Pub. L. 110–275, title I, § 163(c), July 15, 2008, 122 Stat. 2571, provided that: ''The amendments made by this section [amending this section] shall apply to plan years beginning on or after January 1, 2010.''

Pub. L. 110–275, title I, § 164(f)(2), July 15, 2008, 122 Stat. 2575, provided that: ''The amendment made by paragraph (1) [amending this section] shall take effect on a date specified by the Secretary of Health and Human Services (but in no case later than January 1, 2010), and shall apply to all specialized Medicare Advantage plans for special needs individuals regardless of when the plan first entered the Medicare Advantage program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.].''

Pub. L. 110–275, title I, § 165(b), July 15, 2008, 122 Stat. 2575, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to plan years beginning on or after January 1, 2010.''

EFFECTIVE AND TERMINATION DATES OF 2003 AMENDMENT

Amendment by sections 221(d)(3) and 222(a)(2), (3), (h), (*l*)(1) of Pub. L. 108–173 applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108–173, set out as an Effective Date of 2003 Amendment note under section 1395w–21 of this title.

Pub. L. 108–173, title II, § 233(a)(3), Dec. 8, 2003, 117 Stat. 2209, provided that: ''The amendments made by this subsection [amending this section] shall apply on and after the date of the enactment of this Act [Dec. 8, 2003] but shall not apply to contract years beginning on or after January 1, 2006.''

Pub. L. 108–173, title VII, § 722(c), Dec. 8, 2003, 117 Stat. 2348, provided that: ''The amendments made by this section [amending this section] shall apply with respect to contract years beginning on and after January 1, 2006.''

Amendment by section 948(b)(2) of Pub. L. 108–173 effective, except as otherwise provided, as if included in the enactment of BIPA (the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, H.R. 5661, as enacted by section 1(a)(6) of Public Law 106–554), see section 948(e) of Pub. L. 108–173, set out as an Effective Date of 2003 Amendment note under section 1314 of this title.

EFFECTIVE DATE OF 2000 AMENDMENT

Amendment by section 1(a)(6) [title V, § 521(b)] of Pub. L. 106–554 applicable with respect to initial determinations made on or after Oct. 1, 2002, see section 1(a)(6) [title V, § 521(d)] of Pub. L. 106–554, set out as a note under section 1320c–3 of this title.

Pub. L. 106–554, § 1(a)(6) [title VI, § 611(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–560, provided that: ''The amendments made by this section [amending this section and section 1395w–23 of this title] are effective on the date of the enactment of this Act [Dec. 21, 2000] and shall apply to national coverage determinations and legislative changes in benefits occurring on or after such date.''

Pub. L. 106–554, § 1(a)(6) [title VI, § 621(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–565, provided that: ''The amendment made by subsection (a) [amending this section] shall apply with respect to contracts entered into or renewed on or after the date of the enactment of this Act [Dec. 21, 2000].''

EFFECTIVE DATE OF 1999 AMENDMENT

Amendment by section 1000(a)(6) [title III, § 321(k)(6)(B)] of Pub. L. 106–113 effective as if included in the enactment of the Balanced Budget Act of 1997, Pub. L. 105–33, except as otherwise provided, see section 1000(a)(6) [title III, § 321(m)] of Pub. L. 106–113, set out as a note under section 1395d of this title.

Pub. L. 106–113, div. B, § 1000(a)(6) [title V, § 520(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–386, provided that: ''The amendments made by subsection (a) [amending this section] apply to contract years beginning on or after January 1, 2000.''

IMPLEMENTATION OF 2020 AMENDMENT

Pub. L. 116–127, div. F, § 6003(b), Mar. 18, 2020, 134 Stat. 204, provided that: ''Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement the amendments made by this section [amending this section] by program instruction or otherwise.''

MEDPAC STUDY

Pub. L. 106–554, § 1(a)(6) [title VI, § 621(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–565, provided that:

''(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study analyzing the effects of the amendment made by subsection (a) [amending this section] on Medicare+Choice organizations. In conducting such study, the Commission shall examine the effects (if any) such amendment has had—

''(A) on the scope of additional benefits provided under the Medicare+Choice program;

''(B) on the administrative and other costs incurred by Medicare+Choice organizations; and

''(C) on the contractual relationships between such organizations and skilled nursing facilities.

''(2) REPORT.—Not later than 2 years after the date of the enactment of this Act [Dec. 21, 2000], the Commission shall submit to Congress a report on the study conducted under paragraph (1).''

TRANSITIONAL PASS-THROUGH OF ADDITIONAL COSTS UNDER MEDICARE+CHOICE PROGRAM FOR 2000

Pub. L. 106–113, div. B, § 1000(a)(6) [title II, § 227(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–355, provided that: ''The provisions of subparagraphs (A) and (B) of section 1852(a)(5) of the Social Security Act (42 U.S.C. 1395w–22(a)(5)) shall apply with respect to the coverage of additional benefits for immunosuppressive drugs under the amendments made by this section [amending sections 1395k and 1395x of this title] for drugs furnished in 2000 in the same manner as if such amendments constituted a national coverage determination described in the matter in such section before subparagraph (A).''

§ 1395w–23. Payments to Medicare+Choice organizations

(a) Payments to organizations

(1) Monthly payments

(A) In general

Under a contract under section 1395w–27 of this title and subject to subsections (e), (g), (i), and (*l*) and section 1395w–28(e)(4) of this title, the Secretary shall make monthly payments under this section in advance to each Medicare+Choice organization, with respect to coverage of an individual under this part in a Medicare+Choice payment area for a month, in an amount determined as follows:

(i) Payment before 2006

For years before 2006, the payment amount shall be equal to 1/12 of the annual MA capitation rate (as calculated under subsection (c)(1)) with respect to that individual for that area, adjusted under subparagraph (C) and reduced by the amount of any reduction elected under section 1395w–24(f)(1)(E) of this title.

(ii) Payment for original fee-for-service benefits beginning with 2006

For years beginning with 2006, the amount specified in subparagraph (B).

(B) Payment amount for original fee-for-service benefits beginning with 2006

(i) Payment of bid for plans with bids below benchmark

In the case of a plan for which there are average per capita monthly savings described in section 1395w–24(b)(3)(C) or 1395w–24(b)(4)(C) of this title, as the case may be, the amount specified in this subparagraph is equal to the unadjusted MA statutory non-drug monthly bid amount, adjusted under subparagraph (C) and (if applicable) under subparagraphs (F) and (G), plus the amount (if any) of any rebate under subparagraph (E).

(ii) Payment of benchmark for plans with bids at or above benchmark

In the case of a plan for which there are no average per capita monthly savings described in section 1395w–24(b)(3)(C) or 1395w–24(b)(4)(C) of this title, as the case may be, the amount specified in this subparagraph is equal to the MA area-specific non-drug monthly benchmark amount, adjusted under subparagraph (C) and (if applicable) under subparagraphs (F) and (G).

(iii) Payment of benchmark for MSA plans

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

(iv) Authority to apply frailty adjustment under PACE payment rules for certain specialized MA plans for special needs individuals

(I) In general

Notwithstanding the preceding provisions of this paragraph, for plan year 2011 and subsequent plan years, in the case of a plan described in subclause (II), the Secretary may apply the payment rules under section 1395eee(d) of this title (other than paragraph (3) of such section) rather than the payment rules that would otherwise apply under this part, but only to the extent necessary to reflect the costs of treating high concentrations of frail individuals.

(II) Plan described

A plan described in this subclause is a specialized MA plan for special needs individuals described in section 1395w–28(b)(6)(B)(ii) of this title that is fully integrated with capitated contracts with States for Medicaid benefits, including long-term care, and that have similar average levels of frailty (as determined by the Secretary) as the PACE program.

(C) Demographic adjustment, including adjustment for health status

(i) In general

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

(ii) Application of coding adjustment

For 2006 and each subsequent year:

(I) In applying the adjustment under clause (i) for health status to payment amounts, the Secretary shall ensure that such adjustment reflects changes in treatment and coding practices in the fee-for-service sector and reflects differences in coding patterns between Medicare Advantage plans and providers under part[1] A and B to the extent that the Secretary has identified such differences.

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

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

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

(iii) Improvements to risk adjustment for special needs individuals with chronic health conditions

(I) In general

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

[1] So in original. Probably should be ''parts''.

MA plans for special needs individuals (as defined in section 1395w–28(b)(6) of this title).

(II) Individuals described

An individual described in this subclause is a special needs individual described in subsection (b)(6)(B)(iii)[2] who enrolls in a specialized MA plan for special needs individuals on or after January 1, 2011.

(III) Evaluation

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

(IV) Publication of evaluation and revisions

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

(D) Separate payment for Federal drug subsidies

In the case of an enrollee in an MA–PD plan, the MA organization offering such plan also receives—

(i) subsidies under section 1395w–115 of this title (other than under subsection (g)); and

(ii) reimbursement for premium and cost-sharing reductions for low-income individuals under section 1395w–114(c)(1)(C) of this title.

(E) Payment of rebate for plans with bids below benchmark

In the case of a plan for which there are average per capita monthly savings described in section 1395w–24(b)(3)(C) or 1395w–24(b)(4)(C) of this title, as the case may be, the amount specified in this subparagraph is the amount of the monthly rebate computed under section 1395w–24(b)(1)(C)(i) of this title for that plan and year (as reduced by the amount of any credit provided under section 1395w–24(b)(1)(C)(iv)[2] of this title).

(F) Adjustment for intra-area variations

(i) Intra-regional variations

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

(ii) Intra-service area variations

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

(G) Adjustment relating to risk adjustment

The Secretary shall adjust payments with respect to MA plans as necessary to ensure that—

(i) the sum of—

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

(II) the MA monthly basic beneficiary premium under section 1395w–24(b)(2)(A) of this title; equals

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

(H) Special rule for end-stage renal disease

The Secretary shall establish separate rates of payment to a Medicare+Choice organization with respect to classes of individuals determined to have end-stage renal disease and enrolled in a Medicare+Choice plan of the organization. Such rates of payment shall be actuarially equivalent to rates that would have been paid with respect to other enrollees in the MA payment area (or such other area as specified by the Secretary) under the provisions of this section as in effect before December 8, 2003. In accordance with regulations, the Secretary shall provide for the application of the seventh sentence of section 1395rr(b)(7) of this title to payments under this section covering the provision of renal dialysis treatment in the same manner as such sentence applies to composite rate payments described in such sentence. In establishing such rates, the Secretary shall provide for appropriate adjustments to increase each rate to reflect the demonstration rate (including the risk adjustment methodology associated with such rate) of the social health maintenance organization end-stage renal disease capitation demonstrations (established by section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993), and shall compute such rates by taking into account such factors as renal treatment modality, age, and the underlying cause of the end-stage renal disease. The Secretary may apply the competitive bidding methodology provided for in this section, with appropriate adjustments to account for the risk adjustment methodology applied to end stage renal disease payments.

[2] See References in Text note below.

(I) Improvements to risk adjustment for 2019 and subsequent years

(i) In general

In order to determine the appropriate adjustment for health status under subparagraph (C)(i), the following shall apply:

(I) Taking into account total number of diseases or conditions

The Secretary shall take into account the total number of diseases or conditions of an individual enrolled in an MA plan. The Secretary shall make an additional adjustment under such subparagraph as the number of diseases or conditions of an individual increases.

(II) Using at least 2 years of diagnostic data

The Secretary may use at least 2 years of diagnosis data.

(III) Providing separate adjustments for dual eligible individuals

With respect to individuals who are dually eligible for benefits under this subchapter and subchapter XIX, the Secretary shall make separate adjustments for each of the following:

(aa) Full-benefit dual eligible individuals (as defined in section 1396u–5(c)(6) of this title).

(bb) Such individuals not described in item (aa).

(IV) Evaluation of mental health and substance use disorders

The Secretary shall evaluate the impact of including additional diagnosis codes related to mental health and substance use disorders in the risk adjustment model.

(V) Evaluation of chronic kidney disease

The Secretary shall evaluate the impact of including the severity of chronic kidney disease in the risk adjustment model.

(VI) Evaluation of payment rates for end-stage renal disease

The Secretary shall evaluate whether other factors (in addition to those described in subparagraph (H)) should be taken into consideration when computing payment rates under such subparagraph.

(ii) Phased-in implementation

The Secretary shall phase-in any changes to risk adjustment payment amounts under subparagraph (C)(i) under this subparagraph over a 3-year period, beginning with 2019, with such changes being fully implemented for 2022 and subsequent years.

(iii) Opportunity for review and public comment

The Secretary shall provide an opportunity for review of the proposed changes to such risk adjustment payment amounts under this subparagraph and a public comment period of not less than 60 days before implementing such changes.

(2) Adjustment to reflect number of enrollees

(A) In general

The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled with an organization under this part and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

(B) Special rule for certain enrollees

(i) In general

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

(ii) Exception

No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement described in section 1395w–22(c) of this title at the time the individual enrolled with the organization.

(3) Establishment of risk adjustment factors

(A) Report

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

(B) Data collection

In order to carry out this paragraph, the Secretary shall require Medicare+Choice organizations (and eligible organizations with risk-sharing contracts under section 1395mm of this title) to submit data regarding inpatient hospital services for periods beginning on or after July 1, 1997, and data regarding other services and other information as the Secretary deems necessary for periods beginning on or after July 1, 1998. The Secretary may not require an organization to submit such data before January 1, 1998.

(C) Initial implementation

(i) In general

The Secretary shall first provide for implementation of a risk adjustment meth-

odology that accounts for variations in per capita costs based on health status and other demographic factors for payments by no later than January 1, 2000.

(ii) Phase-in

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

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

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

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

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

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

(iii) Data for risk adjustment methodology

Such risk adjustment methodology for 2004 and each succeeding year, shall be based on data from inpatient hospital and ambulatory settings.

(iv) Full implementation of risk adjustment for congestive heart failure enrollees for 2001

(I) Exemption from phase-in

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

(II) Period of application

Subclause (I) shall only apply during the 1-year period beginning on January 1, 2001.

(D) Uniform application to all types of plans

Subject to section 1395w–28(e)(4) of this title, the methodology shall be applied uniformly without regard to the type of plan.

(4) Payment rule for federally qualified health center services

If an individual who is enrolled with an MA plan under this part receives a service from a federally qualified health center that has a written agreement with the MA organization that offers such plan for providing such a service (including any agreement required under section 1395w–27(e)(3) of this title)—

(A) the Secretary shall pay the amount determined under section 1395*l*(a)(3)(B) of this title directly to the federally qualified health center not less frequently than quarterly; and

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

(b) Annual announcement of payment rates

(1) Annual announcements

(A) For 2005

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

(i) MA capitation rates

The annual MA capitation rate for each MA payment area for 2005.

(ii) Adjustment factors

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

(B) For 2006 and subsequent years

For a year after 2005—

(i) Initial announcement

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

(I) MA capitation rates; MA local area benchmark

The annual MA capitation rate for each MA payment area for the year.

(II) Adjustment factors

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

(ii) Regional benchmark announcement

The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), on a timely basis before the calendar year concerned, with respect to each MA region and each MA regional plan for which a bid was submitted under section 1395w–24 of this title, the MA region-specific non-drug monthly benchmark amount for that region for the year involved.

(iii) Benchmark announcement for CCA local areas

The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), on a timely basis before the calendar year concerned, with respect to each CCA area (as defined in section 1395w–29(b)(1)(A)[2] of this title), the CCA non-drug monthly benchmark amount under section 1395w–29(e)(1)[2] of this title for that area for the year involved.

(2) Advance notice of methodological changes

At least 45 days (or, in 2017 and each subsequent year, at least 60 days) before making the

announcement under paragraph (1) for a year, the Secretary shall provide for notice to Medicare+Choice organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity (in 2017 and each subsequent year, of no less than 30 days) to comment on such proposed changes.

