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Major Provisions of the Medicare Modernization and Prescription Drug Act of 2002, H.R. 4954, as Passed by the House

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Major Provisions of the Medicare Modernization and Prescription Drug Act of 2002, H.R. 4954, as Passed by the House

Summary

On June 28, 2002, the House passed H.R. 4954, the Medicare Modernization and Prescription Drug Act of 2002. This bill represents a reconciliation of the slight differences in measures reported by the two House Committees, Ways and Means and Energy and Commerce, which share jurisdiction over the Medicare program.

This bill would establish a voluntary Medicare prescription drug benefit under a new Part D. The bill would rely on private plans to provide coverage and to bear some of the financial risk for drug costs; federal subsidies would be provided to encourage participation. Coverage would be provided through prescription drug plans (PDPs) or Medicare+Choice (M+C) plans. Beneficiaries could purchase either a standard plan or an actuarially equivalent plan. For 2005, "standard coverage" would be defined as having a $250 deductible, 20% cost-sharing for drug costs between $251 and $1,000, 50% cost-sharing for drug costs between $1,001 and the initial coverage limit of $2,000, and then no coverage until the beneficiary had out-of-pocket costs of $3,700 ($4,800 in total spending); once the beneficiary reached the $3,700 catastrophic limit full coverage would be provided. Low income subsidies would be provided for persons with incomes below 175% of poverty.

The Medicare+Choice (M+C) provisions of this bill would increase payments to M+C plans and establish a new M+C payment system based on competitive bidding. Additionally, this bill would establish a four-site demonstration program for "competitive demonstration areas" that have a high concentration of M+C enrollees. Part B premium amounts for fee-for-service Medicare beneficiaries in these demonstration sites could also be adjusted. The bill would make a number of other changes to the M+C program, including permanently changing reporting dates and deadlines, creating specialized M+C plans for special needs beneficiaries, permanently extending M+C savings accounts (MSAs) and other changes.

Additionally, H.R. 4954 would increase funding and make other changes to the Medicare program for services provided by hospitals, home health agencies, skilled nursing facilities, physicians, durable medical equipment suppliers, and others. The bill would also establish a new Medicare Benefits Administration to administer the prescription drug and Medicare+Choice programs. In addition, the bill includes a number of regulatory reforms.

This report will be updated, as necessary, to reflect additional legislative action.

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Major Provisions of the Medicare Modernization and Prescription Drug Act of 2002, H.R. 4954,as Passed by the House

Introduction

On June 28, 2002, the House passed H.R. 4954, the Medicare Modernization and Prescription Drug Act of 2002. Two House committees share jurisdiction over Medicare and took action on the bill. The House Ways and Means Committee ordered reported the Chairman's amendment to H.R. 4954, on June 18, 2002, and filed its report (H. Rept. 107-537) on June 26, 2002. The House Energy and Commerce Committee ordered reported similar legislation on June 21, 2002. The Commerce Committee had broken the measure (which included some non-Medicare provisions) into 12 bills which were reported on June 26, 2002. (H.Rept. 107-540, H.Rept. 107-541, H.Rept. 107-542, H.Rept. 107-549, H.Rept. 107-550, and H.Rept. 107-551 were on the Medicare provisions). The differences between the two bills were resolved and incorporated into an amendment to H.R. 4954 submitted to the House Rules Committee on June 27, 2002; the Rules Committee reported a rule (H.Res. 465) for consideration of the bill on the same day. The bill passed the House by a vote of 221-208.[1]

This bill would establish a voluntary Medicare prescription drug benefit under a new Part D. The bill would rely on private plans to provide coverage and to bear some of the financial risk for drug costs; federal subsidies would be provided to encourage participation. Coverage would be provided through prescription drug plans (PDPs) or Medicare+Choice (M+C) plans. Beneficiaries could purchase either a standard plan or an actuarially equivalent plan. For 2005, "standard coverage" would be defined as having a $250 deductible, 20% cost-sharing for drug costs between $251 and $1,000, 50% cost-sharing for drug costs between $1,001 and the initial coverage limit of $2,000, and then no coverage until the beneficiary had out-of-pocket costs of $3,700 ($4,800 in total spending); once the beneficiary reached the $3,700 catastrophic limit full coverage would be provided. Low income subsidies would be provided for persons with incomes below 175% of poverty.

The M+C provisions of this bill would increase payments to M+C plans and establish a new M+C payment system based on competitive bidding. Additionally, this bill would establish a four-site demonstration program for "competitive demonstration areas" that have a high concentration of M+C enrollees. Part B premium amounts for fee-for-service Medicare beneficiaries in these demonstration

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[1] For the complete text of the House-passed bill see: *Congressional Record*, v.148, no.89, June 27, 2002, H4226-H4270.

sites could also be adjusted. The bill would make a number of other changes to the M+C program, including permanently changing reporting dates and deadlines, creating specialized M+C plans for special needs beneficiaries, permanently extending M+C medical savings accounts (MSAs), and other changes.

Additionally, H.R. 4954 would increase funding and make other changes to the Medicare program for services provided by hospitals, home health agencies, skilled nursing facilities, physicians, and others. It would require competitive bidding for suppliers of durable medical equipment. The bill would also establish a new Medicare Benefits Administration to administer the prescription drug and Medicare+Choice programs. In addition, the bill includes a number of regulatory reforms.

For more detailed information on the Medicare issues discussed in the paper, see the following: 1) CRS Report RL30819, *Medicare Prescription Drug Coverage for Beneficiaries: Background and Issues*; 2) CRS Report RL31199, *Medicare: Payments to Physicians*; 3) CRS Report RL30587, *Medicare+Choice Payments*; 4) CRS Report RL30702, *Medicare+Choice*; 5) CRS Report RL31058, *Medicare Structural Reform: Background and Options*; and 6) CRS Report RL31023, *Summary of the Medicare Regulatory and Contracting Reform Act of 2001*.

Provisions of H.R. 4954, as Passed by the House

Drug Provisions

In General

Provisions	Current law	H.R. 4954
Summary	Medicare does not cover most outpatient prescription drugs.	Effective January 1, 2005, a new optional benefit would be established under a new Part D. The program would rely on private plans to provide coverage and to bear some of the financial risk for drug costs; federal subsidies would be provided to encourage participation. Coverage would be provided through prescription drug plans (PDPs) or Medicare+Choice (M+C) plans. Beneficiaries could purchase either a standard plan or an actuarially equivalent plan. Low income subsidies would be provided for persons with incomes below 175% of poverty. A new Medicare Benefits Administration (MBA) would be established within the Department of Health and Human Services (HHS) to administer the benefit and the M+C program.

