II

111TH CONGRESS
1ST SESSION

S. 1634

To amend titles XVIII and XIX of the Social Security Act to protect and improve the benefits provided to dual eligible individuals under the Medicare and Medicaid programs.

IN THE SENATE OF THE UNITED STATES

AUGUST 6, 2009

Mr. ROCKEFELLER (for himself, Mr. AKAKA, and Mr. BROWN) introduced the following bill; which was read twice and referred to the Committee on Finance

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A BILL

To amend titles XVIII and XIX of the Social Security Act to protect and improve the benefits provided to dual eligible individuals under the Medicare and Medicaid programs.

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Prescription Drug Coverage Improvement Act''.

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

Sec. 1. Short title; table of contents.

TITLE I—MEDICARE AND MEDICAID IMPROVEMENTS

Sec. 101. Providing Federal coverage and payment coordination for low-income Medicare beneficiaries.
Sec. 102. Creating a Medicare operated prescription drug plan option.
Sec. 103. Accreditation requirement for all specialized Medicare Advantage plans and revisions relating to specialized Medicare Advantage plans for special needs individuals.
Sec. 104. Providing better care coordination for low-income beneficiaries in Medicare part D.
Sec. 105. Improving transition of new dual eligible individuals to Medicare prescription drug coverage and presumptive eligibility for low-income subsidies.
Sec. 106. Required information on transition from skilled nursing facilities and nursing facilities to part D plans.
Sec. 107. Streamlined pharmacy compliance packaging.
Sec. 108. Lowering covered part D drug prices on behalf of Medicare beneficiaries.
Sec. 109. Correction of flaws in determination of phased-down State contribution for Federal assumption of prescription drug costs for dually eligible individuals.
Sec. 110. No impact on eligibility for benefits under other programs.
Sec. 111. Quality indicators for dual eligible individuals.

TITLE II—ADDITIONAL MEDICARE AND MEDICAID IMPROVEMENTS

Subtitle A—Improving the Financial Assistance Available to Low-Income Medicare Beneficiaries

Sec. 201. Improving assets tests for Medicare Savings Program and low-income subsidy program.
Sec. 202. Eliminating barriers to enrollment.
Sec. 203. Elimination of part D cost-sharing for certain non-institutionalized full-benefit dual eligible individuals.
Sec. 204. Exemption of balance in any pension or retirement plan from resources for determination of eligibility for low-income subsidy.
Sec. 205. Cost-sharing protections for low-income subsidy-eligible individuals.

Subtitle B—Other Improvements

Sec. 211. Enrollment improvements under Medicare parts C and D.
Sec. 212. Medicare plan complaint system.
Sec. 213. Uniform exceptions and appeals process.
Sec. 214. Prohibition on conditioning Medicaid eligibility for individuals enrolled in certain creditable prescription drug coverage on enrollment in the Medicare part D drug program.
Sec. 215. Office of the Inspector General annual report on part D formularies' inclusion of drugs commonly used by dual eligibles.
Sec. 216. HHS ongoing study and annual reports on coverage for dual eligibles.
Sec. 217. Authority to obtain information.

TITLE I—MEDICARE AND MEDICAID IMPROVEMENTS

SEC. 101. PROVIDING FEDERAL COVERAGE AND PAYMENT COORDINATION FOR LOW-INCOME MEDICARE BENEFICIARIES.

(a) ESTABLISHMENT OF FEDERAL COORDINATED HEALTH CARE OFFICE.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—Not later than October 1, 2009, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a Federal Coordinated Health Care Office.

(B) ESTABLISHMENT AND REPORTING TO CMS ADMINISTRATOR.—The Federal Coordinated Health Care Office shall—

(i) be established within the Centers for Medicare & Medicaid Services; and

(ii) report directly to the Administrator of the Centers for Medicare & Medicaid Services.

(2) PURPOSE.—The purpose of the Federal Coordinated Health Care Office is to bring together officials of the Medicare and Medicaid programs at the

Centers for Medicare & Medicaid Services in order to—

(A) more effectively integrate benefits under the Medicare program under title XVIII of the Social Security Act and the Medicaid program under title XIX of such Act; and

(B) improve the coordination between the Federal Government and States for individuals eligible for benefits under both such programs in order to ensure that such individuals get full access to the items and services to which they are entitled under titles XVIII and XIX of the Social Security Act.

(3) GOALS.—The goals of the Federal Coordinated Health Care Office are as follows:

(A) Providing dual eligible individuals full access to the benefits to which such individuals are entitled under the Medicare and Medicaid programs.

(B) Simplifying the processes for dual eligible individuals to access the items and services they are entitled to under the Medicare and Medicaid programs.

(C) Improving the quality of health care and long-term services for dual eligible individuals.

(D) Increasing beneficiary understanding of and satisfaction with coverage under the Medicare and Medicaid programs.

(E) Eliminating regulatory conflicts between rules under the Medicare and Medicaid programs.

(F) Improving care continuity and ensuring safe and effective care transitions.

(G) Eliminating cost-shifting between the Medicare and Medicaid program and among related health care providers.

(H) Improving the quality of performance of providers of services and suppliers under the Medicare and Medicaid programs.

(4) SPECIFIC RESPONSIBILITIES.—The specific responsibilities of the Federal Coordinated Health Care Office are as follows:

(A) Providing States, specialized MA plans for special needs individuals (as defined in section 1859(b)(6) of the Social Security Act (42 U.S.C. 1395w–28(b)(6))), physicians and other relevant entities or individuals with the edu-

cation and tools necessary for developing programs that align benefits under the Medicare and Medicaid programs for dual eligible individuals.

(B) Working with the Director of the Congressional Budget Office and the Director of the Office of Management and Budget, and in consultation with the Medicare Payment Advisory Commission and the Medicaid and CHIP Payment and Access Commission, to, not later than January 1, 2011, establish dynamic scoring for benefits for dual eligible individuals to account for total spending and savings for comparable risk groups under the Medicare program.

(C) Supporting State efforts to coordinate and align acute care and long-term care services for dual eligible individuals with other items and services furnished under the Medicare program.

(D) Providing support for coordination of contracting and oversight by States and the Centers for Medicare & Medicaid Services with respect to the integration of the Medicare and

Medicaid programs in a manner that is supportive of the goals described in paragraph (3).

(5) REPORT.—The Secretary shall, as part of the budget transmitted under section 1105(a) of title 31, United States Code, submit to Congress an annual report containing recommendations for legislation that would improve care coordination and benefits for dual eligible individuals.

(b) ADDITION OF MEDICAID REPRESENTATIVES TO MEDICARE PAYMENT ADVISORY COMMISSION AND CONSULTATION WITH MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION.—

(1) ADDITION OF MEDICAID REPRESENTATIVE TO MEDICARE PAYMENT ADVISORY COMMISSION.—Section 1805(c)(2)(B) of the Social Security Act (42 U.S.C. 1395b–6(c)(2)(B)) is amended by adding at the end the following sentence: ''Such membership shall also include at least 2 individuals who are nationally recognized for their expertise in financing, benefits, and provider payment policies under the program under title XIX.''.

(2) CONSULTATION WITH MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION.—Section 1805(b) of the Social Security Act (42 U.S.C.

1395b–6(b)) is amended by adding at the end the following new paragraph:

''(9) CONSULTATION WITH MEDICAID AND CHIP PAYMENT AND ACCESS COMMISSION.—In carrying out the duties of the Commission under this subsection, the Commission shall consult with the Medicaid and CHIP Payment and Access Commission established under section 506 of the Children's Health Insurance Program Reauthorization Act of 2009 (Public Law 111–3) on an ongoing basis.''.

(c) MACPAC FUNDING AND TECHNICAL AMENDMENTS.—

(1) FUNDING.—Section 1900(f) of the Social Security Act (42 U.S.C. 1396(f)) is amended—

(A) in the subsection heading, by striking ''AUTHORIZATION OF APPROPRIATIONS'' and inserting ''FUNDING'';

(B) in paragraph (1), by inserting ''(other than for fiscal year 2009)'' before ''in the same manner''; and

(C) by striking paragraph (2) and inserting the following:

''(2) APPROPRIATION.—Out of any funds in the Treasury not otherwise appropriated, there is appro-

priated to MACPAC $11,403,000 for fiscal year 2009 to carry out the provisions of this section.

''(3) AUTHORIZATION.—In addition to amounts made available under paragraph (2), there are authorized to be appropriated for fiscal years beginning with fiscal year 2010, such sums as may be necessary to carry out the provisions of this section.

''(4) AVAILABILITY.—Amounts made available under paragraphs (2) and (3) to carry out the provisions of this section shall remain available until expended.''.

(2) TECHNICAL AMENDMENTS.—Section 1900(b) of such Act (42 U.S.C. 1396) is amended—

(A) in paragraph (1)(D), by striking ''June 1'' and inserting ''June 15''; and

(B) by adding at the end the following:

''(10) CONSULTATION WITH MEDPAC.—

''(A) IN GENERAL.—MACPAC shall regularly consult with the Medicare Payment Advisory Commission (in this paragraph referred to as 'MedPAC') established under section 1805 in carrying out its duties under this section.

