

(C) CONSEQUENCE OF TERMINATION.—

(i) TERMINATIONS FOR CAUSE.—Any individual whose election is terminated under clause (i) or (ii) of subparagraph (B) is deemed to have elected the original medicare fee-for-service program option described in subsection (a)(1)(A).

(ii) TERMINATION BASED ON PLAN TERMINATION OR SERVICE AREA REDUCTION.—Any individual whose election is terminated under subparagraph (B)(iii) shall have a special election period under subsection (e)(4)(A) in which to change coverage to coverage under another Medicare+Choice plan. Such an individual who fails to make an election during such period is deemed to have chosen to change coverage to the original medicare fee-for-service program option described in subsection (a)(1)(A).

(D) ORGANIZATION OBLIGATION WITH RESPECT TO ELECTION FORMS.—Pursuant to a contract under section 1857, each Medicare+Choice organization receiving an election form under subsection (c)(2) shall transmit to the Secretary (at such time and in such manner as the Secretary may specify) a copy of such form or such other information respecting the election as the Secretary may specify.

(h) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—

(1) SUBMISSION.—No marketing material or application form may be distributed by a Medicare+Choice organization to (or for the use of) Medicare+Choice eligible individuals unless—

(A) at least 45 days (or 10 days in the case described in paragraph (5)) before the date of distribution the organization has submitted the material or form to the Secretary for review, and

(B) the Secretary has not disapproved the distribution of such material or form.

(2) REVIEW.—The standards established under section 1856 shall include guidelines for the review of any material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.

(3) DEEMED APPROVAL (1-STOP SHOPPING).—In the case of material or form that is submitted under paragraph (1)(A) to the Secretary or a regional office of the Department of Health and Human Services and the Secretary or the office has not disapproved the distribution of marketing material or form under paragraph (1)(B) with respect to a Medicare+Choice plan in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the plan and organization except with regard to that portion of such material or form that is specific only to an area involved.

(4) PROHIBITION OF CERTAIN MARKETING PRACTICES.—Each Medicare+Choice organization shall conform to fair marketing standards, in relation to Medicare+Choice plans offered under this part, included in the standards established under section 1856. Such standards—

(A) shall not permit a Medicare+Choice organization to provide for, subject to subsection (j)(2)(C), cash, gifts, prizes, or other monetary rebates as an inducement for enrollment or otherwise;

(B) may include a prohibition against a Medicare+Choice organization (or agent of such an organization) completing any portion of any election form used to carry out elections under this section on behalf of any individual;

(C) shall not permit a Medicare Advantage organization (or the agents, brokers, and other third parties representing such organization) to conduct the prohibited activities described in subsection (j)(1); and

(D) shall only permit a Medicare Advantage organization (and the agents, brokers, and other third parties representing such organization) to conduct the activities described in subsection (j)(2) in accordance with the limitations established under such subsection.

(5) SPECIAL TREATMENT OF MARKETING MATERIAL FOLLOWING MODEL MARKETING LANGUAGE.—In the case of marketing material of an organization that uses, without modification, proposed model language specified by the Secretary, the period specified in paragraph (1)(A) shall be reduced from 45 days to 10 days.

(6) REQUIRED INCLUSION OF PLAN TYPE IN PLAN NAME.—For plan years beginning on or after January 1, 2010, a Medicare Advantage organization must ensure that the name of each Medicare Advantage plan offered by the Medicare Advantage organization includes the plan type of the plan (using standard terminology developed by the Secretary).

(7) STRENGTHENING THE ABILITY OF STATES TO ACT IN COLLABORATION WITH THE SECRETARY TO ADDRESS FRAUDULENT OR INAPPROPRIATE MARKETING PRACTICES.—

(A) APPOINTMENT OF AGENTS AND BROKERS.—Each Medicare Advantage organization shall—

(i) only use agents and brokers who have been licensed under State law to sell Medicare Advantage plans offered by the Medicare Advantage organization;

(ii) in the case where a State has a State appointment law, abide by such law; and

(iii) report to the applicable State the termination of any such agent or broker, including the reasons for such termination (as required under applicable State law).

(B) COMPLIANCE WITH STATE INFORMATION REQUESTS.—Each Medicare Advantage organization shall comply in a timely manner with any request by a State for information regarding the performance of a licensed agent, broker, or other third party representing the Medicare Advantage organization as part of an investigation by the State into the conduct of the agent, broker, or other third party.

(i) EFFECT OF ELECTION OF MEDICARE+CHOICE PLAN OPTION.—

(1) PAYMENTS TO ORGANIZATIONS.—Subject to sections 1852(a)(5), 1853(a)(4), 1853(g), 1853(h), 1886(d)(11), 1886(h)(3)(D), and 1853(m), payments under a contract with a Medicare+Choice organization under section 1853(a) with respect to an individual electing a Medicare+Choice plan offered by the organization shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A and B for items and services furnished to the individual.

(2) ONLY ORGANIZATION ENTITLED TO PAYMENT.—Subject to sections 1853(a)(4), 1853(e), 1853(g), 1853(h), 1857(f)(2), 1858(h), 1886(d)(11), and 1886(h)(3)(D), only the Medicare+Choice organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.

(3) FFS PAYMENT FOR EXPENSES FOR KIDNEY ACQUISITIONS.—*Paragraphs (1) and (2) do not apply with respect to expenses for organ acquisitions for kidney transplants described in section 1852(a)(1)(B)(i).*

(j) PROHIBITED ACTIVITIES DESCRIBED AND LIMITATIONS ON THE CONDUCT OF CERTAIN OTHER ACTIVITIES.—

(1) PROHIBITED ACTIVITIES DESCRIBED.—The following prohibited activities are described in this paragraph:

(A) UNSOLICITED MEANS OF DIRECT CONTACT.—Any unsolicited means of direct contact of prospective enrollees, including soliciting door-to-door or any outbound telemarketing without the prospective enrollee initiating contact.

(B) CROSS-SELLING.—The sale of other non-health related products (such as annuities and life insurance) during any sales or marketing activity or presentation conducted with respect to a Medicare Advantage plan.

(C) MEALS.—The provision of meals of any sort, regardless of value, to prospective enrollees at promotional and sales activities.

(D) SALES AND MARKETING IN HEALTH CARE SETTINGS AND AT EDUCATIONAL EVENTS.—Sales and marketing activities for the enrollment of individuals in Medicare Advantage plans that are conducted—

(i) in health care settings in areas where health care is delivered to individuals (such as physician offices and pharmacies), except in the case where such activities are conducted in common areas in health care settings; and

(ii) at educational events.

(2) LIMITATIONS.—The Secretary shall establish limitations with respect to at least the following:

(A) SCOPE OF MARKETING APPOINTMENTS.—The scope of any appointment with respect to the marketing of a Medicare Advantage plan. Such limitation shall require advance agreement with a prospective enrollee on the scope of the marketing appointment and documentation of such agreement by the Medicare Advantage organization. In the

case where the marketing appointment is in person, such documentation shall be in writing.

