Cybele—
JML asks that you not distribute.

Rural PCCM
CONTRACTING:
Can this be organized to be subsets of More Tasks through Private Contracting

DRAFT 10/7/99

# TITLE I—MAKING MEDICARE MORE COMPETITIVE AND EFFICIENT

## Part A—Private Sector Purchasing and Quality Improvement

### Tools for Original Medicare

**SEC. 101. PREFERRED PARTICIPANTS.**

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1866 the following new section:

**"SEC. 1866A. PREFERRED PARTICIPANTS.**

"(a) PROGRAM AUTHORITY.—

"(1) IN GENERAL.—The Secretary shall implement, in 2001 and succeeding years, a preferred participant program, under which the Secretary enters into agreements for the furnishing of health care items and service at discounted rates by individuals and entities participating in the programs under parts A and B of this title that provide high-quality, low-cost health care.

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

"(3) ADMINISTRATION BY CONTRACT.—

"(A) AUTHORIZATION.—Except as otherwise specifically provided, the Secretary shall administer the program under this section in accordance with section 1866M.

"(B) PREFERENCE FOR CONTRACTING WITH PREFERRED

PROVIDER ORGANIZATIONS.—In awarding a contract for the administration of this section under section 1866M(c), the Secretary shall accord a preference to entities with substantial experience in managing a health insurance program using a network of preferred participants .

"(b) PREFERRED PARTICIPANT AGREEMENT.—

"(1) CRITERIA AND TERMS.—In order to be eligible to participate in the programs under parts A and B as a preferred participant, an individual or entity shall meet the following conditions:

"(A) MEDICARE PARTICIPATION AGREEMENT.—The individual or entity shall, as applicable—

"(i) have in effect an agreement with the Secretary under section 1842(h) or 1866(a), or

"(ii) be an entity that otherwise provides health care items and services under this title and accepts assignment under section 1842(b)(18).

"(B) PARTICIPATION CRITERIA.—The individual or entity shall meet the criteria established by the Secretary under section 1866M(b)(4) (relating to quality, cost-effectiveness, categories of participant in service area, and such other standards or criteria as the Secretary may establish).

"(C) PAYMENT RATE.—The individual or entity shall agree to accept payment, for covered health care items and services furnished during the term of the agreement, at the rates negotiated under this section, in lieu of any payment to which the individual or entity would otherwise be entitled under this title.

"(2) DURATION.—A preferred participant agreement under this section shall be for a calendar year (or, in the case of an agreement commencing after the January 1 of a year, for the duration of such calendar year), and shall be annually renewable, at the option of the participant, while the participant continues to meet all applicable conditions of participation.

"(c) BONUSES.—

"(1) PAYMENTS.—The Secretary shall have discretion to make bonus payments to program administrators and preferred participants that the Secretary finds to have achieved exceptional performance;

"(2) LIMITATIONS.—The Secretary—

"(A) may limit bonus payments under paragraph (1) to particular service areas, types of preferred participant, or kinds of items or services; and

"(B) shall limit such payments to amounts not exceeding in the aggregate 50 percent of the savings to this title attributable to the program under this section.

"(d) OPTION TO REDUCE COST-SHARING.—

"(1) IN GENERAL.—Notwithstanding sections 1813 and 1833, the Secretary may reduce or eliminate deductibles or coinsurance with respect to any of the items and services furnished under this section.

"(2) OPTION TO LIMIT BY CATEGORY.—The Secretary may limit the reduction or elimination of deductibles, copayments, or coinsurance under paragraph (1) to particular service areas or to particular items or services.".

(b) DEFINITIONS.—Section 1861 is amended by adding at the end the following new

subsection:

"(uu) PREFERRED PARTICIPANT.—The term 'preferred participant' means an individual or entity that furnishes health care items or services under part A or B and that has in effect an agreement under section 1866A(b).".

**SEC. 102. CENTERS OF EXCELLENCE.**

(a) IN GENERAL.—Title XVIII, as previously amended by this part, is further amended by inserting after section 1866A the following new section:

**"SEC. 1866B. CENTERS OF EXCELLENCE.**

"(a) IN GENERAL.—

"(1) COMPETITION TO FURNISH BUNDLED ITEMS AND SERVICES.—The Secretary, in and after 2001, shall use a competitive process to enter into agreements with specific hospitals or other entities for the furnishing of bundled groups of items and services related to surgical procedures, and for the furnishing to hospital inpatients of other bundled groups of items and services (unrelated to surgical procedures) specified by the Secretary. Such items and services may include any items or services covered under this title that the Secretary determines to be appropriate, including post-hospital items and services.

"(2) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary may administer the program under this section in accordance with section 1866M.

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

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

"(2) implement a quality improvement plan approved by the Secretary;

"(3) guarantee not to discriminate in the furnishing of health care items or services on the basis of health status, medical condition (including both physical and mental illnesses), receipt of health care, medical history, genetic information, or disability; and

"(4) meet such other requirements as the Secretary may establish.

"(c) PAYMENT.—

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

"(2) PAYMENT LIMITATION.—

"(A) LIMITATION ON AGGREGATE PAYMENTS TO ENTITIES.—The aggregate amount of payments to entities under this title made by the Secretary for items and services furnished in a year under this section shall be less than the aggregate amount of the payments that the Secretary would otherwise have made for such items and services.

"(B) LIMITATION ON PAYMENTS TO PARTICULAR ENTITIES.—In no case shall the amount of payments to an entity for items and services furnished in a year under this section exceed the amount of the payments that the Secretary would otherwise have made for such items and services.

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

renewal).

"(e) INCENTIVES FOR USE OF CENTERS.—The Secretary may permit entities under an agreement under this section to furnish additional services or to waive beneficiary cost-sharing, subject to the approval of the Secretary.

"(f) BENEFICIARY LOCK-IN.—Notwithstanding any other provision of this title, an individual who elects to receive items and services under an arrangement described in subsection (a)(1) with respect to an episode of care shall not be entitled to payment under this title for any such item or service furnished with respect to such episode of care other than through such arrangement, subject to such exceptions as the Secretary may prescribe for emergency medical conditions under section 1852(d)(3)(B) and other cases of urgent need.".

(b) EXCEPTION TO LIMITS ON PHYSICIAN REFERRALS.—Section 1877(b) is amended—

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

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

"(4) PRIVATE SECTOR PURCHASING AND QUALITY IMPROVEMENT TOOLS FOR ORIGINAL MEDICARE.—In the case of a designated health service, if the designated health service is included in the services under section 1866B.".

**SEC. 103. PRIMARY CARE CASE MANAGEMENT SERVICES.**

(a) PROGRAM AUTHORIZED.—Title XVIII, as previously amended by this part, is further amended by inserting after section 1866B the following new section:

**"SEC. 1866C. PRIMARY CARE CASE MANAGEMENT SERVICES.**

"(a) IN GENERAL.—

"(1) PROGRAM AUTHORITY.—The Secretary is authorized to implement a primary care case management services program under which, in appropriate circumstances, an individual enrolled in both of the programs under parts A and B may elect to have health care services covered under this title managed and coordinated by a designated case manager.

"(2) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary may administer the program under this section in accordance with section 1866M.