''(B) DATA SHARING.—MACPAC and MedPAC shall have unrestricted access to all deliberations, records, and nonproprietary data

of the other such entity, respectively, immediately upon the request of the either such entity.''.

(d) RULE OF CONSTRUCTION.—Nothing in this section—

(1) requires mandatory integrated care under the Medicare or Medicaid programs under titles XVIII and XIX, respectively, of the Social Security Act;

(2) promotes enrollment in specialized MA plans for special needs individuals (as defined in section 1859(b)(6) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)));

(3) promotes the development of Medicaid managed care for dual eligible individuals; or

(4) prevents dual eligible individuals from electing to remain in the original Medicare fee-for-service option, or the right to make such election being protected.

SEC. 102. CREATING A MEDICARE OPERATED PRESCRIPTION DRUG PLAN OPTION.

(a) MEDICARE OPERATED PRESCRIPTION DRUG PLAN OPTION.—

(1) IN GENERAL.—Subpart 2 of part D of the Social Security Act is amended by inserting after

section 1860D–11 (42 U.S.C. 1395w–111) the following new section:

''MEDICARE OPERATED PRESCRIPTION DRUG PLAN OPTION

''SEC. 1860D–11A. (a) IN GENERAL.—Notwithstanding any other provision of this part, for each year (beginning with 2011), in addition to any plans offered under section 1860D–11, the Secretary shall offer one or more Medicare operated prescription drug plans (as defined in subsection (b)) with a service area that consists of the entire United States and shall enter into negotiations in accordance with section 1860D–11A(i) with pharmaceutical manufacturers to reduce the purchase cost of covered part D drugs for eligible part D individuals who enroll in such a plan.

''(b) MEDICARE OPERATED PRESCRIPTION DRUG PLAN DEFINED.—For purposes of this part, the term 'Medicare operated prescription drug plan' means a prescription drug plan that offers qualified prescription drug coverage and access to negotiated prices described in section 1860D–2(a)(1)(A).

''(c) MONTHLY BENEFICIARY PREMIUM.—

''(1) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The monthly beneficiary premium for qualified prescription drug coverage and access to negotiated prices described in section 1860D–

2(a)(1)(A) to be charged under a Medicare operated prescription drug plan shall be uniform nationally. Such premium for months in 2010 and each succeeding year shall be equal to the product of—

"(A) the beneficiary premium percentage (as specified in section 1860D–13(a)(3)); and

"(B) the average monthly per capita actuarial cost of offering the Medicare operated prescription drug plan for the year involved, including administrative expenses.

"(2) PREMIUM SUBSIDY FOR APPLICABLE SUBSIDY ELIGIBLE INDIVIDUALS.—

"(A) FULL SUBSIDY ELIGIBLE INDIVIDUALS.—In the case of an applicable subsidy eligible individual described in paragraph (4)(A), the individual is entitled under this section to an income-related premium subsidy equal to 100 percent of the monthly beneficiary premium of the Medicare operated prescription drug plan.

"(B) OTHER SUBSIDY ELIGIBLE INDIVIDUALS.—In the case of an applicable subsidy eligible individual described in paragraph (4)(B), the individual is entitled under this section to

an income-related premium subsidy determined on a linear sliding scale as follows:

"(i) One hundred percent of the amount described in subparagraph (A) for individuals with incomes at or below 135 percent of such level.

"(ii) Seventy-five percent of such amount for individuals with incomes above 135 percent of such level and at or below 140 percent of such level.

"(iii) Fifty percent of such amount for individuals with incomes above 140 percent of such level and at or below 145 percent of such level.

"(iv) Twenty-five percent of such amount for individuals with incomes above 145 percent of such level and below 150 percent of such level.

"(v) Zero percent of such amount for individuals with incomes at 150 percent of such level.

"(3) COST-SHARING FOR APPLICABLE SUBSIDY ELIGIBLE INDIVIDUALS.—

"(A) FULL-SUBSIDY ELIGIBLE INDIVIDUALS.—In the case of an applicable subsidy eli-

gible individual described in paragraph (4)(A), the provisions of section 1860D–14(a)(1) shall apply, except the premium subsidy under paragraph (2)(A) shall be substituted for the premium subsidy under subparagraph (A) of such section 1860D–14(a)(1).

''(B) OTHER SUBSIDY ELIGIBLE INDIVIDUALS.—In the case of an applicable subsidy eligible individual described in paragraph (4)(B), the provisions of section 1860D–14(a)(2) shall apply, except the premium subsidy under paragraph (2)(B) shall be substituted for the premium subsidy under subparagraph (A) of such section 1860D–14(a)(2).

''(4) DEFINITION OF APPLICABLE SUBSIDY ELIGIBLE INDIVIDUALS.—For purposes of paragraphs (2) and (3), the term 'applicable subsidy eligible individual' means the following:

''(A) FULL-SUBSIDY ELIGIBLE INDIVIDUALS.—

''(i) INDIVIDUALS WITH INCOME BELOW 135 PERCENT OF POVERTY LINE.—Any individual who—

''(I) is enrolled in a Medicare operated prescription drug plan;

"(II) is determined to have income that is below 135 percent of the poverty line applicable to a family of the size involved; and

"(III) meets the resources requirement described in section 1860D–14(a)(3)(E), as amended by section 201 of the Medicare Prescription Drug Coverage Improvement Act.

"(ii) CERTAIN OTHER INDIVIDUALS.—Any individual who is enrolled in a Medicare operated prescription drug plan who—

"(I) is a full-benefit dual eligible individual (as defined in section 1935(c)(6));

"(II) receives benefits under the supplemental security income program under title XVI; or

"(III) is eligible for medical assistance under clause (i), (iii), or (iv) of section 1902(a)(10)(E).

"(B) OTHER SUBSIDY ELIGIBLE INDIVIDUALS.—Any individual who—

"(i) is not described in paragraph (1);

"(ii) is enrolled in a Medicare operated prescription drug plan;

"(iii) is determined to have income that is below 150 percent of the poverty line applicable to a family of the size involved; and

"(iv) meets the resources requirement described in section 1860D–14(a)(3)(E), as amended by section 201 of the Medicare Prescription Drug Coverage Improvement Act.

"(d) USE OF A FORMULARY AND FORMULARY INCENTIVES.—

"(1) USE OF A FORMULARY.—

"(A) IN GENERAL.—With respect to the operation of a Medicare operated prescription drug plan, the Secretary shall establish and apply a formulary (and may include formulary incentives described in paragraph (5)(C)(ii)) in accordance with this subsection in order to—

"(i) increase patient safety;

"(ii) increase appropriate use and reduce inappropriate use of drugs; and

"(iii) reward value.

"(B) DEFAULT INITIAL FORMULARY.—Until such time as the Secretary establishes and applies the initial formulary under paragraph (5), a Medicare operated prescription drug plan shall be required to include all drugs approved for safety and effectiveness as a prescription drug under the Federal Food, Drug, and Cosmetic Act that are covered part D drugs (and may include formulary incentives described in paragraph (5)(C)(ii)).

"(2) REQUIREMENTS FOR FORMULARIES.—The Secretary shall establish a formulary that meets the following requirements:

"(A) Except as provided in subparagraph (B), the formulary includes the covered outpatient drugs of any manufacturer which has entered into and complies with an agreement with the Secretary under this section.

"(B) A covered outpatient drug may be excluded with respect to the treatment of a specific disease or condition for an identified population (if any) only if, based on the drug's labeling (or, in the case of a drug the prescribed use of which is not approved under the Federal Food, Drug, and Cosmetic Act but is a medi-

cally accepted indication (as defined in section 1860D–2(e)(4))), the excluded drug does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcome of such treatment for such population over other drugs included in the formulary and there is a written explanation (available to the public) of the basis for the exclusion.

''(C) The Secretary permits coverage of a drug excluded from the formulary pursuant to a prior authorization program that is consistent with paragraph (3).

''(D) The formulary meets such other requirements as the Secretary may impose in order to achieve program savings consistent with protecting the health of program beneficiaries.

A prior authorization program established under paragraph (3) is not a formulary subject to the requirements of this paragraph.

''(3) REQUIREMENTS OF PRIOR AUTHORIZATION PROGRAMS.—The Secretary may require, with respect to drugs dispensed on or after July 1, 1991, the approval of the drug before its dispensing for

any medically accepted indication (as defined in section 1860D–2(e)(4)) only if the system providing for such approval—

"(A) provides response by telephone or other telecommunication device within 24 hours of a request for prior authorization; and

"(B) provides for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation (as defined by the Secretary).

"(4) OTHER PERMISSIBLE RESTRICTIONS.—The Secretary may impose limitations, with respect to all such drugs in a therapeutic class, on the minimum or maximum quantities per prescription or on the number of refills, if such limitations are necessary to improve patient safety, discourage waste, or address instances of fraud or abuse by individuals in any manner authorized under this Act.