(B) CO-BRANDING.—The use of the name or logo of a co-branded network provider on Medicare Advantage plan membership and marketing materials.

(C) LIMITATION OF GIFTS TO NOMINAL DOLLAR VALUE.—The offering of gifts and other promotional items other than those that are of nominal value (as determined by the Secretary) to prospective enrollees at promotional activities.

(D) COMPENSATION.—The use of compensation other than as provided under guidelines established by the Secretary. Such guidelines shall ensure that the use of compensation creates incentives for agents and brokers to enroll individuals in the Medicare Advantage plan that is intended to best meet their health care needs.

(E) REQUIRED TRAINING, ANNUAL RETRAINING, AND TESTING OF AGENTS, BROKERS, AND OTHER THIRD PARTIES.—The use by a Medicare Advantage organization of any individual as an agent, broker, or other third party representing the organization that has not completed an initial training and testing program and does not complete an annual retraining and testing program.

BENEFITS AND BENEFICIARY PROTECTIONS

SEC. 1852. (a) BASIC BENEFITS.—

(1) REQUIREMENT.—

(A) IN GENERAL.—Except as provided in section 1859(b)(3) for MSA plans and except as provided in paragraph (6) for MA regional plans, each Medicare+Choice plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI, benefits under the original medicare fee-for-service program option (and, for plan years before 2006, additional benefits required under section 1854(f)(1)(A)).

(B) BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION DEFINED.—

(i) IN GENERAL.—For purposes of this part, the term “benefits under the original medicare fee-for-service program option” means those items and services (other than hospice care or coverage for organ acquisitions for kidney transplants, including as covered under section 1881(d)) for which benefits are available under parts A and B to individuals entitled to benefits under part A and enrolled under part B, with cost-sharing for those services as required under parts A and B or, subject to clause (iii), an actuarially equivalent level of cost-sharing as determined in this part.

(ii) SPECIAL RULE FOR REGIONAL PLANS.—In the case of an MA regional plan in determining an actuarially equivalent level of cost-sharing with respect to benefits under the original medicare fee-for-service program option, there shall only be taken into account, with respect to the application of section 1858(b)(2),

such expenses only with respect to subparagraph (A) of such section.

(iii) LIMITATION ON VARIATION OF COST SHARING FOR CERTAIN BENEFITS.—Subject to clause (v), cost-sharing for services described in clause (iv) shall not exceed the cost-sharing required for those services under parts A and B.

(iv) SERVICES DESCRIBED.—The following services are described in this clause:

(I) Chemotherapy administration services.

(II) Renal dialysis services (as defined in section 1881(b)(14)(B)).

(III) Skilled nursing care.

(IV) Such other services that the Secretary determines appropriate (including services that the Secretary determines require a high level of predictability and transparency for beneficiaries).

(v) EXCEPTION.—In the case of services described in clause (iv) for which there is no cost-sharing required under parts A and B, cost-sharing may be required for those services in accordance with clause (i).

(2) SATISFACTION OF REQUIREMENT.—

(A) IN GENERAL.—A Medicare+Choice plan (other than an MSA plan) offered by a Medicare+Choice organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider or other person that has a contract with the organization offering the plan, if the plan provides payment in an amount so that—

(i) the sum of such payment amount and any cost sharing provided for under the plan, is equal to at least

(ii) the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing permitted under such parts).

(B) REFERENCE TO RELATED PROVISIONS.—For provision relating to—

(i) limitations on balance billing against Medicare+Choice organizations for non-contract providers, see sections 1852(k) and 1866(a)(1)(O), and

(ii) limiting actuarial value of enrollee liability for covered benefits, see section 1854(e).

(C) ELECTION OF UNIFORM COVERAGE DETERMINATION.—

In the case of a Medicare+Choice organization that offers a Medicare+Choice plan in an area in which more than one local coverage determination is applied with respect to different parts of the area, the organization may elect to have the local coverage determination for the part of the area that is most beneficial to Medicare+Choice enrollees (as identified by the Secretary) apply with respect to all Medicare+Choice enrollees enrolled in the plan.

(3) SUPPLEMENTAL BENEFITS.—

(A) BENEFITS INCLUDED SUBJECT TO SECRETARY'S APPROVAL.—Each Medicare+Choice organization may provide

to individuals enrolled under this part, other than under an MSA plan (without affording those individuals an option to decline the coverage), supplemental health care benefits that the Secretary may approve. The Secretary shall approve any such supplemental benefits unless the Secretary determines that including such supplemental benefits would substantially discourage enrollment by Medicare+Choice eligible individuals with the organization.

(B) AT ENROLLEES' OPTION.—

(i) IN GENERAL.—Subject to clause (ii), a Medicare+Choice organization may provide to individuals enrolled under this part supplemental health care benefits that the individuals may elect, at their option, to have covered.

(ii) SPECIAL RULE FOR MSA PLANS.—A Medicare+Choice organization may not provide, under an MSA plan, supplemental health care benefits that cover the deductible described in section 1859(b)(2)(B). In applying the previous sentence, health benefits described in section 1882(u)(2)(B) shall not be treated as covering such deductible.

(C) APPLICATION TO MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLANS.—Nothing in this paragraph shall be construed as preventing a Medicare+Choice private fee-for-service plan from offering supplemental benefits that include payment for some or all of the balance billing amounts permitted consistent with section 1852(k) and coverage of additional services that the plan finds to be medically necessary. Such benefits may include reductions in cost-sharing below the actuarial value specified in section 1854(e)(4)(B).

(4) ORGANIZATION AS SECONDARY PAYER.—Notwithstanding any other provision of law, a Medicare+Choice organization may (in the case of the provision of items and services to an individual under a Medicare+Choice plan under circumstances in which payment under this title is made secondary pursuant to section 1862(b)(2)) charge or authorize the provider of such services to charge, in accordance with the charges allowed under a law, plan, or policy described in such section—

(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services, or

(B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

(5) NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If there is a national coverage determination or legislative change in benefits required to be provided under this part made in the period beginning on the date of an announcement under section 1853(b) and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a Medicare+Choice organization of providing the benefits that are the subject of such national coverage determination and that such change in costs was not in-

corporated in the determination of the annual Medicare+Choice capitation rate under section 1853 included in the announcement made at the beginning of such period, then, unless otherwise required by law—

(A) such determination or legislative change in benefits shall not apply to contracts under this part until the first contract year that begins after the end of such period, and

(B) if such coverage determination or legislative change provides for coverage of additional benefits or coverage under additional circumstances, section 1851(i)(1) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period.

The projection under the previous sentence shall be based on an analysis by the Chief Actuary of the Centers for Medicare & Medicaid Services of the actuarial costs associated with the coverage determination or legislative change in benefits.