(3) Explanation of assumptions

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

(4) Continued computation and publication of county-specific per capita fee-for-service expenditure information

The Secretary, through the Chief Actuary of the Centers for Medicare & Medicaid Services, shall provide for the computation and publication, on an annual basis beginning with 2001 at the time of publication of the annual Medicare+Choice capitation rates under paragraph (1), of the following information for the original medicare fee-for-service program under parts A and B (exclusive of individuals eligible for coverage under section 426–1 of this title) for each Medicare+Choice payment area for the second calendar year ending before the date of publication:

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

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

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

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

(c) Calculation of annual Medicare+Choice capitation rates

(1) In general

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

(A) Blended capitation rate

For a year before 2005, the sum of—

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

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

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

(B) Minimum amount

12 multiplied by the following amount:

(i) For 1998, $367 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title for the area).

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

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

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

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

(C) Minimum percentage increase

(i) For 1998, 102 percent of the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title for the Medicare+Choice payment area.

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

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

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

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

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

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

(D) 100 percent of fee-for-service costs

(i) In general

For each year specified in clause (ii), the adjusted average per capita cost for the year involved, determined under section 1395mm(a)(4) of this title and adjusted as appropriate for the purpose of risk adjustment, for the MA payment area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under sections,[3] 1395w–4(*o*), and[3] 1395ww(n) and 1395ww(h) of this title.

(ii) Periodic rebasing

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

(iii) Inclusion of costs of VA and DOD military facility services to medicare-eligible beneficiaries

In determining the adjusted average per capita cost under clause (i) for a year, such cost shall be adjusted to include the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this subchapter if individuals entitled to benefits under this subchapter had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

(2) Area-specific and national percentages

For purposes of paragraph (1)(A)—

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

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

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

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

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

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

(3) Annual area-specific Medicare+Choice capitation rate

(A) In general

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

(i) for 1998 is, subject to subparagraph (D), the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title for the area, increased by the national per capita Medicare+Choice growth percentage for 1998 (described in paragraph (6)(A)); or

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

(B) Removal of medical education from calculation of adjusted average per capita cost

(i) In general

In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 1998), the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title shall be adjusted to exclude from the rate the applicable percent (specified in clause (ii)) of the payment adjustments described in subparagraph (C).

(ii) Applicable percent

For purposes of clause (i), the applicable percent for—

(I) 1998 is 20 percent,

(II) 1999 is 40 percent,

(III) 2000 is 60 percent,

(IV) 2001 is 80 percent, and

(V) a succeeding year is 100 percent.

(C) Payment adjustment

(i) In general

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

(I) for the indirect costs of medical education under section 1395ww(d)(5)(B) of this title, and

(II) for direct graduate medical education costs under section 1395ww(h) of this title.

(ii) Treatment of payments covered under State hospital reimbursement system

To the extent that the Secretary estimates that an annual per capita rate of payment for 1997 described in clause (i) reflects payments to hospitals reimbursed under section 1395f(b)(3) of this title, the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

(D) Treatment of areas with highly variable payment rates

In the case of a Medicare+Choice payment area for which the annual per capita rate of payment determined under section 1395mm(a)(1)(C) of this title for 1997 varies by more than 20 percent from such rate for 1996, for purposes of this subsection the Secretary may substitute for such rate for 1997 a rate that is more representative of the costs of the enrollees in the area.

[3] So in original.

(E) Inclusion of costs of DOD and VA military facility services to Medicare-eligible beneficiaries

In determining the area-specific MA capitation rate under subparagraph (A) for a year (beginning with 2004), the annual per capita rate of payment for 1997 determined under section 1395mm(a)(1)(C) of this title shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this subchapter if individuals entitled to benefits under this subchapter had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

(4) Input-price-adjusted annual national Medicare+Choice capitation rate

(A) In general

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

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

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

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

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

(B) National standardized annual Medicare+Choice capitation rate

In subparagraph (A)(i), the ''national standardized annual Medicare+Choice capitation rate'' for a year is equal to—

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

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

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

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

(C) Special rules for 1998

In applying this paragraph for 1998—

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

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

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

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

(iii) for part A services, 70 percent of payments attributable to such services shall be adjusted by the index used under section 1395ww(d)(3)(E) of this title to adjust payment rates for relative hospital wage levels for hospitals located in the payment area involved;

(iv) for part B services—

(I) 66 percent of payments attributable to such services shall be adjusted by the index of the geographic area factors under section 1395w–4(e) of this title used to adjust payment rates for physicians' services furnished in the payment area, and

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

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

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

(5) Payment adjustment budget neutrality factor

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

(6) "National per capita Medicare+Choice growth percentage" defined

(A) In general

In this part, the ''national per capita Medicare+Choice growth percentage'' for a year is the percentage determined by the Secretary, by March 1st before the beginning of the year involved, to reflect the Secretary's estimate of the projected per capita rate of growth in expenditures under this subchapter for an individual entitled to benefits under part A and enrolled under part B, excluding expenditures attributable to subsections (a)(7) and (*o*) of section 1395w–4 of this title and subsections (b)(3)(B)(ix) and (n) of section 1395ww of this title, reduced by the number of percentage points specified in

subparagraph (B) for the year. Separate determinations may be made for aged enrollees, disabled enrollees, and enrollees with end-stage renal disease.

(B) Adjustment

The number of percentage points specified in this subparagraph is—

(i) for 1998, 0.8 percentage points,

(ii) for 1999, 0.5 percentage points,

(iii) for 2000, 0.5 percentage points,

(iv) for 2001, 0.5 percentage points,

(v) for 2002, 0.3 percentage points, and

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

(C) Adjustment for over or under projection of national per capita Medicare+Choice growth percentage

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

(7) Adjustment for national coverage determinations and legislative changes in benefits

If the Secretary makes a determination with respect to coverage under this subchapter or there is a change in benefits required to be provided under this part that the Secretary projects will result in a significant increase in the costs to Medicare+Choice of providing benefits under contracts under this part (for periods after any period described in section 1395w–22(a)(5) of this title), the Secretary shall adjust appropriately the payments to such organizations under this part. Such projection and adjustment shall be based on an analysis by the Chief Actuary of the Centers for Medicare & Medicaid Services of the actuarial costs associated with the new benefits.

(d) MA payment area; MA local area; MA region defined

(1) MA payment area

In this part, except as provided in this subsection, the term ''MA payment area'' means—

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

(B) with respect to an MA regional plan, an MA region (as established under section 1395w–27a(a)(2) of this title).

(2) MA local area

The term ''MA local area'' means a county or equivalent area specified by the Secretary.

(3) Rule for ESRD beneficiaries

In the case of individuals who are determined to have end stage renal disease, the Medicare+Choice payment area shall be a State or such other payment area as the Secretary specifies.

(4) Geographic adjustment

(A) In general

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

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

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

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

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

(B) Budget neutrality adjustment

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

(C) Metropolitan based system

The metropolitan based system described in this subparagraph is one in which—

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

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

(D) Areas

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

(e) Special rules for individuals electing MSA plans

(1) In general

If the amount of the Medicare+Choice monthly MSA premium (as defined in section 1395w–24(b)(2)(C) of this title) for an MSA plan

for a year is less than 1/12 of the annual Medicare+Choice capitation rate applied under this section for the area and year involved, the Secretary shall deposit an amount equal to 100 percent of such difference in a Medicare+Choice MSA established (and, if applicable, designated) by the individual under paragraph (2).

(2) Establishment and designation of Medicare+Choice medical savings account as requirement for payment of contribution

In the case of an individual who has elected coverage under an MSA plan, no payment shall be made under paragraph (1) on behalf of an individual for a month unless the individual—

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

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

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

(3) Lump-sum deposit of medical savings account contribution

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

(f) Payments from Trust Funds

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

(g) Special rule for certain inpatient hospital stays

In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1395ww(d)(1)(B) of this title), a rehabilitation hospital described in section 1395ww(d)(1)(B)(ii) of this title or a distinct part rehabilitation unit described in the matter following clause (v)[2] of section 1395ww(d)(1)(B) of this title, or a long-term care hospital (described in section 1395ww(d)(1)(B)(iv) of this title) as of the effective date of the individual's—

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

(A) payment for such services until the date of the individual's discharge shall be made under this subchapter through the Medicare+Choice plan or the original medicare fee-for-service program option described in section 1395w–21(a)(1)(A) of this title (as the case may be) elected before the election with such organization,

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

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

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

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

(B) payment for such services during the stay shall not be made under section 1395ww(d) of this title or other payment provision under this subchapter for inpatient services for the type of facility, hospital, or unit involved, described in the matter preceding paragraph (1), as the case may be, or by any succeeding Medicare+Choice organization, and

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

(h) Special rule for hospice care

(1) Information

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

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

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

(2) Payment

If an individual who is enrolled with a Medicare+Choice organization under this part makes an election under section 1395d(d)(1) of this title to receive hospice care from a particular hospice program—

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

(B) payment for other services for which the individual is eligible notwithstanding the individual's election of hospice care under section 1395d(d)(1) of this title, including services not related to the individual's terminal illness, shall be made by the Secretary to the Medicare+Choice organization or the provider or supplier of the service instead of payments calculated under subsection (a); and

(C) the Secretary shall continue to make monthly payments to the Medicare+Choice organization in an amount equal to the value of the additional benefits required under section 1395w–24(f)(1)(A) of this title.

(i) New entry bonus

(1) In general

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

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

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

(2) Period of application

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

(3) Limitation to organization offering first plan in an area

Paragraph (1) shall only apply to payment to the first Medicare+Choice organization that offers a Medicare+Choice plan in each Medicare+Choice payment area, except that if more than one such organization first offers such a plan in an area on the same date, paragraph (1) shall apply to payment for such organizations.

(4) Construction

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

(5) Offered defined

In this subsection, the term ''offered'' means, with respect to a Medicare+Choice plan as of a date, that a Medicare+Choice eligible individual may enroll with the plan on that date, regardless of when the enrollment takes effect or when the individual obtains benefits under the plan.

(j) Computation of benchmark amounts

For purposes of this part, subject to subsection (*o*), the term ''MA area-specific non-drug monthly benchmark amount'' means for a month in a year—

(1) with respect to—

(A) a service area that is entirely within an MA local area, subject to section 1395w–29(d)(2)(A)[2] of this title, an amount equal to 1/12 of the annual MA capitation rate under subsection (c)(1) for the area for the year (or, for 2007, 2008, 2009, and 2010, 1/12 of the applicable amount determined under subsection (k)(1) for the area for the year; for 2011, 1/12 of the applicable amount determined under subsection (k)(1) for the area for 2010; and, beginning with 2012, 1/12 of the blended benchmark amount determined under subsection (n)(1) for the area for the year), adjusted as appropriate (for years before 2007) for the purpose of risk adjustment; or

(B) a service area that includes more than one MA local area, an amount equal to the average of the amounts described in subparagraph (A) for each such local MA area, weighted by the projected number of enrollees in the plan residing in the respective local MA areas (as used by the plan for purposes of the bid and disclosed to the Secretary under section 1395w–24(a)(6)(A)(iii) of this title), adjusted as appropriate (for years before 2007) for the purpose of risk adjustment; or

(2) with respect to an MA region for a month in a year, the MA region-specific non-drug monthly benchmark amount, as defined in section 1395w–27a(f) of this title for the region for the year.

(k) Determination of applicable amount for purposes of calculating the benchmark amounts

(1) Applicable amount defined

For purposes of subsection (j), subject to paragraphs (2), (4), and (5), the term ''applicable amount'' means for an area—

(A) for 2007—

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

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

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

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

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

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

(B) for a subsequent year—

(i) if such year is not specified under subsection (c)(1)(D)(ii), an amount equal to the amount determined under this paragraph for the area for the previous year (determined without regard to paragraphs (2), (4), and (5)), increased by the national per capita MA growth percentage, described in subsection (c)(6) for that succeeding year, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

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

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

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

(2) Phase-out of budget neutrality factor

(A) In general

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

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

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

(B) Percent determined

(i) In general

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

(ii) Numerator based on difference between demographic rate and risk rate

(I) In general

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

(II) Demographic rate

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

(III) Risk rate

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

(iii) Denominator based on risk rate

The denominator described in this clause is equal to the total amount estimated for the year under clause (ii)(III).

(iv) Requirements

In estimating the amounts under the previous clauses, the Secretary shall—

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

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

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

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

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

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

(v) Authority

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

(C) Applicable phase-out factor

For purposes of subparagraph (A)(ii), the term ''applicable phase-out factor'' means—

(i) for 2007, 0.55;

(ii) for 2008, 0.40;

(iii) for 2009, 0.25; and

(iv) for 2010, 0.05.

(D) Termination of application

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

(3) No revision in percent

(A) In general

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

(B) Rule of construction

Nothing in this subsection shall be construed to limit the authority of the Sec-

retary to make adjustments to the applicable amounts determined under paragraph (1) as appropriate for purposes of updating data or for purposes of adopting an improved risk adjustment methodology.

(4) Phase-out of the indirect costs of medical education from capitation rates

(A) In general

After determining the applicable amount for an area for a year under paragraph (1) (beginning with 2010), the Secretary shall adjust such applicable amount to exclude from such applicable amount the phase-in percentage (as defined in subparagraph (B)(i)) for the year of the Secretary's estimate of the standardized costs for payments under section 1395ww(d)(5)(B) of this title in the area for the year. Any adjustment under the preceding sentence shall be made prior to the application of paragraph (2).

(B) Percentages defined

For purposes of this paragraph:

(i) Phase-in percentage

The term ''phase-in percentage'' means, for an area for a year, the ratio (expressed as a percentage, but in no case greater than 100 percent) of—

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

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

(ii) Maximum cumulative adjustment percentage

The term ''maximum cumulative adjustment percentage'' means, for—

(I) 2010, 0.60 percent; and

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

(iii) Standardized IME cost percentage

The term ''standardized IME cost percentage'' means, for an area for a year, the per capita costs for payments under section 1395ww(d)(5)(B) of this title (expressed as a percentage of the fee-for-service amount specified in subparagraph (C)) for the area and the year.

(C) Fee-for-service amount

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

(5) Exclusion of costs for kidney acquisitions from capitation rates

After determining the applicable amount for an area for a year under paragraph (1) (beginning with 2021), the Secretary shall adjust such applicable amount to exclude from such applicable amount the Secretary's estimate of the standardized costs for payments for organ acquisitions for kidney transplants covered under this subchapter (including expenses covered under section 1395rr(d) of this title) in the area for the year.

***(l)* Application of eligible professional incentives for certain MA organizations for adoption and meaningful use of certified EHR technology**

(1) In general

Subject to paragraphs (3) and (4), in the case of a qualifying MA organization, the provisions of sections 1395w–4(*o*) and 1395w–4(a)(7) of this title shall apply with respect to eligible professionals described in paragraph (2) of the organization who the organization attests under paragraph (6) to be meaningful EHR users in a similar manner as they apply to eligible professionals under such sections. Incentive payments under paragraph (3) shall be made to and payment adjustments under paragraph (4) shall apply to such qualifying organizations.

(2) Eligible professional described

With respect to a qualifying MA organization, an eligible professional described in this paragraph is an eligible professional (as defined for purposes of section 1395w–4(*o*) of this title) who—

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

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

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

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

(3) Eligible professional incentive payments

(A) In general

In applying section 1395w–4(*o*) of this title under paragraph (1), instead of the additional payment amount under section 1395w–4(*o*)(1)(A) of this title and subject to subparagraph (B), the Secretary may substitute an amount determined by the Secretary to the extent feasible and practical to be similar to the estimated amount in the aggregate that would be payable if payment for services furnished by such professionals was payable under part B instead of this part.

(B) Avoiding duplication of payments

(i) In general

In the case of an eligible professional described in paragraph (2)—

(I) that is eligible for the maximum incentive payment under section 1395w–4(*o*)(1)(A) of this title for the same payment period, the payment incentive shall be made only under such section and not under this subsection; and

(II) that is eligible for less than such maximum incentive payment for the same payment period, the payment incentive shall be made only under this subsection and not under section 1395w–4(*o*)(1)(A) of this title.