Program Design

Provisions	Current law	H.R. 4954
Benefits	No provision	"Qualified coverage" would be either "standard coverage" or "actuarially equivalent coverage." In 2005, "standard coverage" would be defined as having a $250 deductible, 20% cost-sharing for drug costs between $251 and $1,000, 50% cost-sharing for drug costs between $1,001 and the initial coverage limit of $2,000, and then no coverage until the beneficiary had out-of-pocket costs of $3,700 ($4,800 in total spending); once the beneficiary reached the $3,700 catastrophic limit full coverage would be provided. The dollar amounts would be increased in

Provisions	Current law	H.R. 4954
		future years by the percentage increase in the average per capita expenditures for covered drugs for the year ending the previous July. Out-of-pocket costs counting toward the limit would include costs paid by the individual (or by another individual such as a family member), paid on behalf of a low-income individual under the subsidy provisions, or paid under Medicaid. Any costs for which the individual was reimbursed by insurance or by another third-party payment arrangement could not be counted. Plans could offer more generous drug coverage, if approved by the MBA Administrator.
Premiums	No provision	The plan sponsor would establish the premium amount, subject to approval by the Administrator. The premium for a prescription drug plan could not vary among individuals enrolled in the plan in the same service area, unless the individuals were subject to penalties for late enrollment. Premiums would be paid to the plans. However, PDP sponsors would be required to permit each enrollee to pay premiums through withholding from social security checks in the same manner Part B premium payments are withheld through an electronic funds transfer.
Eligibility	No provision	All beneficiaries enrolled in Medicare Part A or Part B could elect to enroll in Part D through enrollment in a Medicare+Choice plan with prescription drug coverage or in a PDP. The Administrator of the new MBA would establish an enrollment process. An initial election period would be established. For current beneficiaries this would be the 6-month period beginning November 2004; for future beneficiaries it would be the same 7-month period applicable for initial Part B enrollment. Special election periods would apply for persons who involuntarily lose other drug coverage. Persons electing coverage at the first opportunity and maintaining continuous coverage would be guaranteed the protection of community rating.

Provisions	Current law	H.R. 4954
Relationship to Medicare+Choice	No provision	A Medicare+Choice enrollee would obtain benefits through the Medicare+Choice plan if the plan provided qualified drug coverage. A Medicare+Choice plan could not offer drug coverage (other than that already required under Medicare) unless the coverage was at least qualified prescription drug coverage.

Administration; Financial Risk

Provisions	Current law	H.R. 4954
Federal administration	No provision	The new MBA, within HHS, would administer the new Part D drug benefit and the Medicare+Choice program. (The Centers for Medicare and Medicaid Services (CMS) would retain responsibility for the traditional fee-for-service program.) A Medicare Policy Advisory Board would be established within the MBA.
Administration of benefit	No provision	The benefit would be administered by a Medicare+Choice plan or PDP. A PDP plan sponsor would be an entity certified under Part D as meeting the Part D standards and requirements. In general, a PDP sponsor would have to be licensed under state law as a risk bearing entity eligible to offer health benefits or health insurance coverage in each state in which it offered a prescription drug plan.
Establishment of plan/benefit	No provision	Each PDP sponsor would be required to submit to the MBA Administrator information on the qualified drug coverage to be provided, including the premium. The Administrator could not approve the premium unless it accurately reflected: 1) the value of benefits provided; and 2) the 67% federal subsidy for standard benefits (see below). PDP plan sponsors would be required to enter into a contract with the Administrator; the contract could cover more than one plan. The Administrator would have the same authority to negotiate the terms and conditions of the plans as the Director of Personnel Management has with respect to Federal Employee Health Benefits (FEHB) plans.

Provisions	Current law	H.R. 4954
Plan enrollment	No provision	Beneficiaries would enroll in a M+C plan with prescription drug coverage or in a PDP.
Federal payments to plans	No provision	The federal government would pay direct subsidies and reinsurance payments to PDPs, Medicare+Choice plans, and qualified retiree plans which would equal 67% of the value of standard coverage. Direct subsidies would be equal to 37% of the value of standard coverage provided under the plan. Reinsurance payments would be equal to 30% of the value of standard coverage. Reinsurance payments would be provided for: 1) 30% of an individual's allowable drug costs over the initial copayment threshold ($1,000 in 2005) but not over the initial coverage limit ($2,000 in 2005); and 2) 80% for costs over the out-of-pocket limit ($3,700 in 2005). The Administrator would proportionately adjust payments so that total reinsurance payments for the year equaled 30% of total payments by qualifying plans for standard coverage during the year. The Administrator could adjust direct subsidy payments in order to avoid risk selection.
Assumption of financial risk	No provision	Plans would be required to assume full financial risk on a prospective basis for covered benefits except: 1) as covered by federal direct subsidy payments or reinsurance payments for high cost enrollees; or 2) as covered by federal incentive payments to encourage plans to expand service areas for existing plans or establish new plans. The entity could obtain insurance or make other arrangements for the cost of coverage provided to enrollees.
Access	No provision	The Administrator would assure that all eligible individuals residing in the U.S. would have a choice of enrollment in at least two qualifying plan options (at least one of which was a PDP) in their area of residence. The requirement would not be satisfied if only one PDP sponsor or M+C organization offered all the qualifying plans in the area. If necessary to ensure such access, the Administrator would be authorized to provide financial

Provisions	Current law	H.R. 4954
		incentives, including the partial underwriting of risk, for a PDP sponsor to expand its service area under an existing prescription drug plan to adjoining or additional areas, or to establish such a plan, including offering such plan on a regional or nationwide basis. The assistance would be available only so long as, and to the extent necessary, to assure the guaranteed access. However, the Administrator could never provide for the full underwriting of financial risk for any PDP sponsor, nor could the Administrator provide for any assumption of financial risk for a public PDP sponsor offering a nationwide drug plan. Additionally, the Administrator would be directed to seek to maximize the assumption of financial risk by PDP sponsors and M+C organizations.