"(5) DEVELOPMENT OF INITIAL FORMULARY.—

"(A) IN GENERAL.—In selecting covered part D drugs for inclusion in a formulary, the Secretary shall consider clinical benefit and price.

"(B) ROLE OF AHRQ.—The Director of the Agency for Healthcare Research and Quality

shall be responsible for assessing the clinical benefit of covered part D drugs and making recommendations to the Secretary regarding which drugs should be included in the formulary. In conducting such assessments and making such recommendations, the Director shall—

''(i) consider safety concerns including those identified by the Federal Food and Drug Administration;

''(ii) use available data and evaluations, with priority given to randomized controlled trials, to examine clinical effectiveness, comparative effectiveness, safety, and enhanced compliance with a drug regimen;

''(iii) use the same classes of drugs developed by United States Pharmacopeia for this part;

''(iv) consider evaluations made by—

''(I) the Director under section 1013 of Medicare Prescription Drug, Improvement, and Modernization Act of 2003;

''(II) other Federal entities, such as the Secretary of Veterans Affairs; and

''(III) other private and public entities, such as the Drug Effectiveness Review Project and Medicaid programs; and

''(v) recommend to the Secretary—

''(I) those drugs in a class that provide a greater clinical benefit, including fewer safety concerns or less risk of side-effects, than another drug in the same class that should be included in the formulary;

''(II) those drugs in a class that provide less clinical benefit, including greater safety concerns or a greater risk of side-effects, than another drug in the same class that should be excluded from the formulary; and

''(III) drugs in a class with same or similar clinical benefit for which it would be appropriate for the Secretary to competitively bid (or negotiate) for placement on the formulary.

"(C) CONSIDERATION OF AHRQ RECOMMENDATIONS.—

"(i) IN GENERAL.—Not later than January 1, 2011, the Secretary, after taking into consideration the recommendations under subparagraph (B)(v), shall establish a formulary, and formulary incentives, to encourage use of covered part D drugs that—

"(I) have a lower cost and provide a greater clinical benefit than other drugs;

"(II) have a lower cost than other drugs with same or similar clinical benefit; and

"(III) drugs that have the same cost but provide greater clinical benefit than other drugs.

"(ii) FORMULARY INCENTIVES.—The formulary incentives under clause (i) may be in the form of one or more of the following:

"(I) Tiered copayments.

"(II) Prior authorization.

"(III) Step therapy.

''(IV) Medication therapy management.

''(V) Generic drug substitution.

''(iii) FLEXIBILITY.—In applying such formulary incentives the Secretary may decide not to impose any cost-sharing for a covered part D drug for which—

''(I) the elimination of cost sharing would be expected to increase compliance with a drug regimen; and

''(II) compliance would be expected to produce savings under part A or B or both.

''(iv) DEVELOPMENT OF TRANSPARENT PROCESS TO EXPLAIN FORMULARY INCENTIVES.—Not later than January 1, 2011, the Secretary shall develop and implement a transparent process to identify and explain to beneficiaries formulary incentives under clause (i). Such process shall be designed to assist beneficiaries in understanding how prior authorization requests and other formulary incentives will be evaluated.

''(6) LIMITATIONS ON FORMULARY.—In any formulary established under this subsection, the formulary may not be changed during a year, except—

''(A) to add a generic version of a covered part D drug that entered the market;

''(B) to remove such a drug for which a safety problem is found; and

''(C) to add a drug that the Secretary identifies as a drug which treats a condition for which there has not previously been a treatment option or for which a clear and significant benefit has been demonstrated over other covered part D drugs.

''(7) ADDING DRUGS TO THE INITIAL FORMULARY.—

''(A) USE OF ADVISORY COMMITTEE.—The Secretary shall establish and appoint an advisory committee (in this paragraph referred to as the 'advisory committee')—

''(i) to review petitions from drug manufacturers, health care provider organizations, patient groups, and other entities for inclusion of a drug in, or other changes to, such formulary; and

"(ii) to recommend any changes to the formulary established under this subsection.

"(B) COMPOSITION.—The advisory committee shall be composed of 9 members and shall include representatives of physicians, pharmacists, and consumers and others with expertise in evaluating prescription drugs. The Secretary shall select members based on their knowledge of pharmaceuticals and the Medicare and Medicaid populations. Members shall be deemed to be special Government employees for purposes of applying the conflict of interest provisions under section 208 of title 18, United States Code, and no waiver of such provisions for such a member shall be permitted.

"(C) CONSULTATION.—The advisory committee shall consult, as necessary, with physicians who are specialists in treating the disease for which a drug is being considered.

"(D) REQUEST FOR STUDIES.—The advisory committee may request the Agency for Healthcare Research and Quality or an academic or research institution to study and make

a report on a petition described in subparagraph (A)(ii) in order to assess—

"(i) clinical effectiveness;

"(ii) comparative effectiveness;

"(iii) safety; and

"(iv) enhanced compliance with a drug regimen.

"(E) RECOMMENDATIONS.—The advisory committee shall make recommendations to the Secretary regarding—

"(i) whether a covered part D drug is found to provide a greater clinical benefit, including fewer safety concerns or less risk of side-effects, than another drug in the same class that is currently included in the formulary and should be included in the formulary;

"(ii) whether a covered part D drug is found to provide less clinical benefit, including greater safety concerns or a greater risk of side-effects, than another drug in the same class that is currently included in the formulary and should not be included in the formulary; and

"(iii) whether a covered part D drug has the same or similar clinical benefit to a drug in the same class that is currently included in the formulary and whether the drug should be included in the formulary.

"(F) LIMITATIONS ON REVIEW OF MANUFACTURER PETITIONS.—The advisory committee shall not review a petition of a drug manufacturer under subparagraph (A)(ii) with respect to a covered part D drug unless the petition is accompanied by the following:

"(i) Raw data from clinical trials on the safety and effectiveness of the drug.

"(ii) Any data from clinical trials conducted using active controls on the drug or drugs that are the current standard of care.

"(iii) Any available data on comparative effectiveness of the drug.

"(iv) Any other information the Secretary requires for the advisory committee to complete its review.

"(G) RESPONSE TO RECOMMENDATIONS.—The Secretary shall review the recommendations of the advisory committee and if the Sec-

retary accepts such recommendations the Secretary shall modify the formulary established under this subsection accordingly. Nothing in this section shall preclude the Secretary from adding to the formulary a drug for which the Director of the Agency for Healthcare Research and Quality or the advisory committee has not made a recommendation.

''(H) NOTICE OF CHANGES.—The Secretary shall provide timely notice to beneficiaries and health professionals about changes to the formulary or formulary incentives.

''(I) STABILITY OF BENEFIT.—Once a covered part D drug has been added to the formulary established under this subsection, the drug may not be removed from the formulary for at least a 3-year period, unless the Secretary determines there are safety or efficacy concerns with respect to the drug.

''(8) NON-EXCLUDABLE DRUGS.—The following drugs or classes of drugs shall not be excluded from the default initial formulary (as described in paragraph (1)(B)) or the initial formulary established by the Secretary (as described in paragraph (5)):

''(A) Barbiturates.

''(B) Benzodiazepines.

''(e) INFORMING BENEFICIARIES.—

''(1) IN GENERAL.—The Secretary shall take steps to inform beneficiaries about the availability of a Medicare operated prescription drug plan or plans including providing information in the annual handbook distributed to all beneficiaries and adding information to the official public Medicare website related to prescription drug coverage available through this part.

''(2) SOLE RESPONSIBILITY FOR MARKETING BY THE SECRETARY.—

''(A) IN GENERAL.—The Secretary shall have sole responsibility for marketing Medicare operated prescription drug plans.

''(B) AUTHORIZATION.—There is authorized to be appropriated to the Secretary such sums as are necessary to carry out such marketing.

''(f) APPLICATION OF ALL OTHER REQUIREMENTS FOR PRESCRIPTION DRUG PLANS.—Except as specifically provided in this section, any Medicare operated drug plan shall meet the same requirements as apply to any other prescription drug plan, including the requirements of section 1860D–4(b)(1) relating to assuring pharmacy access.

''(g) AUTOMATIC ENROLLMENT.—The Secretary shall establish procedures to provide for the automatic enrollment of subsidy eligible individuals (as defined in section 1860D–14(a)(3)) in a Medicare operated prescription drug plan in the case where such individuals lose their current prescription drug coverage, become part D eligible individuals, or in instances where the amount of the monthly beneficiary premium under the prescription drug plan the individual is enrolled in is greater than the premium subsidy amount described in section 1860D–14(b).

''(h) RULE OF CONSTRUCTION REGARDING ELIGIBILITY FOR MEDICAL ASSISTANCE.—In no case may enrollment in a Medicare operated prescription drug plan affect the eligibility of an individual to receive medical assistance under a State plan under title XIX.''.

