upon request, a manufacturer with a hearing concerning such a termination, but such hearing shall not delay the effective date of the termination. Failure of a State to provide any advance notice of such a termination as required by regulation shall not affect the State's right to terminate coverage of the drugs affected by such termination as of the effective date of such termination.

"(ii) BY A MANUFACTURER.—A manufacturer may terminate its participation in the master rebate agreement under this section for any reason. Any such termination shall not be effective until the calendar quarter beginning at least 60 days after the date the manufacturer provides notice to the Secretary.

"(iii) EFFECTIVENESS OF TERMINATION.—Any termination under this subparagraph shall not affect rebates due under the agreement before the effective date of its termination.

"(iv) NOTICE TO STATES.—In the case of a termination under this subparagraph, the Secretary shall provide notice of such termination to the States within not less than 30 days before the effective date of such termination.

"(v) APPLICATION TO TERMINATIONS OF OTHER AGREEMENTS.—The provisions of this subparagraph shall apply to the terminations of master agreements described in section 8126(a) of title 38, United States Code.

"(C) DELAY BEFORE REENTRY.—In the case of any rebate agreement with a manufacturer under this section which is terminated, another such agreement with the manufacturer (or a successor manufacturer) may not be entered into until a period of 1 calendar quarter has elapsed since the date of the termination.

unless the Secretary finds good cause for an earlier reinstatement of such an agreement.

"(5) SETTLEMENT OF DISPUTES.—

"(A) SECRETARY.—The Secretary shall have the authority to resolve, settle, and compromise disputes regarding the amounts of rebates owed under this section and section 1927.

"(B) STATE.—Each State, with respect to covered outpatient drugs paid for under the State's State plan, shall have authority, independent of the Secretary's authority under subparagraph (A), to resolve, settle, and compromise disputes regarding the amounts of rebates owed under this section. Any such action shall be deemed to comply with the requirements of this title, and such covered outpatient drugs shall be eligible for payment under the State plan under this title.

"(C) AMOUNT OF REBATE.—The Secretary shall limit the amount of the rebate payable in any case in which the Secretary determines that, because of unusual circumstances or questionable data, the provisions of subsection (c) result in a rebate amount that is inequitable or otherwise inconsistent with the purposes of this section.

"(c) DETERMINATION OF AMOUNT OF REBATE.—

"(1) BASIC REBATE FOR SINGLE SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE DRUGS.—

"(A) IN GENERAL.—Except as provided in paragraph (2), the amount of the rebate specified in this subsection with respect to a State participating in the master rebate agreement for a rebate period (as defined in subsection (i)(7)) with respect to each dosage form and strength of a single source drug or an innovator multiple source drug shall be equal to the product of—

"(i) the total number of units of each dosage form and strength paid for under the State plan in the rebate period (as reported by the State); and

"(ii) the greater of—

"(I) the difference between the average manufacturer price and the best price (as defined in subparagraph (C)) for the dosage form and strength of the drug, or

"(II) the minimum rebate percentage (specified in subparagraph (B)) of such average manufacturer price,

for the rebate period.

"(B) MINIMUM REBATE PERCENTAGE.—For purposes of subparagraph (A)(ii)(II), the 'minimum rebate percentage' is 15 percent.

"(C) BEST PRICE DEFINED.—For purposes of this section—

"(i) IN GENERAL.—The term 'best price' means, with respect to a single source drug or innovator multiple source drug of a manufacturer, the lowest price available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the United States, excluding—

"(I) any prices charged on or after October 1, 1992, to the Indian Health Service, the Department of Veterans Affairs, a State home receiving funds under section 1741 of title 38, United States Code, the Department of Defense, the Public Health Service, or a covered entity described in section 340B(a)(4) of the Public Health Service Act,

"(II) any prices charged under the Federal Supply Schedule of the General Services Administration,

"(III) any prices used under a State pharmaceutical assistance program, and

"(IV) any depot prices and single award contract prices, as defined by the Secretary, of any agency of the Federal Government.