Pricing; Cost Controls

Provisions	Current law	H.R. 4954
Drug pricing and payment	No provision	The PDP sponsor would determine payments and would be expected to negotiate discounts.
Access to negotiated prices	No provision	Both standard coverage and actuarially equivalent coverage would have to provide beneficiaries access to negotiated prices (including applicable discounts) even when no benefits may be payable because the beneficiary has reached the initial coverage limit.
Cost controls/formularies	No provision	Plans would be allowed to have formularies restricting coverage to certain drugs. Plans electing to use a formulary would be required to establish a pharmaceutical and therapeutic committee (that included at least one practicing physician and one practicing pharmacist) to develop and revise the formulary. The formulary would be required to include drugs within all therapeutic categories and classes of covered drugs (although not necessarily for all drugs within such categories and classes). An enrollee would have the right to appeal to obtain coverage for a drug not on the formulary if the prescribing physician determined that the formulary drug

Provisions	Current law	H.R. 4954
		was not as effective for the individual or had adverse effects for the individual.

Requirements

Provisions	Current law	H.R. 4954
Beneficiary protections	No provision	Plans would be required to comply with a number of beneficiary protection provisions including those related to: 1) community-rated premiums; 2) non-discrimination; 3) information disclosure; 4) assuring the participation of a sufficient number of pharmacies; 5) issuance of a card so beneficiaries could assure access to negotiated prices when coverage is not otherwise available under the plan; 6) a cost and drug utilization management program including medication therapy management and an electronic prescription drug program that provides for electronic transfer of prescriptions and provision of information to the prescribing health professional; and 7) provisions for hearing appeals and resolving grievances.

Low-Income Subsidies

Provisions	Current law	H.R. 4954
Subsidies	No provision	Low-income persons would receive a premium subsidy (based on the value of standard coverage). Individuals with incomes at or below 150% of poverty (and assets below $4,000) would have a subsidy equal to 100% of the value of standard drug coverage provided under the plan. Individuals with incomes between 150% and 175% of poverty would have a sliding scale premium subsidy ranging from 100% of such value at 150% of poverty to 0% of such value at 175% of poverty. For both groups, beneficiary cost-sharing for spending up to the initial coverage limit ($2,000 in 2005) would be reduced to an amount not to exceed $2 for a multiple source or generic drug and $5 for a non-preferred drug. PDPs could not

Provisions	Current law	H.R. 4954
		charge individuals receiving cost-sharing subsidies more than $5 per prescription. PDPs could reduce to zero the cost-sharing otherwise applicable for generic drugs.

Relationship to Other Coverage

Provisions	Current law	H.R. 4954
Relationship to Medicaid	Some low-income Medicare beneficiaries are also eligible for full Medicaid benefits (including drugs); these are known as dual eligibles. Some low-income Medicare beneficiaries are only entitled to Medicaid assistance for Medicare Part B premiums, and, in certain cases, Medicare cost-sharing charges.	States would be required to make eligibility determinations for low-income subsidies; there would be a phase-in of the federal assumption of associated administrative costs. (Alternatively, the eligibility determinations could be made by the Social Security Administration.) There would also be a federal phase-in of the costs of premiums and cost-sharing subsidies for dual eligibles. States would be required to maintain Medicaid benefits as a wrap around to Medicare benefits for dual eligibles; states could require that these persons elect Part D drug coverage. The bill would also exempt any prices negotiated by a PDP, Medicare+Choice plan, or qualified retiree program from Medicaid's determination of "best price" for purposes of the Medicaid drug rebate program.
Relationship to private plans	No provision	Qualified prescription drug plans offered by employers to retirees would be eligible for direct subsidies and reinsurance payments. At a minimum, qualified retiree coverage would have to meet the requirements for qualified prescription drug coverage.
Relationship to Medigap	Beneficiaries with Medigap insurance generally select from one of 10 standardized plans, though not all 10 plans are offered in all states. The 10 plans are known as Plans A through Plan J. Plans H, I, and J offer some drug coverage.	Effective January 1, 2005, the issuance of new Medigap policies with prescription drug coverage would be prohibited unless 1) the policies replace another policy with drug coverage; or 2) policies met requirements for two new standardized policies. The first new policy would have the following benefits (notwithstanding other provisions of law relating to core benefits): 1) coverage of 50% of the cost-sharing otherwise applicable (except

Provisions	Current law	H.R. 4954
		coverage of 100% cost-sharing applicable for preventive benefits); 2) no coverage of the Part B deductible; 3) coverage of all hospital coinsurance for long stays (as in current core package); and 4) a limitation on annual out-of-pocket costs of $4,000 in 2005 (increased in future years by an appropriate inflation adjustment as specified by the Secretary). The second new policy would have the same benefit structure as the first new policy, except that: 1) coverage would be provided for 75%, rather than 50%, of cost-sharing otherwise applicable; and 2) the limitation on out-of-pocket costs would be $2,000, rather than $4,000. Both policies could provide for coverage of Part D cost-sharing; however, neither policy could cover the Part D deductible. The bill would require plans to sell any of the Plans A through Plan G to certain persons; these are individuals who enroll in Part D within 63 days and who were covered until then by Medigap policy H, I, or J.

Drug Card; Transitional Low-Income Assistance

Provisions	Current law	H.R. 4954
Discount Drug Card Program	On July 12, 2001, the President announced a new national drug discount card program for Medicare beneficiaries, an initiative undertaken by the Administration without direct statutory authorization. Under this program, CMS would endorse drug card programs meeting certain requirements. This program was viewed as an interim step until a legislative reform package, including both a drug benefit and other Medicare reforms, was enacted. Implementation of the drug discount card program was delayed by court action. However, CMS was allowed to proceed with rule-making. On March 6, 2002, CMS issued proposed rule-making.	The provision would require the Secretary to endorse prescription drug discount programs meeting certain requirements and to make available information on such programs to beneficiaries. The program: 1) would have to pass on to enrollees discounts on drugs, including discounts negotiated with manufacturers; 2) could not be limited to mail order drugs; 3) would have to provide pharmaceutical support services, such as education and counseling, and services to prevent adverse drug interactions; 4) would have to provide information to enrollees that the Secretary identified as being necessary to provide for informed choice by beneficiaries among endorsed programs; 5) would have to safeguard individually identifiable information in accordance with the Health Insurance Portability and