(ii) Methods

In the case of an eligible professional described in paragraph (2) who is eligible for

an incentive payment under section 1395w–4(*o*)(1)(A) of this title but is not described in clause (i) for the same payment period, the Secretary shall develop a process—

(I) to ensure that duplicate payments are not made with respect to an eligible professional both under this subsection and under section 1395w–4(*o*)(1)(A) of this title; and

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

(C) Fixed schedule for application of limitation on incentive payments for all eligible professionals

In applying section 1395w–4(*o*)(1)(B)(ii) of this title under subparagraph (A), in accordance with rules specified by the Secretary, a qualifying MA organization shall specify a year (not earlier than 2011) that shall be treated as the first payment year for all eligible professionals with respect to such organization.

(4) Payment adjustment

(A) In general

In applying section 1395w–4(a)(7) of this title under paragraph (1), instead of the payment adjustment being an applicable percent of the fee schedule amount for a year under such section, subject to subparagraph (D), the payment adjustment under paragraph (1) shall be equal to the percent specified in subparagraph (B) for such year of the payment amount otherwise provided under this section for such year.

(B) Specified percent

The percent specified under this subparagraph for a year is 100 percent minus a number of percentage points equal to the product of—

(i) the number of percentage points by which the applicable percent (under section 1395w–4(a)(7)(A)(ii) of this title) for the year is less than 100 percent; and

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

(C) Medicare physician expenditure proportion

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

(D) Application of payment adjustment

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

(5) Qualifying MA organization defined

In this subsection and subsection (m), the term ''qualifying MA organization'' means a Medicare Advantage organization that is organized as a health maintenance organization (as defined in section 300gg–91(b)(3) of this title).

(6) Meaningful EHR user attestation

For purposes of this subsection and subsection (m), a qualifying MA organization shall submit an attestation, in a form and manner specified by the Secretary which may include the submission of such attestation as part of submission of the initial bid under section 1395w–24(a)(1)(A)(iv)[4] of this title, identifying—

(A) whether each eligible professional described in paragraph (2), with respect to such organization is a meaningful EHR user (as defined in section 1395w–4(*o*)(2) of this title) for a year specified by the Secretary; and

(B) whether each eligible hospital described in subsection (m)(1),[5] with respect to such organization, is a meaningful EHR user (as defined in section 1395ww(n)(3) of this title) for an applicable period specified by the Secretary.

(7) Posting on website

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

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

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

(8) Limitation on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise, of—

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

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

(C) the methodology and standards for determining a meaningful EHR user under section 1395w–4(*o*)(2) of this title, including specification of the means of demonstrating meaningful EHR use under section 1395w–4(*o*)(3)(C)[6] of this title and selection of measures under section 1395w–4(*o*)(3)(B)[7] of this title.

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[4] So in original. Section 1395w–24(a)(1)(A) of this title does not contain a cl. (iv).

[5] So in original. Probably should be ''(m)(2),''.

[6] So in original. Probably should be ''1395w–4(*o*)(2)(C)''.

[7] So in original. Probably should be ''1395w–4(*o*)(2)(B)''.

(m) Application of eligible hospital incentives for certain MA organizations for adoption and meaningful use of certified EHR technology

(1) Application

Subject to paragraphs (3) and (4), in the case of a qualifying MA organization, the provisions of sections 1395ww(n) and 1395ww(b)(3)(B)(ix) of this title shall apply with respect to eligible hospitals described in paragraph (2) of the organization which the organization attests under subsection (*l*)(6) to be meaningful EHR users in a similar manner as they apply to eligible hospitals under such sections. Incentive payments under paragraph (3) shall be made to and payment adjustments under paragraph (4) shall apply to such qualifying organizations.

(2) Eligible hospital described

With respect to a qualifying MA organization, an eligible hospital described in this paragraph is an eligible hospital (as defined in section 1395ww(n)(6)(B) of this title) that is under common corporate governance with such organization and serves individuals enrolled under an MA plan offered by such organization.

(3) Eligible hospital incentive payments

(A) In general

In applying section 1395ww(n)(2) of this title under paragraph (1), instead of the additional payment amount under section 1395ww(n)(2) of this title, there shall be substituted an amount determined by the Secretary to be similar to the estimated amount in the aggregate that would be payable if payment for services furnished by such hospitals was payable under part A instead of this part. In implementing the previous sentence, the Secretary—

(i) shall, insofar as data to determine the discharge related amount under section 1395ww(n)(2)(C) of this title for an eligible hospital are not available to the Secretary, use such alternative data and methodology to estimate such discharge related amount as the Secretary determines appropriate; and

(ii) shall, insofar as data to determine the medicare share described in section 1395ww(n)(2)(D) of this title for an eligible hospital are not available to the Secretary, use such alternative data and methodology to estimate such share, which data and methodology may include use of the inpatient-bed-days (or discharges) with respect to an eligible hospital during the appropriate period which are attributable to both individuals for whom payment may be made under part A or individuals enrolled in an MA plan under a Medicare Advantage organization under this part as a proportion of the estimated total number of patient-bed-days (or discharges) with respect to such hospital during such period.

(B) Avoiding duplication of payments

(i) In general

In the case of a hospital that for a payment year is an eligible hospital described in paragraph (2) and for which at least one-third of their discharges (or bed-days) of Medicare patients for the year are covered under part A, payment for the payment year shall be made only under section 1395ww(n) of this title and not under this subsection.

(ii) Methods

In the case of a hospital that is an eligible hospital described in paragraph (2) and also is eligible for an incentive payment under section 1395ww(n) of this title but is not described in clause (i) for the same payment period, the Secretary shall develop a process—

(I) to ensure that duplicate payments are not made with respect to an eligible hospital both under this subsection and under section 1395ww(n) of this title; and

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

(4) Payment adjustment

(A) Subject to paragraph (3), in the case of a qualifying MA organization (as defined in subsection (*l*)(5)), if, according to the attestation of the organization submitted under subsection (*l*)(6) for an applicable period, one or more eligible hospitals (as defined in section 1395ww(n)(6)(B) of this title) that are under common corporate governance with such organization and that serve individuals enrolled under a plan offered by such organization are not meaningful EHR users (as defined in section 1395ww(n)(3) of this title) with respect to a period, the payment amount payable under this section for such organization for such period shall be the percent specified in subparagraph (B) for such period of the payment amount otherwise provided under this section for such period.

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

(i) the number of the percentage point reduction effected under section 1395ww(b)(3)(B)(ix)(I) of this title for the period; and

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

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

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

such hospitals, that are not meaningful EHR users for such period.

(5) Posting on website

The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format—

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

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

(6) Limitations on review

There shall be no administrative or judicial review under section 1395ff of this title, section 1395*oo* of this title, or otherwise, of—

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

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

(C) the methodology and standards for determining a meaningful EHR user under section 1395ww(n)(3) of this title, including specification of the means of demonstrating meaningful EHR use under subparagraph (C) of such section and selection of measures under subparagraph (B) of such section.

(n) Determination of blended benchmark amount

(1) In general

For purposes of subsection (j), subject to paragraphs (3), (4), and (5), the term ''blended benchmark amount'' means for an area—

(A) for 2012 the sum of—

(i) ½ of the applicable amount for the area and year; and

(ii) ½ of the amount specified in paragraph (2)(A) for the area and year; and

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

(2) Specified amount

(A) In general

The amount specified in this subparagraph for an area and year is the product of—

(i) the base payment amount specified in subparagraph (E) for the area and year adjusted to take into account the phase-out in the indirect costs of medical education from capitation rates described in subsection (k)(4) and, for 2021 and subsequent years, the exclusion of payments for organ acquisitions for kidney transplants from the capitation rate as described in subsection (k)(5); and

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

(B) Applicable percentage

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

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

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

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

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

(C) Periodic ranking

For purposes of this paragraph in the case of an area located—

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

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

(D) 1-year transition for changes in applicable percentage

If, for a year after 2012, there is a change in the quartile in which an area is ranked compared to the previous year, the applicable percentage for the area in the year shall be the average of—

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

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

(E) Base payment amount

Subject to subparagraphs (F) and (G), the base payment amount specified in this subparagraph—

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

(ii) for a subsequent year that—

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

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

(F) Application of indirect medical education phase-out

The base payment amount specified in subparagraph (E) for a year shall be adjusted in the same manner under paragraph (4) of subsection (k) as the applicable amount is adjusted under such subsection.

(G) Application of kidney acquisitions adjustment

The base payment amount specified in subparagraph (E) for a year (beginning with 2021) shall be adjusted in the same manner under paragraph (5) of subsection (k) as the applicable amount is adjusted under such subsection.

(3) Alternative phase-ins

(A) 4-year phase-in for certain areas

If the difference between the applicable amount (as defined in subsection (k)) for an area for 2010 and the projected 2010 benchmark amount (as defined in subparagraph (C)) for the area is at least $30 but less than $50, the blended benchmark amount for the area is—

(i) for 2012 the sum of—

(I) ¾ of the applicable amount for the area and year; and

(II) ¼ of the amount specified in paragraph (2)(A) for the area and year;

(ii) for 2013 the sum of—

(I) ½ of the applicable amount for the area and year; and

(II) ½ of the amount specified in paragraph (2)(A) for the area and year;

(iii) for 2014 the sum of—

(I) ¼ of the applicable amount for the area and year; and

(II) ¾ of the amount specified in paragraph (2)(A) for the area and year; and

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

(B) 6-year phase-in for certain areas

If the difference between the applicable amount (as defined in subsection (k)) for an area for 2010 and the projected 2010 benchmark amount (as defined in subparagraph (C)) for the area is at least $50, the blended benchmark amount for the area is—

(i) for 2012 the sum of—

(I) ⅚ of the applicable amount for the area and year; and

(II) ⅙ of the amount specified in paragraph (2)(A) for the area and year;

(ii) for 2013 the sum of—

(I) ⅔ of the applicable amount for the area and year; and

(II) ⅓ of the amount specified in paragraph (2)(A) for the area and year;

(iii) for 2014 the sum of—

(I) ½ of the applicable amount for the area and year; and

(II) ½ of the amount specified in paragraph (2)(A) for the area and year;

(iv) for 2015 the sum of—

(I) ⅓ of the applicable amount for the area and year; and

(II) ⅔ of the amount specified in paragraph (2)(A) for the area and year; and

(v) for 2016 the sum of—

(I) ⅙ of the applicable amount for the area and year; and

(II) ⅚ of the amount specified in paragraph (2)(A) for the area and year; and

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

(C) Projected 2010 benchmark amount

The projected 2010 benchmark amount described in this subparagraph for an area is equal to the sum of—

(i) ½ of the applicable amount (as defined in subsection (k)) for the area for 2010; and

(ii) ½ of the amount specified in paragraph (2)(A) for the area for 2010 but determined as if there were substituted for the applicable percentage specified in clause (ii) of such paragraph the sum of—

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

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

(4) Cap on benchmark amount

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

(5) Non-application to PACE plans

This subsection shall not apply to payments to a PACE program under section 1395eee of this title.

***(o)* Applicable percentage quality increases**

(1) In general

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

(A) for 2012, by 1.5 percentage points;

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

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

(2) Increase for qualifying plans in qualifying counties

The increase applied under paragraph (1) for a qualifying plan located in a qualifying county for a year shall be doubled.

(3) Qualifying plans and qualifying county defined; application of increases to low enrollment and new plans

For purposes of this subsection:

(A) Qualifying plan

(i) In general

The term ''qualifying plan'' means, for a year and subject to paragraph (4), a plan

that had a quality rating under paragraph (4) of 4 stars or higher based on the most recent data available for such year.

(ii) Application of increases to low enrollment plans

(I) 2012

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

(II) 2013 and subsequent years

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

(iii) Application of increases to new plans

(I) In general

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

(aa) for 2012, by 1.5 percentage points;

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

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

(II) New MA plan defined

The term ''new MA plan'' means, with respect to a year, a plan offered by an organization or sponsor that has not had a contract as a Medicare Advantage organization in the preceding 3-year period.

(B) Qualifying county

The term ''qualifying county'' means, for a year, a county—

(i) that has an MA capitation rate that, in 2004, was based on the amount specified in subsection (c)(1)(B) for a Metropolitan Statistical Area with a population of more than 250,000;

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

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

(4) Quality determinations for application of increase

(A) Quality determination

The quality rating for a plan shall be determined according to a 5-star rating system (based on the data collected under section 1395w–22(e) of this title).

(B) Plans that failed to report

An MA plan which does not report data that enables the Secretary to rate the plan for purposes of this paragraph shall be counted as having a rating of fewer than 3.5 stars.

(C) Special rule for first 3 plan years for plans that were converted from a reasonable cost reimbursement contract

For purposes of applying paragraph (1) and section 1395w–24(b)(1)(C) of this title for the first 3 plan years under this part in the case of an MA plan to which deemed enrollment applies under section 1395w–21(c)(4) of this title—

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

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

(D) Special rule to prevent the artificial inflation of star ratings after the consolidation of Medicare Advantage plans offered by a single organization

(i) In general

If—

(I) a Medicare Advantage organization has entered into more than one contract with the Secretary with respect to the offering of Medicare Advantage plans; and

(II) on or after January 1, 2019, the Secretary approves a request from the organization to consolidate the plans under one or more contract[8] (in this subparagraph referred to as a ''closed contract'') with the plans offered under a separate contract (in this subparagraph referred to as the ''continuing contract'');

with respect to the continuing contract, the Secretary shall adjust the quality rating under the 5-star rating system and any quality increase under this subsection and rebate amounts under section 1395w–24 of this title to reflect an enrollment-weighted average of scores or ratings for the continuing and closed contracts, as determined appropriate by the Secretary.

(ii) Application

An adjustment under clause (i) shall apply for any year for which the quality rating of the continuing contract is based primarily on a measurement period that is prior to the first year in which a closed contract is no longer offered.

(5) Exception for PACE plans

This subsection shall not apply to payments to a PACE program under section 1395eee of this title.

[8] So in original. Probably should be ''contracts''.

(6) Quality measurement at the plan level for SNPs

(A) In general

Subject to subparagraph (B), the Secretary may require reporting of data under section 1395w–22(e) of this title for, and apply under this subsection, quality measures at the plan level for specialized MA plans for special needs individuals instead of at the contract level.

(B) Considerations

Prior to applying quality measurement at the plan level under this paragraph, the Secretary shall—

(i) take into consideration the minimum number of enrollees in a specialized MA plan for special needs individuals in order to determine if a statistically significant or valid measurement of quality at the plan level is possible under this paragraph;

(ii) take into consideration the impact of such application on plans that serve a disproportionate number of individuals dually eligible for benefits under this subchapter and under subchapter XIX;

(iii) if quality measures are reported at the plan level, ensure that MA plans are not required to provide duplicative information; and

(iv) ensure that such reporting does not interfere with the collection of encounter data submitted by MA organizations or the administration of any changes to the program under this part as a result of the collection of such data.

(C) Application

If the Secretary applies quality measurement at the plan level under this paragraph—

(i) such quality measurement may include Medicare Health Outcomes Survey (HOS), Healthcare Effectiveness Data and Information Set (HEDIS), Consumer Assessment of Healthcare Providers and Systems (CAHPS) measures and quality measures under part D; and

(ii) the Secretary shall consider applying administrative actions, such as remedies described in section 1395w–27(g)(2) of this title, at the plan level.

(7) Determination of feasibility of quality measurement at the plan level for all MA plans

(A) Determination of feasibility

The Secretary shall determine the feasibility of requiring reporting of data under section 1395w–22(e) of this title for, and applying under this subsection, quality measures at the plan level for all MA plans under this part.