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

"(1) INDIVIDUAL ELIGIBILITY CRITERIA.—The Secretary shall specify criteria to be used in making a determination as to whether an individual may appropriately be enrolled in primary care case management under this section, which shall include at least the following:

"(A) INDIVIDUAL NEED.—The criteria shall require, as a condition of eligibility, a finding of one or more of specified characteristics, such as health condition (or combinations of health conditions), medical history, history of health care use (including pattern of inappropriate emergency room use and multiple hospitalizations) indicating a need for professional management and coordination of care.

"(B) COST-EFFECTIVENESS AND QUALITY OF CARE.—

"(i) IN GENERAL.—The criteria shall require a finding of factors

indicating that professional management and coordination of care could improve health status outcomes and reduce total costs of care.

"(ii) COST-EFFECTIVENESS TEST.—No individual shall be eligible for services under this section absent a finding by the Secretary that provision of such services can reasonably be expected to reduce total costs to the programs under this title for health care services provided to such individual.

"(2) GEOGRAPHICAL RESTRICTION.—In determining geographic areas in which to implement a primary care case management program, the Secretary may consider such factors as high cost of medical care, number or concentration of individuals in the geographic area who would be eligible for such services, and the availability of adequate numbers of physicians qualified to be primary care case managers.

"(3) INFORMATION DISSEMINATION; SOLICITATION OF APPLICATIONS.—The Secretary shall develop and implement procedures designed to facilitate enrollment of eligible individuals in the program under this section, including—

"(A) dissemination of information on eligibility criteria and program benefits to physicians and other individuals and entities furnishing healthcare items and services; to entities administering the provisions of sections 1816 and 1842; and individuals covered under the programs under parts A and B; and

"(B) solicitation of recommendations by individuals and entities furnishing healthcare items and services, and by entities administering benefits under this title, for enrollment of individuals in the program under this section;

and

"(C) notification of individuals of their probable eligibility, and solicitation of their applications, for enrollment in the program under this section.

"(c) ENROLLMENT OF INDIVIDUALS.—

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

"(2) ENROLLMENT PERIOD.—

"(A) EFFECTIVE DATE AND DURATION.—Enrollment of an individual in the program under this section shall be effective as of the first day of the month following the month in which the Secretary approves the individual's application under paragraph (1), shall remain in effect for six months, and shall be automatically renewed for additional six-month periods, unless terminated in accordance with subparagraph (B).

"(B) TERMINATION.—The Secretary shall terminate enrollment of an individual in the program under this section—

"(i) at the request of the enrolled individual—

"(I) for cause, at any time; and

"(II) without cause, during the first three months of an initial term of enrollment, or at the end of any six-month period of

enrollment:

"(ii) at the end of any six-month period of enrollment, upon a determination that the individual no longer meets the criteria for eligibility; and

"(iii) on the effective date of enrollment of the individual in a Medicare+Choice plan under part C.

"(d) PROGRAM.—The primary care case management program under this section shall include the following elements:

"(1) BASIC CASE MANAGEMENT SERVICES.—Enrolled individuals shall receive primary care case management services as defined in section 1905(t)(1).

"(2) CASE MANAGEMENT AND COORDINATION REQUIREMENT.—Notwithstanding any other provision of this title, an individual enrolled in the program under this section shall not be entitled to payment under this title for any health care item or service unless the case manager with which the individual is enrolled has furnished, or coordinated the furnishing of, such item or service, subject to such exceptions as the Secretary may prescribe for emergency medical conditions under section 1852(d)(3)(B) and other cases of urgent need.

"(3) SECRETARY'S OPTION TO PROVIDE ADDITIONAL BENEFITS.—

"(A) IN GENERAL.—Subject to the cost-effectiveness criteria specified in subsection (b)(1)(B)(ii), the Secretary may by regulation specify additional benefits, as described in subparagraph (B), that will be available to individuals enrolled in the program under this section, in order to encourage enrollment in, or

to improve the effectiveness of such program.

"(B) ADDITIONAL BENEFITS DESCRIBED.—

"(i) ADDITIONAL HEALTH CARE ITEMS AND SERVICES.—The Secretary may provide, in accordance with this paragraph, that primary care case management services under this section will include additional items or services such as routine physical examinations or screening, transportation services, and such other items or services as the Secretary may specify.

"(ii) REDUCTION OR ELIMINATION OF COST SHARING.—Notwithstanding sections 1813, 1833, and 1859B, the Secretary may increase the Government's percentage of the payment for any item or service covered under part A, B, or D (and in such case the percentage specified in the applicable provision of section 1813, 1833, or 1859B shall be deemed to be amended accordingly).

"(e) PRIMARY CARE CASE MANAGERS.—

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

"(A) be a physician or physician group practice with an agreement with the Secretary under section 1842(h) to provide physician's services under part B;

"(B) have entered into a primary care case management agreement; and

"(C) meet such criteria as the Secretary may establish (which may include experience in the provision of case management or primary care physician's

services).

"(2) AGREEMENT TERM; PAYMENT.—

"(A) DURATION AND RENEWAL.—A case management agreement under this subsection shall be for one year and may be noncompetitively renewed if the Secretary is satisfied that the case manager continues to meet the conditions of participation specified in paragraph (1).

"(B) PAYMENT FOR SERVICES.—A case manager with an agreement under this section shall be paid a case management fee for each individual enrolled under the agreement.

"(f) DEFINITIONS.—For purposes of this section—

"(1) the terms 'primary care case management services' and 'primary care' have the meanings given those terms in paragraphs (1) and (4) of section 1905(t);

"(2) the term 'primary care case manager' means an individual or entity with an agreement with the Secretary under this section; and

"(3) the term 'primary care case management agreement' means an agreement under this section between the Secretary and a primary care case manager—

"(A) under which the case manager undertakes to furnish or to locate, coordinate, and monitor the furnishing of all items and services under this title to all individuals enrolled with the case manager; and

"(B) which includes the terms specified in subparagraphs (A) through (D) of section 1905(t)(3) and such other terms as the Secretary may require.".

(b) COVERAGE OF PCCM SERVICES AS A PART B MEDICAL SERVICE.—Section

1861(s) is amended—

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

(2) in the first sentence—

(A) by striking "and" at the end of paragraph (14);

(B) by striking the period at the end of paragraph (15) and inserting "; and"; and

(C) by adding after paragraph (15) the following new paragraph:

"(16) primary care case management services furnished in accordance with section 1866C.".

**SEC. 104. DISEASE MANAGEMENT SERVICES.**

(a) PROGRAM AUTHORIZED.—Title XVIII, as previously amended by this part, is further amended by adding after section 1866C the following new section:

**"SEC. 1866D. DISEASE MANAGEMENT SERVICES.**

"(a) IN GENERAL.—

"(1) PROGRAM AUTHORITY.—The Secretary, beginning in 2001, may implement a program in accordance with the provisions of this section under which certain individuals eligible for benefits under this title may, in appropriate circumstances, receive disease management services from entities designated by the Secretary with respect to diagnoses that are amenable to such management.

"(2) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary may administer the program under this section in accordance with

section 1866M.

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

"(1) MEDICARE ELIGIBILITY.—The individual is entitled to benefits under part A, is enrolled in the program under part B, and is not enrolled in a Medicare+Choice plan under part C.

"(2) DIAGNOSIS AND RELATED CHARACTERISTICS.—

"(A) IN GENERAL.—The individual has been diagnosed with—

"(i) congestive heart failure, hypertension, coronary artery disease, asthma, or diabetes; or

"(ii) any other diagnosis as to which the Secretary has determined that the provision of disease management services can improve health outcomes and lower costs of care.