(6) SPECIAL BENEFIT RULES FOR REGIONAL PLANS.—In the case of an MA plan that is an MA regional plan, benefits under the plan shall include the benefits described in paragraphs (1) and (2) of section 1858(b).

(7) LIMITATION ON COST-SHARING FOR DUAL ELIGIBLES AND QUALIFIED MEDICARE BENEFICIARIES.—In the case of an individual who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)) or a qualified medicare beneficiary (as defined in section 1905(p)(1)) and who is enrolled in a specialized Medicare Advantage plan for special needs individuals described in section 1859(b)(6)(B)(ii), the plan may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under title XIX if the individual were not enrolled in such plan.

(b) ANTIDISCRIMINATION.—

(1) **BENEFICIARIES.—**

[(A) IN GENERAL.—A Medicare+Choice organization] BENEFICIARIES.—A Medicare Advantage organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act. The Secretary shall not approve a plan of an organization if the Secretary determines that the design of the plan and its benefits are likely to substantially discourage enrollment by certain MA eligible individuals with the organization.

[(B) CONSTRUCTION.—Subparagraph (A) shall not be construed as requiring a Medicare+Choice organization to enroll individuals who are determined to have end-stage renal disease, except as provided under section 1851(a)(3)(B).]

(2) PROVIDERS.—A Medicare+Choice organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit a plan from

including providers only to the extent necessary to meet the needs of the plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

(c) DISCLOSURE REQUIREMENTS.—

(1) DETAILED DESCRIPTION OF PLAN PROVISIONS.—A Medicare+Choice organization shall disclose, in clear, accurate, and standardized form to each enrollee with a Medicare+Choice plan offered by the organization under this part at the time of enrollment and at least annually thereafter, the following information regarding such plan:

(A) SERVICE AREA.—The plan's service area.

(B) BENEFITS.—Benefits offered under the plan, including information described in section 1851(d)(3)(A) and exclusions from coverage and, if it is an MSA plan, a comparison of benefits under such a plan with benefits under other Medicare+Choice plans.

(C) ACCESS.—The number, mix, and distribution of plan providers, out-of-network coverage (if any) provided by the plan, and any point-of-service option (including the supplemental premium for such option).

(D) OUT-OF-AREA COVERAGE.—Out-of-area coverage provided by the plan.

(E) EMERGENCY COVERAGE.—Coverage of emergency services, including—

(i) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

(ii) the process and procedures of the plan for obtaining emergency services; and

(iii) the locations of (I) emergency departments, and (II) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

(F) SUPPLEMENTAL BENEFITS.—Supplemental benefits available from the organization offering the plan, including—

(i) whether the supplemental benefits are optional,

(ii) the supplemental benefits covered, and

(iii) the Medicare+Choice monthly supplemental beneficiary premium for the supplemental benefits.

(G) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in nonpayment.

(H) PLAN GRIEVANCE AND APPEALS PROCEDURES.—All plan appeal or grievance rights and procedures.

(I) QUALITY IMPROVEMENT PROGRAM.—A description of the organization's quality improvement program under subsection (e).

(2) DISCLOSURE UPON REQUEST.—Upon request of a Medicare+Choice eligible individual, a Medicare+Choice organization must provide the following information to such individual:

- (A) The general coverage information and general comparative plan information made available under clauses (i) and (ii) of section 1851(d)(2)(A).
 - (B) Information on procedures used by the organization to control utilization of services and expenditures.
 - (C) Information on the number of grievances, redeterminations, and appeals and on the disposition in the aggregate of such matters.
 - (D) An overall summary description as to the method of compensation of participating physicians.
- (d) ACCESS TO SERVICES.—
- (1) IN GENERAL.—A Medicare+Choice organization offering a Medicare+Choice plan may select the providers from whom the benefits under the plan are provided so long as—
- (A) the organization makes such benefits available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits;
 - (B) when medically necessary the organization makes such benefits available and accessible 24 hours a day and 7 days a week;
 - (C) the plan provides for reimbursement with respect to services which are covered under subparagraphs (A) and (B) and which are provided to such an individual other than through the organization, if—
 - (i) the services were not emergency services (as defined in paragraph (3)), but (I) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition, and (II) it was not reasonable given the circumstances to obtain the services through the organization,
 - (ii) the services were renal dialysis services and were provided other than through the organization because the individual was temporarily out of the plan's service area, or
 - (iii) the services are maintenance care or post-stabilization care covered under the guidelines established under paragraph (2);
 - (D) the organization provides access to appropriate providers, including credentialed specialists, for medically necessary treatment and services; and
 - (E) coverage is provided for emergency services (as defined in paragraph (3)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization.
- (2) GUIDELINES RESPECTING COORDINATION OF POST-STABILIZATION CARE.—A Medicare+Choice plan shall comply with such guidelines as the Secretary may prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1867.
- (3) DEFINITION OF EMERGENCY SERVICES.—In this subsection—

(A) IN GENERAL.—The term “emergency services” means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

(i) are furnished by a provider that is qualified to furnish such services under this title, and

(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (B)).

(B) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.—The term “emergency medical condition” means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,

(ii) serious impairment to bodily functions, or

(iii) serious dysfunction of any bodily organ or part.

(4) ASSURING ACCESS TO SERVICES IN MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLANS.—In addition to any other requirements under this part, in the case of a Medicare+Choice private fee-for-service plan, the organization offering the plan must demonstrate to the Secretary that the organization has sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan. Subject to paragraphs (5) and (6), the Secretary shall find that an organization has met such requirement with respect to any category of health care professional or provider if, with respect to that category of provider—

(A) the plan has established payment rates for covered services furnished by that category of provider that are not less than the payment rates provided for under part A, part B, or both, for such services, or

(B) the plan has contracts or agreements (other than deemed contracts or agreements under subsection (j)(6)) with a sufficient number and range of providers within such category to meet the access standards in subparagraphs (A) through (E) of paragraph (1),

or a combination of both. The previous sentence shall not be construed as restricting the persons from whom enrollees under such a plan may obtain covered benefits, except that, if a plan entirely meets such requirement with respect to a category of health care professional or provider on the basis of subparagraph (B), it may provide for a higher beneficiary copayment in the case of health care professionals and providers of that category who do not have contracts or agreements (other than deemed contracts or agreements under subsection (j)(6)) to provide covered services under the terms of the plan.

(5) REQUIREMENT OF CERTAIN NONEMPLOYER MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS TO USE CONTRACTS WITH PROVIDERS.—

(A) IN GENERAL.—For plan year 2011 and subsequent plan years, in the case of a Medicare Advantage private fee-for-service plan not described in paragraph (1) or (2) of section 1857(i) operating in a network area (as defined in subparagraph (B)), the plan shall meet the access standards under paragraph (4) in that area only through entering into written contracts as provided for under subparagraph (B) of such paragraph and not, in whole or in part, through the establishment of payment rates meeting the requirements under subparagraph (A) of such paragraph.