(2) EFFECTIVE DATE.—The amendment made by this subsection shall take effect as if included in the enactment of section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

(b) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—

(A) Section 1860D–3(a) of the Social Security Act (42 U.S.C. 1395w–103(a)) is amend-

ed by adding at the end the following new paragraph:

''(4) AVAILABILITY OF THE MEDICARE OPERATED PRESCRIPTION DRUG PLAN.—A Medicare operated prescription drug plan (as defined in section 1860D–11A(c)) shall be offered nationally in accordance with section 1860D–11A.''.

(B)(i) Section 1860D–3 of the Social Security Act (42 U.S.C. 1395w–103) is amended by adding at the end the following new subsection:

''(c) PROVISIONS ONLY APPLICABLE IN 2006, 2007, 2008, AND 2009.—The provisions of this section shall only apply with respect to 2006, 2007, 2008, and 2009.''.

(C) Section 1860D–11(g) of such Act (42 U.S.C. 1395w–111(g)) is amended by adding at the end the following new paragraph:

''(8) NO AUTHORITY FOR FALLBACK PLANS AFTER 2009.—A fallback prescription drug plan shall not be available after December 31, 2009.''.

(D) Section 1860D–13(c)(3) of such Act (42 U.S.C. 1395w–113(c)(3)) is amended—

(i) in the heading, by inserting ''AND MEDICARE OPERATED PRESCRIPTION DRUG PLANS'' after ''FALLBACK PLANS''; and

(ii) by inserting ''or a Medicare operated prescription drug plan'' after ''a fallback prescription drug plan''.

(E) Section 1860D–14(a) of the Social Security Act (42 U.S.C. 1395w–114(a)) is amended—

(i) in paragraph (1), by striking ''In the'' and inserting ''Subject to section 1860D–11A(c)(2)(A), in the''; and

(ii) in paragraph (2), by striking ''In the'' and inserting ''Subject to section 1860D–11A(c)(2)(B), in the''.

(F) Section 1860D–16(b)(1) of such Act (42 U.S.C.1395w–116(b)(1)) is amended—

(i) in subparagraph (C), by striking ''and'' after the semicolon at the end;

(ii) in subparagraph (D), by striking the period at the end and inserting ''; and''; and

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

''(E) payments for expenses incurred with respect to the operation of Medicare operated prescription drug plans under section 1860D–11A.''.

(H) Section 1860D–41(a) of such Act (42 U.S.C. 1395w–151(a)) is amended by adding at the end the following new paragraph:

''(19) MEDICARE OPERATED PRESCRIPTION DRUG PLAN.—The term 'Medicare operated prescription drug plan' has the meaning given such term in section 1860D–11A(c).''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall take effect as if included in the enactment of section 101 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.

SEC. 103. ACCREDITATION REQUIREMENT FOR ALL SPECIALIZED MEDICARE ADVANTAGE PLANS AND REVISIONS RELATING TO SPECIALIZED MEDICARE ADVANTAGE PLANS FOR SPECIAL NEEDS INDIVIDUALS.

(a) ACCREDITATION REQUIREMENT.—Section 1859(f) of the Social Security Act (42 U.S.C. 1395w–28(f)) is amended—

(1) in paragraphs (2)(B), (3)(B), and (4)(B), by striking ''paragraph (5)'' and inserting ''paragraphs (5) and (6)(B)'' each place it appears; and

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

''(6) ACCREDITATION REQUIREMENT FOR ALL SNPS.—

''(A) ESTABLISHMENT OF ACCREDITATION PROGRAM.—Not later than January 1, 2011, the Secretary, acting through the Director of the Agency for Healthcare Research and Quality and the Administrator of the Centers for Medicare & Medicaid Services, shall enter into a contract with the National Committee for Quality Assurance under which the National Committee for Quality Assurance shall develop an accreditation (and reaccreditation) program for all specialized MA plans for special needs individuals (as defined in subsection (b)(6)), including specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii).

''(B) REQUIREMENT.—The requirement described in this subparagraph is that, effective for plan years beginning on or after January 1, 2012, a specialized MA plan for special needs individuals (as so defined) meet the accreditation standards developed by the National Committee for Quality Assurance under the contract under subparagraph (A).''.

(b) REVISIONS RELATING TO SPECIALIZED MEDICARE ADVANTAGE PLANS FOR SPECIAL NEEDS INDIVIDUALS.—Section 1859 of the Social Security Act (42 U.S.C. 1395w–28) is amended—

(1) in subsection (f)(3)—

(A) in subparagraph (D), in the first sentence, by inserting ''and the plan provides for the coordination of coverage for benefits under this title (including this part) and such medical assistance'' before the period at the end; and

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

''(E) The plan meets the requirements described in subsection (g).''; and

(2) by adding at the end the following new subsection:

''(g) ADDITIONAL REQUIREMENTS FOR DUAL SNPS.—The following requirements are described in this subsection:

''(1) PROVISION OF INFORMATION.—The plan provides special needs individuals described in subsection (b)(6)(B)(ii) up-front information about formularies and utilization management strategies under the plan as part of the information disclosed under section 1852(c)(1).

''(2) PREMIUM.—The premium under the plan does not exceed the premium subsidy amount described in section 1860D–14(b).

''(3) FORMULARY.—

''(A) IN GENERAL.—Subject to subparagraph (B), the plan has a formulary that, based on the most recent data available, covers at least—

''(i) 95 percent of the 200 most commonly prescribed non-duplicative generic covered part D drugs for the population of individuals entitled to (or enrolled for) benefits under part A or enrolled under part B; and

''(ii) 95 percent of the 200 most commonly prescribed non-duplicative brand name covered part D drugs for such population.

''(B) INCLUSION OF DRUGS IN CERTAIN CATEGORIES AND CLASSES.—The plan formulary shall include all covered part D drugs in the categories and classes identified by the Secretary under section 1860D–4(b)(3)(G)(i).

''(4) PHARMACY ACCESS.—The plan secures participation in its network of a sufficient number of

pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access by at least 90 percent of enrollees who are residing in long-term care facilities within the region.

''(5) OPERATION OF A DEDICATED CUSTOMER ASSISTANCE PHONE LINE.—The plan shall maintain a toll-free number or numbers for inquiries concerning the plan that is solely for the use of such individuals, the designated representatives of such individuals (including designated family members), advocates of such individuals, providers of services, and suppliers.

''(6) E-PRESCRIBING.—The plan adopts electronic prescribing for enrollees, in accordance with section 1860D–4(e), to coordinate care.

''(7) DEMONSTRATE EXPERIENCE AND EXPERTISE.—The plan demonstrates, to the satisfaction of the Secretary, with input from the States, sufficient experience and expertise in serving low-income, publicly insured, or previously uninsured populations.

''(8) REDUCING HEALTH DISPARITIES.—The plan has established and implemented systems and processes which have been approved by the Secretary to address and reduce health disparities based on

race, ethnicity, gender, age, and socio-economic status.

''(9) PROFICIENCY IN CARE COORDINATION.—The plan demonstrates, to the satisfaction of the Secretary, proficiency in care coordination for the purpose of providing, or arranging for the provision of, services to assist individuals enrolled in the plan in obtaining access to other public and private benefits, including services to address non-medical and psycho-social needs.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to plan year beginning on or after January 1, 2011.

SEC. 104. PROVIDING BETTER CARE COORDINATION FOR LOW-INCOME BENEFICIARIES IN MEDICARE PART D.

(a) CONTINUOUS UPDATING OF ELIGIBILITY AND ENROLLMENT DATA FOR DUAL ELIGIBLE INDIVIDUALS.—

(1) STATE REQUIREMENT.—Section 1935(a) of the Social Security Act (42 U.S.C. 1396u–5(a)) is amended by adding at the end the following new paragraph:

''(4) UPDATING OF ELIGIBILITY AND ENROLLMENT INFORMATION ON A ROLLING BASIS.—Begin-

ning not later than October 1, 2011, the State shall update information with respect to the eligibility and enrollment of individuals receiving any kind of medical assistance under the State plan, including medical assistance for payment of Medicare cost-sharing described in section 1905(p)(3), in MA plans and prescription drug plans under parts C and D, respectively, of title XVIII (including eligibility determinations under paragraph (2) and screening and enrollment under paragraph (3)) not less frequently than on a weekly basis.''.

(2) SECRETARIAL REQUIREMENTS.—Section 1935(d) of the Social Security Act (42 U.S.C. 1396u–5(d)) is amended by adding at the end the following new paragraph:

''(3) UPDATING OF ELIGIBILITY AND ENROLLMENT INFORMATION ON A ROLLING BASIS.—The Secretary shall update information with respect to the eligibility and enrollment of individuals receiving any kind of medical assistance under this title, including medical assistance for payment of Medicare cost-sharing described in section 1905(p)(3), in MA plans and prescription drug plans under parts C and D, respectively, of title XVIII as it is received, but not less frequently than on a weekly basis.''.