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

"(3) RESIDENCE IN SERVICE AREA.—The individual resides in a geographic area served by a disease management organization with an agreement under this section and with the capacity to provide appropriate disease management services to the individual.

"(4) REFERRAL BY QUALIFIED INDIVIDUAL OR ENTITY.—The individual has been referred for consideration for such services by an individual or entity identified in subsection (c)(2).

"(5) COST-EFFECTIVENESS.—Provision of disease management services to the individual can reasonably be expected to reduce total costs to the programs under this title.

"(c) IDENTIFICATION AND NOTIFICATION OF ELIGIBLE INDIVIDUALS.—The Secretary shall develop and implement procedures designed to facilitate enrollment of eligible individuals in the program under this section, including—

"(1) dissemination of information on eligibility criteria and program benefits to physicians and other individuals and entities furnishing health care items and services; to entities administering the provisions of sections 1816 and 1842; and individuals covered under the programs under parts A and B;

"(2) solicitation of referrals by individuals and entities furnishing health care items and services, and by entities administering benefits under this title, for enrollment of individuals in the program under this section; and

"(3) solicitation of the applications of individuals referred under paragraph (2) for enrollment in the program under this section.

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

"(1) EFFECTIVE DATE AND DURATION.—Enrollment of an individual with a disease management organization under this section shall be for such period (not to

exceed 12 months) as the Secretary shall prescribe, and shall be automatically renewed for additional periods, unless terminated in accordance with paragraph (2).

"(2) TERMINATION.—The Secretary shall terminate enrollment of an individual in the program under this section—

"(A) at the request of the enrolled individual—

"(i) for cause, at any time; and

"(ii) without cause—

"(I) during the first three months of an initial term of enrollment that is six months or longer; or

"(II) at the end of any period of enrollment;

"(B) at the end of any period of enrollment, upon a determination that the individual no longer meets the criteria for eligibility; and

"(C) on the effective date of enrollment of the individual in a Medicare+Choice plan under part C.

"(e) COVERAGE RULES FOR INDIVIDUALS ENROLLED IN PROGRAM.—

"(1) IN GENERAL.—In the case of an individual enrolled with a disease management organization on the basis of a qualified diagnosis under this section—

"(A) payment shall be made in accordance with this section for disease management services described in subsection (f) furnished by such organization; and

"(B) payment for other health care items and services related to such diagnosis shall be subject to paragraph (2).

"(2) DISEASE MANAGEMENT AND COORDINATION AUTHORITY.—Notwithstanding any other provision of this title, the Secretary may provide that an individual enrolled with a disease management organization under this section shall not be entitled to payment under this title for any health care item or service related to the managed diagnosis or condition unless such organization has furnished, or coordinated the furnishing of, such item or service, subject to such exceptions as the Secretary may prescribe for emergency medical conditions under section 1852(d)(3)(B) and other cases of urgent need.

"(f) DISEASE MANAGEMENT SERVICES.—

"(1) IN GENERAL.—Disease management services provided to an individual under this section may include—

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

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

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

"(D) patient education and counseling;

"(E) home nursing visits, as appropriate;

"(F) providing access for consultations by telephone with physicians or other appropriate medical professionals, including 24-hour availability for

emergency consultations;

"(G) physician's services;

"(H) managing and facilitating the transition to other care arrangements after termination of the disease management enrollment; and

"(I) such other services as the Secretary shall determine to be appropriate, including services for which payment is not otherwise available under this title.

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

"(g) AGREEMENTS WITH DISEASE MANAGEMENT ORGANIZATIONS.—

"(1) ENTITIES ELIGIBLE.—Entities qualified to enter into agreements with the Secretary for the provision of disease management services under this section include entities that demonstrate a record of success in—

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

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

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

"(A) have in effect an agreement with the Secretary setting forth such obligations of the entity as a disease management organization under this section as the Secretary shall prescribe;

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

"(C) guarantee that the entity will not distribute materials marketing disease management services to individuals eligible to receive services under this section without the Secretary's prior review and approval;

"(D) guarantee not to discriminate in the furnishing of disease management services on the basis of health status, medical condition (including both physical and mental illnesses), receipt of health care, medical history, genetic information, or disability; and

"(E) meet such other conditions as the Secretary may establish.

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

"(h) STANDARDS.—

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

"(A) a performance standard with respect to health status of enrolled individuals, including procedures for establishing a baseline and measuring

changes in health outcomes with respect to managed diseases or health conditions;

"(B) a requirement that the organization meet all applicable licensure and accreditation standards; and

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

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

"(i) PAYMENT.—

"(1) TERMS OF PAYMENT.—The Secretary may negotiate or otherwise establish any payment terms and rates for service packages developed under subsection (f)(2) that can reasonably be expected to result in reduced total costs to the programs under this title.

"(2) BONUSES.—

"(A) BONUS PAYMENTS.—Bonus payments may be made to disease management organizations in amounts not exceeding in the aggregate 50 percent of the savings to this title attributable to the program under this section.

"(B) ELIGIBILITY.—In order for a disease management organization to be eligible for a bonus payment under this paragraph, the Secretary must find that the organization has, through provision of disease management services, achieved

savings and improved outcomes of care.

"(3) WITHHOLDING OF PAYMENTS.—An agreement under subsection (g) may provide that the Secretary may withhold up to ten percent of the amount due a disease management organization under the basis of payment established under paragraph (1) until such time as such organization meets a standard or standards specified in such agreement.".

(b) COVERAGE OF DISEASE MANAGEMENT SERVICES AS A PART B MEDICAL SERVICE.—Section 1861(s), as amended by section 103, is further amended—

(1) by striking "and" at the end of paragraph (15);

(2) by striking the period at the end of paragraph (16) and inserting "and"; and

(3) by adding after paragraph (16) the following new paragraph:

"(17) disease management services furnished in accordance with section 1866D.".

(c) EXCEPTION TO LIMITS ON PHYSICIAN REFERRALS.—Section 1877(b)(4), as added by section 102(b), is amended by inserting before the period "or 1866D".

**SEC. 105. COMPETITIVE ACQUISITION OF ITEMS AND SERVICES.**

(a) PROGRAM AUTHORIZED.—Title XVIII, as previously amended by this part, is further amended by adding after section 1866D the following new section:

**"SEC. 1866E. COMPETITIVE ACQUISITION OF ITEMS AND SERVICES.**

"(a) IN GENERAL.—

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

"(2) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary may administer the program under this section in accordance with section 1866M.

"(b) ESTABLISHMENT OF COMPETITIVE ACQUISITION AREAS.—

"(1) IN GENERAL.—The Secretary shall establish competitive acquisition areas for agreement award purposes for the furnishing under part B of the items and services described in subsection (d) after 2001. The Secretary may establish different competitive acquisition areas under this subsection for different classes of items and services.

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

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

"(1) IN GENERAL.—The Secretary shall conduct a competition among individuals and entities supplying items and services described in subsection (d) for each competitive acquisition area established under subsection (b) for each class of items and services.

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

the agreement are expected to be less than the total amounts that would otherwise be paid.

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

"(d) SERVICES DESCRIBED.—The items and services to which this section applies are all items and services covered under part B (except for physician's services as defined by 1861(r)) that the Secretary may specify.".