(B) NETWORK AREA DEFINED.—For purposes of subparagraph (A), the term “network area” means, for a plan year, an area which the Secretary identifies (in the Secretary’s announcement of the proposed payment rates for the previous plan year under section 1853(b)(1)(B)) as having at least 2 network-based plans (as defined in subparagraph (C)) with enrollment under this part as of the first day of the year in which such announcement is made.

(C) NETWORK-BASED PLAN DEFINED.—

(i) IN GENERAL.—For purposes of subparagraph (B), the term “network-based plan” means—

(I) except as provided in clause (ii), a Medicare Advantage plan that is a coordinated care plan described in section 1851(a)(2)(A)(i);

(II) a network-based MSA plan; and

(III) a reasonable cost reimbursement plan under section 1876.

(ii) EXCLUSION OF NON-NETWORK REGIONAL PPOS.—The term “network-based plan” shall not include an MA regional plan that, with respect to the area, meets access adequacy standards under this part substantially through the authority of section 422.112(a)(1)(ii) of title 42, Code of Federal Regulations, rather than through written contracts.

(6) REQUIREMENT OF ALL EMPLOYER MEDICARE ADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS TO USE CONTRACTS WITH PROVIDERS.—For plan year 2011 and subsequent plan years, in the case of a Medicare Advantage private fee-for-service plan that is described in paragraph (1) or (2) of section 1857(i), the plan shall meet the access standards under paragraph (4) only through entering into written contracts as provided for under subparagraph (B) of such paragraph and not, in whole or in part, through the establishment of payment rates meeting the requirements under subparagraph (A) of such paragraph.

(e) QUALITY IMPROVEMENT PROGRAM.—

(1) IN GENERAL.—Each MA organization shall have an ongoing quality improvement program for the purpose of improving the quality of care provided to enrollees in each MA plan offered by such organization.

(2) CHRONIC CARE IMPROVEMENT PROGRAMS.—As part of the quality improvement program under paragraph (1), each MA organization shall have a chronic care improvement program. Each chronic care improvement program shall have a method for monitoring and identifying enrollees with multiple or suffi-

ciently severe chronic conditions that meet criteria established by the organization for participation under the program.

(3) DATA.—

(A) COLLECTION, ANALYSIS, AND REPORTING.—

(i) IN GENERAL.—Except as provided in clauses (ii) and (iii) with respect to plans described in such clauses and subject to subparagraph (B), as part of the quality improvement program under paragraph (1), each MA organization shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality. With respect to MA private fee-for-service plans and MSA plans, the requirements under the preceding sentence may not exceed the requirements under this subparagraph with respect to MA local plans that are preferred provider organization plans, except that, for plan year 2010, the limitation under clause (iii) shall not apply and such requirements shall apply only with respect to administrative claims data.

(ii) SPECIAL REQUIREMENTS FOR SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—In addition to the data required to be collected, analyzed, and reported under clause (i) and notwithstanding the limitations under subparagraph (B), as part of the quality improvement program under paragraph (1), each MA organization offering a specialized Medicare Advantage plan for special needs individuals shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality with respect to the requirements described in paragraphs (2) through (5) of subsection (f). Such data may be based on claims data and shall be at the plan level.

(iii) APPLICATION TO LOCAL PREFERRED PROVIDER ORGANIZATIONS AND MA REGIONAL PLANS.—Clause (i) shall apply to MA organizations with respect to MA local plans that are preferred provider organization plans and to MA regional plans only insofar as services are furnished by providers or services, physicians, and other health care practitioners and suppliers that have contracts with such organization to furnish services under such plans.

(iv) DEFINITION OF PREFERRED PROVIDER ORGANIZATION PLAN.—In this subparagraph, the term “preferred provider organization plan” means an MA plan that—

(I) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

(II) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

(III) is offered by an organization that is not licensed or organized under State law as a health maintenance organization.

(B) LIMITATIONS.—

(i) TYPES OF DATA.—The Secretary shall not collect under subparagraph (A) data on quality, outcomes, and beneficiary satisfaction to facilitate consumer choice and program administration other than the types of data that were collected by the Secretary as of November 1, 2003.

(ii) CHANGES IN TYPES OF DATA.—Subject to subclause (iii), the Secretary may only change the types of data that are required to be submitted under subparagraph (A) after submitting to Congress a report on the reasons for such changes that was prepared in consultation with MA organizations and private accrediting bodies.

(iii) CONSTRUCTION.—Nothing in the subsection shall be construed as restricting the ability of the Secretary to carry out the duties under section 1851(d)(4)(D).

(4) TREATMENT OF ACCREDITATION.—

(A) IN GENERAL.—The Secretary shall provide that a Medicare+Choice organization is deemed to meet all the requirements described in any specific clause of subparagraph (B) if the organization is accredited (and periodically reaccredited) by a private accrediting organization under a process that the Secretary has determined assures that the accrediting organization applies and enforces standards that meet or exceed the standards established under section 1856 to carry out the requirements in such clause.

(B) REQUIREMENTS DESCRIBED.—The provisions described in this subparagraph are the following:

(i) Paragraphs (1) through (3) of this subsection (relating to quality improvement programs).

(ii) Subsection (b) (relating to antidiscrimination).

(iii) Subsection (d) (relating to access to services).

(iv) Subsection (h) (relating to confidentiality and accuracy of enrollee records).

(v) Subsection (i) (relating to information on advance directives).

(vi) Subsection (j) (relating to provider participation rules).

(vii) The requirements described in section 1860D-4(j), to the extent such requirements apply under section 1860D-21(c).

(C) TIMELY ACTION ON APPLICATIONS.—The Secretary shall determine, within 210 days after the date the Secretary receives an application by a private accrediting organization and using the criteria specified in section 1865(a)(2), whether the process of the private accrediting organization meets the requirements with respect to any specific clause in subparagraph (B) with respect to which the application is made. The Secretary may not deny such an application on the basis that it seeks to meet the requirements with respect to only one, or more than one, such specific clause.

(D) CONSTRUCTION.—Nothing in this paragraph shall be construed as limiting the authority of the Secretary under section 1857, including the authority to terminate contracts with Medicare+Choice organizations under subsection (c)(2) of such section.

(f) GRIEVANCE MECHANISM.—Each Medicare+Choice organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and enrollees with Medicare+Choice plans of the organization under this part.

(g) COVERAGE DETERMINATIONS, RECONSIDERATIONS, AND APPEALS.—

(1) DETERMINATIONS BY ORGANIZATION.—

(A) IN GENERAL.—A Medicare+Choice organization shall have a procedure for making determinations regarding whether an individual enrolled with the plan of the organization under this part is entitled to receive a health service under this section and the amount (if any) that the individual is required to pay with respect to such service. Subject to paragraph (3), such procedures shall provide for such determination to be made on a timely basis.

(B) EXPLANATION OF DETERMINATION.—Such a determination that denies coverage, in whole or in part, shall be in writing and shall include a statement in understandable language of the reasons for the denial and a description of the reconsideration and appeals processes.