(B) Consideration of change

After making a determination under subparagraph (A), the Secretary shall consider requiring such reporting and applying such quality measures at the plan level as described in such subparagraph[3]

(Aug. 14, 1935, ch. 531, title XVIII, § 1853, as added Pub. L. 105–33, title IV, § 4001, Aug. 5, 1997, 111 Stat. 299; amended Pub. L. 106–113, div. B, § 1000(a)(6) [title V, §§ 511(a), 512, 514(a), 517], Nov. 29, 1999, 113 Stat. 1536, 1501A–380, 1501A–382 to 1501A–384; Pub. L. 106–554, § 1(a)(6) [title VI, §§ 601(a), 602(a), 603, 605(a), 606(a)(2)(A), 607, 608(a), 611(a)], Dec. 21, 2000, 114 Stat. 2763, 2763A–554 to 2763A–559; Pub. L. 107–188, title V, § 532(d)(1), June 12, 2002, 116 Stat. 696; Pub. L. 108–173, title I, § 101(e)(3)(D), title II, §§ 211(a)–(e)(1), 221(d)(1), (4), 222(d)–(f), (i), 237(b)(1), (2)(B), 241(b)(1), title VII, § 736(d)(1), title IX, § 900(e)(1)(G), Dec. 8, 2003, 117 Stat. 2151, 2176–2178, 2192, 2193, 2200–2202, 2204, 2212, 2213, 2220, 2357, 2371; Pub. L. 109–171, title V, § 5301, Feb. 8, 2006, 120 Stat. 48; Pub. L. 110–275, title I, § 161(a), (b), July 15, 2008, 122 Stat. 2568, 2569; Pub. L. 111–5, div. B, title IV, §§ 4101(c), (e), 4102(c), (d)(3), Feb. 17, 2009, 123 Stat. 473, 476, 484, 486; Pub. L. 111–148, title III, §§ 3201(a)(1), (2)(A), (b), (e)(1), (2)(A)(ii)–(iv), (f)(1), (g), (h), (i)(2), 3202(b)(2), 3203, 3205(b), (f), title X, § 10318, Mar. 23, 2010, 124 Stat. 442, 444–447, 450, 452, 454–458, 948; Pub. L. 111–152, title I, § 1102(a)–(c)(3), (e), Mar. 30, 2010, 124 Stat. 1040, 1043, 1046; Pub. L. 112–240, title VI, § 639, Jan. 2, 2013, 126 Stat. 2357; Pub. L. 114–10, title II, § 209(d), Apr. 16, 2015, 129 Stat. 150; Pub. L. 114–106, § 2, Dec. 18, 2015, 129 Stat. 2222; Pub. L. 114–113, div. O, title VI, § 602(b)(2), Dec. 18, 2015, 129 Stat. 3024; Pub. L. 114–255, div. C, title XVII, § 17006(b), (f)(1), Dec. 13, 2016, 130 Stat. 1334, 1336; Pub. L. 115–123, div. E, title III, § 50311(d), title XII, § 53112, Feb. 9, 2018, 132 Stat. 198, 305.)

Editorial Notes

REFERENCES IN TEXT

Subsection (b)(6)(B)(iii), referred to in subsec. (a)(1)(C)(iii)(II), probably means section 1395w–28(b)(6)(B)(iii) of this title. This section does not contain a subsec. (b)(6)(B)(iii).

Section 1395w–24(b)(1)(C)(iv) of this title, referred to in subsec. (a)(1)(E), was redesignated section 1395w–24(b)(1)(C)(v) of this title by Pub. L. 111–148, title III, § 3202(b)(1)(B), Mar. 23, 2010, 124 Stat. 454, and subsequently redesignated section 1395w–24(b)(1)(C)(viii) of this title by Pub. L. 111–152, title I, § 1102(d)(2), Mar. 30, 2010, 124 Stat. 1045.

Section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993, referred to in subsec. (a)(1)(H), is section 2355 of Pub. L. 98–369, div. B, title III, July 18, 1984, 98 Stat. 1103, as amended by section 13567(b) of Pub. L. 103–66, title XIII, Aug. 10, 1993, 107 Stat. 608, which is not classified to the Code.

Section 1395w–29 of this title, referred to in subsecs. (b)(1)(B)(iii) and (j)(1)(A), was repealed by Pub. L. 111–152, title I, § 1102(f), Mar. 30, 2010, 124 Stat. 1046.

The Internal Revenue Code of 1986, referred to in subsec. (e)(2)(A), is classified generally to Title 26, Internal Revenue Code.

The matter following clause (v) of section 1395ww(d)(1)(B) of this title, referred to in subsec. (g), now follows cl. (vi) of section 1395ww(d)(1)(B) of this title following the redesignation of subcl. (II) of cl. (iv) of subsec. (d)(1)(B) as cl. (vi) by Pub. L. 114–255, div. C, title XV, § 15008(a)(2)(B), Dec. 13, 2016, 130 Stat. 1321.

AMENDMENTS

2018—Subsec. (*o*)(4)(D). Pub. L. 115–123, § 53112, added subpar. (D).

Subsec. (*o*)(6), (7). Pub. L. 115–123, § 50311(d), added pars. (6) and (7).

2016—Subsec. (a)(1)(C)(i). Pub. L. 114–255, § 17006(f)(1)(A), which directed substitution of ''Subject to subparagraph (I), the Secretary'' for ''The Sec-

retary'', was executed by making the substitution in the first sentence to reflect the probable intent of Congress.

Subsec. (a)(1)(I). Pub. L. 114–255, §17006(f)(1)(B), added subpar. (I).

Subsec. (k)(1). Pub. L. 114–255, §17006(b)(1)(A)(i), substituted ''paragraphs (2), (4), and (5)'' for ''paragraphs (2) and (4)'' in introductory provisions.

Subsec. (k)(1)(B)(i). Pub. L. 114–255, §17006(b)(1)(A)(ii), substituted ''paragraphs (2), (4), and (5)'' for ''paragraphs (2) and (4)''.

Subsec. (k)(5). Pub. L. 114–255, §17006(b)(1)(B), added par. (5).

Subsec. (n)(2)(A)(i). Pub. L. 114–255, §17006(b)(2)(A), inserted before semicolon at end ''and, for 2021 and subsequent years, the exclusion of payments for organ acquisitions for kidney transplants from the capitation rate as described in subsection (k)(5)''.

Subsec. (n)(2)(E). Pub. L. 114–255, §17006(b)(2)(B), substituted ''subparagraphs (F) and (G)'' for ''subparagraph (F)'' in introductory provisions.

Subsec. (n)(2)(G). Pub. L. 114–255, §17006(b)(2)(C), added subpar. (G).

2015—Subsec. (b)(2). Pub. L. 114–106 inserted ''(or, in 2017 and each subsequent year, at least 60 days)'' after ''45 days'' and ''(in 2017 and each subsequent year, of no less than 30 days)'' after ''opportunity''.

Subsec. (m)(2), (4)(A). Pub. L. 114–113 substituted ''1395ww(n)(6)(B)'' for ''1395ww(n)(6)(A)''.

Subsec. (*o*)(4)(C). Pub. L. 114–10 added subpar. (C).

2013—Subsec. (a)(1)(C)(ii)(III). Pub. L. 112–240 substituted ''1.5 percentage points'' for ''1.3 percentage points'' and ''5.9 percent'' for ''5.7 percent''.

2010—Subsec. (a)(1)(B)(i), (ii). Pub. L. 111–148, §3201(f)(1)(B), which directed amendment of subpar. (B) by inserting ''and any performance bonus under subsection (n)'' before period at end of cl. (i) and substituting ''(G), plus the amount (if any) of any performance bonus under subsection (n)'' for ''(G)'' in cl. (ii), was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (a)(1)(B)(iv). Pub. L. 111–148, §3205(b), added cl. (iv).

Subsec. (a)(1)(C)(ii). Pub. L. 111–152, §1102(e)(2), substituted ''and each subsequent year'' for ''through 2010'' in introductory provisions.

Pub. L. 111–152, §1102(e)(1), which directed the substitution of ''of coding adjustment'' for ''during phaseout of budget neutrality factor'' in heading, was executed by making the substitution for ''during phase-out of budget neutrality factor'' to reflect the probable intent of Congress.

Subsec. (a)(1)(C)(ii)(II). Pub. L. 111–152, §1102(e)(3)(A)–(C), inserted ''annually'' before ''conduct an analysis'' and ''on a timely basis'' after ''are incorporated'', substituted ''for 2008 and subsequent years'' for ''only for 2008, 2009, and 2010'', and inserted ''and updated as appropriate'' after ''as available''.

Subsec. (a)(1)(C)(ii)(III), (IV). Pub. L. 111–152, §1102(e)(3)(D), which directed amendment ''in subclause (II)'' of subsec. (a)(1)(C)(ii) by adding subcls. (III) and (IV) at the end, was executed by adding subcls. (III) and (IV) after subcl. (II), to reflect the probable intent of Congress.

Subsec. (a)(1)(C)(iii). Pub. L. 111–148, §3205(f), added cl. (iii).

Pub. L. 111–148, §3203, which directed amendment of subpar. (C) by adding cl. (iii) relating to application of coding intensity adjustment for 2011 and subsequent years, was repealed by Pub. L. 111–152, §1102(a). As enacted, text read as follows:

''(I) REQUIREMENT TO APPLY IN 2011 THROUGH 2013.—In order to ensure payment accuracy, the Secretary shall conduct an analysis of the differences described in clause (ii)(I). The Secretary shall ensure that the results of such analysis are incorporated into the risk scores for 2011, 2012, and 2013.

''(II) AUTHORITY TO APPLY IN 2014 AND SUBSEQUENT YEARS.—The Secretary may, as appropriate, incorporate the results of such analysis into the risk scores for 2014 and subsequent years.''

See Effective Date of 2010 Amendment note below.

Subsec. (b)(1)(B)(i). Pub. L. 111–148, §3201(e)(2)(A)(ii), which directed amendment of cl. (i) by substituting ''MA local area (as defined in subsection (d)(2))'' for ''MA payment area'' in introductory provisions and ''MA local area (as so defined)'' for ''MA payment area'' in subcl. (I), was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (b)(4). Pub. L. 111–148, §3201(e)(2)(A)(iii), which directed substitution of ''MA local area (as so defined)'' for ''Medicare Advantage payment area'', was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (c)(1). Pub. L. 111–148, §3201(e)(2)(A)(iv), which directed amendment of par. (1) by striking ''a Medicare Advantage payment area that is'' in introductory provisions and substituting ''MA local area (as defined in subsection (d)(2))'' for ''MA payment area'' in subpar. (D)(i), was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (c)(6). Pub. L. 111–148, §3201(b), which directed amendment of par. (6) by substituting ''for 2003 through 2010'' for ''for a year after 2002'' in cl. (vi) and adding cl. (vii), which read ''for 2011, 3 percentage points; and'', and cl. (viii), which read ''for a year after 2011, 0 percentage points.'', was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (d). Pub. L. 111–148, §3201(e)(1)(A), which directed substitution of ''MA region; MA local plan service area'' for ''MA region'' in heading, was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (d)(1)(A). Pub. L. 111–148, §3201(e)(1)(B), which directed substitution of ''with respect to an MA local plan—

''(i) for years before 2012, an MA local area (as defined in paragraph (2)); and

''(ii) for 2012 and succeeding years, a service area that is an entire urban or rural area, as applicable (as described in paragraph (5)); and''

for ''with respect to an MA local plan, an MA local area (as defined in paragraph (2)); and'', was repealed by Pub. L. 111–152, §1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (d)(5). Pub. L. 111–148, §3201(e)(1)(C), which directed the addition of par. (5), was repealed by Pub. L. 111–152, §1102(a). As enacted, text read as follows: ''For 2012 and succeeding years, the service area for an MA local plan shall be an entire urban or rural area in each State as follows:

''(A) URBAN AREAS.—

''(i) IN GENERAL.—Subject to clause (ii) and subparagraphs (C) and (D), the service area for an MA local plan in an urban area shall be the Core Based Statistical Area (in this paragraph referred to as a 'CBSA') or, if applicable, a conceptually similar alternative classification, as defined by the Director of the Office of Management and Budget.

''(ii) CBSA COVERING MORE THAN ONE STATE.—In the case of a CBSA (or alternative classification) that covers more than one State, the Secretary shall divide the CBSA (or alternative classification) into separate service areas with respect to each State covered by the CBSA (or alternative classification).

''(B) RURAL AREAS.—Subject to subparagraphs (C) and (D), the service area for an MA local plan in a rural area shall be a county that does not qualify for inclusion in a CBSA (or alternative classification), as defined by the Director of the Office of Management and Budget.

''(C) REFINEMENTS TO SERVICE AREAS.—For 2015 and succeeding years, in order to reflect actual patterns of health care service utilization, the Secretary may adjust the boundaries of service areas for MA local plans in urban areas and rural areas under subparagraphs (A) and (B), respectively, but may only do so based on recent analyses of actual patterns of care.

''(D) ADDITIONAL AUTHORITY TO MAKE LIMITED EXCEPTIONS TO SERVICE AREA REQUIREMENTS FOR MA LOCAL

PLANS.—The Secretary may, in addition to any adjustments under subparagraph (C), make limited exceptions to service area requirements otherwise applicable under this part for MA local plans that have in effect (as of March 23, 2010)—

''(i) agreements with another MA organization or MA plan that preclude the offering of benefits throughout an entire service area; or

''(ii) limitations in their structural capacity to support adequate networks throughout an entire service area as a result of the delivery system model of the MA local plan.''

See Effective Date of 2010 Amendment note below.

Subsec. (d)(6). Pub. L. 111–148, § 3201(i)(2), which directed the addition of par. (6), was repealed by Pub. L. 111–152, § 1102(a). As enacted, text read as follows: ''For years beginning with 2012, in the case of a PACE program under section 1395eee of this title, the MA payment area shall be the MA local area (as defined in paragraph (2)).'' See Effective Date of 2010 Amendment note below.

Subsec. (j). Pub. L. 111–152, § 1102(c)(1), inserted ''subject to subsection (*o*),'' after ''For purposes of this part,'' in introductory provisions.

Pub. L. 111–148, § 3201(a)(1)(A)–(C)(i), which directed the designation of existing provisions as par. (1), the insertion of par. (1) heading, the redesignation of former pars. (1) and (2) as subpars. (A) and (B), respectively, and former subpars. (A) and (B) of former par. (1) as cls. (i) and (ii) of subpar. (A), respectively, and the realignment of margins, was repealed by Pub. L. 111–152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (j)(1)(A). Pub. L. 111–152, § 1102(b)(1), substituted ''for the area for the year (or, for 2007, 2008, 2009, and 2010, 1/12 of the applicable amount determined under subsection (k)(1) for the area for the year; for 2011, 1/12 of the applicable amount determined under subsection (k)(1) for the area for 2010; and, beginning with 2012, 1/12 of the blended benchmark amount determined under subsection (n)(1) for the area for the year)'' for ''(or, beginning with 2007, 1/12 of the applicable amount determined under subsection (k)(1)) for the area for the year''.

Pub. L. 111–148, § 3201(a)(1)(C)(ii), (iii), which, in cl. (i), directed substitution of ''section 1395w–29(d)(2)(A) of this title, an amount equal to—'' for ''section 1395w–29(d)(2)(A) of this title, an amount equal to'', subcls. (I) to (VI) for ''1/12 of the annual MA capitation rate under subsection (c)(1) (or, beginning with 2007, 1/12 of the applicable amount determined under subsection (k)(1)) for the area for the year, adjusted as appropriate (for years before 2007) for the purpose of risk adjustment; or'', and, in cl. (ii), directed substitution of ''clause (i)'' for ''subparagraph (A)'', was repealed by Pub. L. 111–152, § 1102(a). As enacted, subcls. (I) to (VI) read as follows:

''(I) for years before 2007, 1/12 of the annual MA capitation rate under subsection (c)(1) for the area for the year, adjusted as appropriate for the purpose of risk adjustment;

''(II) for 2007 through 2011, 1/12 of the applicable amount determined under subsection (k)(1) for the area for the year;

''(III) for 2012, the sum of—

''(aa) 2/3 of the quotient of—

''(AA) the applicable amount determined under subsection (k)(1) for the area for the year; and

''(BB) 12; and

''(bb) 1/3 of the MA competitive benchmark amount (determined under paragraph (2)) for the area for the month;

''(IV) for 2013, the sum of—

''(aa) 1/3 of the quotient of—

''(AA) the applicable amount determined under subsection (k)(1) for the area for the year; and

''(BB) 12; and

''(bb) 2/3 of the MA competitive benchmark amount (as so determined) for the area for the month;

''(V) for 2014, the MA competitive benchmark amount for the area for a month in 2013 (as so determined), increased by the national per capita MA growth percentage, described in subsection (c)(6) for 2014, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

''(VI) for 2015 and each subsequent year, the MA competitive benchmark amount (as so determined) for the area for the month; or''.