(b) ITEMS AND SERVICES TO BE FURNISHED ONLY THROUGH COMPETITIVE ACQUISITION.—Section 1862(a)(42 U.S.C. 1395y(a)) is amended—

(1) by striking "or" at the end of paragraph (20),

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

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

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

(c) EFFECTIVE DATE.—The amendments made by subsections (a) and (b) apply to items and services furnished after 2001.

**SEC. 106. FLEXIBLE PURCHASING.**

Title XVIII, as previously amended by this part, is further amended by adding after section 1866E the following new section:

"SEC. 1866F. FLEXIBLE PURCHASING AND ADMINISTRATIVE ARRANGEMENTS.

"(a) IN GENERAL.—

"(1) PROGRAM AUTHORITY.—The Secretary may enter into agreements with selected providers and other entities that furnish items or services under the programs established by this title under which the Secretary may use—

"(A) alternative claims processing, administrative, and related procedures, and

"(B) reduced payment rates or alternative payment methodologies.

"(2) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary may administer the program under this section in accordance with section 1866M.

"(b) SAVINGS TO BENEFICIARIES.—Agreements under this section may provide for reductions in cost sharing by individuals entitled to benefits under this title who receive services under an agreement under this section.

"(c) REQUIREMENTS—Under an agreement under this section—

"(1) the provisions of subtitle B of title XI (42 U.S.C. 1320c et seq.), other provisions concerned with quality of care, and conditions of participation shall apply unchanged,

"(2) the Secretary shall certify that the amounts to be paid under an agreement are less than the amounts that otherwise would be paid,

"(3) individuals entitled to benefits under this title may not be required to pay

more than the amounts that they otherwise would be required to pay.

"(4) the agreement shall be for a fixed term (but may be renewed), and

"(5) the terms of the agreement shall be subject to periodic review.

"(d) WAIVER OF COMPETITION REQUIREMENTS.—Agreements may be entered into under this section without regard to provisions of law requiring competition.".

**SEC. 107. BUNDLED PAYMENTS PER CASE.**

(a) IN GENERAL.—Title XVIII, as previously amended by this part, is further amended by inserting after section 1866F the following new section:

**"SEC. 1866G. BUNDLED PAYMENTS PER CASE.**

"(a) IN GENERAL.—

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

"(2) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary may administer the program under this section in accordance with section 1866M.

"(b) BASIS OF SELECTION.—

"(1) SELECTION CRITERIA.—The Secretary shall select entities for agreements under this section on the basis of ability to provide services more efficiently, to provide

improved coordination of care, to offer additional benefits, and to meet quality and other standards and beneficiary protection and other requirements set by the Secretary.

"(2) ANTIDISCRIMINATION LIMITATION.—The Secretary shall not select an entity for an agreement under this section unless the entity guarantees not to discriminate in the furnishing of health care items or services on the basis of health status, medical condition (including both physical and mental illnesses), receipt of health care, medical history, genetic information, or disability.

"(c) PAYMENT.—Payment under this section shall be made on the basis of negotiated or all-inclusive rates. The amount of payment made by the Secretary to an entity under this title for services covered under an agreement under this section shall be less than the aggregate amount of the payments that the Secretary would have otherwise made for the services.

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

"(e) INCENTIVES TO BENEFICIARIES FOR USE OF CONTRACTING ENTITIES.—Entities under a contract under this section may furnish additional services or waive cost-sharing, subject to the approval of the Secretary.

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

(b) EXCEPTION TO LIMITS ON PHYSICIAN REFERRALS.—Section 1877(b)(4), as amended by section 104(c), is further amended by striking "1866B or 1866D" and inserting

"1866B, 1866D, or 1866G".

**SEC. 108. DEMONSTRATION OF BONUS PAYMENTS FOR HEALTH CARE GROUPS.**

(a) IN GENERAL.—Title XVIII, as previously amended by this part, is further amended by inserting after section 1866G the following new section:

**"SEC. 1866H. DEMONSTRATION OF BONUS PAYMENTS FOR HEALTH CARE GROUPS.**

"(a) DEMONSTRATION PROGRAM AUTHORIZED.—

"(1) IN GENERAL.—The Secretary shall conduct demonstration projects to test and, if proven effective, expand the use of incentives to health care groups participating in the program under this title that—

"(A) encourage coordination of the care furnished to individuals covered by the insurance programs under this title by institutional and other providers, practitioners, and suppliers of health care items and services;

"(B) encourage investment in administrative structures and processes to ensure efficient service delivery; and

"(C) reward physicians for improving health outcomes.

"(2) ADMINISTRATION BY CONTRACT.—Except as otherwise specifically provided, the Secretary may administer the program under this section in accordance with section 1866M.

"(3) DEFINITIONS.—For purposes of this section, terms have the following meanings:

"(A) PHYSICIAN.—The term 'physician' means any individual who furnishes services which may be paid for as physician's services under this title.

"(B) HEALTH CARE GROUP.—The term 'health care group' means a group of physicians (as defined in subparagraph (A)) organized at least in part for the purpose of providing physician's services under this title. As the Secretary finds appropriate, a health care group may include a hospital and any other individual or entity furnishing items or services for which payment may be made under this title that is affiliated with the health care group under an arrangement structured so that such individual or entity participates in a demonstration under this section and will share in any bonus earned under subsection (d).

"(b) ELIGIBILITY CRITERIA.—

"(1) IN GENERAL.—The Secretary is authorized to establish criteria for health care groups eligible to participate in a demonstration under this section, including criteria relating to numbers of health care professionals in, and of patients served by, the group, scope of services provided, and quality of care.

"(2) PAYMENT METHOD.—A health care group participating in the demonstration under this section shall agree with respect to services furnished to beneficiaries within the scope of the demonstration (as determined under subsection (c))—

"(A) to be paid on a fee-for-service basis; and

"(B) that payment with respect to all such services furnished by members of the health care group to such beneficiaries shall (where determined appropriate

by the Secretary) be made to a single entity.

"(3) DATA REPORTING.—A health care group participating in a demonstration under this section shall report to the Secretary such data, at such times and in such format as the Secretary may require, concerning health care outcomes, patient satisfaction, and such other matters as the Secretary may find necessary for purposes of monitoring and evaluation of the demonstration under this section.

"(c) PATIENTS WITHIN SCOPE OF DEMONSTRATION.—

"(1) IN GENERAL.—The Secretary shall specify, in accordance with this subsection, the criteria for identifying those patients of a health care group who shall be considered within the scope of the demonstration under this section for purposes of application of subsection (d) and for assessment of the effectiveness of the group in achieving the objectives of this section.

"(2) MEDICARE COVERAGE.—Beneficiaries within the scope of a demonstration under this section shall be individuals who are entitled to benefits under part A and enrolled in the program under part B, and who are not enrolled in a Medicare+Choice program under part C.

"(3) OTHER CRITERIA.—The Secretary may establish additional criteria for inclusion of beneficiaries within a demonstration under this section, which may include residence in a geographic area served by the health care group, frequency of contact with physicians in the group, or other factors or criteria that the Secretary finds to be appropriate.

"(4) NOTICE REQUIREMENTS.—In the case of each beneficiary determined to

be within the scope of a demonstration under this section with respect to a specific health care group, the Secretary shall ensure that such beneficiary is notified of the incentives, and of any waivers of coverage or payment rules, applicable to such group under such demonstration.