(2) RECONSIDERATIONS.—

(A) IN GENERAL.—The organization shall provide for reconsideration of a determination described in paragraph (1)(B) upon request by the enrollee involved. The reconsideration shall be within a time period specified by the Secretary, but shall be made, subject to paragraph (3), not later than 60 days after the date of the receipt of the request for reconsideration.

(B) PHYSICIAN DECISION ON CERTAIN RECONSIDERATIONS.—A reconsideration relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician with appropriate expertise in the field of medicine which necessitates treatment who is other than a physician involved in the initial determination.

(3) EXPEDITED DETERMINATIONS AND RECONSIDERATIONS.—

(A) RECEIPT OF REQUESTS.—

(i) ENROLLEE REQUESTS.—An enrollee in a Medicare+Choice plan may request, either in writing or orally, an expedited determination under paragraph (1) or an expedited reconsideration under paragraph (2) by the Medicare+Choice organization.

(ii) PHYSICIAN REQUESTS.—A physician, regardless whether the physician is affiliated with the organization or not, may request, either in writing or orally, such an expedited determination or reconsideration.

(B) ORGANIZATION PROCEDURES.—

(i) IN GENERAL.—The Medicare+Choice organization shall maintain procedures for expediting organization determinations and reconsiderations when, upon request of an enrollee, the organization determines that the application of the normal time frame for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(ii) EXPEDITION REQUIRED FOR PHYSICIAN REQUESTS.—In the case of a request for an expedited determination or reconsideration made under subparagraph (A)(ii), the organization shall expedite the determination or reconsideration if the request indicates that the application of the normal time frame for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

(iii) TIMELY RESPONSE.—In cases described in clauses (i) and (ii), the organization shall notify the enrollee (and the physician involved, as appropriate) of the determination or reconsideration under time limitations established by the Secretary, but not later than 72 hours of the time of receipt of the request for the determination or reconsideration (or receipt of the information necessary to make the determination or reconsideration), or such longer period as the Secretary may permit in specified cases.

(4) INDEPENDENT REVIEW OF CERTAIN COVERAGE DENIALS.—The Secretary shall contract with an independent, outside entity to review and resolve in a timely manner reconsiderations that affirm denial of coverage, in whole or in part. The provisions of section 1869(c)(5) shall apply to independent outside entities under contract with the Secretary under this paragraph.

(5) APPEALS.—An enrollee with a Medicare+Choice plan of a Medicare+Choice organization under this part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is \$100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is \$1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the organization shall be entitled to be parties to that judicial review. In applying subsections (b) and (g) of section 205 as provided in this paragraph, and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human

Services, respectively. The provisions of section 1869(b)(1)(E)(iii) shall apply with respect to dollar amounts specified in the first 2 sentences of this paragraph in the same manner as they apply to the dollar amounts specified in section 1869(b)(1)(E)(i).

(h) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Insofar as a Medicare+Choice organization maintains medical records or other health information regarding enrollees under this part, the Medicare+Choice organization shall establish procedures—

(1) to safeguard the privacy of any individually identifiable enrollee information;

(2) to maintain such records and information in a manner that is accurate and timely; and

(3) to assure timely access of enrollees to such records and information.

(i) INFORMATION ON ADVANCE DIRECTIVES.—Each Medicare+Choice organization shall meet the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

(j) RULES REGARDING PROVIDER PARTICIPATION.—

(1) PROCEDURES.—Insofar as a Medicare+Choice organization offers benefits under a Medicare+Choice plan through agreements with physicians, the organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under such a plan. Such procedures shall include—

(A) providing notice of the rules regarding participation,

(B) providing written notice of participation decisions that are adverse to physicians, and

(C) providing a process within the organization for appealing such adverse decisions, including the presentation of information and views of the physician regarding such decision.

(2) CONSULTATION IN MEDICAL POLICIES.—A Medicare+Choice organization shall consult with physicians who have entered into participation agreements with the organization regarding the organization's medical policy, quality, and medical management procedures.

(3) PROHIBITING INTERFERENCE WITH PROVIDER ADVICE TO ENROLLEES.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), a Medicare+Choice organization (in relation to an individual enrolled under a Medicare+Choice plan offered by the organization under this part) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

(B) CONSCIENCE PROTECTION.—Subparagraph (A) shall not be construed as requiring a Medicare+Choice plan to

provide, reimburse for, or provide coverage of a counseling or referral service if the Medicare+Choice organization offering the plan—

(i) objects to the provision of such service on moral or religious grounds; and

(ii) in the manner and through the written instrumentalities such Medicare+Choice organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization or plan adopts a change in policy regarding such a counseling or referral service.

(C) CONSTRUCTION.—Nothing in subparagraph (B) shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

(D) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this paragraph, the term “health care professional” means a physician (as defined in section 1861(r)) or other health care professional if coverage for the professional’s services is provided under the Medicare+Choice plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

(4) LIMITATIONS ON PHYSICIAN INCENTIVE PLANS.—

(A) IN GENERAL.—No Medicare+Choice organization may operate any physician incentive plan (as defined in subparagraph (B)) unless the organization provides assurances satisfactory to the Secretary that the following requirements are met:

(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or group.

(B) PHYSICIAN INCENTIVE PLAN DEFINED.—In this paragraph, the term “physician incentive plan” means any com-

pensation arrangement between a Medicare+Choice organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization under this part.

(5) LIMITATION ON PROVIDER INDEMNIFICATION.—A Medicare+Choice organization may not provide (directly or indirectly) for a health care professional, provider of services, or other entity providing health care services (or group of such professionals, providers, or entities) to indemnify the organization against any liability resulting from a civil action brought for any damage caused to an enrollee with a Medicare+Choice plan of the organization under this part by the organization's denial of medically necessary care.

(6) SPECIAL RULES FOR MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLANS.—For purposes of applying this part (including subsection (k)(1)) and section 1866(a)(1)(O), a hospital (or other provider of services), a physician or other health care professional, or other entity furnishing health care services is treated as having an agreement or contract in effect with a Medicare+Choice organization (with respect to an individual enrolled in a Medicare+Choice private fee-for-service plan it offers), if—

(A) the provider, professional, or other entity furnishes services that are covered under the plan to such an enrollee; and

(B) before providing such services, the provider, professional, or other entity —

(i) has been informed of the individual's enrollment under the plan, and

(ii) either—

(I) has been informed of the terms and conditions of payment for such services under the plan, or

(II) is given a reasonable opportunity to obtain information concerning such terms and conditions, in a manner reasonably designed to effect informed agreement by a provider.

The previous sentence shall only apply in the absence of an explicit agreement between such a provider, professional, or other entity and the Medicare+Choice organization.