Provisions	Current law	H.R. 4954
		accountability Act (HIPAA); and 6) would have to meet requirements the Secretary found necesssary to participate in the transitional low-income assistance program (see below). A beneficiary could only be enrolled in one endorsed program at a time. Annual enrollment fees could not exceed $25. The Secretary would provide for an appropriate transition and discontinuance of the card program at the time benefits became available under the new Part D.
Transitional Low-Income Assistance Program	No provision	The bill would provide for the implementation of a transitional prescription drug assistance program for Medicare beneficiaries with incomes under 175% of poverty who did not have drug coverage under Medicaid, Medigap, group health insurance, or federally-supported health care programs under the Department of Defense, Veterans Administration, Federal Employees Health Benefits program, or the Indian Health Care Improvement Act. Individuals eligible for assistance would have to be enrolled under a prescription drug discount card program (or an alternative state program approved by the Secretary). Appropriations totaling $300 million in FY 2003, $2.1 billion in FY 2004, and $500 million in FY 2005 would be available. Funds would be allotted among the states based on the proportion of Medicare beneficiaries with incomes below 175% of poverty. The assistance would be in the form of a discount in addition to that available under the discount card program. States could continue to provide assistance under their own pharmaceutical assistance programs.

Medicare+Choice

Medicare+Choice Payments

Provisions	Current law	H.R. 4954
Medicare+Choice (M+C) Payments	M+C plans are paid an administered monthly payment amount, (M+C payment rate), for each enrollee. The payment area rate is the highest of one of three amounts: 1) a minimum payment (floor) rate, 2) a blend of an area-specific (local) rate and a national rate, or 3) a minimum increase from the prior year's rate. Each year, the three payment amounts are updated by formulas set in statute. Both the floor and the blend are updated by a measure of growth in program spending, the national growth percentage. The minimum increase is 2% over the prior year's amount. After preliminary M+C payment rates are determined, a budget neutrality adjustment is required to determine final payment rates. This adjustment is made so that estimated total M+C payments in a given year will be equal to the total payments that would be made if payments were based solely on area-specific rates. The budget neutrality adjustment may only be applied to the blended rates because rates cannot be reduced below the floor or minimum increase amounts. The blend payment is also adjusted to remove the direct and indirect costs of graduate medical education.	This provision would modify current law payments for 2003 and 2004, and add a fourth amount, based on 100% of fee-for-service (FFS) costs, set at the adjusted average per capita cost (AAPCC) for that year. The AAPCC would include costs for FFS beneficiaries only and not the costs for M+C enrollees. Two adjustments would be made to the AAPCC: 1) to remove direct medical education costs, and 2) to include payments that would have been made for services provided to Medicare beneficiaries, who instead used services from the Departments of Veterans Affairs (VA) and Defense (DOD). Adjustments would also be made to the blend: 1) revise the national average, to reflect only M+C enrollees, not all beneficiaries; 2) no budget neutrality adjustment, and 3) include VA and DOD amounts (described above) in the area-specific rate. Budget neutrality would be eliminated in 2003. For 2003 and 2004, the minimum percentage increase would be 3% above the previous year's amount. New payment rates would be announced within 4 weeks after enactment.
Medicare+Choice Competition Program	See Current law description, above, of *Medicare+Choice (M+C) Payments*	Beginning in 2005, there would be a new M+C payment based on competitive bidding amounts. A benchmark amount would be set for each payment area and plans would develop a bid amount. Enrollees would be eligible for rebates, under certain circumstances. The Administrator could negotiate and/or reject monthly bid amounts (including portions of the bid), that are not supported by the actuarial bases provided by plans. The FFS area-specific non-drug benchmark amount would be set at the largest of one of three amounts; 1) the minimum

Provisions	Current law	H.R. 4954
		update amount, 2) the minimum percentage increase amount, or 3) a percentage of FFS costs (100% of FFS in 2005-2007 and 95% FFS thereafter). While the FFS payment mechanism established for 2003 and 2004 (described above) would exclude only the direct costs of graduate medical education, the FFS payments in the competition program would exclude both direct and indirect graduate medical education costs. Both the benchmark and the bids would be risk adjusted based on county or statewide assumptions, or based on a determination by the Administrator. If the risk adjusted benchmark exceeded the risk adjusted bid (for statutory non-drug benefits), beneficiaries would qualify for rebates of 75% of the difference. The government would retain the remaining 25% of the difference. If instead, the monthly bid exceeded the benchmark, then enrollees would pay the difference, in the form of an increased M+C premium. Plans would be paid based on their bid amounts. For plans with bids below the benchmark, their payment would be the bid amount, risk adjusted for demographic and health status factors, plus the rebate amount. The rebate amount would be distributed to the plan's enrollees by one of the approved methods. For plans with bids at or above the benchmark, their payments would equal the benchmark amount, risk adjusted for demographic and health status factors. Effective for payments and premiums for months beginning with January 2005.
Demonstration Program for competitive-demonstration areas	See Current law description, above, of *Medicare+Choice (M+C) Payments*	This provision would establish a demonstration program for "competitive-demonstration areas" defined as an area with a substantial number of M+C enrollees that during open season offers at least two M+C plans by different organizations, and that during March of the previous year had at least 50% of M+C eligibles enrolled in an M+C plan. The demonstration program would be limited to a maximum of four sites and no

Provisions	Current law	H.R. 4954
		area could be designated as a competitive-demonstration area for more than 2 years. The Administrator would have the authority to choose a demonstration area, from among qualified areas. Similar to the competition program, a benchmark amount would be set for each payment area and plans would develop a bid amount. The Administrator would set the annual choice non-drug benchmark amount, defined as the sum of the weighted FFS and M+C components. The weighted FFS component equals the national FFS market share for the year (defined as the nationwide proportion of M+C eligibles during March of the previous year who were not enrolled in an M+C plan) multiplied by the FFS area-specific non-drug bid (100% of the FFS payment mechanism adjusted to exclude graduate medical education costs and include Veterans Administration (VA) and Department of Defense (DOD) costs for Medicare beneficiaries). The M+C component equals 1 minus the FFS market share for the year multiplied by the weighted average of plan bids for the area and year. The weighted average of plan bids equals the sum of the proportion of each plan's enrollees in the area times the unadjusted monthly non-drug bid amount, as calculated for each plan. Rebates (or additional required premiums) and payments to plans would be calculated in a similar method as that used for the Medicare competition program. FFS beneficiaries in competitive areas, could have an adjustment made to their Medicare Part B premium. If the FFS area specific non-drug bid was less than or equal to the choice non-drug benchmark, the Part B premium would be reduced by 75% of the difference. However, if the FFS area specific non-drug bid was greater than the choice non-drug benchmark, then the Part B premium would be increased by the full amount of the difference. Effective January 1, 2005.