(b) IDENTIFYING DUAL ELIGIBLE INDIVIDUALS IN DATA RECORDS.—

(1) IN GENERAL.—Section 1859 of the Social Security Act (42 U.S.C. 1305w–28), as amended by section 103, is amended by adding at the end the following new subsection:

''(h) IDENTIFYING DUAL ELIGIBLE INDIVIDUALS IN DATA RECORDS.—

''(1) IDENTIFICATION BY THE SECRETARY.—Beginning on January 1, 2010, the Secretary shall clearly identify all dual eligible individuals that are enrolled in MA plans and prescription drug plans for the current plan year and reflect the low-income subsidy status of such individuals for each plan year in every data record file maintained in the Medicare electronic database and every such file that is used to enroll or adjudicate claims for such individuals.

''(2) IDENTIFICATION BY MA PLANS AND PRESCRIPTION DRUG PLANS.—Beginning on January 1, 2010, each MA plan and prescription drug plan shall clearly identify all dual eligible individuals that are enrolled in the plan for the current plan year and reflect the low-income subsidy status of such individuals for the plan year in every data record file main-

tained by the plan that is used to enroll or adjudicate claims for such individuals under the plan.

''(3) REGULATIONS.—The Secretary shall establish regulations to carry out this subsection. Such regulations shall require that—

''(A) for each plan year and each dual eligible individual, the Secretary identify on the Medicare enrollment database dual eligible status that has been verified with a State or the District of Columbia;

''(B) for each plan year and each dual eligible individual, the Secretary identify on the Medicare enrollment database the low-income subsidy level of the individual; and

''(C) each data file that is necessary to ensure that such dual eligible status is transmitted to an MA plan or a prescription drug plan, at the time the Secretary certifies the enrollment of the dual eligible individual in the plan.

''(4) DEFINITION OF DUAL ELIGIBLE INDIVIDUAL.—The term 'dual eligible individual' means a special needs individual described in subsection (b)(6)(B)(ii).''.

(2) CONFORMING AMENDMENT.—Section 1860D–42 of the Social Security Act (42 U.S.C. 1395w–152) is amended by adding at the end the following new subsection:

''(c) IDENTIFYING DUAL ELIGIBLE INDIVIDUALS IN DATA RECORDS.—For provisions regarding the identification by prescription drug plans of dual eligible individuals in data records, see section 1859(h).''.

(c) ASSURING CONTINUITY OF PRESCRIPTION DRUG COVERAGE FOR DUAL ELIGIBLES.—

(1) IN GENERAL.—Section 1935(d)(1) of the Social Security Act (42 U.S.C. 1396u–5(d)(1)) is amended—

(A) by inserting ''on and after the date described in subparagraph (B),'' after ''notwithstanding any other provision of this title,'';

(B) by striking ''In the case of'' and inserting the following:

''(A) IN GENERAL.—In the case of''; and

(C) by adding at the end the following:

''(B) DATE DESCRIBED.—For purposes of subparagraph (A), the date described in this subparagraph is the date on which the State confirms with a Medicare Advantage plan under part C of title XVIII or a prescription drug

plan under part D of such title (including a Medicare operated prescription drug plan under section 1860D–11A), as applicable—

"(i) that the part D eligible individual (as so defined) who is described in subsection (c)(6)(A)(ii) is enrolled with such plan; and

"(ii) the cost-sharing and premiums applicable for the individual for such plan.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) take effect on January 1, 2011.

(d) COLLECTION AND SHARING OF DRUG UTILIZATION DATA AND FORMULARY INFORMATION FOR FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—Section 1860D–42 of the Social Security Act, as amended by subsection (b), is amended by adding at the end the following new subsection:

"(d) COLLECTION AND SHARING OF DRUG UTILIZATION DATA AND FORMULARY INFORMATION FOR FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

"(1) PLAN REQUIREMENT.—A PDP sponsor of a prescription drug plan (including a Medicare operated prescription drug plan under section 1860D–

11A) and an MA organization offering an MA–PD plan shall submit to the Secretary such information regarding the drug utilization of enrollees in such plans who are full-benefit dual eligible individuals (as defined in section 1935(c)(6)) and any formularies under the plans such individuals are enrolled in as the Secretary determines appropriate to carry out paragraph (2). Such information shall be submitted—

"(A) on a rolling basis (as determined appropriate by the Secretary); and

"(B) using a single, uniform reporting process.

"(2) COLLECTION AND SHARING OF DATA.—The Secretary shall collect data on the drug utilization of full-benefit dual eligible individuals (as so defined) and on any formularies under the plans such individuals are enrolled in. The Secretary shall share such data with the States and the District of Columbia on as close to a real-time basis as possible.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 2010.

SEC. 105. IMPROVING TRANSITION OF NEW DUAL ELIGIBLE INDIVIDUALS TO MEDICARE PRESCRIPTION DRUG COVERAGE AND PRESUMPTIVE ELIGIBILITY FOR LOW-INCOME SUBSIDIES.

(a) UPDATING THE POINT OF SALE FACILITATED ENROLLMENT PROCESS.—

(1) PROVIDING BETTER INITIAL PROTECTION FOR DUAL ELIGIBLE INDIVIDUALS.—Beginning January 1, 2011, each contractor under the Point of Sale Facilitated Enrollment process of the Department of Health and Human Services shall enroll full-benefit dual eligible individuals (as defined in section 1935(c)(6)) into a Medicare operated prescription drug plan under section 1860D–11A of the Social Security Act, as added by section 102.

(2) COMPETITIVE BIDDING OF POINT OF SALE CONTRACT.—The Secretary of Health and Human Services shall establish procedures to ensure that each contract entered into under such process on or after January 1, 2010, under the Medicare program under title XVIII of the Social Security Act is rebid every 3 years through a competitive bidding process.

(3) REQUIRING BETTER EDUCATION ABOUT POINT OF SALE FACILITATED ENROLLMENT PROCESS.—Not later than January 1, 2010, the Secretary of Health and Human Services shall have a

comprehensive plan in place for proactively educating beneficiaries under the Medicare prescription drug program under part D of title XVIII of the Social Security Act, pharmacists, skilled nursing facilities (as defined in section 1819(a) of such Act (42 U.S.C. 1395i–3(a))), nursing facilities (as defined in section 1919(a) of such Act (42 U.S.C. 1396r(a))), counselors under State health insurance assistance programs (SHIPs), and other advocacy organizations (including disability organizations) about the Point of Sale Facilitated Enrollment process. Under such plan—

(A) information about the Point of Sale Facilitated Enrollment process shall be included in all mailers to the entities and individuals described in the preceding sentence prior to the annual, coordinated election period described in section 1851(e)(3) of the Social Security Act (42 U.S.C. 1395w–21(e)(3)); and

(B) a description of such process and other relevant information shall be prominently displayed on the Medicare Internet website throughout the year.

(4) MANDATORY USE OF POINT OF SALE FACILITATED ENROLLMENT PROCESS.—Section

1860D–4(b)(1) of the Social Security Act (42 U.S.C. 1395w–104(b)(1)) is amended by adding at the end the following new subparagraph:

"(F) MANDATORY USE OF POINT OF SALE FACILITATED ENROLLMENT PROCESS.—Notwithstanding any other provision of law, beginning January 1, 2011, the terms and conditions under subparagraph (A) shall require participating pharmacies to use the Point of Sale Facilitated Enrollment process of the Department of Health and Human Services.".

(b) PRESUMPTIVE ELIGIBILITY AND MANDATORY TRANSITION PERIOD FOR SUBSIDY ELIGIBLE INDIVIDUALS.—Section 1860D–14 of the Social Security Act (42 U.S.C. 1395w–104) is amended—

(1) by redesignating subsection (d) as subsection (e); and

(2) by inserting after subsection (c) the following new subsection:

"(d) PRESUMPTIVE ELIGIBILITY AND MANDATORY TRANSITION PERIOD.—

"(1) PRESUMPTIVE ELIGIBILITY.—An individual shall be presumed to be a subsidy eligible individual (as defined in section 1860D–14(a)(3)) if the individual presents at the pharmacy with—

''(A) reliable evidence of—

''(i) Medicaid enrollment, such as a Medicaid card, recent history of Medicaid billing in the pharmacy patient profile, a copy of a current Medicaid award letter, or confirmation from a Medicaid enrollment database; or

''(ii) eligibility for an income-related subsidy under section 1860D–14, such as a low-income subsidy notice from the Secretary or the Commissioner of Social Security, or confirmation from a Social Security enrollment database; and

''(B) reliable evidence of Medicare enrollment, such as a Medicare identification card, a Medicare enrollment approval letter, a Medicare Summary Notice, or confirmation from an official Medicare hotline or Medicare database.

''(2) MAKING SUBSIDY ELIGIBLE INDIVIDUALS WHOLE.—

''(A) IN GENERAL.—In the case of a subsidy eligible individual (as so defined) who, between November 15, 2005, and December 31, 2009, has wrongly been forced to pay higher copayments, premiums, and deductibles than

those applicable under this part and part C for such individual, the subsidy eligible individual shall be eligible for compensation under the program under this title.