See Effective Date of 2010 Amendment note below.

Subsec. (j)(2), (3). Pub. L. 111–148, § 3201(a)(1)(D), which directed addition of pars. (2) and (3), was repealed by Pub. L. 111–152, § 1102(a). As enacted, pars. (2) and (3) read as follows:

''(2) COMPUTATION OF MA COMPETITIVE BENCHMARK AMOUNT.—

''(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (3), for months in each year (beginning with 2012) for each MA payment area the Secretary shall compute an MA competitive benchmark amount equal to the weighted average of the unadjusted MA statutory non-drug monthly bid amount (as defined in section 1395w–24(b)(2)(E) of this title) for each MA plan in the area, with the weight for each plan being equal to the average number of beneficiaries enrolled under such plan in the reference month (as defined in section 1395w–27a(f)(4) of this title, except that, in applying such definition for purposes of this paragraph, 'to compute the MA competitive benchmark amount under section 1395w–23(j)(2) of this title' shall be substituted for 'to compute the percentage specified in subparagraph (A) and other relevant percentages under this part').

''(B) WEIGHTING RULES.—

''(i) SINGLE PLAN RULE.—In the case of an MA payment area in which only a single MA plan is being offered, the weight under subparagraph (A) shall be equal to 1.

''(ii) USE OF SIMPLE AVERAGE AMONG MULTIPLE PLANS IF NO PLANS OFFERED IN PREVIOUS YEAR.—In the case of an MA payment area in which no MA plan was offered in the previous year and more than 1 MA plan is offered in the current year, the Secretary shall use a simple average of the unadjusted MA statutory non-drug monthly bid amount (as so defined) for purposes of computing the MA competitive benchmark amount under subparagraph (A).

''(3) CAP ON MA COMPETITIVE BENCHMARK AMOUNT.—In no case shall the MA competitive benchmark amount for an area for a month in a year be greater than the applicable amount that would (but for the application of this subsection) be determined under subsection (k)(1) for the area for the month in the year.''

See Effective Date of 2010 Amendment note below.

Subsec. (k)(2). Pub. L. 111–148, § 3201(a)(1)(E), (2)(A), which directed amendment of par. (2) by substituting ''and subsequent years'' for ''through 2010'' in subpar. (A) and ''(j)(1)(A)(i)'' for ''(j)(1)(A)'' in subpar. (B)(ii)(III), and by adding, in subpar. (C), cl. (v), which read ''for 2011 and subsequent years, 0.00.'', was repealed by Pub. L. 111–152, § 1102(a). See Effective Date of 2010 Amendment note below.

Subsec. (n). Pub. L. 111–152, § 1102(b)(2), added subsec. (n).

Pub. L. 111–148, § 3201(f)(1)(A), which directed addition of subsec. (n) relating to performance bonuses, was repealed by Pub. L. 111–152, § 1102(a). As enacted, text read as follows:

''(1) CARE COORDINATION AND MANAGEMENT PERFORMANCE BONUS.—

''(A) IN GENERAL.—For years beginning with 2014, subject to subparagraph (B), in the case of an MA plan that conducts 1 or more programs described in subparagraph (C) with respect to the year, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to the product of—

''(i) 0.5 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year; and

''(ii) the total number of programs described in clauses (i) through (ix) of subparagraph (C) that the Secretary determines the plan is conducting for the year under such subparagraph.

''(B) LIMITATION.—In no case may the total amount of payment with respect to a year under subparagraph (A) be greater than 2 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year, as determined prior to the application of risk adjustment under paragraph (4).

''(C) PROGRAMS DESCRIBED.—The following programs are described in this paragraph:

''(i) Care management programs that—

''(I) target individuals with 1 or more chronic conditions;

''(II) identify gaps in care; and

''(III) facilitate improved care by using additional resources like nurses, nurse practitioners, and physician assistants.

''(ii) Programs that focus on patient education and self-management of health conditions, including interventions that—

''(I) help manage chronic conditions;

''(II) reduce declines in health status; and

''(III) foster patient and provider collaboration.

''(iii) Transitional care interventions that focus on care provided around a hospital inpatient episode, including programs that target post-discharge patient care in order to reduce unnecessary health complications and readmissions.

''(iv) Patient safety programs, including provisions for hospital-based patient safety programs in contracts that the Medicare Advantage organization offering the MA plan has with hospitals.

''(v) Financial policies that promote systematic coordination of care by primary care physicians across the full spectrum of specialties and sites of care, such as medical homes, capitation arrangements, or pay-for-performance programs.

''(vi) Programs that address, identify, and ameliorate health care disparities among principal at-risk subpopulations.

''(vii) Medication therapy management programs that are more extensive than is required under section 1395w–104(c) of this title (as determined by the Secretary).

''(viii) Health information technology programs, including clinical decision support and other tools to facilitate data collection and ensure patient-centered, appropriate care.

''(ix) Such other care management and coordination programs as the Secretary determines appropriate.

''(D) CONDUCT OF PROGRAM IN URBAN AND RURAL AREAS.—An MA plan may conduct a program described in subparagraph (C) in a manner appropriate for an urban or rural area, as applicable.

''(E) REPORTING OF DATA.—Each Medicare Advantage organization shall provide to the Secretary the information needed to determine whether they are eligible for a care coordination and management performance bonus at a time and in a manner specified by the Secretary.

''(F) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of programs described in subparagraph (C) for which an MA plan receives a care coordination and management performance bonus under this paragraph. The Comptroller General shall monitor auditing activities conducted under this subparagraph.

''(2) QUALITY PERFORMANCE BONUSES.—

''(A) QUALITY BONUS.—For years beginning with 2014, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to an MA plan that achieves at least a 3 star rating (or comparable rating) on a rating system described in subparagraph (C) in an amount equal to—

''(i) in the case of a plan that achieves a 3 star rating (or comparable rating) on such system 2 percent of the national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year; and

''(ii) in the case of a plan that achieves a 4 or 5 star rating (or comparable rating[)] on such system, 4 percent of such national monthly per capita cost for the year.

''(B) IMPROVED QUALITY BONUS.—For years beginning with 2014, in the case of an MA plan that does not receive a quality bonus under subparagraph (A) and is an improved quality MA plan with respect to the year (as identified by the Secretary), the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to 1 percent of such national monthly per capita cost for the year.

''(C) USE OF RATING SYSTEM.—For purposes of subparagraph (A), a rating system described in this paragraph is—

''(i) a rating system that uses up to 5 stars to rate clinical quality and enrollee satisfaction and performance at the Medicare Advantage contract or MA plan level; or

''(ii) such other system established by the Secretary that provides for the determination of a comparable quality performance rating to the rating system described in clause (i).

''(D) DATA USED IN DETERMINING SCORE.—

''(i) IN GENERAL.—The rating of an MA plan under the rating system described in subparagraph (C) with respect to a year shall be based on based on the most recent data available.

''(ii) PLANS THAT FAIL TO REPORT DATA.—An MA plan which does not report data that enables the Secretary to rate the plan for purposes of subparagraph (A) or identify the plan for purposes of subparagraph (B) shall be counted, for purposes of such rating or identification, as having the lowest plan performance rating and the lowest percentage improvement, respectively.

''(3) QUALITY BONUS FOR NEW AND LOW ENROLLMENT MA PLANS.—

''(A) NEW MA PLANS.—For years beginning with 2014, in the case of an MA plan that first submits a bid under section 1395w–24(a)(1)(A) of this title for 2012 or a subsequent year, only receives enrollments made during the coverage election periods described in section 1395w–21(e) of this title, and is not able to receive a bonus under subparagraph (A) or (B) of paragraph (2) for the year, the Secretary shall, in addition to any other payment provided under this part, make monthly payments, with respect to coverage of an individual under this part, to the MA plan in an amount equal to 2 percent of national monthly per capita cost for expenditures for individuals enrolled under the original medicare fee-for-service program for the year. In its fourth year of operation, the MA plan shall be paid in the same manner as other MA plans with comparable enrollment.

''(B) LOW ENROLLMENT PLANS.—For years beginning with 2014, in the case of an MA plan that has low enrollment (as defined by the Secretary) and would not otherwise be able to receive a bonus under subparagraph (A) or (B) of paragraph (2) or subparagraph (A) of this paragraph for the year (referred to in this subparagraph as a 'low enrollment plan'), the Secretary shall use a regional or local mean of the rating of all MA plans in the region or local area, as determined appropriate by the Secretary, on measures used to determine whether MA plans are eligible for a quality or an improved quality bonus, as applicable, to determine whether the low enrollment plan is eligible for a bonus under such a subparagraph.

''(4) RISK ADJUSTMENT.—The Secretary shall risk adjust a performance bonus under this subsection in the same manner as the Secretary risk adjusts beneficiary

rebates described in section 1395w–24(b)(1)(C) of this title.

''(5) NOTIFICATION.—The Secretary, in the annual announcement required under subsection (b)(1)(B) for 2014 and each succeeding year, shall notify the Medicare Advantage organization of any performance bonus (including a care coordination and management performance bonus under paragraph (1), a quality performance bonus under paragraph (2), and a quality bonus for new and low enrollment plans under paragraph (3)) that the organization will receive under this subsection with respect to the year. The Secretary shall provide for the publication of the information described in the previous sentence on the Internet website of the Centers for Medicare & Medicaid Services.''

See Effective Date of 2010 Amendment note below.

Subsec. (n)(2)(B). Pub. L. 111–152, § 1102(c)(2), which directed insertion of '', subject to subsection (*o*)'' after ''as follows'' could not be executed because ''as follows'' did not appear in text.

Subsec. (n)(6). Pub. L. 111–148, § 3202(b)(2), which directed that subsec. (n), as added by Pub. L. 111–148, § 3201(f), be amended by adding a par. (6), was not executed to reflect the probable intent of Congress and the subsequent repeal of § 3201(f) by Pub. L. 111–152, § 1102(a). See Amendment note above.

Subsec. (*o*). Pub. L. 111–152, § 1102(c)(3), added subsec. (*o*).

Pub. L. 111–148, § 3201(g), which directed addition of subsec. (*o*) relating to grandfathering supplemental benefits for current enrollees after implementation of competitive bidding, was repealed by Pub. L. 111–152, § 1102(a). As enacted, text read as follows:

''(1) IDENTIFICATION OF AREAS.—The Secretary shall identify MA local areas in which, with respect to 2009, average bids submitted by an MA organization under section 1395w–24(a) of this title for MA local plans in the area are not greater than 75 percent of the adjusted average per capita cost for the year involved, determined under section 1395mm(a)(4) of this title, for the area for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1395w–4(*o*), 1395ww(n), and 1395ww(h) of this title.

''(2) ELECTION TO PROVIDE REBATES TO GRANDFATHERED ENROLLEES.—

''(A) IN GENERAL.—For years beginning with 2012, each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) may elect to provide rebates to grandfathered enrollees under section 1395w–24(b)(1)(C) of this title. In the case where an MA organization makes such an election, the monthly per capita dollar amount of such rebates shall not exceed the applicable amount for the year (as defined in subparagraph (B)).

''(B) APPLICABLE AMOUNT.—For purposes of this subsection, the term 'applicable amount' means—

''(i) for 2012, the monthly per capita dollar amount of such rebates provided to enrollees under the MA local plan with respect to 2011; and

''(ii) for a subsequent year, 95 percent of the amount determined under this subparagraph for the preceding year.

''(3) SPECIAL RULES FOR PLANS IN IDENTIFIED AREAS.—Notwithstanding any other provision of this part, the following shall apply with respect to each Medicare Advantage organization offering an MA local plan in an area identified by the Secretary under paragraph (1) that makes an election described in paragraph (2):

''(A) PAYMENTS.—The amount of the monthly payment under this section to the Medicare Advantage organization, with respect to coverage of a grandfathered enrollee under this part in the area for a month, shall be equal to—

''(i) for 2012 and 2013, the sum of—

''(I) the bid amount under section 1395w–24(a) of this title for the MA local plan; and

''(II) the applicable amount (as defined in paragraph (2)(B)) for the MA local plan for the year.

''(ii) for 2014 and subsequent years, the sum of—

''(I) the MA competitive benchmark amount under subsection (j)(1)(A)(i) for the area for the month, adjusted, only to the extent the Secretary determines necessary, to account for induced utilization as a result of rebates provided to grandfathered enrollees (except that such adjustment shall not exceed 0.5 percent of such MA competitive benchmark amount); and

''(II) the applicable amount (as so defined) for the MA local plan for the year.

''(B) REQUIREMENT TO SUBMIT BIDS UNDER COMPETITIVE BIDDING.—The Medicare Advantage organization shall submit a single bid amount under section 1395w–24(a) of this title for the MA local plan. The Medicare Advantage organization shall remove from such bid amount any effects of induced demand for care that may result from the higher rebates available to grandfathered enrollees under this subsection.

''(C) NONAPPLICATION OF BONUS PAYMENTS AND ANY OTHER REBATES.—The Medicare Advantage organization offering the MA local plan shall not be eligible for any bonus payment under subsection (n) or any rebate under this part (other than as provided under this subsection) with respect to grandfathered enrollees.

''(D) NONAPPLICATION OF UNIFORM BID AND PREMIUM AMOUNTS TO GRANDFATHERED ENROLLEES.—Section 1395w–24(c) of this title shall not apply with respect to the MA local plan.

''(E) NONAPPLICATION OF LIMITATION ON APPLICATION OF PLAN REBATES TOWARD PAYMENT OF PART B PREMIUM.—Notwithstanding clause (iii) of section 1395w–24(b)(1)(C) of this title, in the case of a grandfathered enrollee, a rebate under such section may be used for the purpose described in clause (ii)(III) of such section.

''(F) RISK ADJUSTMENT.—The Secretary shall risk adjust rebates to grandfathered enrollees under this subsection in the same manner as the Secretary risk adjusts beneficiary rebates described in section 1395w–24(b)(1)(C) of this title.

''(4) DEFINITION OF GRANDFATHERED ENROLLEE.—In this subsection, the term 'grandfathered enrollee' means an individual who is enrolled (effective as of March 23, 2010) in an MA local plan in an area that is identified by the Secretary under paragraph (1).''

See Effective Date of 2010 Amendment note below.

Subsec. (p). Pub. L. 111–148, § 3201(h), which directed addition of subsec. (p) relating to transitional extra benefits, was repealed by Pub. L. 111–152, § 1102(a). As enacted, text read as follows:

''(1) IN GENERAL.—For years beginning with 2012, the Secretary shall provide transitional rebates under section 1395w–24(b)(1)(C) of this title for the provision of extra benefits (as specified by the Secretary) to enrollees described in paragraph (2).

''(2) ENROLLEES DESCRIBED.—An enrollee described in this paragraph is an individual who—

''(A) enrolls in an MA local plan in an applicable area; and

''(B) experiences a significant reduction in extra benefits described in clause (ii) of section 1395w–24(b)(1)(C) of this title as a result of competitive bidding under this part (as determined by the Secretary).

''(3) APPLICABLE AREAS.—In this subsection, the term 'applicable area' means the following:

''(A) The 2 largest metropolitan statistical areas, if the Secretary determines that the total amount of such extra benefits for each enrollee for the month in those areas is greater than $100.