Other Major Medicare+Choice Provisions

Provisions	Current law	H.R. 4954
Permanent changes to reporting deadlines and annual, coordinated election period	The Public Health Security and Bioterrorism Preparedness and Response Act of 2002, P.L. 107-188, made temporary changes to reporting dates and deadlines: 1) the M+C payment rate announcement moved from no later than March 1 to no later than the second Monday in May for 2003 and 2004, 2) the plan deadline for submitting ACRs and other information moved from no later than July 1 to no later than the second Monday in September for 2002, 2003, and 2004, and 3) the annual coordinated election period moved from the month of November to November 15 through December 31 for 2002, 2003, and 2004.	This provision would permanently extend the deadline changes that were temporarily changed by P.L. 107-188. CMS would make its annual announcement of payment rates no later than the second Monday in May of each year. The deadline for plans to submit their information would be no later than the second Monday in September. The annual coordinated election period would take place from November 15 through December 31 of each year.
Specialized Medicare+Choice plans for special needs beneficiaries	One model for providing a specialized M+C plan, EverCare, operates as a demonstration program. EverCare, is designed to study the effectiveness of managing acute-care needs of nursing home residents by pairing physicians and geriatric nurse practitioners. EverCare, receives a fixed capitated payment, based on a percentage of the AAPCC, for all nursing home resident Medicare enrollees.	This provision would establish a new M+C option – specialized M+C plans for special needs beneficiaries (such as the EverCare demonstration). Special needs beneficiaries are defined as those M+C eligible individuals who are institutionalized, entitled to Medicaid, or meet requirements determined by the Secretary. Enrollment in specialized M+C plans could be limited to special needs beneficiaries until January 1, 2007.
Medical Savings Accounts (MSAs)	The Balanced Budget Act authorized a demonstration for M+C MSAs. The M+C option combines a high-deductible health insurance plan with an M+C MSA. New enrollment is not allowed after 2003 or after the number of enrollees reaches 390,000. However, to date, no private plans have established an M+C MSA for Medicare beneficiaries.	This provision would eliminate the requirement for quality assurance programs for M+C MSAs. It would permanently extend M+C MSAs and remove the enrollment cap. Non-contract M+C MSA providers would be subject to the same balanced billing limitations as non-contract coordinated care M+C plan providers.

Provisions	Current law	H.R. 4954
Extension of reasonable cost contracts	Cost-based plans are reimbursed by Medicare for the actual cost of furnishing covered services, less the estimated value of beneficiary cost sharing. The Secretary can not extend or renew a reasonable cost reimbursement contract for any period beyond December 31, 2004.	This provision would allow a reasonable cost contract to be extended or renewed beyond December 31, 2004 if there were no coordinated care M+C plans in its service area. A cost contract could re-enter a previously served area if all other coordinated care M+C plans in the area terminated their contracts.
Extension of Social Health Maintenance Organizations (SHMO) demonstration	The Deficit Reduction Act of 1984 established a 3-year SHMO demonstration to provide prepaid, capitated payments for integrated health and long-term care services. The demonstration has been extended several times.	The provisions would further extend the waivers permitting operation of SHMOs through December 31, 2004. Nothing would prevent a SHMO from offering an M+C plan.

Provider Payment Provisions

Inpatient Hospital Services

Provisions	Current law	H.R. 4954
Increase in hospital update factor	Each year, Medicare's operating payments to hospitals are increased or updated by a factor that is determined in part by the projected increase in the hospital market basket index (MBI). Currently, the update factor is set at MBI-0.55 percentage points for FY2002 and FY2003 and at the MBI for subsequent years.	For FY2003, the hospital update factor would be MBI-0.25 percentage points for all hospitals except sole community hospitals (SCHs) which would receive an update factor of the MBI.
Transition to one standardized amount	Under its prospective payment system (PPS), Medicare pays acute hospitals in large urban areas using a standardized amount (or payment per discharge) that is 1.6% larger than the standardized amount used to reimburse hospitals in other areas (both rural areas and smaller urban areas).	For FY2003 discharges, the per discharge payment for hospitals in other areas would be increased by half the difference between the current amount and the larger payment to hospitals in large urban areas. For FY2004, the Secretary would compute an updated payment amount for hospitals in large urban areas which would be used to pay all hospitals. Starting in FY2005, the Secretary would compute an updated payment amount for all hospitals which would be used to pay all hospitals.
Relief for Certain Non-Teaching Hospitals	BBA 97 provided temporary special payment for certain hospitals that did not receive a teaching or a	Certain non-teaching hospitals would receive an additional increase of 5 percentage points in its annual update for

Provisions	Current law	H.R. 4954
	disproportionate share hospital (DSH) adjustment. To qualify, a hospital had to be in a state where this subset of hospitals collectively had a negative PPS operating margin (that is, had Medicare allowable operating costs greater than Medicare operating prospective payments) AND had to have a negative PPS operating margin for the fiscal year in question. Qualifying hospitals received a 0.5% update in FY1998 (when other hospitals received a 0% update) and a 0.8% update in FY1999 (when other hospitals received a 0.5% update).	FY2003, FY2004, and FY2005 respectively. Non-teaching hospitals in rural areas would qualify if all rural hospitals in the state (including rural teaching hospitals) had a negative PPS operating margin in FY1999. Non-teaching hospitals in urban areas would qualify if all urban hospitals in the state (including teaching hospitals) had a PPS operating margin that is less than 103% in FY1999.
Increase in Disproportionate Share Hospital (DSH) adjustment	Medicare makes additional payments to certain acute hospitals that serve a large number of low income Medicare and Medicaid patients. Different formulas are used to establish a hospital's DSH payment adjustment, depending upon the hospital's location, number of beds and status as a rural referral center or sole community hospital.	Starting for FY2003 discharges, the DSH adjustment for certain hospitals would be based on a blend of their current DSH adjustment and the current DSH adjustment for large urban hospitals; this new DSH adjustment would be capped at 10% for most hospitals. A hospital's new DSH adjustment would be calculated on a blended transition basis which would be completed in FY2007.
Recognition of new technology in inpatient hospital payments	BIPA established that Medicare's inpatient hospital payment system should include a mechanism to recognize the costs of new medical services and technologies for discharges beginning on or after October 1, 2001. The additional hospital payments can be made by the means of a new technology groups, an add-on payment, a payment adjustment, or other mechanism, but cannot be a separate fee schedule and must be budget-neutral.	The Secretary would be required to establish certain thresholds to indicate whether DRG payments are inadequate and would be directed to identify distinct DRGs in preference to add-on payments for new technology wherever possible. The Secretary would be required to deem that a technology provides substantial improvement on an existing treatment depending upon FDA's treatment of such technology. Other requirements with respect to new technology would also be established.