''(B) ESTABLISHMENT OF PROCESS FOR REFUND OF AMOUNT INCORRECTLY PAID.—The Secretary shall establish a process under which—

''(i) prescription drug plans and MA–PD plans are billed for copayments and deductibles inappropriately charged to subsidy eligible individuals during retroactive coverage periods;

''(ii) the amounts incorrectly paid by the subsidy eligible individual as a result of those inappropriate charges are refunded directly to the individual, either through a rebate on future payments of premiums under part B or through a direct payment to the individual; and

''(iii) prescription drug plans and MA–PD plans are required to provide detailed accounting to the Secretary of the basis for any rebate or payment to a subsidy eligible individual under this subpara-

graph, including the applicable period of retroactive coverage for the subsidy eligible individual and whether the rebate or credit is with respect to an inappropriately charged copayment or deductible.

''(C) NOTIFICATION.—Subsidy eligible individuals shall be notified of the requirements of this subsection in their 2010 plan year materials.

''(D) NO EFFECT ON ELIGIBILITY FOR OTHER BENEFITS.—Amounts refunded to a subsidy eligible individual under this subsection shall be disregarded for purposes of determining or continuing the beneficiary's eligibility for receipt of benefits under any other Federal, State, or locally funded assistance program, including benefits paid under titles II, XVI, XVIII, XIX, or XXI.''.

SEC. 106. REQUIRED INFORMATION ON TRANSITION FROM SKILLED NURSING FACILITIES AND NURSING FACILITIES TO PART D PLANS.

(a) SKILLED NURSING FACILITIES.—Section 1819(b) of the Social Security Act (42 U.S.C. 1395i–3(b)) is amended by adding at the end the following new paragraph:

''(9) INFORMATION ON TRANSITION TO PRESCRIPTION DRUG COVERAGE.—A skilled nursing facility must provide information to residents and the families of residents on how to transition to prescription drug coverage under MA–PD plans under part C and prescription drug plans under part D upon discharge from the facility.''.

(b) NURSING FACILITIES.—Section 1919(b) of the Social Security Act (42 U.S.C. 1395i–3(b)) is amended by adding at the end the following new paragraph:

''(9) INFORMATION ON TRANSITIONING TO PRESCRIPTION DRUG COVERAGE.—A nursing facility must provide information to residents and the families of residents on how to transition to prescription drug coverage under MA–PD plans under part C and prescription drug plans under part D upon discharge from the facility.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2011.

SEC. 107. STREAMLINED PHARMACY COMPLIANCE PACKAGING.

(a) IN GENERAL.—Section 1860D–4(b)(3) of the Social Security Act (42 U.S.C. 1395w–104(b)(3)) is amended by adding at the end the following new subparagraph:

''(G) STREAMLINED PHARMACY COMPLIANCE PACKAGING FOR DUAL ELIGIBLE INDIVIDUALS.—A PDP sponsor of a prescription drug plan shall streamline pharmacy compliance packaging for individuals enrolled in the plan who—

''(i) are entitled to medical assistance under a State plan under title XVIII; and

''(ii) reside in a nursing home.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to drugs dispensed on or after January 1, 2010.

SEC. 108. LOWERING COVERED PART D DRUG PRICES ON BEHALF OF MEDICARE BENEFICIARIES.

(a) REPEAL OF PROHIBITION.—Section 1860D–11 of the Social Security Act (42 U.S.C. 1395w–111) is amended by striking subsection (i) and inserting the following:

''(i) LOWERING COVERED PART D DRUG PRICES.—

''(1) IN GENERAL.—The Secretary shall reduce the purchase cost of covered part D drugs by implementing 2 or more of the following strategies on an annual basis (beginning with 2011):

''(A) Negotiating directly with pharmaceutical manufacturers for additional discounts, rebates, and other price concessions that may

be made available to Medicare operated prescription drug plans under section 1860D–11A for covered part D drugs.

''(B) Entering into rebate agreements with manufacturers to provide to the Secretary a rebate for any covered outpatient drug of a manufacturer dispensed during a rebate period specified in the agreement to a subsidy eligible individual described (or treated as described) in section 1860D–14(a)(1) for which payment was made by a PDP sponsor under part D of title XVIII or an MA organization under part C of such title for such period in an amount determined in the same manner as the rebate amount for such drug would have been determined under subsection (c) of section 1927 if the dispensing of the drug to such individual was paid for by a State and subject to a rebate agreement entered into under such section (and allocating any such rebates received among the prescription drug plans of such PDP sponsors and MA–PD plans offered by such organizations based on the enrollment of such individuals in such plans).

"(C) In consultation with the Director of the Agency for Healthcare Research and Quality, using data from relevant and unbiased studies on the comparative clinical effectiveness of covered part D drugs to—

"(i) educate physicians and pharmacists; and

"(ii) provide information to PDP sponsors of prescription drug plans and MA organizations offering MA–PD plans for use in making decisions regarding plan formularies.

"(D) Instituting prescription drug prices negotiated under the Federal Supply Schedule of the General Services Administration for the reimbursement of covered part D drugs.

"(2) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the PDP sponsor of a prescription drug plan or an MA organization offering an MA–PD plan from obtaining a discount or reduction of the price for a covered part D drug below the price negotiated by the Secretary for a Medicare-operated plan under paragraph (1)(A).

''(3) ANNUAL REPORTS TO CONGRESS.—Not later than January 1, 2012, and annually thereafter, the Secretary shall submit to the Committee on Finance of the Senate and to the Committee on Ways and Means, the Committee on Energy and Commerce, and the Committee on Oversight and Government Reform of the House of Representatives a report on the strategies implemented by the Secretary under paragraph (1) to achieve lower prices on covered part D drugs for beneficiaries, including the prices of such covered part D drugs and any price concessions achieved by the Secretary as a result of such implementation.''.

SEC. 109. CORRECTION OF FLAWS IN DETERMINATION OF PHASED-DOWN STATE CONTRIBUTION FOR FEDERAL ASSUMPTION OF PRESCRIPTION DRUG COSTS FOR DUALLY ELIGIBLE INDIVIDUALS.

Section 1935(c) of the Social Security Act (42 U.S.C. 1396u–5(c)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking ''Each'' and inserting ''Subject to paragraph (7), each''; and

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

''(7) MODIFICATION OF DETERMINATION OF AMOUNT OF STATE CONTRIBUTION.—Not later than January 1, 2011, the Secretary of Health and Human Services (in this section referred to as the 'Secretary'), acting through the Director of the Federal Coordinated Health Care Office established under section 101 of the Medicare Prescription Drug Reform Act of 2009, shall promulgate regulations for modifying the factors used to determine the product under paragraph (1)(A) for each State and month that take into account the following with respect to each State:

''(A) Factoring into the determination of base year State Medicaid per capita expenditures for covered part D drugs for full-benefit dual eligible individuals under paragraph (3) all payments collected by a State under agreements under section 1927 for outpatient prescription drugs purchased in 2003 (not just for such payments that were collected by the State in 2003).

''(B) Pharmacy cost savings measures implemented by the State during the period that begins with 2003 and ends with 2006.

''(C) Substituting under paragraph (4) a State-specific growth factor in lieu of the national applicable growth factor for 2004 and succeeding years based on the annual percentage increase in the State's average per capita aggregate expenditures for covered outpatient drugs.

Such regulations shall include procedures for adjusting payments to States under section 1903(a) to take into account any overpayments or underpayments which the Secretary determines on the basis of such modifications were made by States under this subsection for 2004 and succeeding years.''.

SEC. 110. NO IMPACT ON ELIGIBILITY FOR BENEFITS UNDER OTHER PROGRAMS.

(a) IN GENERAL.—Section 1860D–14(a)(3) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)), is amended—

(1) in subparagraph (A), in the matter preceding clause (i), by striking ''subparagraph (F)'' and inserting ''subparagraphs (F) and (H)''; and

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

''(H) NO IMPACT ON ELIGIBILITY FOR BENEFITS UNDER OTHER PROGRAMS.—The

availability of premium and cost-sharing subsidies under this section shall not be treated as benefits or otherwise taken into account in determining an individual's eligibility for, or the amount of benefits under, any other Federal program.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on the date of enactment of this Act.

SEC. 111. QUALITY INDICATORS FOR DUAL ELIGIBLE INDIVIDUALS.

Section 1154(a) of the Social Security Act (42 U.S.C. 1320c–3(a)) is amended by inserting after paragraph (11) the following new paragraph:

''(12) For all contracts entered into on or after August 1, 2011, the organization shall produce a statistically valid subsample of quality indicators applicable to dual eligible beneficiaries under titles XVIII and XIX.''.

TITLE II—ADDITIONAL MEDICARE AND MEDICAID IMPROVEMENTS

Subtitle A—Improving the Financial Assistance Available to Low-Income Medicare Beneficiaries

SEC. 201. IMPROVING ASSETS TESTS FOR MEDICARE SAVINGS PROGRAM AND LOW-INCOME SUBSIDY PROGRAM.