''(B) A county where—

''(i) the MA area-specific non-drug monthly benchmark amount for a month in 2011 is equal to the legacy urban floor amount (as described in subsection (c)(1)(B)(iii)), as determined by the Secretary for the area for 2011;

''(ii) the percentage of Medicare Advantage eligible beneficiaries in the county who are enrolled in

an MA plan for 2009 is greater than 30 percent (as determined by the Secretary); and

''(iii) average bids submitted by an MA organization under section 1395w–24(a) of this title for MA local plans in the county for 2011 are not greater than the adjusted average per capita cost for the year involved, determined under section 1395mm(a)(4) of this title, for the county for individuals who are not enrolled in an MA plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1395w–4(*o*), 1395ww(n), and 1395ww(h) of this title.

''(C) If the Secretary determines appropriate, a county contiguous to an area or county described in subparagraph (A) or (B), respectively.

''(4) REVIEW OF PLAN BIDS.—In the case of a bid submitted by an MA organization under section 1395w–24(a) of this title for an MA local plan in an applicable area, the Secretary shall review such bid in order to ensure that extra benefits (as specified by the Secretary) are provided to enrollees described in paragraph (2).

''(5) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1395i of this title and the Federal Supplementary Medical Insurance Trust Fund established under section 1395t of this title, in such proportion as the Secretary determines appropriate, of an amount not to exceed $5,000,000,000 for the period of fiscal years 2012 through 2019 for the purpose of providing transitional rebates under section 1395w–24(b)(1)(C) of this title for the provision of extra benefits under this subsection.''

See Effective Date of 2010 Amendment note below.

Subsec. (p)(3)(A). Pub. L. 111–148, §10318, which directed that subsec. (p)(3)(A), as added by Pub. L. 111–148, §3201(h), be amended by inserting ''in 2009'' before the period at the end, was not executed to reflect the probable intent of Congress and the subsequent repeal of §3201(h) by Pub. L. 111–152, §1102(a). See Amendment note above.

2009—Subsec. (a)(1)(A). Pub. L. 111–5, §4101(e)(1), substituted ''(i), and (*l*)'' for ''and (i)''.

Subsec. (c)(1)(D)(i). Pub. L. 111–5, §4102(d)(3)(A)(i), substituted '', 1395w–4(*o*), and 1395ww(n)'' for ''1395w–4(*o*)''.

Pub. L. 111–5, §4101(e)(2)(A), substituted ''sections 1395w–4(*o*) and 1395ww(h) of this title'' for ''section 1395ww(h) of this title''.

Subsec. (c)(6)(A). Pub. L. 111–5, §4102(d)(3)(A)(ii), inserted ''and subsections (b)(3)(B)(ix) and (n) of section 1395ww of this title'' after ''1395w–4 of this title''.

Pub. L. 111–5, §4101(e)(2)(B), inserted ''excluding expenditures attributable to subsections (a)(7) and (*o*) of section 1395w–4 of this title,'' after ''under part B,''.

Subsec. (f). Pub. L. 111–5, §4102(d)(3)(B), inserted ''and subsection (m)'' after ''under subsection (*l*)''.

Pub. L. 111–5, §4101(e)(3), inserted ''and for payments under subsection (*l*)'' after ''with the organization''.

Subsec. (*l*). Pub. L. 111–5, §4101(c), added subsec. (*l*).

Subsec. (m). Pub. L. 111–5, §4102(c), added subsec. (m).

2008—Subsec. (k)(1). Pub. L. 110–275, §161(a)(1), (b), substituted ''paragraphs (2) and (4)'' for ''paragraph (2)'' in introductory provisions and cl. (i) of subpar. (B).

Subsec. (k)(4). Pub. L. 110–275, §161(a)(2), added par. (4).

2006—Subsec. (a)(1)(C). Pub. L. 109–171, §5301(b), designated existing provisions as cl. (i), inserted heading, and added cl. (ii).

Subsec. (j)(1)(A). Pub. L. 109–171, §5301(a)(1)(A), inserted ''(or, beginning with 2007, 1/12 of the applicable amount determined under subsection (k)(1))'' after ''subsection (c)(1)'' and ''(for years before 2007)'' after ''adjusted as appropriate''.

Subsec. (j)(1)(B). Pub. L. 109–171, §5301(a)(1)(B), inserted ''(for years before 2007)'' after ''adjusted as appropriate''.

Subsec. (k). Pub. L. 109–171, §5301(a)(2), added subsec. (k).

2003—Subsec. (a)(1)(A). Pub. L. 108–173, §222(e)(1)(B), substituted ''amount determined as follows:'' and cls. (i) and (ii) for ''amount'' and provisions describing amount equal to 1/12 of the annual Medicare+Choice capitation rate, reduced by the amount of any reduction elected under section 1395w–24(f)(1)(E) of this title and adjusted for certain factors.

Subsec. (a)(1)(B) to (G). Pub. L. 108–173, §222(e)(1)(B), added subpars. (B) to (G). Former subpar. (B) redesignated (H).

Subsec. (a)(1)(H). Pub. L. 108–173, §222(i), substituted as second sentence provisions relating to actuarial equivalence of rates of payment to rates that would have been paid with respect to other enrollees in the MA payment area under this section as in effect before Dec. 8, 2003, for provisions relating to actuarial equivalence of rates of payment to rates paid to other enrollees in the Medicare+Choice payment area and inserted sentence at end authorizing application of the competitive bidding methodology provided for in this section, with appropriate adjustments to account for the risk adjustment methodology applied to end stage renal disease payments.

Pub. L. 108–173, §222(e)(1)(A), redesignated subpar. (B) as (H).

Subsec. (a)(3)(C)(ii). Pub. L. 108–173, §736(d)(1)(A), substituted ''clause (iv)'' for ''clause (iii)'' in introductory provisions.

Subsec. (a)(3)(C)(iii), (iv). Pub. L. 108–173, §736(d)(1)(B), redesignated cl. (iii), relating to full implementation of risk adjustment for congestive heart failure enrollees for 2001, as (iv).

Subsec. (a)(4). Pub. L. 108–173, §237(b)(1), added par. (4).

Subsec. (b)(1). Pub. L. 108–173, §222(f)(1), amended heading and text of par. (1) generally, substituting provisions relating to announcements of payment rates for 2005 and for 2006 and subsequent years for provisions relating to announcement for years before 2004, for 2004 and 2005, and for years after 2005.

Subsec. (b)(1)(B)(iii). Pub. L. 108–173, §241(b)(1)(B), added cl. (iii).

Subsec. (b)(3). Pub. L. 108–173, §222(f)(2), substituted ''in such announcement'' for ''in the announcement in sufficient detail so that Medicare+Choice organizations can compute monthly adjusted Medicare+Choice capitation rates for individuals in each Medicare+Choice payment area which is in whole or in part within the service area of such an organization''.

Subsec. (b)(4). Pub. L. 108–173, §900(e)(1)(G)(i), substituted ''Centers for Medicare & Medicaid Services'' for ''Health Care Financing Administration'' in introductory provisions.

Subsec. (c)(1). Pub. L. 108–173, §221(d)(4), inserted ''that is an MA local area'' after ''for a Medicare+Choice payment area'' in introductory provisions.

Pub. L. 108–173, §211(a)(2), substituted ''(C), or (D)'' for ''or (C)'' in introductory provisions.

Subsec. (c)(1)(A). Pub. L. 108–173, §211(b)(1), (c)(1)(A), substituted ''For a year before 2005, the sum'' for ''The sum'' in introductory provisions and inserted ''(for a year other than 2004)'' after ''multiplied'' in concluding provisions.

Subsec. (c)(1)(B)(iv). Pub. L. 108–173, §211(c)(1)(B), substituted '', 2003, and 2004'' for ''and each succeeding year''.

Subsec. (c)(1)(C)(iv). Pub. L. 108–173, §211(c)(1)(C), substituted ''and 2003'' for ''and each succeeding year''.

Subsec. (c)(1)(C)(v). Pub. L. 108–173, §211(c)(1)(D), added cl. (v).

Subsec. (c)(1)(D). Pub. L. 108–173, §211(a)(1), added subpar. (D).

Subsec. (c)(3)(A). Pub. L. 108–173, §211(d)(1), substituted ''subparagraphs (B) and (E)'' for ''subparagraph (B)'' in introductory provisions.

Subsec. (c)(3)(E). Pub. L. 108–173, §211(d)(2), added subpar. (E).

Subsec. (c)(5). Pub. L. 108–173, §736(d)(1)(C), substituted ''(a)(3)(C)(iv)'' for ''(a)(3)(C)(iii)''.

Pub. L. 108–173, §237(b)(2)(B), substituted ''subsections (a)(3)(C)(iii), (a)(4), and (i)'' for ''subsections (a)(3)(C)(iii) and (i)''.

Pub. L. 108–173, § 211(b)(2), inserted ''(other than 2004)'' after ''for each year''.

Subsec. (c)(6)(C). Pub. L. 108–173, § 211(c)(2), inserted '', except that for purposes of paragraph (1)(C)(v)(II), no such adjustment shall be made for a year before 2004'' before period at end.

Subsec. (c)(7). Pub. L. 108–173, § 900(e)(1)(G)(ii), substituted ''Centers for Medicare & Medicaid Services'' for ''Health Care Financing Administration''.

Subsec. (d). Pub. L. 108–173, § 221(d)(1)(A), substituted ''MA payment area; MA local area; MA region defined'' for '' 'Medicare+Choice payment area' defined'' in heading.

Subsec. (d)(1). Pub. L. 108–173, § 221(d)(1)(C), amended heading and text of par. (1) generally. Prior to amendment, text read as follows: ''In this part, except as provided in paragraph (3), the term 'Medicare+Choice payment area' means a county, or equivalent area specified by the Secretary.''

Subsec. (d)(2), (3). Pub. L. 108–173, § 221(d)(1)(B), (D), added par. (2) and redesignated former par. (2) as (3). Former par. (3) redesignated (4).

Subsec. (d)(4). Pub. L. 108–173, § 221(d)(1)(B), redesignated par. (3) as (4).

Subsec. (d)(4)(A). Pub. L. 108–173, § 221(d)(1)(E)(i), inserted ''for MA local plans'' after ''paragraph (1)'' in introductory provisions.

Subsec. (d)(4)(A)(iii). Pub. L. 108–173, § 221(d)(1)(E)(ii), substituted ''paragraph (1)(A)'' for ''paragraph (1)''.

Subsec. (d)(4)(B). Pub. L. 108–173, § 221(d)(1)(E)(iii), inserted ''with respect to MA local plans'' after ''established under this section'' and ''for such plans'' after ''payments under this section'' and ''made under this section''.

Subsec. (f). Pub. L. 108–173, § 101(e)(3)(D), in heading, substituted ''Trust Funds'' for ''Trust Fund'' and, after first sentence, inserted ''Payments to MA organizations for statutory drug benefits provided under this subchapter are made from the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.''

Subsec. (g). Pub. L. 108–173, § 211(e)(1)(A), inserted '', a rehabilitation hospital described in section 1395ww(d)(1)(B)(ii) of this title or a distinct part rehabilitation unit described in the matter following clause (v) of section 1395ww(d)(1)(B) of this title, or a long-term care hospital (described in section 1395ww(d)(1)(B)(iv) of this title)'' after ''1395ww(d)(1)(B) of this title)'' in introductory provisions.

Subsec. (g)(2)(B). Pub. L. 108–173, § 211(e)(1)(B), inserted ''or other payment provision under this subchapter for inpatient services for the type of facility, hospital, or unit involved, described in the matter preceding paragraph (1), as the case may be,'' after ''1395ww(d) of this title''.

Subsec. (j). Pub. L. 108–173, § 222(d), added subsec. (j).

Subsec. (j)(1)(A). Pub. L. 108–173, § 241(b)(1)(A), inserted ''subject to section 1395w–29(d)(2)(A) of this title,'' after ''within an MA local area,''.

2002—Subsec. (b)(1). Pub. L. 107–188 in introductory provisions substituted ''for years before 2004 and after 2005 not later than March 1 before the calendar year concerned and for 2004 and 2005 not later than the second Monday in May before the respective calendar year'' for ''not later than March 1 before the calendar year concerned''.

2000—Subsec. (a)(1)(A). Pub. L. 106–554, § 1(a)(6) [title VI, § 606(a)(2)(A)], inserted ''reduced by the amount of any reduction elected under section 1395w–24(f)(1)(E) of this title and'' after ''for that area,''.

Subsec. (a)(1)(B). Pub. L. 106–554, § 1(a)(6) [title VI, § 605(a)], inserted at end ''In establishing such rates, the Secretary shall provide for appropriate adjustments to increase each rate to reflect the demonstration rate (including the risk adjustment methodology associated with such rate) of the social health maintenance organization end-stage renal disease capitation demonstrations (established by section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993), and shall compute such rates by taking into account such factors as renal treatment modality, age, and the underlying cause of the end-stage renal disease.''

Subsec. (a)(3)(C)(ii). Pub. L. 106–554, § 1(a)(6) [title VI, § 607(a)(1)], substituted ''Except as provided in clause (iii), such risk adjustment'' for ''Such risk adjustment''.

Subsec. (a)(3)(C)(ii)(I). Pub. L. 106–554, § 1(a)(6) [title VI, § 603(1)(A)], substituted ''and each succeeding year through 2003'' for ''and 2001'' and struck out ''and'' at end.

Subsec. (a)(3)(C)(ii)(II) to (V). Pub. L. 106–554, § 1(a)(6) [title VI, § 603(1)(B)], added subcls. (II) to (V) and struck out former subcl. (II) which read as follows: ''not more than 20 percent of such capitation rate in 2002.''

Subsec. (a)(3)(C)(iii). Pub. L. 106–554, § 1(a)(6) [title VI, § 607(a)(2)], added cl. (iii) relating to full implementation of risk adjustment for congestive heart failure enrollees for 2001.

Pub. L. 106–554, § 1(a)(6) [title VI, § 603(2)], added cl. (iii) relating to data for risk adjustment methodology.

Subsec. (c)(1)(B)(ii), (iii). Pub. L. 106–554, § 1(a)(6) [title VI, § 601(a)(2)], added cls. (ii) and (iii). Former cl. (ii) redesignated (iv).

Subsec. (c)(1)(B)(iv). Pub. L. 106–554, § 1(a)(6) [title VI, § 601(a)(1), (3)], redesignated cl. (ii) as (iv) and substituted ''2002 and each succeeding year'' for ''a succeeding year'' and ''clause (iii)'' for ''clause (i)''.

Subsec. (c)(1)(C)(ii), (iii). Pub. L. 106–554, § 1(a)(6) [title VI, § 602(a)(2)], added cls. (ii) and (iii). Former cl. (ii) redesignated (iv).

Subsec. (c)(1)(C)(iv). Pub. L. 106–554, § 1(a)(6) [title VI, § 602(a)(1), (3)], redesignated cl. (ii) as (iv) and substituted ''2002 and each succeeding year'' for ''a subsequent year''.

Subsec. (c)(5). Pub. L. 106–554, § 1(a)(6) [title VI, § 607(b)], substituted ''subsections (a)(3)(C)(iii) and (i)'' for ''subsection (i)''.

Subsec. (c)(7). Pub. L. 106–554, § 1(a)(6) [title VI, § 611(a)], amended heading and text of par. (7) generally. Prior to amendment, text read as follows: ''If the Secretary makes a determination with respect to coverage under this subchapter that the Secretary projects will result in a significant increase in the costs to Medicare+Choice of providing benefits under contracts under this part (for periods after any period described in section 1395w–22(a)(5) of this title), the Secretary shall adjust appropriately the payments to such organizations under this part.''

Subsec. (i)(1). Pub. L. 106–554, § 1(a)(6) [title VI, § 608(a)], in introductory provisions, inserted '', or filed notice with the Secretary as of October 3, 2000, that they will not be offering such a plan as of January 1, 2001'' after ''January 1, 2000''.