Rural Providers

Provisions	Current law	H.R. 4954
Changes to critical access hospital payments	Critical access hospitals (CAHs) are limited-service hospitals that provide 24-hour emergency care services with no more than 15 acute care beds or up 25 beds, including 10 swing beds, in limited cases. CAHs are not eligible for periodic interim payments (PIP) for their inpatient services.	The Secretary would be required to specify standards for determining whether a CAH has significant seasonal variations in patient admissions to warrant a 5-bed increase and still retain its CAH classification. Certain hospitals with swing bed agreements would be able to use up to 25 beds for acute care services at any given time as long as no more than 10 beds were ever used for long-term care services. Such hospitals would not be eligible for the increase in their bed limit for seasonal variations. Starting

Provisions	Current law	H.R. 4954
		with payments made on or after January 1, 2003, eligible CAHs would be able to receive payments made on a PIP basis for inpatient services. Other provisions that would affect CAHs are included.
Extension of the Rural Hospital Flexibility Grant Program	The Rural Hospital Flexibility Grant Program that awards grants to states for certain rural health care planning, implementation and development activities and to hospitals that have applied to be CAHs for certain purposes expires in FY2002.	The provision would extend the grant program which permits annual appropriations from the Medicare's Federal Hospital Insurance Trust Fund of $25 million through FY2007.

Graduate Medical Education Reimbursement

Provisions	Current law	H.R. 4954
Increase in Indirect Medical Education (IME) Adjustment	Medicare makes additional payments to teaching hospitals using an adjustment based on a formula that incorporates the number of residents to beds in the hospital. Currently the IME adjustment is set at 6.5% in FY2002 and 5.5% for FY2003 and subsequently.	This provision would set the IME adjustment at 6% in FY2003, 5.9% in FY2004 and 5.5% for FY2005.
Redistribution of unused resident positions	With certain exceptions, Medicare limits the total number of residents in a hospital's approved teaching programs that are reimbursed based on the number that were reported by the hospital in its cost reporting period ending on or before December 31, 1996. The cap is calculated as a 3-year rolling average, that is, the resident count will be based on the average of the resident count in the current year and the 2 preceding years.	Starting in January 1, 2003, if a teaching hospital's resident reference level (or the number of residents at the hospital in a given time period) is less than its applicable resident limit, its total number of Medicare-reimbursed resident positions would be reduced by 75% of the difference. The resident reference level would be the highest number of allopathic and osteopathic resident position (before the application of any weighting factors) for the hospital during the reference period. The Secretary would be authorized to increase the resident limits by an aggregate number that does not exceed the overall reduction in such limits. The Secretary would first distribute the increased residents to programs in hospital located in rural areas and hospitals in smaller urban areas on a first-come-first-served basis with certain restrictions. No more than 25 positions would be given to any hospitals and would be reimbursed at the locality adjusted national average per resident amount. Reductions in residents

Provisions	Current law	H.R. 4954
		would affect a hospital's IME adjustment, but increased counts would not affect a hospital's IME adjustment.
Extension of update limitation on high cost programs	Medicare pays hospitals for its share of direct graduate medical education (DGME) costs in approved programs. Hospitals with per resident amounts (PRA) above 140% of an adjusted national average amount had payments frozen for FY2001 and FY2002, and would receive a limited update in FY2003-FY2005.	Hospitals with PRAs above 140% of the geographically adjusted national average amount in FY2001 or FY2002 would receive those amounts through FY2012.

Skilled Nursing Facilities (SNFs)

Provisions	Current law	H.R. 4954
Payments	Medicare uses a system of daily rates to pay for care in a SNF. There are 44 daily rate categories, known as resource utilization groups (RUGS). BIPA 2000 increased the skilled nursing care component of each RUG (for the April 2000 - September 2002 period) by 16.66% over and above the RUG rates for SNF care as specified in the July 2000 regulations, and subsequently updated.	The bill would provide for an the increase in the nursing component of each RUG, over and above the rates specified in the final rule published July 2000, and subsequently updated, of 12% in FY2003, 10% in FY2004, and 8% in FY2005.

Hospice

Provisions	Current law	H.R. 4954
Payments	Medicare pays for hospice care for terminally ill beneficiaries at daily rates that differ depending on the level of care, i.e., routine home care, continuous home care, inpatient respite care, and general inpatient care.	The Medicare daily payment rate for hospice care furnished in a frontier area would be increased by 10% for services furnished on or after January 1, 2003, and before January 1, 2008.

Home Health

Provisions	Current law	H.R. 4954
Payments	In the first year of the home health PPS (FY2001), payments to home health agencies were to be calculated so that, in that year, Medicare total spending for home health care would be the same as it would have been had	The adjustment to PPS rates based on the 15% reduction in the per visit and per beneficiary limits would be eliminated.

Provisions	Current law	H.R. 4954
	the previous payment system remained in effect, but with the cost of the previous system calculated to include a 15% cut to limits on payments per visit and per beneficiary. However, Congress postponed the adjustment to PPS rates based on the 15% cut to October 1, 2002.	
Payment updates	Home health PPS amounts are updated annually by the increase in the home health market basket index minus 1.1 percentage points in FY2002 and FY2003 and by the full increase in the market basket index in subsequent years.	The implementation updates to the home health PPS amounts would be changed from the start of a fiscal year to the start of a calendar year. Payments would be increased by 2.0 percentage points for 2003; by 1.1 percentage points for 2004; and by 2.7percentage points for 2005.
Outcome and Assessment Information Set (OASIS)	BBA 97 authorized the Secretary to require all home health agencies to submit information that the Secretary considered necessary for development of a reliable case mix system. The Secretary has implemented OASIS; agencies are required to collect OASIS data and report information to their state survey agency.	The Secretary would be required to establish and appoint a task force, the OASIS Task Force, to examine the data collection and reporting requirements under OASIS.