(a) APPLICATION OF HIGHEST LEVEL PERMITTED UNDER LIS.—

(1) TO FULL-PREMIUM SUBSIDY ELIGIBLE INDIVIDUALS.—Section 1860D–14(a) of the Social Security Act (42 U.S.C. 1395w–114(a)) is amended—

(A) in paragraph (1), in the matter before subparagraph (A), by inserting ''(or, beginning with 2010, paragraph (3)(E))'' after ''paragraph (3)(D)''; and

(B) in paragraph (3)(A)(iii), by striking ''(D) or''.

(2) ANNUAL INCREASE IN LIS RESOURCE TEST.—Section 1860D–14(a)(3)(E)(i) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(E)(i)) is amended—

(A) by striking ''and'' at the end of subclause (I);

(B) in subclause (II), by inserting ''(before 2010)'' after ''subsequent year'';

(C) by striking the period at the end of subclause (II) and inserting a semicolon;

(D) by inserting after subclause (II) the following new subclauses:

''(III) for 2010, $27,500 (or $55,000 in the case of the combined value of the individual's assets or resources and the assets or resources of the individual's spouse); and

''(IV) for a subsequent year, the dollar amounts specified in this subclause (or subclause (III)) for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year.''; and

(E) in the last sentence, by inserting ''or (IV)'' after ''subclause (II)''.

(3) APPLICATION OF LIS TEST UNDER MEDICARE SAVINGS PROGRAM.—Section 1905(p)(1)(C) of

the Social Security Act (42 U.S.C. 1396d(p)(1)(C)) is amended by striking ''subparagraph (D)'' and all that follows through the period at the end and inserting the following: ''section 1860D–14(a)(3)(E) applicable to an individual or to the individual and the individual's spouse (as the case may be)''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to eligibility determinations for income-related subsidies and Medicare cost-sharing furnished for periods beginning on or after January 1, 2010.

SEC. 202. ELIMINATING BARRIERS TO ENROLLMENT.

(a) ENCOURAGING APPLICATION OF PROCEDURES UNDER MEDICARE SAVINGS PROGRAM.—Section 1905(p) of the Social Security Act (42 U.S.C. 1396d(p)) is amended by adding at the end the following new paragraph:

''(7) The Secretary shall take all reasonable steps to encourage States to provide for administrative verification of income and automatic reenrollment (as provided under subparagraphs (C)(iii) and (G) of section 1860D–14(a)(3) in the case of the low-income subsidy program).''.

(b) ENSURING THAT SSA AND STATES CAN ELECTRONICALLY PROCESS ALL LOW-INCOME SUBSIDY PROGRAM APPLICATIONS.—Section 1860D–14(a)(3)(B)(i) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(B)(i)) is amended by inserting after the first

sentence the following new sentence: ''Not later than January 1, 2012, the State plan and the Commissioner shall have in place procedures to ensure the capacity to process all applications for determinations (including all applications that are not in English) electronically.''.

SEC. 203. ELIMINATION OF PART D COST-SHARING FOR CERTAIN NON-INSTITUTIONALIZED FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.

(a) IN GENERAL.—Section 1860D–14(a)(1)(D)(i) of the Social Security Act (42 U.S.C. 1395w–114(a)(1)(D)(i)) is amended—

(1) in the heading, by striking ''INSTITUTIONALIZED INDIVIDUALS.—In'' and inserting ''ELIMINATION OF COST-SHARING FOR CERTAIN FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

''(I) INSTITUTIONALIZED INDIVIDUALS.—In''; and

(2) by adding at the end the following new subclauses:

''(II) CERTAIN OTHER INDIVIDUALS.—In the case of an individual who is a full-benefit dual eligible individual and who is being provided medical assistance for home and community-based services under subsection

(c), (d), (e), (i), or (j) of section 1915 or pursuant to section 1115, the elimination of any beneficiary coinsurance described in section 1860D–2(b)(2) (for all amounts through the total amount of expenditures at which benefits are available under section 1860D–2(b)(4)).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to drugs dispensed on or after January 1, 2010.

SEC. 204. EXEMPTION OF BALANCE IN ANY PENSION OR RETIREMENT PLAN FROM RESOURCES FOR DETERMINATION OF ELIGIBILITY FOR LOW-INCOME SUBSIDY.

(a) IN GENERAL.—Section 1860D–14(a)(3) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)) is amended—

(1) in subparagraph (D), in the matter before clause (i), by striking ''life insurance policy exclusion provided under subparagraph (G)'' and inserting ''additional exclusions provided under subparagraphs (G) and (H)'';

(2) in subparagraph (E)(i), in the matter before subclause (I), by striking ''life insurance policy ex-

clusion provided under subparagraph (G)'' and inserting ''additional exclusions provided under subparagraphs (G) and (H)''; and

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

''(H) PENSION OR RETIREMENT PLAN EXCLUSION.—In determining the resources of an individual (and the eligible spouse of the individual, if any) under section 1613 for purposes of subparagraphs (D) and (E), no balance in any pension or retirement plan shall be taken into account.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2010, and shall apply to determinations of eligibility for months beginning with January 2010.

SEC. 205. COST-SHARING PROTECTIONS FOR LOW-INCOME SUBSIDY-ELIGIBLE INDIVIDUALS.

(a) IN GENERAL.—Section 1860D–14(a) of the Social Security Act (42 U.S.C. 1395w–114(a)) is amended—

(1) in paragraph (1)(D), by adding at the end the following new clause:

''(iv) OVERALL LIMITATION ON COST-SHARING.—In the case of all such individuals, a limitation on aggregate cost-sharing

under this part for a year not to exceed 2.5 percent of income.''; and

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

''(F) OVERALL LIMITATION ON COST-SHARING.—A limitation on aggregate cost-sharing under this part for a year not to exceed 2.5 percent of income.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply as of January 1, 2010.

Subtitle B—Other Improvements

SEC. 211. ENROLLMENT IMPROVEMENTS UNDER MEDICARE PARTS C AND D.

(a) SPECIAL ELECTION PERIOD DURING FIRST 60 DAYS OF ENROLLMENT IN A NEW PLAN.—

(1) IN GENERAL.—Section 1851(e)(4) of the Social Security Act (42 U.S.C. 1395w(e)(4)) is amended—

(A) in subparagraph (C), by striking ''or'' at the end;

(B) by redesignating subparagraph (D) as subparagraph (E); and

(C) by inserting after subparagraph (C) the following new subparagraph:

''(D) the individual has been enrolled in such plan for fewer than 60 days; or''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect on the date that is 90 days after the date of enactment of this Act.

(b) EXTENSION OF THE ANNUAL, COORDINATED ELECTION PERIOD.—

(1) IN GENERAL.—Section 1851(e)(3)(B)(iv) of the Social Security Act (42 U.S.C. 1395w–1(e)(3)(B)(iv)) is amended by striking ''November 15'' and inserting ''October 1''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to annual, coordinated election periods beginning after the date of enactment of this Act.

(c) COORDINATION UNDER PARTS C AND D OF THE CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT PERIOD FOR THE FIRST 3 MONTHS OF THE YEAR.—

(1) IN GENERAL.—Section 1860D–1(b)(1)(B)(iii) of the Social Security Act (42 U.S.C. 1395w–101(b)(1)(B)(iii)) is amended by striking '', (C),''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 2010.

SEC. 212. MEDICARE PLAN COMPLAINT SYSTEM.

(a) SYSTEM.—Section 1808 of the Social Security Act (42 U.S.C. 1395b–9) is amended—

(1) in subsection (c)(2)—

(A) in subparagraph (B)(iii), by striking ''adjustment; and'' and inserting ''adjustment);'';

(B) in subparagraph (C), by striking the period at the end and inserting ''; and''; and

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

''(D) develop and maintain the plan complaint system under subsection (d).''; and

(2) by adding at the end the following new subsection:

''(d) PLAN COMPLAINT SYSTEM.—

''(1) SYSTEM.—

''(A) IN GENERAL.—The Secretary shall develop and maintain a plan complaint system, (in this subsection referred to as the 'system') to—

''(i) collect and maintain information on plan complaints;

''(ii) track plan complaints from the date the complaint is logged into the sys-

tem through the date the complaint is resolved; and

"(iii) otherwise improve the process for reporting plan complaints.

"(B) TIMEFRAME.—The Secretary shall have the system in place by not later than the date that is 6 months after the date of enactment of this subsection.

"(C) PLAN COMPLAINT DEFINED.—In this subsection, the term 'plan complaint' means a complaint that is received (including by telephone, letter, e-mail, or any other means) by the Secretary (including by a regional office, the Medicare Beneficiary Ombudsman, a subcontractor, a carrier, a fiscal intermediary, and a Medicare administrative contractor) from a Medicare Advantage eligible individual or a part D eligible individual (or an individual representing such an individual) regarding a Medicare Advantage organization, a Medicare Advantage plan, a prescription drug plan sponsor, or a prescription drug plan, including, but not limited to, complaints relating to marketing, enrollment, covered drugs, premiums and cost-sharing, and plan customer service, grievances

and appeals, participating providers. Such term also includes plan complaints that are received by the Secretary directly from the organization offering the plan relating to complaints by such individuals.