"(ii) SPECIAL RULES.—The term 'best price'—

"(I) shall be inclusive of cash discounts, free goods that are contingent on any purchase requirement, volume discounts, and rebates (other than rebates under this section),

"(II) shall be determined without regard to special packaging, labeling, or identifiers on the dosage form or product or package,

"(III) shall not take into account prices that are merely nominal in amount, and

"(IV) shall exclude rebates paid under this section or any other rebates paid to a State participating in the master rebate agreement.

"(2) ADDITIONAL REBATE FOR SINGLE SOURCE AND INNOVATOR MULTIPLE SOURCE DRUGS.—

"(A) IN GENERAL.—The amount of the rebate specified in this subsection with respect to a State participating in the master rebate agreement for a rebate period, with respect to each dosage form and strength of a single source drug or an innovator multiple source drug, shall be increased by an amount equal to the product of—

"(i) the total number of units of such dosage form and strength dispensed after December 31, 1990, for which payment was made under the State plan for the rebate period; and

"(ii) the amount (if any) by which—

"(I) the average manufacturer price for the dosage form and strength of the drug for the period, exceeds

"(II) the average manufacturer price for such dosage form and strength for the calendar quarter beginning July 1, 1990 (without regard to whether or not the drug has been sold or transferred to an entity, including a division or subsidiary of the manufacturer, after the first day of such quarter), increased by the percentage by which the Consumer Price Index for All Urban Consumers (United States city average) for the month before the month in which the rebate period begins exceeds such index for September 1990.

"(B) TREATMENT OF SUBSEQUENTLY APPROVED DRUGS.—In the case of a covered outpatient drug approved by the Food and Drug Administration after October 1, 1990, clause (ii)(II) of subparagraph (A) shall be applied by substituting 'the first full calendar quarter after the day on which the drug was first marketed' for 'the calendar quarter beginning July 1, 1990' and 'the month prior to the first month of the first full calendar quarter after the day on which the drug was first marketed' for 'September 1990'.

"(3) REBATE FOR OTHER DRUGS.—

"(A) IN GENERAL.—The amount of the rebate paid to a State participating in the master rebate agreement for a rebate period with respect to each dosage form and strength of covered outpatient drugs (other than single source drugs and innovator multiple source drugs) shall be equal to the product of—

"(i) the applicable percentage (as described in subparagraph (B)) of the average manufacturer price for the dosage form and strength for the rebate period, and

"(ii) the total number of units of such dosage form and strength dispensed after December 31,

1990, for which payment was made under the State plan for the rebate period.

"(B) APPLICABLE PERCENTAGE DEFINED.—For purposes of subparagraph (A)(i), the 'applicable percentage' is 11 percent.

"(4) LIMITATION ON AMOUNT OF REBATE TO AMOUNTS PAID FOR CERTAIN DRUGS.—

"(A) IN GENERAL.—Upon request of the manufacturer of a covered outpatient drug, the Secretary shall limit, in accordance with subparagraph (B), the amount of the rebate under this subsection with respect to a dosage form and strength of such drug if the majority of the estimated number of units of such dosage form and strength that are subject to rebates under this section were dispensed to inpatients of nursing facilities.

"(B) AMOUNT OF REBATE.—In the case of a covered outpatient drug subject to subparagraph (A), the amount of the rebate specified in this subsection for a rebate period, with respect to each dosage form and strength of such drug, shall not exceed the amount paid under the State plan with respect to such dosage form and strength of the drug in the rebate period (without consideration of any dispensing fees paid).

"(5) SUPPLEMENTAL REBATES PROHIBITED.—No rebates shall be required to be paid by manufacturers with respect to covered outpatient drugs furnished to individuals in any State that provides for the collection of such rebates in excess of the rebate amount payable under this section.