Physicians

Provisions	Current law	H.R. 4954
Payments	Medicare pays for services of physicians and certain non-physician practitioners on the basis of a fee schedule. The fee schedule assigns relative values to services which are adjusted for geographic variations in costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor. The conversion factor for 2002 dropped 5.4% from the 2001 amount; updates for the next several years are also projected to be negative. The law provides a formula for calculating the annual update to the conversion factor. Several factors enter into the calculation of the formula including: 1) the sustainable growth rate (SGR), which is essentially a target for Medicare spending growth for physicians' services; and 2) the Medicare economic index (MEI),	For 2003, the update to the conversion factor would be set at 2%. The calculation for 2004 and 2005 would be modified, thereby making it less likely that physician spending would reach levels that would trigger reductions in the conversion factor. When calculating the update adjustment factor for 2004 and 2005, actual 2002 spending data would be used as the measure of allowable costs for 2002. In addition, spending from January 1, 2002, rather than April 1, 1996 would be used as the beginning date for calculating the base period for the SGR calculation. The provision would also modify the formula for calculating the sustainable growth rate. For 2003, 2004, and 2005, 1 percentage point would be added to the GDP factor. The provision would also make a permanent

Provisions	Current law	H.R. 4954
	which measures inflation in the inputs needed to produce physicians' services; and 3) an adjustment that modifies the update, which would otherwise be allowable by the MEI, to bring spending in line with the SGR target. The fee schedule update reflects the success or failure in meeting the target. If expenditures exceed the target, the update for a future year is reduced. One component of the SGR is the gross domestic product (GDP)	change in the computation of the GDP, beginning for 2002. It would replace the current factor which measures the 1-year change from the preceding year with the annual average change over the preceding 10 years.
Studies	No provision	GAO would be required to: 1) conduct a study on access of beneficiaries to physicians' services; and 2) conduct a study on geographic differences in the physician fee schedule.

Durable Medical Equipment (DME)

Provisions	Current law	H.R. 4954
Competitive acquisition	BBA 97 authorized the Secretary to conduct up to five demonstration projects to test competitive bidding as a way for Medicare to price and pay for Part B services other than physician services. Medicare has implemented competitive bidding demonstrations for durable medical equipment, prosthetics, orthotics, and supplies.	The provision would replace the current demonstration authority. It would require the Secretary to establish and implement programs under which competitive acquisition areas were established throughout the U.S. The areas could differ for different items and services. The programs would be phased-in over a period of not longer than 3 years with competition under the programs occurring in at least one-third of the areas in 2004 and at least two-thirds of the areas in 2005. Items and services covered under the programs would be: 1) DME paid for by Medicare (except for products used in infusion) and inhalation drugs used in connection with DME; and 2) "off-the-shelf orthotics." The Secretary would be required to conduct a competition among entities supplying covered items and services for each competitive acquisition area in which the program was implemented for such items and services. The Secretary would award contracts to more than one entity submitting a bid in each area for an item or service. Payments could not be made for services provided by a contractor in a

Provisions	Current law	H.R. 4954
		competition area unless the contractor had submitted a bid and the Secretary had awarded a contract to the entity.

Ambulance Services

Provisions	Current law	H.R. 4954
Payments	BBA 97 provided for the phase-in of a national fee schedule. The fee schedule became effective April 1, 2002. By regulation, it is to be phased-in over the April 2002-January 2006 period. Under the phase-in schedule, a gradually decreasing portion of the payment is based on the previously existing payment methodology (reasonable charges or reasonable costs) and a gradually increasing percentage on the national fee schedule. In 2002, the blend is 80% of existing payments and 20% of the fee schedule. The blend is 60%/40% in 2003, 40%/60% in 2004, and 20%/80% in 2005. Beginning in 2006, the payment is to be based entirely on the fee schedule.	The provision would substitute a new phase-in methodology and lengthen the phase-in schedule. The phase-in calculation would be based on a blend of the national fee schedule and a regional fee schedule. The regional fee schedule would be established by the Secretary for each of the nine census regions using the methodology used for calculating the regional conversion factor and regional mileage rate used for the national fee schedule. It would also use the same payment adjustments and the same relative value units as used for the national fee schedule. In 2003, the blended rate would be based 20% on the national fee schedule and 80% on the regional fee schedule. The blend would be 40%/60% in 2004, 60%/40% in 2005, and 80%/20% in 2006. Beginning in 2007, the payment would be based entirely on the national fee schedule. Payments for trips above 50 miles would be increased by at least one-quarter of the amount otherwise established under the fee schedule.

Physical and Occupational Therapy

Provisions	Current law	H.R. 4954
Therapy caps	BBA 97 established annual payment limits for all outpatient therapy services provided by non-hospital providers. There were two per beneficiary limits. The first was a $1,500 per beneficiary annual cap for all outpatient physical therapy services and speech language pathology services. The second was a $1,500 per beneficiary annual cap for all outpatient occupational therapy services. BBRA 99 suspended application of the	Application of the therapy caps would be suspended for an additional 2 years through 2004.

Provisions	Current law	H.R. 4954
	therapy limits in 2000 and 2001. BIPA extended the suspension through 2002.	

Renal

Provisions	Current law	H.R. 4954
Payments	Dialysis facilities providing care to beneficiaries with end-stage renal disease (ESRD) receive a fixed prospective payment amount for each dialysis treatment.	The composite rate would be increased 1.2% for services furnished in 2004.

Beneficiaries

Physicals

Provisions	Current law	H.R. 4954
Initial preventive physical	Medicare covers a number of preventive services. However, it does not cover routine physical examinations.	The program would cover an initial preventive physical examination provided by a physician for persons first covered under Part B on or after January 1, 2004. Covered services would be physicians services, excluding clinical laboratory tests. The exam would be covered if performed within the first 6 months of Part B coverage. The Part B deductible and coinsurance would be waived for initial preventive physical exams.

Part B Premiums

Provisions	Current Law	H.R. 4954
Part B Premiums	Beneficiaries who delay enrollment ion Part B after their initial enrollment period are subject to a late enrollment period.	Military retirees and their dependents over age 65 who delayed enrollment in Part B would not be subject to a late enrollment penalty if they enrolled in Part B in 2001, 2002, or 2003. The provision would apply to premiums beginning January 2003.