"(d) INCENTIVES.—

"(1) PERFORMANCE TARGET.—The Secretary shall establish for each health care group participating in a demonstration under this section—

"(A) a base expenditure amount, equal to the average total payments under parts A, B, and D for patients served by the health care group on a fee-for-service basis in a base period determined by the Secretary; and

"(B) an annual per capita expenditure target for patients determined to be within the scope of the demonstration, reflecting the base expenditure amount adjusted for risk and expected growth rates.

"(2) INCENTIVE BONUS.—The Secretary shall pay to each participating health care group (subject to paragraph (4)) a bonus for each year under the demonstration equal to a portion of the Medicare savings realized for such year from a reduction in total fee-for-service expenditures relative to the performance target, adjusted to reflect both the share of such services that were furnished directly by physicians in the health care group and the actual risk profile of patients served compared to that assumed in the performance target.

"(3) ADDITIONAL BONUS FOR PROCESS AND OUTCOME IMPROVEMENTS.—The Secretary may also pay to a participating health care group

(subject to paragraph (4)) an additional bonus for a year equal to such portion as the Secretary may designate of the saving to the Medicare program resulting from process improvements made by and patient outcome improvements attributable to activities of the group.

"(4) LIMITATION.—The Secretary shall limit bonus payments under this section as necessary to ensure that the aggregate expenditures under this title (inclusive of bonus payments) with respect to patients within the scope of the demonstration do not exceed the amount which the Secretary estimates would be expended if the demonstration projects under this section were not implemented.

"(e) DEMONSTRATION SITES AND IMPLEMENTATION OF PROJECT RESULTS.—

"(1) SELECTION OF DEMONSTRATION PROJECTS.—The Secretary shall implement up to ten demonstrations under this section, selected competitively on the basis of criteria determined by the Secretary.

"(2) EXPANSION OF PROJECTS; IMPLEMENTATION OF DEMONSTRATION PROJECT RESULTS.—

"(A) EXPANSION OF PROJECTS.—If a report under subsection (f) contains an evaluation that demonstration projects—

"(i) reduce expenditures under the Medicare program; and

"(ii) increase the quality of health care services provided to individuals served,

the Secretary shall continue the existing demonstration projects under the terms

and conditions of agreements with health care groups and may expand the number of demonstration projects.

"(B) IMPLEMENTATION OF DEMONSTRATION PROJECT RESULTS.—If a report under subsection (f) contains an evaluation as described in subparagraph (A), the Secretary may issue regulations to implement, on a permanent basis, the components of the demonstration project that are beneficial to the Medicare program.

"(f) REPORT TO CONGRESS.—

"(1) IN GENERAL.—Not later than two years after the Secretary implements the initial demonstration projects under this section, and biennially over the succeeding six years, the Secretary shall submit to Congress a report regarding the demonstration projects conducted under this section.

"(2) CONTENTS OF REPORT.—The report in paragraph (1) shall include the following:

"(A) A description of the demonstration projects conducted under this section.

"(B) An evaluation of—

"(i) the cost-effectiveness of the demonstration projects;

"(ii) the quality of the health care services provided to Medicare beneficiaries under the demonstration projects; and

"(iii) beneficiary and health care provider satisfaction under the demonstration project.

"(C) Any other information regarding the demonstration projects conducted under this section that the Secretary determines to be appropriate.".

(b) EXCEPTION TO LIMITS ON PHYSICIAN REFERRALS.—Section 1877(b)(4), as amended by sections 104(c) and 107(b), is further amended by striking "or 1866G" and inserting ", 1866G, or 1866H".

**SEC. 109. ADMINISTRATION OF CERTAIN QUALITY IMPROVEMENT PROGRAMS.**

Title XVIII is amended by inserting after section 1866H the following new section:

NEW CONTRACTING AUTHORITY

**"SEC. 1866M. GENERAL PROVISIONS FOR ADMINISTRATION OF CERTAIN QUALITY IMPROVEMENT PROGRAMS.** CONTRACTING.

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

"(1) section 1866A (preferred participants);

"(2) section 1866B (centers of excellence);

"(3) section 1866C (primary care case management);

"(4) section 1866D (disease management);

"(5) section 1866E (competitive bidding and negotiated pricing);

"(6) section 1866F (flexible purchasing and administrative arrangements);

"(7) section 1866G (bundled payments per case); and

"(8) section 1866H (demonstration of bonus payments for health care groups).

"(b) PROVISIONS GENERALLY APPLICABLE TO DESIGNATED PROGRAMS.—The following provisions apply to programs specified in subsection (a), except

as otherwise specifically provided:

"(1) SECRETARY'S DISCRETION AS TO SCOPE OF PROGRAM.—The Secretary shall have discretion to limit the implementation of the program to—

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

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

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

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

"(2) VOLUNTARY RECEIPT OF ITEMS AND SERVICES.—Items and services shall be furnished to an individual under the program only at the individual's election.

"(3) AGREEMENTS.—The Secretary is authorized to enter into agreements with individuals and entities to furnish health care items and services to individuals under the program.

"(4) PROGRAM STANDARDS AND CRITERIA.—The Secretary shall establish performance standards for the program including, as applicable, standards for quality of

health care items and services, cost-effectiveness, beneficiary satisfaction, and such other factors as the Secretary finds appropriate. The eligibility of individuals or entities for the initial award, continuation, and renewal of agreements to provide health care items and services under the program shall be conditioned, at a minimum, on performance that meets or exceeds such standards.

"(5) ADMINISTRATIVE REVIEW OF ADVERSE DECISION.—An individual or entity shall be entitled to a review by the program administrator (or, if the Secretary has not contracted with a program administrator, by the Secretary) of a decision not to enter into or to terminate, or not to renew, an agreement with the individual or entity to provide health care items or services under a program specified in subsection (a).

"(6) BONUSES AND INCENTIVES.—The Secretary may make bonus and incentive payments from the Health Insurance and Supplementary Medical Insurance Trust Funds, under a program specified in subsection (a), in amounts not to exceed in the aggregate the savings to such Trust Funds attributable to such program.

"(7) PAYMENT IN FULL.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), an entity receiving payment from the Secretary under a contract or agreement under a program specified in subsection (a) shall agree to accept such payment as payment in full.

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

"(c) CONTRACTS FOR PROGRAM ADMINISTRATION.—

"(1) IN GENERAL.—The Secretary may administer a program specified in subsection (a) (nationally, or in one or more service areas) through a contract with a program administrator in accordance with the provisions of this subsection.

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

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

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

"(3) CONTRACT AWARD, DURATION, AND RENEWAL.—

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

"(B) NONCOMPETITIVE AWARD AND RENEWAL FOR ENTITIES ADMINISTERING PART A OR PART B PAYMENTS.—The Secretary may enter or renew a contract under this subsection with an entity described in paragraph (2)(A) without regard to the requirements of section 5 of title 41, United States Code.

"(4) APPLICABILITY OF FEDERAL ACQUISITION REGULATION.—The Federal Acquisition Regulation shall apply to program administration contracts under this

subsection.

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

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

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

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

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

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

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

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

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

"(E) ADMINISTRATIVE REVIEW.—Conduct reviews of adverse determinations specified in subparagraph (A).