"(d) LIMITATIONS ON COVERAGE OF DRUGS BY STATES PARTICIPATING IN MASTER AGREEMENT.—

"(1) PERMISSIBLE RESTRICTIONS.—A State participating in the master rebate agreement under this section may—

"(A) subject to prior authorization under its State plan any covered outpatient drug so long as any such

prior authorization program complies with the requirements of paragraph (5); and

"(B) exclude or otherwise restrict coverage under its plan of a covered outpatient drug if—

"(i) the drug is contained in the list referred to in paragraph (2);

"(ii) the drug is subject to such restrictions pursuant to the master rebate agreement or any agreement described in subsection (a)(4); or

"(iii) the State has excluded coverage of the drug from its formulary established in accordance with paragraph (4).

"(2) LIST OF DRUGS SUBJECT TO RESTRICTION.—The following drugs or classes of drugs, or their medical uses, may be excluded from coverage or otherwise restricted by a State participating in the master rebate agreement:

"(A) Agents when used for anorexia, weight loss, or weight gain.

"(B) Agents when used to promote fertility.

"(C) Agents when used for cosmetic purposes or hair growth.

"(D) Agents when used for the symptomatic relief of cough and colds.

"(E) Agents when used to promote smoking cessation.

"(F) Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.

"(G) Nonprescription drugs.

"(H) Covered outpatient drugs which the manufacturer seeks to require as a condition of sale that associated tests or monitoring services be purchased exclusively from the manufacturer or its designee.

"(I) Barbiturates.

"(J) Benzodiazepines.

"(3) ADDITIONS TO DRUG LISTINGS.—The Secretary shall, by regulation, periodically update the list of drugs or

classes of drugs described in paragraph (2), or their medical uses, which the Secretary has determined to be subject to clinical abuse or inappropriate use.

"(4) REQUIREMENTS FOR FORMULARIES.—A State participating in the master rebate agreement may establish a formulary if the formulary meets the following requirements:

"(A) The formulary is developed by a committee consisting of physicians, pharmacists, and other appropriate individuals appointed by the Governor of the State.

"(B) Except as provided in subparagraph (C), the formulary includes the covered outpatient drugs of any manufacturer which has entered into and complies with the agreement under subsection (a) (other than any drug excluded from coverage or otherwise restricted under paragraph (2)).

"(C) A covered outpatient drug may be excluded with respect to the treatment of a specific disease or condition for an identified population (if any) only if, based on the drug's labeling (or, in the case of a drug the prescribed use of which is not approved under the Federal Food, Drug, and Cosmetic Act but is a medically accepted indication, based on information from the appropriate compendia described in subsection (i)(5)), the excluded drug does not have a significant, clinically meaningful therapeutic advantage in terms of safety, effectiveness, or clinical outcome of such treatment for such population over other drugs included in the formulary and there is a written explanation (available to the public) of the basis for the exclusion.

"(D) The State plan permits coverage of a drug excluded from the formulary (other than any drug excluded from coverage or otherwise restricted under paragraph (2)) pursuant to a prior authorization program that is consistent with paragraph (5).

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

A prior authorization program established by a State under paragraph (5) is not a formulary subject to the requirements of this paragraph.

"(5) REQUIREMENTS OF PRIOR AUTHORIZATION PROGRAMS.—The State plan of a State participating in the master rebate agreement may require, as a condition of coverage or payment for a covered outpatient drug for which Federal financial participation is available in accordance with this section, the approval of the drug before its dispensing for any medically accepted indication (as defined in subsection (i)(5)) only if the system providing for such approval—

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

"(B) except with respect to the drugs on the list referred to in paragraph (2), provides for the dispensing of at least a 72-hour supply of a covered outpatient prescription drug in an emergency situation (as defined by the Secretary).

"(6) OTHER PERMISSIBLE RESTRICTIONS.—A State participating in the master rebate agreement may impose limitations, with respect to all such drugs in a therapeutic class, on the minimum or maximum quantities per prescription or on the number of refills, if such limitations are necessary to discourage waste, and may address instances of fraud or abuse by individuals in any manner authorized under this Act.