(7) PROMOTION OF E-PRESCRIBING BY MA PLANS.—

(A) IN GENERAL.—An MA-PD plan may provide for a separate payment or otherwise provide for a differential payment for a participating physician that prescribes covered part D drugs in accordance with an electronic prescription drug program that meets standards established under section 1860D-4(e).

(B) CONSIDERATIONS.—Such payment may take into consideration the costs of the physician in implementing such a program and may also be increased for those participating physicians who significantly increase—

(i) formulary compliance;

(ii) lower cost, therapeutically equivalent alternatives;

- (iii) reductions in adverse drug interactions; and
- (iv) efficiencies in filing prescriptions through reduced administrative costs.

(C) STRUCTURE.—Additional or increased payments under this subsection may be structured in the same manner as medication therapy management fees are structured under section 1860D-4(c)(2)(E).

(k) TREATMENT OF SERVICES FURNISHED BY CERTAIN PROVIDERS.—

(1) IN GENERAL.—Except as provided in paragraph (2), a physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a Medicare+Choice organization described in section 1851(a)(2)(A) or with an organization offering an MSA plan shall accept as payment in full for covered services under this title that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but not enrolled with a Medicare+Choice organization under this part) also applies with respect to an individual so enrolled.

(2) APPLICATION TO MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLANS.—

(A) BALANCE BILLING LIMITS UNDER MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLANS IN CASE OF CONTRACT PROVIDERS.—

(i) IN GENERAL.—In the case of an individual enrolled in a Medicare+Choice private fee-for-service plan under this part, a physician, provider of services, or other entity that has a contract (including through the operation of subsection (j)(6)) establishing a payment rate for services furnished to the enrollee shall accept as payment in full for covered services under this title that are furnished to such an individual an amount not to exceed (including any deductibles, coinsurance, copayments, or balance billing otherwise permitted under the plan) an amount equal to 115 percent of such payment rate.

(ii) PROCEDURES TO ENFORCE LIMITS.—The Medicare+Choice organization that offers such a plan shall establish procedures, similar to the procedures described in section 1848(g)(1)(A), in order to carry out the previous sentence.

(iii) ASSURING ENFORCEMENT.—If the Medicare+Choice organization fails to establish and enforce procedures required under clause (ii), the organization is subject to intermediate sanctions under section 1857(g).

(B) ENROLLEE LIABILITY FOR NONCONTRACT PROVIDERS.—For provision—

(i) establishing minimum payment rate in the case of noncontract providers under a Medicare+Choice private fee-for-service plan, see section 1852(a)(2); or

(ii) limiting enrollee liability in the case of covered services furnished by such providers, see paragraph (1) and section 1866(a)(1)(O).

(C) INFORMATION ON BENEFICIARY LIABILITY.—

(i) IN GENERAL.—Each Medicare+Choice organization that offers a Medicare+Choice private fee-for-service plan shall provide that enrollees under the plan who are furnished services for which payment is sought under the plan are provided an appropriate explanation of benefits (consistent with that provided under parts A and B and, if applicable, under Medicare supplemental policies) that includes a clear statement of the amount of the enrollee's liability (including any liability for balance billing consistent with this subsection) with respect to payments for such services.

(ii) ADVANCE NOTICE BEFORE RECEIPT OF INPATIENT HOSPITAL SERVICES AND CERTAIN OTHER SERVICES.—In addition, such organization shall, in its terms and conditions of payments to hospitals for inpatient hospital services and for other services identified by the Secretary for which the amount of the balance billing under subparagraph (A) could be substantial, require the hospital to provide to the enrollee, before furnishing such services and if the hospital imposes balance billing under subparagraph (A)—

(I) notice of the fact that balance billing is permitted under such subparagraph for such services, and

(II) a good faith estimate of the likely amount of such balance billing (if any), with respect to such services, based upon the presenting condition of the enrollee.

(1) RETURN TO HOME SKILLED NURSING FACILITIES FOR COVERED POST-HOSPITAL EXTENDED CARE SERVICES.—

(1) ENSURING RETURN TO HOME SNF.—

(A) IN GENERAL.—In providing coverage of post-hospital extended care services, a Medicare+Choice plan shall provide for such coverage through a home skilled nursing facility if the following conditions are met:

(i) ENROLLEE ELECTION.—The enrollee elects to receive such coverage through such facility.

(ii) SNF AGREEMENT.—The facility has a contract with the Medicare+Choice organization for the provision of such services, or the facility agrees to accept substantially similar payment under the same terms and conditions that apply to similarly situated skilled nursing facilities that are under contract with the Medicare+Choice organization for the provision of such services and through which the enrollee would otherwise receive such services.

(B) MANNER OF PAYMENT TO HOME SNF.—The organization shall provide payment to the home skilled nursing facility consistent with the contract or the agreement described in subparagraph (A)(ii), as the case may be.

(2) NO LESS FAVORABLE COVERAGE.—The coverage provided under paragraph (1) (including scope of services, cost-sharing, and other criteria of coverage) shall be no less favorable to the enrollee than the coverage that would be provided to the enrollee with respect to a skilled nursing facility the post-hospital extended care services of which are otherwise covered under the Medicare+Choice plan.

(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to do the following:

(A) To require coverage through a skilled nursing facility that is not otherwise qualified to provide benefits under part A for medicare beneficiaries not enrolled in a Medicare+Choice plan.

(B) To prevent a skilled nursing facility from refusing to accept, or imposing conditions upon the acceptance of, an enrollee for the receipt of post-hospital extended care services.

(4) DEFINITIONS.—In this subsection:

(A) HOME SKILLED NURSING FACILITY.—The term “home skilled nursing facility” means, with respect to an enrollee who is entitled to receive post-hospital extended care services under a Medicare+Choice plan, any of the following skilled nursing facilities:

(i) SNF RESIDENCE AT TIME OF ADMISSION.—The skilled nursing facility in which the enrollee resided at the time of admission to the hospital preceding the receipt of such post-hospital extended care services.

(ii) SNF IN CONTINUING CARE RETIREMENT COMMUNITY.—A skilled nursing facility that is providing such services through a continuing care retirement community (as defined in subparagraph (B)) which provided residence to the enrollee at the time of such admission.

(iii) SNF RESIDENCE OF SPOUSE AT TIME OF DISCHARGE.—The skilled nursing facility in which the spouse of the enrollee is residing at the time of discharge from such hospital.

(B) CONTINUING CARE RETIREMENT COMMUNITY.—The term “continuing care retirement community” means, with respect to an enrollee in a Medicare+Choice plan, an arrangement under which housing and health-related services are provided (or arranged) through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period.

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 simi-

lar 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 sub-

clause (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 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 (or, in 2017 and each subsequent year, at least 60 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 (in 2017 and each subsequent year, of no less than 30 days) 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)] *paragraphs (2), (4), and (5)*, 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)~~ *paragraphs (2), (4), and (5)*), 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.