"(F) Perform such other functions as the Secretary may specify.

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

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

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

"(1) RECORDS, REPORTS, AND AUDITS.—The Secretary is authorized to

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

"(2) SHARING OF PROGRAM SAVINGS.—Notwithstanding any provision of this title or title XI, or any other provision of law, the Secretary may share with entities administering or beneficiaries served under programs specified in subsection (a) part of the cost savings achieved by such programs, to the extent provided in the authority for such program.

"(3) EXEMPTION FROM PAPERWORK REDUCTION ACT.—In circumstances identified by the Secretary, with the concurrence of the Director of the Office of Management and Budget, the collection of information by the Secretary from entities with agreements to provide health care items or services under programs specified under subsection (a), and entities with program administration contracts under subsection (c), shall not be subject to the requirements of chapter 35 of title 44, United States Code.

"(e) LIMITATIONS ON JUDICIAL REVIEW.—The following actions and determinations with respect to a program specified in subsection (a) shall not be subject to review by a judicial or administrative tribunal:

"(1) limiting the implementation of a program under subsection (b)(1);

"(2) establishment of program participation standards under subsection (b)(4); or the denial or termination of, or refusal to renew, an agreement with an individual or entity to provide health care items and services under the program;

"(3) establishment of program administration contract performance standards under subsection (c)(5); or the denial or termination of, or refusal to renew, a program administration contract; or the noncompetitive award or renewal of a program administration contract under subsection (c)(3)(B);

"(4) the establishment of payment rates, through negotiation or otherwise, under a program agreement or a program administration contract;

"(5) a determination with respect to a program (where specifically authorized by the program authority)—

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

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

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

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

**SEC. 110. REPORTS TO CONGRESS ON QUALITY IMPROVEMENT PROGRAMS.**

Not later than two years after the date of enactment of the Medicare Modernization Act of 1999, and biennially thereafter for six years, the Secretary shall report to the Congress on the use

of authorities enacted by sections 101 through 108 of this Act. Each report shall address the impact of the use of those authorities on expenditures, access, and quality under the programs under title XVIII of the Social Security Act.

**SEC. 111. INCREASED FLEXIBILITY IN CONTRACTING FOR MEDICARE CLAIMS PROCESSING.**

(a) CARRIERS TO INCLUDE ENTITIES THAT ARE NOT INSURANCE COMPANIES.—

(1) The matter in section 1842(a) (42 U.S.C. 1395u(a)) preceding paragraph (1) is amended by striking "with carriers" and inserting "with agencies and organizations (referred to as carriers)".

(2) Section 1842(f) (42 U.S.C. 1395u(f)) is repealed.

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

(1) Section 1816 (42 U.S.C. 1395h) is amended by striking all that precedes subsection (b) and inserting the following:

**"SEC. 1816. USE OF PUBLIC AGENCIES AND PRIVATE ORGANIZATIONS TO FACILITATE PAYMENTS TO PROVIDERS OF SERVICES.—**

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

"(A) determine (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments

required pursuant to this part to be made to providers of services.

"(B) make payments described in subparagraph (A).

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

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

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

"(F) perform the functions described by subsection (d), and

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

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

(2) Subsections (d) and (e) of section 1816 (42 U.S.C. 1395h) are amended to read as follows:

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

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

"(2) makes its services sufficiently available to meet the needs of the provider of

services, and

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

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

(3)(A) Section 1816(b)(1)(A) (42 U.S.C. 1395h(b)(1)(A)) is amended by striking "after applying the standards, criteria, and procedures" and inserting "after evaluating the ability of the agency or organization to fulfill the contract performance requirements".

(B) Section 1816(f)(1) (42 U.S.C. 1395h(f)(1)) is amended to read as follows:

"(f)(1) The Secretary may consult with Medicare+Choice organizations under part C of this title, providers of services and other persons who furnish items or services for which payment may be made under this title, and organizations and agencies performing functions necessary to carry out the purposes of this part with respect to performance requirements for contracts under subsection (a).".

(C) The second sentence of section 1842(b)(2)(A) (42 U.S.C. 1395u(b)(2)(A)) is amended to read as follows: "The Secretary may consult with Medicare+Choice organizations under part C of this title, providers of services and other persons who furnish items or services for which payment may be made under this title, and organizations and agencies performing functions necessary to carry out the purposes of this part with respect to performance requirements for contracts under subsection (a).".

(D) Section 1842(b)(2)(A) (42 U.S.C. 1395u(b)(2)(A)) is amended by striking the third sentence.

(E) The matter in section 1842(b)(2)(B) (42 U.S.C. 1395u(b)(2)(B)) preceding clause (i) is amended by striking "establish standards" and inserting "develop contract performance requirements".

(F) Section 1842(b)(2)(D) (42 U.S.C. 1395u(b)(2)(D)) is amended by striking "standards and criteria" each place it occurs and inserting "contract performance requirements".

(4)(A) The matter in section 1816(b) (42 U.S.C. 1395h(b)) preceding paragraph (1) is amended by striking "an agreement" and inserting "a contract".

(B) Paragraphs (1)(B) and (2)(A) of section 1816(b) (42 U.S.C. 1395h(b)) are each amended by striking "agreement" and inserting "contract".

(C) The first sentence of section 1816(c)(1) (42 U.S.C. 1395h(c)(1)) is amended by striking "An agreement" and inserting "A contract".

(D) The last sentence of section 1816(c)(1) (42 U.S.C. 1395h(c)(1)) is amended by striking "an agreement" and inserting "a contract".

(E) The matter in section 1816(c)(2)(A) (42 U.S.C. 1395h(c)(2)(A)) preceding clause (i) is amended by striking "agreement" and inserting "contract".

(F) Section 1816(c)(3)(A) (42 U.S.C. 1395h(c)(3)(A)) is amended by striking "agreement" and inserting "contract".

(G) Section 1816(h) (42 U.S.C. 1395h(h)) is amended—

(i) by striking "An agreement" and inserting "A contract", and

(ii) by striking "the agreement" each place it occurs and inserting "the contract".

(H) Section 1816(i)(1) (42 U.S.C. 1395h(i)(1)) is amended by striking "an agreement" and inserting "a contract".

(I) Section 1816(j) (42 U.S.C. 1395h(j)) is amended by striking "An agreement" and inserting "A contract".

(J) Section 1816(k) (42 U.S.C. 1395h(k)) is amended by striking "An agreement" and inserting "A contract".

(K) Section 1816(l) (42 U.S.C. 1395h(l)) is amended by striking "an agreement" and inserting "a contract".

(L) The matter in section 1842(a) (42 U.S.C. 1395u(a)) preceding paragraph (1) is amended by striking "agreements" and inserting "contracts".

(M) Section 1842(h)(3)(A) (42 U.S.C. 1395u(h)(3)(A)) is amended by striking "an agreement" and inserting "a contract".

(5)(A) The matter in section 1816(c)(2)(A) (42 U.S.C. 1395h(c)(2)(A)) preceding clause (i) is amended by inserting "that provides for making payments under this part" after "this section".

(B) Section 1816(c)(3)(A) (42 U.S.C. 1395h(c)(3)(A)) is amended by inserting "that provides for making payments under this part" after "this section".

(C) Section 1816(k) (42 U.S.C. 1395h(k)) is amended by inserting "(as appropriate)" after "submit".