"(e) DRUG USE REVIEW.—

"(1) IN GENERAL.—A State participating in the master rebate agreement may provide for a drug use review program to educate physicians and pharmacists to identify

and reduce the frequency of patterns of fraud, abuse, gross overuse, or inappropriate or medically unnecessary care, among physicians, pharmacists, and patients, or associated with specific drugs or groups of drugs, as well as potential and actual severe adverse reactions to drugs.

"(2) APPLICATION OF STATE STANDARDS.—A State with a drug use review program under this subsection shall establish and operate the program under such standards as it may establish.

"(f) ELECTRONIC CLAIMS MANAGEMENT.—In accordance with chapter 35 of title 44, United States Code (relating to coordination of Federal information policy), the Secretary shall encourage each State to establish, as its principal means of processing claims for covered outpatient drugs under its State plan, a point-of-sale electronic claims management system, for the purpose of performing on-line, real time eligibility verifications, claims data capture, adjudication of claims, and assisting pharmacists (and other authorized persons) in applying for and receiving payment.

"(g) ANNUAL REPORT.—

"(1) IN GENERAL.—Not later than May 1 of each year, the Secretary shall transmit to the Committee on Finance of the Senate, and the Committee on Commerce of the House of Representatives, a report on the operation of this section in the preceding fiscal year.

"(2) DETAILS.—Each report shall include information on—

"(A) ingredient costs paid under this title for single source drugs, multiple source drugs, and nonprescription covered outpatient drugs,

"(B) the total value of rebates received and number of manufacturers providing such rebates,

"(C) the effect of inflation on the value of rebates required under this section,

"(D) trends in prices paid under this title for covered outpatient drugs, and

"(E) Federal and State administrative costs associated with compliance with the provisions of this title.

"(h) EXEMPTION FOR CAPITATED HEALTH CARE ORGANIZATIONS, HOSPITALS, AND CERTAIN NURSING FACILITIES.—

"(1) IN GENERAL.—Except as provided in paragraph (2), the requirements of the master rebate agreement under this section shall not apply with respect to covered outpatient drugs dispensed by or through—

"(A) a capitated health care organization (as defined in section 1504(c)(1)),

"(B) a hospital that dispenses covered outpatient drugs using a drug formulary system and bills the State no more than the hospital's purchasing costs for covered outpatient drugs, or

"(C) a nursing facility which receives payment under this title for health care services, including prescription drugs, on a capitated basis and which dispenses covered outpatient drugs using a drug formulary system.

"(2) CONSTRUCTION IN DETERMINING BEST PRICE.—Nothing in paragraph (1) shall be construed as excluding amounts paid by the entities described in such paragraph for covered outpatient drugs from the determination of the best price (as defined in subsection (c)(1)(C)) for such drugs.

"(i) DEFINITIONS.—In the section—

"(1) AVERAGE MANUFACTURER PRICE.—The term 'average manufacturer price' means, with respect to a covered outpatient drug of a manufacturer for a rebate period, the average price paid to the manufacturer for the drug in the United States by wholesalers for drugs distributed to the retail pharmacy class of trade, after deducting customary prompt pay discounts.

"(2) COVERED OUTPATIENT DRUG.—Subject to the exceptions in paragraph (3), the term 'covered outpatient drug' means—

"(A) of those drugs which are treated as prescribed drugs for purposes of section 1571(a)(8), a drug which may be dispensed only upon prescription (except as provided in subparagraph (D)), and—

"(i) which is approved as a prescription drug under section 505 or 507 of the Federal Food, Drug, and Cosmetic Act;

"(ii)(I) which was commercially used or sold in the United States before the date of the enactment of the Drug Amendments of 1962 or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) which has not been the subject of a final determination by the Secretary that it is a 'new drug' (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act to enforce section 502(f) or 505(a) of such Act; or

"(iii)(I) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a drug, and (II) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such drug under such section because the Secretary has determined that the drug is less than effective for some or all conditions of use prescribed, recommended, or suggested in its labeling;

"(B) a biological product, other than a vaccine which—

"(i) may only be dispensed upon prescription,

"(ii) is licensed under section 351 of the Public Health Service Act, and

"(iii) is produced at an establishment licensed under such section to produce such product;

"(C) insulin certified under section 506 of the Federal Food, Drug, and Cosmetic Act; and

"(D) a drug which may be sold without a prescription (commonly referred to as an 'over-the-counter drug'), if the drug is prescribed by a physician (or other person authorized to prescribe under State law).