New Administrative Entity

Medicare Benefits Administration

Provisions	Current law	H.R. 4954
Establishment of a new agency within Health and Human Services (HHS)	Medicare's administrative structure is not specified in statute. Currently, the Centers for Medicare and Medicaid Services has responsibility for administering the Medicare Program.	An agency, the Medicare Benefits Administration (MBA), would be established within HHS to administer Parts C and D of Medicare (the Medicare+Choice and the prescription drug programs). The Secretary would ensure appropriate coordination between the Administrators of MBA and CMS.
Specified positions and divisions within the MBA	Certain provisions require that (1) the Administrator of the Health Care Financing Administration (HCFA, now known as CMS) be appointed by the President with the advice and consent of the Senate and be paid at level III of the Executive Schedule and (2) the HCFA administrator appoint a Chief Actuary who reports directly to such administrator and is paid at the highest rate of basic pay for the Senior Executive Service.	The MBA would be headed by an Administrator appointed by the President with the advice and consent of the Senate for a 5-year term. The MBA would also have a Deputy Administrator and a Chief Actuary with certain responsibilities. The Secretary would be required to establish an Office of Beneficiary Assistance as a separate operating division within the MBA.
Exemptions from certain federal personnel requirements	No provision	The MBA Administrator would be able to hire employees without regard to certain laws relating to hiring of federal personnel and other employment matters with the approval of the Secretary. This staff would be paid without regard certain laws relating to classification and pay schedules. There is a restriction on the number of employees that could be hired.
Medicare Policy Advisory Board	No provision	A Medicare Policy Advisory Board would be established within the MBA to advise, consult with, and make recommendations to the MBA Administrator with respect to Parts C and D.

Administrative and Procedural Changes

Changes to Issuing Regulations

Provisions	Current law	H.R. 4954
Issuance of regulations	The Secretary is required to prescribe regulations that are necessary to administer Parts A, B and C of the Medicare program.	The Secretary would be required to issue proposed, final and interim final regulations on one business day of every month except under certain limited circumstances.
Regular timeline for publication of final rules	The Secretary must publish a proposed regulation in the *Federal Register*, with at least 60 days to solicit public comment, before issuing the final regulation with certain exceptions. The Secretary must publish in the *Federal Register* no less frequently than every 3 months a list of all manual instructions, interpretative rules, statements of policy, and guidelines which are promulgated to carry out Medicare's law.	The Secretary would be required, in consultation with OMB, to establish and publish a regular timeline for the publication of final regulations. Timelines would vary depending upon regulatory complexity and the scope of public comments, but would not be longer than 3 years except under exceptional circumstances.

Changes to Medicare's Claims Processing Contracts

Provisions	Current law	H.R. 4954
Eligible entities	The Secretary is required to contract with certain entities to process and pay Medicare claims.	Section 1874A would be added to the Social Security Act to permit the Secretary to enter into contracts with any eligible entity to serve as a Medicare administrative contractor.
Contracting requirements	Certain terms and conditions of the contracting agreements for FIs and carriers are specified in the Medicare statute. Medicare regulations coupled with long-standing agency practices have further limited the way that contracts for claims administration services can be established.	The Secretary would use competitive procedures when entering into such a Medicare contract, taking into account performance quality as well as price and other factors. The Secretary would provide incentives to provide quality service and to promote efficiency.

Changes in Medicare's Appeal Processes

Provisions	Current law	H.R. 4954
Transfer Administrative Law Judges (ALJs) from Social Security Administration (SSA) to Health and Human Services (HHS)	Medicare beneficiaries and, in certain circumstances, providers and suppliers of health care services may appeal claims that are denied or payments that are reduced. A hearing by an administrative law judge (ALJ) in the Social Security Administration (SSA) with review by the Department Appeals Board (DAB) are components of the administrative appeals process.	By October 1, 2003, the Commissioner of SSA and the Secretary would develop and transmit to Congress a plan to transfer the functions of the administrative law judges (ALJs) who are responsible for hearing Medicare and Medicare related cases from SSA to HHS. ALJ functions would be transferred no earlier than July 1, 2004 and no later than October 1, 2004.
Expedited access to judicial review	Section 521 of BIPA (which is not yet implemented) amends Section 1869 to establish deadlines for filing appeals and for making decisions in the Medicare appeals process. In general, administrative appeals must be exhausted prior to judicial review.	The Secretary would establish a process where a provider, supplier, and a beneficiary who has filed an appeal may obtain access to judicial review when a review panel determines, within 60 days of a written request and submission of supporting documentation, that no entity has the authority to decide the question of law or regulation and where material facts are not in dispute. The decision would not be subject to review by the Secretary. These provisions would apply to appeals filed on or after October 1, 2003

Provider Education Changes

Provisions	Current law	H.R. 4954
Provider education activities	Medicare's provider education activities are funded through the program management appropriation and through Education and Training component of the Medicare Integrity Program (MIP). Both claims processing contractors (FIs and carriers) and MIP contractors may undertake provider education activities.	The Secretary would be required to (1) coordinate the educational activities provided through the Medicare administrative and MIP contractors and (2) to implement a methodology to measure the specific claims payment error rates of each contractor.
Communication with providers	No provision	By October 1, 2003, the Secretary and each contractor would be required to maintain an Internet site which provides answers to frequently asked questions in an easily accessible form and other materials. Other contractor requirements with respect to toll-free telephone lines and written responses to written inquiries would also be established.

Provisions	Current law	H.R. 4954
Medicare provider and beneficiary ombudsman	No provision	The Secretary would be required to appoint a Medicare Provider and Beneficiary Ombudsman no later than 1 year from enactment to provide assistance to providers, suppliers, and beneficiaries. The Ombudsman would not advocate any payment increases or coverage changes but may identify related issues and problems with payment and coverage policies.

Changes in Medicare's Provider Audit and Overpayment Recovery Processes

Provisions	Current law	H.R. 4954
Prepayment review	No provision.	No later than a year from enactment, Medicare contractors would be permitted to conduct random prepayment reviews in accordance with standard protocol developed by the Secretary. Non-random payment reviews would be permitted only under certain circumstances.
Recovering overpayments	No provision.	Repayment plans would be established under certain circumstances when repayment would cause hardship. Use of extrapolation to establish overpayment amounts would be subject to limits. Requirements for the consent settlement process would be established.
Protection for providers who rely on erroneous guidance	No provision	Providers and suppliers who follow written guidance (which may be transmitted electronically) from the Secretary or Medicare contractors would not be subject to any sanction under certain circumstances.