(D) The matter in section 1842(a) (42 U.S.C. 1395u(a)) preceding paragraph (1) is amended by striking "some or all of the following functions" and inserting "any or all of the following functions, or parts of those functions".

(E) The first sentence of section 1842(b)(2)(C) (42 U.S.C. 1395u(b)(2)(C)) is amended by inserting "(as appropriate)" after "carriers".

(F) The matter preceding subparagraph (A) in the first sentence of section 1842(b)(3) (42 U.S.C. 1395u(b)(3)) is amended by inserting "(as appropriate)" after "contract".

(G) The matter in section 1842(b)(7)(A) (42 U.S.C. 1395u(b)(7)(A)) preceding clause (i) is amended by striking "the carrier" and inserting "a carrier".

(H) The matter in section 1842(b)(11)(A) (42 U.S.C. 1395u(b)(11)(A)) preceding clause (i) is amended by inserting "(as appropriate)" after "each carrier".

(I) The first sentence of section 1842(h)(2) (42 U.S.C. 1395u(h)(2)) is amended by inserting "(as appropriate)" after "shall".

(J) Section 1842(h)(5)(A) (42 U.S.C. 1395u(h)(5)(A)) is amended by inserting "(as appropriate)" after "carriers".

(6)(A) Section 1816(c)(2)(C) (42 U.S.C. 1395h(c)(2)(C)) is amended by striking "hospital, rural primary care hospital, skilled nursing facility, home health agency; hospice program, comprehensive outpatient rehabilitation facility, or rehabilitation agency" and inserting "provider of services".

(B) The matter in section 1816(j) (42 U.S.C. 1395h(j)) preceding paragraph (1) is amended by striking "for home health services, extended care services, or post-hospital extended care services".

(7) Section 1842(a)(3) (42 U.S.C. 1395u(a)(3)) is amended by inserting "(to and from individuals enrolled under this part and to and from physicians and other entities

that furnish items and services)" after "communication".

(8) The matter in section 1842(a) (42 U.S.C. 1395u(a)) preceding paragraph (1), as amended by subsection (b)(4)(L), is amended by striking "carriers with which contracts" and inserting "single contracts under section 1816 and this section together, or separate contracts with eligible agencies and organizations with which contracts".

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

(1) The matter in section 1816(b) (42 U.S.C. 1395h(b)) preceding paragraph (1) is amended by striking "or renew".

(2) The last sentence of section 1816(c)(1) (42 U.S.C. 1395h(c)(1)) is amended by striking "or renewing".

(3) Section 1816(g) (42 U.S.C. 1395h(g)) is repealed.

(4) The last sentence of section 1842(b)(2)(A) (42 U.S.C. 1395u(b)(2)(A)) is amended by striking "or renewing".

(5) Section 1842(b) (42 U.S.C. 1395u(b)) is amended by striking paragraph (5).

(d) REPEAL OF FISCAL INTERMEDIARY REQUIREMENTS THAT ARE NOT COST-EFFECTIVE.—Section 1816(f)(2) (42 U.S.C. 1395h(f)(2)) is amended to read as follows:

"(2) The contract performance requirements described in paragraph (1) shall include, with respect to claims for services furnished under this part by any provider of services other than a hospital, whether such agency or organization is able to process 75 percent of reconsiderations within 60 days and 90 percent of reconsiderations within 90 days.".

(e) REPEAL OF COST REIMBURSEMENT REQUIREMENTS.—

(1) The first sentence of section 1816(c)(1) (42 U.S.C. 1395h(c)(1)) is amended—

(A) by striking the comma after "appropriate" and inserting "and", and

(B) by striking everything after "subsection (a)" up to the period.

(2) Section 1816(c)(1) (42 U.S.C. 1395h(c)(1)) is further amended by striking the second and third sentences.

(3) The first sentence of section 1842(c)(1) (42 U.S.C. 1395h(c)(1)) is amended—

(A) by striking "shall provide" the first place it occurs and inserting "may provide", and

(B) by striking everything after "this part" up to the period.

(4) Section 1842(c)(1) (42 U.S.C. 1395h(c)(1)) is further amended by striking the remaining sentences.

(5) Section 2326(a) of the Deficit Reduction Act of 1984 (42 U.S.C. 1395h nt) is repealed.

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

(1) Section 1816(c) (42 U.S.C. 1395h(c)) is amended by adding at the end the following:

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

"(B)(i) The Secretary may renew a contract with a fiscal intermediary under this section from term to term without regard to section 5 of title 41, United States Code, or any other

provision of law requiring competition, if the fiscal intermediary has met or exceeded the performance requirements established in the current contract.

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

(2) Section 1842(b) (42 U.S.C. 1395u(b)) is amended by striking everything before paragraph (2) and inserting the following:

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

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

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

(g) WAIVER OF COMPETITIVE REQUIREMENTS FOR INITIAL CONTRACTS.—

(1) Contracts under section 1816(a) (42 U.S.C. 1395h(a)) or 1842(a) (42 U.S.C. 1395u(a)) whose periods begin before or during the one year period that begins on the first day of the fourth calendar month that begins after the date of enactment of this Act may be entered into without regard to any provision of law requiring competition.

(2) The amendments made by subsection (f) apply to contracts whose periods begin after the end of the one year period specified in paragraph (1) of this subsection.

(h) YEAR 2000 COMPLIANCE.—

(1) Section 1816(f)(2) (42 U.S.C. 1395h(f)(2)), as amended by subsection (d), is amended—

(A) by striking "shall include," and inserting "shall include—";

(B) by designating the remainder of the paragraph as subparagraph (A) and indenting accordingly;

(C) by striking the period at the end of subparagraph (A), as so designated, and inserting ": and"; and

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

"(B) a requirement that, by such time as the Secretary considers reasonable, the information technology that is used or acquired by the agency or organization to carry out its responsibilities under this title (to the extent that the Secretary finds such information technology is under the control of such agency or organization)—

"(i) meets the definition of 'Year 2000 compliant' under the Federal Acquisition Regulation (concerning accurate processing of date/time data (including calculating, comparing, and sequencing) from, into, and between the twentieth and twenty-first centuries, and the years 1999 and 2000 and leap year calculations) but without regard to whether the information technology is being acquired, and

# MODERNIZING TRADITIONAL MEDICARE

## BIPARTISAN COMMISSION ON THE FUTURE OF MEDICARE

**Breaux-Thomas Proposal.** "The proposal recommends that efforts to contain costs in the fee-for-service plan continue. Toward that end, HCFA would be allowed to pursue competitive purchasing strategies in areas where its payments were not appropriate." *[Building a Better Medicare for Today and Tomorrow, March 16, 1999 (10:20am)]*

**Senator John Breaux.** "For instance, my premium support approach would create a new and improved HCFA by giving it powers that it has long sought including competitive bidding, which they really don't have; negotiated pricing authority, which they desperately need; selective contracting, which would be helpful; and preferred provider arrangements, which I think would improve the system. These are ideas that are incorporated. There may be more than are needed that would make the current fee-for-service a more efficient and more productive program." *[January 26, 1999 Commission meeting]*

**Senator Bill Frist.** "I think we absolutely have to give HCFA not necessarily more power, but the flexibility to compete, and that means some management tools. We're modernizing. We're improving. I think that's what, at least, I would like to see." *[January 26, 1999 Commission meeting]*

**Senator Bob Kerrey.** "But I would hope for those of us who would like to support and like the general outline of it [Breaux-Thomas proposal), I would hope that you will help us and make certain that the fee-for-service component is vigorous, it is competitive, that HCFA can have a competitive offering out there. Because, like Jay Rockefeller, I have got at least half of my population who have no competitive alternative right now. They are going to go with fee-for-service. And it has got to be vigorous." *[February 24, 1999 Commission meeting]*

## NATIONAL ACADEMY OF SOCIAL INSURANCE

"Given that FFS Medicare will continue to cover a substantial numbers of people, its beneficiaries (as well as the taxpayers who help pay for the program) deserve to realize the benefits of management innovations developed in private health plans and elsewhere."