"(3) LIMITING DEFINITION.—The term 'covered outpatient drug' does not include any drug, biological product, or insulin provided as part of, or as incident to and in the same setting as, any of the following (and for which payment may be made under a State plan as part of payment for the following and not as direct reimbursement for the drug):

"(A) Inpatient hospital services.

"(B) Hospice services.

"(C) Dental services, except that drugs for which the State plan authorizes direct reimbursement to the dispensing dentist are covered outpatient drugs.

"(D) Physicians' services.

"(E) Outpatient hospital services.

"(F) Nursing facility services and services provided by an intermediate care facility for the mentally retarded.

"(G) Other laboratory and x-ray services.

"(H) Renal dialysis services.

Such term also does not include any such drug or product for which a National Drug Code number is not required by the Food and Drug Administration or a drug or biological product used for a medical indication which is not a medi-

cally accepted indication. Any drug, biological product, or insulin excluded from the definition of such term as a result of this paragraph shall be treated as a covered outpatient drug for purposes of determining the best price (as defined in subsection (c)(1)(C)) for such drug, biological product, or insulin.

"(4) MANUFACTURER.—The term 'manufacturer' means, with respect to a covered outpatient drug, the entity holding legal title to or possession of the National Drug Code number for such drug.

"(5) MEDICALLY ACCEPTED INDICATION.—The term 'medically accepted indication' means any use for a covered outpatient drug which is approved under the Federal Food, Drug, and Cosmetic Act, or the use of which is supported by one or more citations included or approved for inclusion in any of the following compendia:

"(A) American Hospital Formulary Service Drug Information.

"(B) United States Pharmacopeia-Drug Information.

"(C) American Medical Association Drug Evaluations.

"(D) The DRUGDEX Information System.

"(E) The peer-reviewed medical literature.

"(6) MULTIPLE SOURCE DRUG; INNOVATOR MULTIPLE SOURCE DRUG; NONINNOVATOR MULTIPLE SOURCE DRUG; SINGLE SOURCE DRUG.—

"(A) DEFINED.—

"(i) MULTIPLE SOURCE DRUG.—The term 'multiple source drug' means, with respect to a rebate period, a covered outpatient drug (not including any drug described in paragraph (2)(D)) for which there are 2 or more drug products which—

"(I) are rated as therapeutically equivalent (under the Food and Drug Administration's most recent publication of 'Approved Drug

Products with Therapeutic Equivalence Evaluations'),

"(II) except as provided in subparagraph (B), are pharmaceutically equivalent and bioequivalent, as defined in subparagraph (C) and as determined by the Food and Drug Administration, and

"(III) are sold or marketed in the State during the period.

"(ii) INNOVATOR MULTIPLE SOURCE DRUG.—The term 'innovator multiple source drug' means a multiple source drug that was originally marketed under an original new drug application or product licensing application approved by the Food and Drug Administration.

"(iii) NONINNOVATOR MULTIPLE SOURCE DRUG.—The term 'noninnovator multiple source drug' means a multiple source drug that is not an innovator multiple source drug.

"(iv) SINGLE SOURCE DRUG.—The term 'single source drug' means a covered outpatient drug (other than a drug described in subparagraph (C) or (D) of paragraph (2)) which is produced or distributed under an original new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application or product licensing application.

"(B) EXCEPTION.—Subparagraph (A)(i)(II) shall not apply if the Food and Drug Administration changes by regulation the requirement that, for purposes of the publication described in subparagraph (A)(i)(I), in order for drug products to be rated as therapeutically equivalent, they must be pharmaceuti-

cally equivalent and bioequivalent, as defined in subparagraph (C).