1999—Subsec. (a)(1)(A). Pub. L. 106–113, § 1000(a)(6) [title V, § 512(1)], substituted ''subsections (e), (g), and (i)'' for ''subsections (e) and (f)''.

Subsec. (a)(3)(C). Pub. L. 106–113, § 1000(a)(6) [title V, § 511(a)], designated existing provisions as cl. (i), inserted heading, and added cl. (ii).

Subsec. (b)(4). Pub. L. 106–113, § 1000(a)(6) [title V, § 514(a)], added par. (4).

Subsec. (c)(5). Pub. L. 106–113, § 1000(a)(6) [title V, § 512(2)], inserted ''(other than those attributable to subsection (i))'' after ''payments under this part''.

Subsec. (c)(6)(B)(v). Pub. L. 106–113, § 1000(a)(6) [title V, § 517], substituted ''0.3 percentage points'' for ''0.5 percentage points''.

Subsec. (i). Pub. L. 106–113, § 1000(a)(6) [title V, § 512(3)], added subsec. (i).

Statutory Notes and Related Subsidiaries

CHANGE OF NAME

References to Medicare+Choice deemed to refer to Medicare Advantage or MA, subject to an appropriate transition provided by the Secretary of Health and Human Services in the use of those terms, see section 201 of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2015 AMENDMENT

Amendment by Pub. L. 114–113 applicable as if included in the enactment of Pub. L. 111–5, with certain exceptions, see section 602(d) of Pub. L. 114–113, set out as a note under section 1395ww of this title.

EFFECTIVE DATE OF 2010 AMENDMENT

Repeal of sections 3201 and 3203 of Pub. L. 111–148 and the amendments made by such sections, effective as if included in the enactment of Pub. L. 111–148, see section 1102(a) of Pub. L. 111–152, set out as a note under section 1395w–21 of this title.

EFFECTIVE DATE OF 2003 AMENDMENT

Pub. L. 108–173, title II, §211(e)(2), Dec. 8, 2003, 117 Stat. 2178, provided that: ''The amendments made by paragraph (1) [amending this section] shall apply to contract years beginning on or after January 1, 2004.''

Amendment by sections 221(d)(1), (4) and 222(d)–(f), (i) of Pub. L. 108–173 applicable with respect to plan years beginning on or after Jan. 1, 2006, see section 223(a) of Pub. L. 108–173, set out as a note under section 1395w–21 of this title.

Amendment by section 237(b)(1), (2)(B) of Pub. L. 108–173 applicable to services provided on or after Jan. 1, 2006, and contract years beginning on or after such date, see section 237(e) of Pub. L. 108–173, set out as a note under section 1320a–7b of this title.

EFFECTIVE DATE OF 2002 AMENDMENT

Pub. L. 107–188, title V, §532(d)(2), June 12, 2002, 116 Stat. 697, provided that: ''The amendment made by paragraph (1) [amending this section] shall first apply to announcements for years after 2003.''

EFFECTIVE DATE OF 2000 AMENDMENT

Pub. L. 106–554, §1(a)(6) [title VI, §605(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–556, provided that: ''The amendment made by subsection (a) [amending this section] shall apply to payments for months beginning with January 2002.''

Amendment by section 1(a)(6) [title VI, §606(a)(2)(A)] of Pub. L. 106–554 applicable to years beginning with 2003, see section 1(a)(6) [title VI, §606(b)] of Pub. L. 106–554, set out as a note under section 1395r of this title.

Pub. L. 106–554, §1(a)(6) [title VI, §608(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–559, provided that: ''The amendment made by subsection (a) [amending this section] shall apply as if included in the enactment of BBRA [Pub. L. 106–113, §1000(a)(6)].''

Amendment by section 1(a)(6) [title VI, §611(a)] of Pub. L. 106–554 effective Dec. 21, 2000, and applicable to national coverage determinations and legislative changes in benefits occurring on or after such date, see section 1(a)(6) [title VI, §611(c)] of Pub. L. 106–554, set out as a note under section 1395w–22 of this title.

REPORTS ON RISK ADJUSTMENT MODELS

Pub. L. 114–255, div. C, title XVII, §17006(f)(2)(A)(ii), Dec. 13, 2016, 130 Stat. 1337, provided that: ''Not later than December 31, 2018, and every 3 years thereafter, the Secretary of Health and Human Services shall submit to Congress a report on the risk adjustment model and the ESRD risk adjustment model under the Medicare Advantage program under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.], including any revisions to either such model since the previous report. Such report shall include information on how such revisions impact the predictive ratios under either such model for groups of enrollees in Medicare Advantage plans, including very high and very low cost enrollees, and groups defined by the number of chronic conditions of enrollees.''

MEDPAC STUDY OF AAPCC

Pub. L. 108–173, title II, §211(f), Dec. 8, 2003, 117 Stat. 2178, directed the Medicare Payment Advisory Commission to conduct a study that would assess the method used for determining the adjusted average per capita cost (AAPCC) under section 1395mm(a)(4) of this title, as applied under subsection (c)(1)(A) of this section, and to submit to Congress a report on such study not later than 18 months after Dec. 8, 2003.

IMPLEMENTATION OF 2003 AMENDMENT

Pub. L. 108–173, title II, §211(i), Dec. 8, 2003, 117 Stat. 2179, provided that:

''(1) ANNOUNCEMENT OF REVISED MEDICARE ADVANTAGE PAYMENT RATES.—Within 6 weeks after the date of the enactment of this Act [Dec. 8, 2003], the Secretary [of Health and Human Services] shall determine, and shall announce (in a manner intended to provide notice to interested parties) MA capitation rates under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for 2004, revised in accordance with the provisions of this section [amending this section and section 1395w–22 of this title and enacting provisions set out as notes under this section and section 1395w–21 of this title].

''(2) TRANSITION TO REVISED PAYMENT RATES.—The provisions of section 604 of BIPA [the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, H.R. 5661, as enacted by section 1(a)(6) of Public Law 106–554, set out as a note under this section] (114 Stat. 2763A–555) (other than subsection (a)) shall apply to the provisions of subsections (a) through (d) of this section [amending this section] for 2004 in the same manner as the provisions of such section 604 applied to the provisions of BIPA for 2001.

''(3) SPECIAL RULE FOR PAYMENT RATES IN 2004.—

''(A) JANUARY AND FEBRUARY.—Notwithstanding the amendments made by subsections (a) through (d) [amending this section], for purposes of making payments under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for January and February 2004, the annual capitation rate for a payment area shall be calculated and the excess amount under section 1854(f)(1)(B) of such Act (42 U.S.C. 1395w–24(f)(1)(B)) shall be determined as if such amendments had not been enacted.

''(B) MARCH THROUGH DECEMBER.—Notwithstanding the amendments made by subsections (a) through (d) [amending this section], for purposes of making payments under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for March through December 2004, the annual capitation rate for a payment area shall be calculated and the excess amount under section 1854(f)(1)(B) of such Act (42 U.S.C. 1395w–24(f)(1)(B)) shall be determined, in such manner as the Secretary estimates will ensure that the total of such payments with respect to 2004 is the same as the amounts that would have been if subparagraph (A) had not been enacted.

''(C) CONSTRUCTION.—Subparagraphs (A) and (B) shall not be taken into account in computing such capitation rate for 2005 and subsequent years.

''(4) PLANS REQUIRED TO PROVIDE NOTICE OF CHANGES IN PLAN BENEFITS.—In the case of an organization offering a plan under part C of title XVIII of the Social Security Act [this part] that revises its submission of the information described in section 1854(a)(1) of such Act (42 U.S.C. 1395w–23(a)(1) [1395w–24(a)(1)]) for a plan pursuant to the application of paragraph (2), if such revision results in changes in beneficiary premiums, beneficiary cost-sharing, or benefits under the plan, then by not later than 3 weeks after the date the Secretary approves such submission, the organization offering the plan shall provide each beneficiary enrolled in the plan with written notice of such changes.

''(5) LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869 or section 1878 of the Social Security Act (42 U.S.C. 1395ff and 1395*oo*), or otherwise of any determination made by the Secretary under this subsection or the application of the payment rates determined pursuant to this subsection.''

SPECIAL RULE FOR JANUARY AND FEBRUARY OF 2001

Pub. L. 106–554, §1(a)(6) [title VI, §601(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–554, provided that:

''(1) IN GENERAL.—Notwithstanding the amendments made by subsection (a) [amending this section], for purposes of making payments under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for January and February 2001, the annual Medicare+Choice capitation rate for a Medicare+Choice payment area shall be calculated, and the excess amount under section 1854(f)(1)(B) of such Act (42 U.S.C. 1395w–24(f)(1)(B)) shall be determined, as if such amendments had not been enacted.

''(2) CONSTRUCTION.—Paragraph (1) shall not be taken into account in computing such capitation rate for 2002 and subsequent years.''

Pub. L. 106–554, §1(a)(6) [title VI, §602(b)], Dec. 21, 2000, 114 Stat. 2763, 2763A–555, provided that: ''The provisions of section 601(b) [set out above] shall apply with respect to the amendments made by subsection (a) [amending this section] in the same manner as they apply to the amendments made by section 601(a) [amending this section].''

TRANSITION TO REVISED MEDICARE+CHOICE PAYMENT RATES

Pub. L. 106–554, §1(a)(6) [title VI, §604], Dec. 21, 2000, 114 Stat. 2763, 2763A–555, provided that:

''(a) ANNOUNCEMENT OF REVISED MEDICARE+CHOICE PAYMENT RATES.—Within 2 weeks after the date of the enactment of this Act [Dec. 21, 2000], the Secretary of Health and Human Services shall determine, and shall announce (in a manner intended to provide notice to interested parties) Medicare+Choice capitation rates under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for 2001, revised in accordance with the provisions of this Act.

''(b) REENTRY INTO PROGRAM PERMITTED FOR MEDICARE+CHOICE PROGRAMS.—A Medicare+Choice organization that provided notice to the Secretary of Health and Human Services before the date of the enactment of this Act [Dec. 21, 2000] that it was terminating its contract under part C of title XVIII of the Social Security Act [42 U.S.C. 1395w–21 et seq.] or was reducing the service area of a Medicare+Choice plan offered under such part shall be permitted to continue participation under such part, or to maintain the service area of such plan, for 2001 if it submits the Secretary with the information described in section 1854(a)(1) of the Social Security Act (42 U.S.C. 1395w–24(a)(1)) within 2 weeks after the date revised rates are announced by the Secretary under subsection (a).

''(c) REVISED SUBMISSION OF PROPOSED PREMIUMS AND RELATED INFORMATION.—If—

''(1) a Medicare+Choice organization provided notice to the Secretary of Health and Human Services as of July 3, 2000, that it was renewing its contract under part C of title XVIII of the Social Security Act [this part] for all or part of the service area or areas served under its current contract, and

''(2) any part of the service area or areas addressed in such notice includes a payment area for which the Medicare+Choice capitation rate under section 1853(c) of such Act (42 U.S.C. 1395w–23(c)) for 2001, as determined under subsection (a), is higher than the rate previously determined for such year,

such organization shall revise its submission of the information described in section 1854(a)(1) of the Social Security Act (42 U.S.C. 1395w–24(a)(1)), and shall submit such revised information to the Secretary, within 2 weeks after the date revised rates are announced by the Secretary under subsection (a). In making such submission, the organization may only reduce beneficiary premiums, reduce beneficiary cost-sharing, enhance benefits, utilize the stabilization fund described in section 1854(f)(2) of such Act (42 U.S.C. 1395w–24(f)(2)), or stabilize or enhance beneficiary access to providers (so long as such stabilization or enhancement does not result in increased beneficiary premiums, increased beneficiary cost-sharing, or reduced benefits).

''(d) WAIVER OF LIMITS ON STABILIZATION FUND.—Any regulatory provision that limits the proportion of the excess amount that can be withheld in such stabilization fund for a contract period shall not apply with respect to submissions described in subsections (b) and (c).

''(e) DISREGARD OF NEW RATE ANNOUNCEMENT IN APPLYING PASS-THROUGH FOR NEW NATIONAL COVERAGE DETERMINATIONS.—For purposes of applying section 1852(a)(5) of the Social Security Act (42 U.S.C. 1395w–22(a)(5)), the announcement of revised rates under subsection (a) shall not be treated as an announcement under section 1853(b) of such Act (42 U.S.C. 1395w–23(b)).''

PUBLICATION

Pub. L. 106–554, §1(a)(6) [title VI, §605(c)], Dec. 21, 2000, 114 Stat. 2763, 2763A–556, provided that: ''Not later than 6 months after the date of the enactment of this Act [Dec. 21, 2000], the Secretary of Health and Human Services shall publish for public comment a description of the appropriate adjustments described in the last sentence of section 1853(a)(1)(B) of the Social Security Act (42 U.S.C. 1395w–23(a)(1)(B)), as added by subsection (a). The Secretary shall publish such adjustments in final form by not later than July 1, 2001, so that the amendment made by subsection (a) is implemented on a timely basis consistent with subsection (b) [set out as a note above].''

REPORT ON INCLUSION OF CERTAIN COSTS OF THE DEPARTMENT OF VETERANS AFFAIRS AND MILITARY FACILITY SERVICES IN CALCULATING MEDICARE+CHOICE PAYMENT RATES

Pub. L. 106–554, §1(a)(6) [title VI, §609], Dec. 21, 2000, 114 Stat. 2763, 2763A–559, provided that: ''The Secretary of Health and Human Services shall report to Congress by not later than January 1, 2003, on a method to phase-in the costs of military facility services furnished by the Department of Veterans Affairs, and the costs of military facility services furnished by the Department of Defense, to medicare-eligible beneficiaries in the calculation of an area's Medicare+Choice capitation payment. Such report shall include on a county-by-county basis—

''(1) the actual or estimated cost of such services to medicare-eligible beneficiaries;

''(2) the change in Medicare+Choice capitation payment rates if such costs are included in the calculation of payment rates;

''(3) one or more proposals for the implementation of payment adjustments to Medicare+Choice plans in counties where the payment rate has been affected due to the failure to calculate the cost of such services to medicare-eligible beneficiaries; and

''(4) a system to ensure that when a Medicare+Choice enrollee receives covered services through a facility of the Department of Veterans Affairs or the Department of Defense there is an appropriate payment recovery to the medicare program under title XVIII of the Social Security Act [this subchapter].''

MEDPAC STUDY AND REPORT

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §511(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–380, provided that:

''(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study that evaluates the methodology used by the Secretary of Health and Human Services in developing the risk factors used in adjusting the Medicare+Choice capitation rate paid to Medicare+Choice organizations under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) and includes the issues described in paragraph (2).

''(2) ISSUES TO BE STUDIED.—The issues described in this paragraph are the following:

''(A) The ability of the average risk adjustment factor applied to a Medicare+Choice plan to explain

variations in plans' average per capita medicare costs, as reported by Medicare+Choice plans in the plans' adjusted community rate filings.

''(B) The year-to-year stability of the risk factors applied to each Medicare+Choice plan and the potential for substantial changes in payment for small Medicare+Choice plans.

''(C) For medicare beneficiaries newly enrolled in Medicare+Choice plans in a given year, the correspondence between the average risk factor calculated from medicare fee-for-service data for those individuals from the period prior to their enrollment in a Medicare+Choice plan and the average risk factor calculated for such individuals during their initial year of enrollment in a Medicare+Choice plan.

''(D) For medicare beneficiaries disenrolling from or switching among Medicare+Choice plans in a given year, the correspondence between the average risk factor calculated from data pertaining to the period prior to their disenrollment from a Medicare+Choice plan and the average risk factor calculated from data pertaining to the period after disenrollment.

''(E) An evaluation of the exclusion of 'discretionary' hospitalizations from consideration in the risk adjustment methodology.

''(F) Suggestions for changes or improvements in the risk adjustment methodology.

''(3) REPORT.—Not later than December 1, 2000, the Commission shall submit a report to Congress on the study conducted under paragraph (1), together with any recommendations for legislation that the Commission determines to be appropriate as a result of such study.''