(5) EXCLUSION OF COSTS FOR KIDNEY ACQUISITIONS FROM CAPITATION RATES.—*After determining the applicable amount for an area for a year under paragraph (1) (beginning with 2019), the Secretary shall adjust such applicable amount to exclude from such applicable amount the Secretary’s estimate of the standardized costs for payments for organ acquisitions for kidney transplants covered under this title (including expenses covered under section 1881(d)) in the area for 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 profes-

sionals 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)(B)) 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 eli-

gible 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)(B)) 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, for 2019 and subsequent years, the exclusion of payments for organ acquisitions for kidney transplants from the capitation rate as described in subsection (k)(5); 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)] subparagraphs (F) and (G), 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.

(G) APPLICATION OF KIDNEY ACQUISITIONS ADJUSTMENT.—*The base payment amount specified in subparagraph (E) for a year (beginning with 2019) shall be adjusted in the same manner under paragraph (5) 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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DEFINITIONS; MISCELLANEOUS PROVISIONS

SEC. 1859. (a) DEFINITIONS RELATING TO MEDICARE+CHOICE ORGANIZATIONS.—In this part—

(1) MEDICARE+CHOICE ORGANIZATION.—The term “Medicare+Choice organization” means a public or private entity that is certified under section 1856 as meeting the requirements and standards of this part for such an organization.

(2) PROVIDER-SPONSORED ORGANIZATION.—The term “provider-sponsored organization” is defined in section 1855(d)(1).

(b) DEFINITIONS RELATING TO MEDICARE+CHOICE PLANS.—

(1) MEDICARE+CHOICE PLAN.—The term “Medicare+Choice plan” means health benefits coverage offered under a policy, contract, or plan by a Medicare+Choice organization pursuant to and in accordance with a contract under section 1857.

(2) MEDICARE+CHOICE PRIVATE FEE-FOR-SERVICE PLAN.—The term “Medicare+Choice private fee-for-service plan” means a Medicare+Choice plan that—

(A) reimburses hospitals, physicians, and other providers at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk;

(B) does not vary such rates for such a provider based on utilization relating to such provider; and

(C) does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established by the plan.

Nothing in subparagraph (B) shall be construed to preclude a plan from varying rates for such a provider based on the specialty of the provider, the location of the provider, or other factors related to such provider that are not related to utilization, or to preclude a plan from increasing rates for such a provider based on increased utilization of specified preventive or screening services.

(3) MSA PLAN.—

(A) IN GENERAL.—The term “MSA plan” means a Medicare+Choice plan that—

(i) provides reimbursement for at least the items and services described in section 1852(a)(1) in a year but only after the enrollee incurs countable expenses (as specified under the plan) equal to the amount of an annual deductible (described in subparagraph (B));

(ii) counts as such expenses (for purposes of such deductible) at least all amounts that would have been payable under parts A and B, and that would have been payable by the enrollee as deductibles, coinsurance, or copayments, if the enrollee had elected to receive benefits through the provisions of such parts; and

(iii) provides, after such deductible is met for a year and for all subsequent expenses for items and services referred to in clause (i) in the year, for a level of reimbursement that is not less than—

(I) 100 percent of such expenses, or

(II) 100 percent of the amounts that would have been paid (without regard to any deductibles or coinsurance) under parts A and B with respect to such expenses,

whichever is less.

(B) DEDUCTIBLE.—The amount of annual deductible under an MSA plan—

(i) for contract year 1999 shall be not more than \$6,000; and

(ii) for a subsequent contract year shall be not more than the maximum amount of such deductible for the previous contract year under this subparagraph increased by the national per capita Medicare+Choice growth percentage under section 1853(c)(6) for the year.

If the amount of the deductible under clause (ii) is not a multiple of \$50, the amount shall be rounded to the nearest multiple of \$50.

(4) MA REGIONAL PLAN.—The term “MA regional plan” means an MA plan described in section 1851(a)(2)(A)(i)—

(A) that has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

(B) that provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

(C) the service area of which is one or more entire MA regions.

(5) MA LOCAL PLAN.—The term “MA local plan” means an MA plan that is not an MA regional plan.

(6) SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—

(A) IN GENERAL.—The term “specialized MA plan for special needs individuals” means an MA plan that exclusively serves special needs individuals (as defined in subparagraph (B)) and that, as of January 1, 2010, meets the applicable requirements of paragraph (2), (3), or (4) of subsection (f), as the case may be.

(B) SPECIAL NEEDS INDIVIDUAL.—The term “special needs individual” means an MA eligible individual who—

(i) is institutionalized (as defined by the Secretary);

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

(iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized MA plan described in subparagraph (A) for individuals with severe or disabling chronic conditions who have one or more comorbid and medically complex chronic conditions that are substantially disabling or life threatening, have a high risk of hospitalization or other significant adverse health outcomes, and require specialized delivery systems across domains of care.

The Secretary [may waive application of section 1851(a)(3)(B) in the case of an individual described in clause (i), (ii), or (iii) of this subparagraph and] may apply rules similar to the rules of section 1894(c)(4) for continued eligibility of special needs individuals.

(c) OTHER REFERENCES TO OTHER TERMS.—

(1) MEDICARE+CHOICE ELIGIBLE INDIVIDUAL.—The term “Medicare+Choice eligible individual” is defined in section 1851(a)(3).

(2) MEDICARE+CHOICE PAYMENT AREA.—The term “Medicare+Choice payment area” is defined in section 1853(d).

(3) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE.—The “national per capita Medicare+Choice growth percentage” is defined in section 1853(c)(6).

(4) MEDICARE+CHOICE MONTHLY BASIC BENEFICIARY PREMIUM; MEDICARE+CHOICE MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The terms “Medicare+Choice monthly basic beneficiary premium” and “Medicare+Choice monthly supplemental beneficiary premium” are defined in section 1854(a)(2).

(5) MA LOCAL AREA.—The term “MA local area” is defined in section 1853(d)(2).

(d) COORDINATED ACUTE AND LONG-TERM CARE BENEFITS UNDER A MEDICARE+CHOICE PLAN.—Nothing in this part shall be construed as preventing a State from coordinating benefits under a medicaid plan under title XIX with those provided under a Medicare+Choice plan in a manner that assures continuity of a full-range of acute care and long-term care services to poor elderly or disabled individuals eligible for benefits under this title and under such plan.

(e) RESTRICTION ON ENROLLMENT FOR CERTAIN MEDICARE+CHOICE PLANS.—

(1) IN GENERAL.—In the case of a Medicare+Choice religious fraternal benefit society plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the society offering the plan may restrict the enrollment of individuals under this part to individuals who are members of the church, convention, or group described in paragraph (3)(B) with which the society is affiliated.

(2) MEDICARE+CHOICE RELIGIOUS FRATERNAL BENEFIT SOCIETY PLAN DESCRIBED.—For purposes of this subsection, a Medicare+Choice religious fraternal benefit society plan described in this paragraph is a Medicare+Choice plan described in section 1851(a)(2) that—

(A) is offered by a religious fraternal benefit society described in paragraph (3) only to members of the church, convention, or group described in paragraph (3)(B); and

(B) permits all such members to enroll under the plan without regard to health status-related factors. Nothing in this subsection shall be construed as waiving any plan requirements relating to financial solvency.