"Among the key features of private managed care that the Study Panel concludes may hold promise for FFS Medicare are: disease and case management; incentives to use selected providers; competitive procurement."

"While experimentation [as encouraged by laws in 1996 and 1997] on a small scale is necessary in order to learn, these activities lack a broad mandate from Congress for the flexibility necessary for ongoing improvement of FFS Medicare."

*[Final Report of the Study Panel on Fee-For-Service Medicare: From a Generation Behind to a Generation Ahead: Transforming Traditional Medicare. January 1998.]*

## Enrollment, July 1996

| | Enrollment | Semiannual net change | Percent of HMO Medicare enrollment |
|---|---|---|---|
| | 377,862 | 13,044 | 27.9 |
| | 275,126 | 9,753 | 10.8 |
| | 216,693 | 117,993 | 38.7 |
| | 214,131 | (1,208) | 22.4 |
| Region | 197,846 | 1,137 | 8.4 |
| | 11,688 | 27,758 | 8.8 |
| | 88,100 | 25,956 | 8.8 |
| | 87,059 | 2,934 | 47.0 |
| | 75,050 | (188) | 10.9 |
| | 73,722 | 68,422 | 10.9 |
| | 63,892 | 724 | 20.5 |
| | 60,358 | 7,444 | 835.0 |
| | 59,107 | 14,388 | 10.6 |
| | 58,824 | 4,142 | 35.4 |
| | 55,725 | 1,349 | 8.5 |
| | 55,663 | 4,204 | 20.1 |
| | 53,864 | (23,616) | 7.4 |
| | 50,819 | 3,296 | 27.3 |
| | 50,538 | 26,987 | 5.6 |
| | 50,370 | (1,431) | 11.1 |
| | 46,839 | (126) | 11.0 |
| | 46,701 | 1,706 | 34.9 |
| | 41,274 | 3,081 | 22.6 |
| | 40,810 | 5,708 | 12.8 |
| | 40,764 | 8,877 | 35.5 |

rt.



**TABLE 3.7**

## Benefits for FFS, HMO, PPO, and POS Plans, by Region, 1997

| | National | Northeast | Midwest | South | West |
|---|---|---|---|---|---|
| | | | Percent | | |
| **FFS plans** | | | | | |
| Adult physicals | 57 | 43 | 53 | 68 | 63 |
| Well-baby care | 73 | 68 | 73 | 75 | 84 |
| Childhood immunizations | 75 | 75 | 74 | 74 | 85 |
| Prenatal care | 95 | 93 | 96 | 95 | 97 |
| Mammography | 87 | 94 | 86 | 82 | 94 |
| Screening/pap test | 83 | 90 | 83 | 78 | 94 |
| Outpatient drug | 78 | 91 | 87 | 67 | 88 |
| Outpatient mental | 98 | 98 | 99 | 98 | 98 |
| Inpatient mental | 99 | 99 | 98 | 99 | 98 |
| Chiropractic care | 85 | 93 | 72 | 88 | 89 |
| Prescription drugs | 98 | 98 | 97 | 99 | 99 |
| Vision care | 19 | 33 | 22 | 5 | 48 |
| Dental care | 33 | 31 | 42 | 26 | 53 |
| Hospice care | 86 | 82 | 83 | 90 | 81 |
| **HMO plans** | | | | | |
| Adult physicals | 98 | 99 | 97 | 98 | 99 |
| Well-baby care | 99 | 99 | 99 | 99 | 99 |
| Childhood immunizations | 99 | 99 | 99 | 99 | 99 |
| Prenatal care | 99 | 99 | 100 | 100 | 100 |
| Mammography | 98 | 98 | 99 | 99 | 97 |
| Screening/pap test | 99 | 99 | 99 | 99 | 100 |
| Occupational therapy | 73 | 83 | 85 | 54 | 69 |
| Outpatient mental | 98 | 96 | 99 | 99 | 95 |
| Inpatient mental | 98 | 99 | 99 | 99 | 91 |
| Chiropractic care | 53 | 69 | 36 | 55 | 53 |
| Prescription drugs | 98 | 96 | 99 | 98 | 99 |
| Vision care | 62 | 49 | 33 | 66 | 84 |
| Dental care | 16 | 20 | 11 | 15 | 22 |
| Hospice care | 78 | 63 | 89 | 82 | 74 |
| **PPO plans** | | | | | |
| Adult physicals | 76 | 73 | 82 | 69 | 75 |
| Well-baby care | 87 | 91 | 93 | 79 | 79 |
| Childhood immunizations | 85 | 90 | 92 | 95 | 84 |
| Prenatal care | 97 | 99 | 96 | 98 | 94 |
| Mammography | 95 | 99 | 97 | 91 | 93 |
| Screening pap test | 93 | 93 | 96 | 86 | 95 |
| Occupational therapy | 77 | 89 | 86 | 67 | 65 |
| Outpatient mental | 98 | 97 | 99 | 97 | 97 |
| Inpatient mental | 98 | 100 | 99 | 98 | 95 |
| Chiropractic care | 89 | 95 | 90 | 87 | 86 |
| Prescription drugs | 97 | 93 | 97 | 97 | 99 |
| Vision care | 28 | 47 | 15 | 29 | 54 |
| Dental care | 51 | 41 | 61 | 42 | 45 |
| Hospice care | 86 | 91 | 91 | 77 | 84 |
| **POS plans** | | | | | |
| Adult physicals | 97 | 99 | 97 | 96 | 99 |
| Well-baby care | 98 | 99 | 97 | 96 | 99 |

*Continued*

**TABLE 3.7 (Continued)**

| | National | Northeast | Midwest | South | West |
|---|---|---|---|---|---|
| | | | Percent | | |
| Childhood immunizations | 98 | 99 | 96 | 96 | 99 |
| Prenatal care | 99 | 99 | 98 | 99 | 100 |
| Mammography | 99 | 99 | 98 | 99 | 94 |
| Screening pap test | 99 | 99 | 98 | 99 | 99 |
| Occupational therapy | 82 | 84 | 78 | 82 | 82 |
| Outpatient mental | 99 | 99 | 99 | 99 | 99 |
| Inpatient mental | 99 | 99 | 99 | 99 | 98 |
| Chiropractic care | 84 | 86 | 79 | 84 | 86 |
| Prescription drugs | 97 | 94 | 99 | 96 | 100 |
| Vision care | 51 | 55 | 49 | 42 | 68 |
| Dental care | 27 | 25 | 20 | 28 | 40 |
| Hospice care | 86 | 84 | 91 | 85 | 81 |

Source: KPMG Peat Marwick, Survey of Employer-Sponsored Health Benefits, 1997.