STUDY AND REPORT REGARDING REPORTING OF ENCOUNTER DATA

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §511(c)], Nov. 29, 1999, 113 Stat. 1536, 1501A–381, provided that:

''(1) STUDY.—The Secretary of Health and Human Services shall conduct a study on how to reduce the costs and burdens on Medicare+Choice organizations of their complying with reporting requirements for encounter data imposed by the Secretary in establishing and implementing a risk adjustment methodology used in making payments to such organizations under section 1853 of the Social Security Act (42 U.S.C. 1395w–23). The Secretary shall consult with representatives of Medicare+Choice organizations in conducting the study. The study shall address the following issues:

''(A) Limiting the number and types of sites of services (that are in addition to inpatient sites) for which encounter data must be reported.

''(B) Establishing alternative risk adjustment methods that would require submission of less data.

''(C) The potential for Medicare+Choice organizations to misreport, overreport, or underreport prevalence of diagnoses in outpatient sites of care, the potential for increases in payments to Medicare+Choice organizations from changes in Medicare+Choice plan coding practices (commonly known as 'coding creep') and proposed methods for detecting and adjusting for such variations in diagnosis coding as part of the risk adjustment methodology using encounter data from multiple sites of care.

''(D) The impact of such requirements on the willingness of insurers to offer Medicare+Choice MSA plans and options for modifying encounter data reporting requirements to accommodate such plans.

''(E) Differences in the ability of Medicare+Choice organizations to report encounter data, and the potential for adverse competitive impacts on group and staff model health maintenance organizations or other integrated providers of care based on data reporting capabilities.

''(2) REPORT.—Not later than January 1, 2001, the Secretary shall submit a report to Congress on the study conducted under this subsection, together with any recommendations for legislation that the Secretary determines to be appropriate as a result of such study.''

SPECIAL RULE FOR 2001

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §514(b)], Nov. 29, 1999, 113 Stat. 1536, 1501A–384, provided that: ''In providing for the publication of information under section 1853(b)(4) of the Social Security Act (42 U.S.C. 1395w–23(b)(4)), as added by subsection (a), in 2001, the Secretary of Health and Human Services shall also include the information described in such section for 1998, as well as for 1999.''

DEVELOPMENT OF SPECIAL PAYMENT RULES UNDER MEDICARE+CHOICE PROGRAM FOR FRAIL ELDERLY ENROLLED IN SPECIALIZED PROGRAMS

Pub. L. 106–113, div. B, §1000(a)(6) [title V, §552(a)], Nov. 29, 1999, 113 Stat. 1536, 1501A–392, provided that:

''(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on the development of a payment methodology under the Medicare+Choice program for frail elderly Medicare+Choice beneficiaries enrolled in a Medicare+Choice plan under a specialized program for the frail elderly that—

''(A) accounts for the prevalence, mix, and severity of chronic conditions among such frail elderly Medicare+Choice beneficiaries;

''(B) includes medical diagnostic factors from all provider settings (including hospital and nursing facility settings); and

''(C) includes functional indicators of health status and such other factors as may be necessary to achieve appropriate payments for plans serving such beneficiaries.

''(2) REPORT.—Not later than 1 year after the date of the enactment of this Act [Nov. 29, 1999], the Commission shall submit a report to Congress on the study conducted under paragraph (1), together with any recommendations for legislation that the Commission determines to be appropriate as a result of such study.''

PUBLICATION OF NEW CAPITATION RATES

Pub. L. 105–33, title IV, §4002(i), Aug. 5, 1997, 111 Stat. 330, provided that: ''Not later than 4 weeks after the date of the enactment of this Act [Aug. 5, 1997], the Secretary of Health and Human Services shall announce the annual Medicare+Choice capitation rates for 1998 under section 1853(b) of the Social Security Act [subsec. (b) of this section].''

MEDICARE+CHOICE COMPETITIVE PRICING DEMONSTRATION PROJECT

Pub. L. 105–33, title IV, §§4011, 4012, Aug. 5, 1997, 111 Stat. 334–336, as amended by Pub. L. 106–113, div. B, §1000(a)(6) [title V, §533], Nov. 29, 1999, 113 Stat. 1536, 1501A–389, provided that:

''SEC. 4011. MEDICARE PREPAID COMPETITIVE PRICING DEMONSTRATION PROJECT.

''(a) ESTABLISHMENT OF PROJECT.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary of Health and Human Services (in this subchapter [subchapter A (§§4011–4012) of chapter 2 of subtitle A of title IV of Pub. L. 105–33] referred to as the 'Secretary') shall establish a demonstration project (in this subchapter referred to as the 'project') under which payments to Medicare+Choice organizations in medicare payment areas in which the project is being conducted are determined in accordance with a competitive pricing methodology established under this subchapter.

''(2) DELAY IN IMPLEMENTATION.—The Secretary shall not implement the project until January 1, 2002, or, if later, 6 months after the date the Competitive Pricing Advisory Committee has submitted to Congress a report on each of the following topics:

''(A) INCORPORATION OF ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM INTO PROJECT.—What changes would be required in the project to feasibly incorporate the original medicare fee-for-service program into the project in the areas in which the project is operational.

''(B) QUALITY ACTIVITIES.—The nature and extent of the quality reporting and monitoring activities that should be required of plans participating in the

project, the estimated costs that plans will incur as a result of these requirements, and the current ability of the Health Care Financing Administration to collect and report comparable data, sufficient to support comparable quality reporting and monitoring activities with respect to beneficiaries enrolled in the original medicare fee-for-service program generally.

''(C) RURAL PROJECT.—The current viability of initiating a project site in a rural area, given the site specific budget neutrality requirements of the project under subsection (g), and insofar as the Committee decides that the addition of such a site is not viable, recommendations on how the project might best be changed so that such a site is viable.

''(D) BENEFIT STRUCTURE.—The nature and extent of the benefit structure that should be required of plans participating in the project, the rationale for such benefit structure, the potential implications that any benefit standardization requirement may have on the number of plan choices available to a beneficiary in an area designated under the project, the potential implications of requiring participating plans to offer variations on any standardized benefit package the committee might recommend, such that a beneficiary could elect to pay a higher percentage of out-of-pocket costs in exchange for a lower premium (or premium rebate as the case may be), and the potential implications of expanding the project (in conjunction with the potential inclusion of the original medicare fee-for-service program) to require medicare supplemental insurance plans operating in an area designated under the project to offer a coordinated and comparable standardized benefit package.

''(3) CONFORMING DEADLINES.—Any dates specified in the succeeding provisions of this section shall be delayed (as specified by the Secretary) in a manner consistent with the delay effected under paragraph (2).

''(b) DESIGNATION OF 7 MEDICARE PAYMENT AREAS COVERED BY PROJECT.—

''(1) IN GENERAL.—The Secretary shall designate, in accordance with the recommendations of the Competitive Pricing Advisory Committee under paragraphs (2) and (3), medicare payment areas as areas in which the project under this subchapter will be conducted. In this section, the term 'Competitive Pricing Advisory Committee' means the Competitive Pricing Advisory Committee established under section 4012(a).

''(2) INITIAL DESIGNATION OF 4 AREAS.—

''(A) IN GENERAL.—The Competitive Pricing Advisory Committee shall recommend to the Secretary, consistent with subparagraph (B), the designation of 4 specific areas as medicare payment areas to be included in the project. Such recommendations shall be made in a manner so as to ensure that payments under the project in 2 such areas will begin on January 1, 1999, and in 2 such areas will begin on January 1, 2000.

''(B) LOCATION OF DESIGNATION.—Of the 4 areas recommended under subparagraph (A), 3 shall be in urban areas and 1 shall be in a rural area.

''(3) DESIGNATION OF ADDITIONAL 3 AREAS.—Not later than December 31, 2001, the Competitive Pricing Advisory Committee may recommend to the Secretary the designation of up to 3 additional, specific medicare payment areas to be included in the project.

''(c) PROJECT IMPLEMENTATION.—

''(1) IN GENERAL.—Subject to paragraph (2), the Secretary shall for each medicare payment area designated under subsection (b)—

''(A) in accordance with the recommendations of the Competitive Pricing Advisory Committee—

''(i) establish the benefit design among plans offered in such area,

''(ii) structure the method for selecting plans offered in such area; and

''(iii) establish beneficiary premiums for plans offered in such area in a manner such that a beneficiary who enrolls in an offered plan the per capita bid for which is less than the standard per capita government contribution (as established by the competitive pricing methodology established for such area) may, at the plan's election, be offered a rebate of some or all of the medicare part B premium that such individual must otherwise pay in order to participate in a Medicare+Choice plan under the Medicare+Choice program; and

''(B) in consultation with such Committee—

''(i) establish methods for setting the price to be paid to plans, including, if the Secretaries determines appropriate, the rewarding and penalizing of Medicare+Choice plans in the area on the basis of the attainment of, or failure to attain, applicable quality standards, and

''(ii) provide for the collection of plan information (including information concerning quality and access to care), the dissemination of information, and the methods of evaluating the results of the project.

''(2) CONSULTATION.—The Secretary shall take into account the recommendations of the area advisory committee established in section 4012(b), in implementing a project design for any area, except that no modifications may be made in the project design without consultation with the Competitive Pricing Advisory Committee. In no case may the Secretary change the designation of an area based on recommendations of any area advisory committee.

''(d) MONITORING AND REPORT.—

''(1) MONITORING IMPACT.—Taking into consideration the recommendations of the Competitive Pricing Advisory Committee and the area advisory committees, the Secretary shall closely monitor and measure the impact of the project in the different areas on the price and quality of, and access to, medicare covered services, choice of health plans, changes in enrollment, and other relevant factors.

''(2) REPORT.—Not later than December 31, 2002, the Secretary shall submit to Congress a report on the progress under the project under this subchapter, including a comparison of the matters monitored under paragraph (1) among the different designated areas. The report may include any legislative recommendations for extending the project to the entire medicare population.

''(e) WAIVER AUTHORITY.—The Secretary of Health and Human Services may waive such requirements of title XVIII of the Social Security Act [this subchapter] (as amended by this Act) as may be necessary for the purposes of carrying out the project.

''(f) RELATIONSHIP TO OTHER AUTHORITY.—Except pursuant to this subchapter, the Secretary of Health and Human Services may not conduct or continue any medicare demonstration project relating to payment of health maintenance organizations, Medicare+Choice organizations, or similar prepaid managed care entities on the basis of a competitive bidding process or pricing system described in subsection (a).

''(g) NO ADDITIONAL COSTS TO MEDICARE PROGRAM.—The aggregate payments to Medicare+Choice organizations under the project for any designated area for a fiscal year may not exceed the aggregate payments to such organizations that would have been made under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), as amended by section 4001 [enacting this part and redesignating former part C of this subchapter as part D], if the project had not been conducted.

''(h) DEFINITIONS.—Any term used in this subchapter which is also used in part C of title XVIII of the Social Security Act [this part], as amended by section 4001, shall have the same meaning as when used in such part.

''SEC. 4012. ADVISORY COMMITTEES.

''(a) COMPETITIVE PRICING ADVISORY COMMITTEE.—

''(1) IN GENERAL.—Before implementing the project under this subchapter [subchapter A (§§ 4011–4012) of chapter 2 of subtitle A of title IV of Pub. L. 105–33],

the Secretary shall appoint the Competitive Pricing Advisory Committee, including independent actuaries, individuals with expertise in competitive health plan pricing, and an employee of the Office of Personnel Management with expertise in the administration of the Federal Employees Health Benefit Program, to make recommendations to the Secretary concerning the designation of areas for inclusion in the project and appropriate research design for implementing the project.

''(2) INITIAL RECOMMENDATIONS.—The Competitive Pricing Advisory Committee initially shall submit recommendations regarding the area selection, benefit design among plans offered, structuring choice among health plans offered, methods for setting the price to be paid to plans, collection of plan information (including information concerning quality and access to care), information dissemination, and methods of evaluating the results of the project.

''(3) QUALITY RECOMMENDATION.—The Competitive Pricing Advisory Committee shall study and make recommendations regarding the feasibility of providing financial incentives and penalties to plans operating under the project that meet, or fail to meet, applicable quality standards.

''(4) ADVICE DURING IMPLEMENTATION.—Upon implementation of the project, the Competitive Pricing Advisory Committee shall continue to advise the Secretary on the application of the design in different areas and changes in the project based on experience with its operations.

''(5) SUNSET.—The Competitive Pricing Advisory Committee shall terminate on December 31, 2004.

''(b) APPOINTMENT OF AREA ADVISORY COMMITTEE.—Upon the designation of an area for inclusion in the project, the Secretary shall appoint an area advisory committee, composed of representatives of health plans, providers, and medicare beneficiaries in the area, to advise the Secretary concerning how the project will be implemented in the area. Such advice may include advice concerning the marketing and pricing of plans in the area and other salient factors. The duration of such a committee for an area shall be for the duration of the operation of the project in the area.

''(c) SPECIAL APPLICATION.—Notwithstanding section 9(c) of the Federal Advisory Committee Act (5 U.S.C. App.), the Competitive Pricing Advisory Commission and any area advisory committee (described in subsection (b)) may meet as soon as the members of the commission or committee, respectively, are appointed.''

§ 1395w–24. Premiums and bid amounts

(a) Submission of proposed premiums, bid amounts, and related information

(1) In general

(A) Initial submission

Not later than the second Monday in September of 2002, 2003, and 2004 (or the first Monday in June of each subsequent year), each MA organization shall submit to the Secretary, in a form and manner specified by the Secretary and for each MA plan for the service area (or segment of such an area if permitted under subsection (h)) in which it intends to be offered in the following year the following:

(i) The information described in paragraph (2), (3), (4), or (6)(A) for the type of plan and year involved.

(ii) The plan type for each plan.

(iii) The enrollment capacity (if any) in relation to the plan and area.

(B) Beneficiary rebate information

In the case of a plan required to provide a monthly rebate under subsection (b)(1)(C) for a year, the MA organization offering the plan shall submit to the Secretary, in such form and manner and at such time as the Secretary specifies, information on—

(i) the manner in which such rebate will be provided under clause (ii) of such subsection; and

(ii) the MA monthly prescription drug beneficiary premium (if any) and the MA monthly supplemental beneficiary premium (if any).

(C) Paperwork reduction for offering of MA regional plans nationally or in multi-region areas

The Secretary shall establish requirements for information submission under this subsection in a manner that promotes the offering of MA regional plans in more than one region (including all regions) through the filing of consolidated information.

(2) Information required for coordinated care plans before 2006

For a Medicare+Choice plan described in section 1395w–21(a)(2)(A) of this title for a year before 2006, the information described in this paragraph is as follows:

(A) Basic (and additional) benefits

For benefits described in section 1395w–22(a)(1)(A) of this title—

(i) the adjusted community rate (as defined in subsection (f)(3));

(ii) the Medicare+Choice monthly basic beneficiary premium (as defined in subsection (b)(2)(A));

(iii) a description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of such deductibles, coinsurance, and copayments, described in subsection (e)(1)(A); and

(iv) if required under subsection (f)(1), a description of the additional benefits to be provided pursuant to such subsection and the value determined for such proposed benefits under such subsection.

(B) Supplemental benefits

For benefits described in section 1395w–22(a)(3) of this title—

(i) the adjusted community rate (as defined in subsection (f)(3));

(ii) the Medicare+Choice monthly supplemental beneficiary premium (as defined in subsection (b)(2)(B)); and

(iii) a description of deductibles, coinsurance, and copayments applicable under the plan and the actuarial value of such deductibles, coinsurance, and copayments, described in subsection (e)(2).

(3) Requirements for MSA plans

For an MSA plan for any year, the information described in this paragraph is as follows:

(A) Basic (and additional) benefits

For benefits described in section 1395w–22(a)(1)(A) of this title, the amount of the Medicare+Choice monthly MSA premium.

(B) Supplemental benefits

For benefits described in section 1395w–22(a)(3) of this title, the amount of the