(3) RELIGIOUS FRATERNAL BENEFIT SOCIETY DEFINED.—For purposes of paragraph (2)(A), a “religious fraternal benefit society” described in this section is an organization that—

(A) is described in section 501(c)(8) of the Internal Revenue Code of 1986 and is exempt from taxation under section 501(a) of such Act;

(B) is affiliated with, carries out the tenets of, and shares a religious bond with, a church or convention or association of churches or an affiliated group of churches;

(C) offers, in addition to a Medicare+Choice religious fraternal benefit society plan, health coverage to individuals not entitled to benefits under this title who are members of such church, convention, or group; and

(D) does not impose any limitation on membership in the society based on any health status-related factor.

(4) PAYMENT ADJUSTMENT.—Under regulations of the Secretary, in the case of individuals enrolled under this part under a Medicare+Choice religious fraternal benefit society plan described in paragraph (2), the Secretary shall provide for such adjustment to the payment amounts otherwise established under section 1854 as may be appropriate to assure an appropriate payment level, taking into account the actuarial characteristics and experience of such individuals.

(f) REQUIREMENTS REGARDING ENROLLMENT IN SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—

(1) REQUIREMENTS FOR ENROLLMENT.—In the case of a specialized MA plan for special needs individuals (as defined in subsection (b)(6)), notwithstanding any other provision of this part and in accordance with regulations of the Secretary and for periods before January 1, 2019, the plan may restrict the enrollment of individuals under the plan to individuals who are within one or more classes of special needs individuals.

(2) ADDITIONAL REQUIREMENTS FOR INSTITUTIONAL SNPS.—In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(i), the applicable requirements described in this paragraph are as follows:

(A) Each individual that enrolls in the plan on or after January 1, 2010, is a special needs individuals described in subsection (b)(6)(B)(i). In the case of an individual who is living in the community but requires an institutional level of care, such individual shall not be considered a special needs individual described in subsection (b)(6)(B)(i) unless the determination that the individual requires an institutional level of care was made—

(i) using a State assessment tool of the State in which the individual resides; and

(ii) by an entity other than the organization offering the plan.

(B) The plan meets the requirements described in paragraph (5).

(C) If applicable, the plan meets the requirement described in paragraph (7).

(3) ADDITIONAL REQUIREMENTS FOR DUAL SNPS.—In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii), the applicable requirements described in this paragraph are as follows:

(A) Each individual that enrolls in the plan on or after January 1, 2010, is a special needs individuals described in subsection (b)(6)(B)(ii).

(B) The plan meets the requirements described in paragraph (5).

(C) The plan provides each prospective enrollee, prior to enrollment, with a comprehensive written statement (using standardized content and format established by the Secretary) that describes—

(i) the benefits and cost-sharing protections that the individual is entitled to under the State Medicaid program under title XIX; and

(ii) which of such benefits and cost-sharing protections are covered under the plan.

Such statement shall be included with any description of benefits offered by the plan.

(D) The plan has a contract with the State Medicaid agency to provide benefits, or arrange for benefits to be provided, for which such individual is entitled to receive as medical assistance under title XIX. Such benefits may include long-term care services consistent with State policy.

(E) If applicable, the plan meets the requirement described in paragraph (7).

(4) **ADDITIONAL REQUIREMENTS FOR SEVERE OR DISABLING CHRONIC CONDITION SNPS.**—In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(iii), the applicable requirements described in this paragraph are as follows:

(A) Each individual that enrolls in the plan on or after January 1, 2010, is a special needs individual described in subsection (b)(6)(B)(iii).

(B) The plan meets the requirements described in paragraph (5).

(C) If applicable, the plan meets the requirement described in paragraph (7).

(5) **CARE MANAGEMENT REQUIREMENTS FOR ALL SNPS.**—The requirements described in this paragraph are that the organization offering a specialized MA plan for special needs individuals—

(A) have in place an evidenced-based model of care with appropriate networks of providers and specialists; and

(B) with respect to each individual enrolled in the plan—

(i) conduct an initial assessment and an annual reassessment of the individual’s physical, psychosocial, and functional needs;

(ii) develop a plan, in consultation with the individual as feasible, that identifies goals and objectives, including measurable outcomes as well as specific services and benefits to be provided; and

(iii) use an interdisciplinary team in the management of care.

(6) **TRANSITION AND EXCEPTION REGARDING RESTRICTION ON ENROLLMENT.**—

(A) **IN GENERAL.**—Subject to subparagraph (C), the Secretary shall establish procedures for the transition of applicable individuals to—

(i) a Medicare Advantage plan that is not a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); or

(ii) the original medicare fee-for-service program under parts A and B.

(B) **APPLICABLE INDIVIDUALS.**—For purposes of clause (i), the term “applicable individual” means an individual who—

(i) is enrolled under a specialized MA plan for special needs individuals (as defined in subsection (b)(6)); and

(ii) is not within the 1 or more of the classes of special needs individuals to which enrollment under the plan is restricted to.

(C) **EXCEPTION.**—The Secretary shall provide for an exception to the transition described in subparagraph (A) for a limited period of time for individuals enrolled under a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii) who are no longer eligible for medical assistance under title XIX.

(D) **TIMELINE FOR INITIAL TRANSITION.**—The Secretary shall ensure that applicable individuals enrolled in a spe-

cialized MA plan for special needs individuals (as defined in subsection (b)(6)) prior to January 1, 2010, are transitioned to a plan or the program described in subparagraph (A) by not later than January 1, 2013.

(7) AUTHORITY TO REQUIRE SPECIAL NEEDS PLANS BE NCQA APPROVED.—For 2012 and subsequent years, the Secretary shall require that a Medicare Advantage organization offering a specialized MA plan for special needs individuals be approved by the National Committee for Quality Assurance (based on standards established by the Secretary).

(g) SPECIAL RULES FOR SENIOR HOUSING FACILITY PLANS.—

(1) IN GENERAL.—In the case of a Medicare Advantage senior housing facility plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the service area of such plan may be limited to a senior housing facility in a geographic area.

(2) MEDICARE ADVANTAGE SENIOR HOUSING FACILITY PLAN DESCRIBED.—For purposes of this subsection, a Medicare Advantage senior housing facility plan is a Medicare Advantage plan that—

(A) restricts enrollment of individuals under this part to individuals who reside in a continuing care retirement community (as defined in section 1852(1)(4)(B));

(B) provides primary care services onsite and has a ratio of accessible physicians to beneficiaries that the Secretary determines is adequate;

(C) provides transportation services for beneficiaries to specialty providers outside of the facility; and

(D) has participated (as of December 31, 2009) in a demonstration project established by the Secretary under which such a plan was offered for not less than 1 year.

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