''(2) PROCESS CRITERIA.—In developing the system, the Secretary shall establish a process for reporting plan complaints. Such process shall meet the following criteria:

''(A) ACCESSIBLE.—The process is widely known and easy to use.

''(B) INVESTIGATIVE CAPACITY.—The process involves the appropriate experts, resources, and methods to assess complaints and determine whether they reflect an underlying pattern.

''(C) INTERVENTION AND FOLLOW-THROUGH.—The process triggers appropriate interventions and monitoring based on substantiated complaints.

''(D) QUALITY IMPROVEMENT ORIENTATION.—The process guides quality improvement.

''(E) RESPONSIVENESS.—The process routinely provides consistent, clear, and substantive responses to complaints.

''(F) TIMELINES.—Each process step is completed within a reasonable, established timeframe, and mechanisms exist to deal quickly with complaints of an emergency nature requiring immediate attention.

''(G) OBJECTIVE.—The process is unbiased, balancing the rights of each party.

''(H) PUBLIC ACCOUNTABILITY.—The process makes complaint information available to the public.

''(3) STANDARD DATA REPORTING REQUIREMENTS.—

''(A) IN GENERAL.—The Secretary shall establish standard data reporting requirements for reporting plan complaints under the system.

''(B) MODEL ELECTRONIC COMPLAINT FORM.—The Secretary shall develop a model electronic complaint form to be used for reporting plan complaints under the system. Such form shall be prominently displayed on the front page of the Medicare.gov Internet website

and on the Internet website of the Medicare Beneficiary Ombudsman.

''(4) ALL COMPLAINTS REQUIRED TO BE LOGGED INTO THE SYSTEM.—Every plan complaint shall be logged into the system.

''(5) CASEWORK NOTATIONS.—The system shall provide for the inclusion of any casework notations throughout the complaint process on the record of a plan complaint.

''(6) MEDICARE BENEFICIARY OMBUDSMAN.—The Secretary shall carry out this subsection acting through the Medicare Beneficiary Ombudsman.''.

(b) FUNDING.—There are authorized to be appropriated such sums as may be necessary for the costs of carrying out section 1808(d) of the Social Security Act, as added by subsection (a).

(c) REPORTS.—

(1) SECRETARY.—

(A) ONGOING STUDY.—The Medicare Beneficiary Ombudsman (under subsection (c) of section 1808) of the Social Security Act (42 U.S.C. 1395b–9) shall conduct an ongoing study of the plan complaint system established under subsection (d) of such section (as added by subsection (a)), in this subsection referred to

as the ''system''. Such study shall include an analysis of—

(i) the numbers and types of complaints reported under the system;

(ii) geographic variations in such complaints;

(iii) the timeliness of agency or plan responses to such complaints; and

(iv) the resolution of such complaints.

(B) QUARTERLY REPORTS.—Not later than 6 months after the implementation of the system, and every 3 months thereafter, the Secretary of Health and Human Services shall submit to Congress a report on the study conducted under subparagraph (A), together with recommendations for such legislation and administrative actions as the Secretary determines appropriate.

(2) INSPECTOR GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct an evaluation of the system. Not later than 1 year after the implementation of the system, the Inspector General shall submit to Congress a report on such evaluation, together with recommendations for such legislation and administra-

tive actions as the Inspector General determines appropriate.

SEC. 213. UNIFORM EXCEPTIONS AND APPEALS PROCESS.

(a) IN GENERAL.—Section 1860D–4(b)(3) of the Social Security Act (42 U.S.C. 1395w–104(b)(3)), as amended by section 107, is amended by adding at the end the following new subparagraph:

"(G) USE OF SINGLE, UNIFORM EXCEPTIONS AND APPEALS PROCESS.—Notwithstanding any other provision of this part, a PDP sponsor of a prescription drug plan or an MA organization offering an MA–PD plan shall—

"(i) use a single, uniform exceptions and appeals process with respect to the determination of prescription drug coverage for an enrollee under the plan; and

"(ii) provide instant access to such process by enrollees through a toll-free telephone number and an Internet website.".

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to exceptions and appeals on or after January 1, 2011.

SEC. 214. PROHIBITION ON CONDITIONING MEDICAID ELIGIBILITY FOR INDIVIDUALS ENROLLED IN CERTAIN CREDITABLE PRESCRIPTION DRUG COVERAGE ON ENROLLMENT IN THE MEDICARE PART D DRUG PROGRAM.

(a) IN GENERAL.—Section 1935 of the Social Security Act (42 U.S.C. 1396v) is amended by adding at the end the following:

''(f) PROHIBITION ON CONDITIONING ELIGIBILITY FOR MEDICAL ASSISTANCE FOR INDIVIDUALS ENROLLED IN CERTAIN CREDITABLE PRESCRIPTION DRUG COVERAGE ON ENROLLMENT IN MEDICARE PRESCRIPTION DRUG BENEFIT.—

''(1) IN GENERAL.—A State shall not condition eligibility for medical assistance under the State plan for a part D eligible individual (as defined in section 1860D–1(a)(3)(A)) who is enrolled in creditable prescription drug coverage described in any of subparagraphs (C) through (H) of section 1860D–13(b)(4) on the individual's enrollment in a prescription drug plan under part D of title XVIII or an MA–PD plan under part C of such title.

''(2) COORDINATION OF BENEFITS WITH PART D FOR OTHER INDIVIDUALS.—Nothing in this subsection shall be construed as prohibiting a State from coordinating medical assistance under the

State plan with benefits under part D of title XVIII for individuals not described in paragraph (1).''.

SEC. 215. OFFICE OF THE INSPECTOR GENERAL ANNUAL REPORT ON PART D FORMULARIES' INCLUSION OF DRUGS COMMONLY USED BY DUAL ELIGIBLES.

(a) ONGOING STUDY.—The Inspector General of the Department of Health and Human Services shall conduct an ongoing study of the extent to which formularies used by prescription drug plans and MA–PD plans under part D include drugs commonly used by full-benefit dual eligible individuals (as defined in section 1935(c)(6) of the Social Security Act (42 U.S.C. 1396u–5(c)(6))).

(b) ANNUAL REPORTS.—Not later than July 1 of each year (beginning with 2010), the Inspector General shall submit to Congress a report on the study conducted under paragraph (1), together with such recommendations as the Inspector General determines appropriate.

SEC. 216. HHS ONGOING STUDY AND ANNUAL REPORTS ON COVERAGE FOR DUAL ELIGIBLES.

(a) ONGOING STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct an ongoing study to track—

(A) how many of the new full benefit dual eligible individuals (as defined in section 1935(c)(6) of the Social Security Act (42 U.S.C. 1395u–5(c)(6))) enroll in a plan under part D of title XVIII of such Act and receive retroactive prescription drug coverage under the plan; and

(B) if such retroactive coverage is provided to such individuals—

(i) the number of months of coverage provided; and

(ii) the amount of reimbursements to individuals and to individuals that made payments for prescription drugs on their behalf for costs incurred during retroactive coverage periods.

(2) DATA TO USE.—In conducting the study with respect to the requirements under paragraph (1)(B), the Secretary shall examine prescription drug utilization data reported by Medicare part D plans.

(b) ANNUAL REPORTS ON ONGOING STUDY.—Not later than March 1 of each year (beginning with 2010), the Secretary shall submit a report to Congress containing the results of the study conducted under subsection (a),

together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(c) ANNUAL REPORTS ON SPENDING AND OUTCOMES.—Not later than January 1 of each year (beginning with 2013), the Secretary shall collect data and submit a report to Congress that includes the following information:

(1) Annual total expenditures (disaggregated by Federal and State expenditures) for dually eligible beneficiaries under title XVIII and under State plans and waivers under title XIX.

(2) An analysis of health outcomes for dually eligible beneficiaries, disaggregated by subtypes of beneficiaries (as determined by the Secretary).

(3) An analysis of the extent to which dually eligible beneficiaries are able to access benefits under title XVIII and under State plans and waivers under title XIX.

SEC. 217. AUTHORITY TO OBTAIN INFORMATION.

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

''AUTHORITY OF THE COMPTROLLER GENERAL TO OBTAIN INFORMATION

''SEC. 1899. No provision in this Act in effect on the date of enactment of this section or enacted after such date shall be construed to limit, amend, or supersede the authority of the Comptroller General of the United States to obtain agency records pursuant to section 716 of title 31, United States Code, including any information obtained by, or disclosed to, the Secretary under part C or D of this title, except to the extent that such provision expressly and specifically refers to this section and provides for such limitation, amendment, or supersession.''.

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