"(C) DEFINITIONS.—For purposes of this paragraph—

"(i) drug products are pharmaceutically equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form and meet compendial or other applicable standards of strength, quality, purity, and identity,

"(ii) drugs are bioequivalent if they do not present a known or potential bioequivalence problem, or, if they do present such a problem, they are shown to meet an appropriate standard of bioequivalence, and

"(iii) a drug product is considered to be sold or marketed in a State if it appears in a published national listing of average wholesale prices selected by the Secretary, if the listed product is generally available to the public through retail pharmacies in that State.

"(7) REBATE PERIOD.—The term 'rebate period' means, with respect to an agreement under subsection (a), a calendar quarter or other period specified by the Secretary with respect to the payment of rebates under such agreement.".

SEC. 2004. STATE ELECTION; TERMINATION OF CURRENT PROGRAM; AND TRANSITION.

(a) TERMINATION OF CURRENT PROGRAM; LIMITATION ON MEDICAID PAYMENTS IN FISCAL YEAR 1997.—

(1) REPEAL OF TITLE.—Title XIX of the Social Security Act is repealed effective October 1, 1997, except that the repeal of section 1928 of such Act is effective on the date of the enactment of this Act and the succeeding two sections of such title shall be effective during fiscal year 1996 in the same manner and to the same extent as such sections were effective during fiscal year 1995.

(2) LIMITATION ON OBLIGATION AUTHORITY.—Notwithstanding any other provision of such title—

(A) FISCAL YEAR 1997.—Subject to subparagraph (B), the Secretary of Health and Human Services (in this section referred to as the "Secretary") may enter into obligations under such title with any State (as defined for purposes of such title) for expenses incurred during fiscal year 1997, but not in excess of the sum determined under clauses (i), (ii) and (iv) of section 1511(a)(2)(A) of the Social Security Act (as added by section 2) for that State for fiscal year 1997.

(B) NONE AFTER EFFECTIVE DATE.—The Secretary is not authorized to enter into any obligation with any State under title XIX of such Act for expenses incurred on or after the earlier of—

(i) October 1, 1997, or

(ii) the first day of the first quarter on which the State plan under title XV of such Act (as added by section 2) is first effective.

(C) AGREEMENT.—A State's submission of claims for payment under section 1903 of such Act on or after October 1, 1996, is deemed to constitute the State's acceptance of the obligation limitation under subparagraph (A) (including the formula for computing the amount of such obligation limitation).

(D) EFFECT ON MEDICAL ASSISTANCE.—Effective October 1, 1996—

(i) except as provided in this paragraph, the Federal Government has no obligation to provide payment with respect to items and services provided under title XIX of the Social Security Act, and

(ii) such title and title XV of such Act shall not be construed as providing for an entitlement, under Federal law in relation to the Federal Government, in an individual or person (including any

provider) at the time of provision or receipt of services.

(3) REQUIREMENT FOR TIMELY SUBMITTAL OF CLAIMS.—No payment shall be made to a State under title XIX of such Act with respect to an obligation incurred before October 1, 1996, unless the State has submitted to the Secretary, by not later than April 1, 1997, a claim for Federal financial participation for expenses paid by the State with respect to such obligations. Nothing in paragraph (2) shall be construed as affecting the obligation of the Federal Government to pay claims described in the previous sentence.

(b) TRANSITION PROVISIONS.—

(1) Notwithstanding any other provision of law, in the case where payment has been made under section 1903(a) of the Social Security Act to a State before March 1, 1996, and for which a disallowance has not been taken as of such date (or, if so taken, has not been completed, including judicial review, by such date), the Secretary of Health and Human Services shall discontinue the disallowance proceeding and, if such disallowance has been taken as of the date of the enactment of this Act, any payment reductions effected shall be rescinded and the payments returned to the State.

(2) The repeal under subsection (a)(1) of section 1928 of the Social Security Act shall not affect the distribution of vaccines purchased and delivered to the States before the date of the enactment of this Act. No vaccine may be purchased after such date by the Federal Government or any State under any contract under section 1928(d) of the Social Security Act.

(3) No judicial or administrative decision rendered regarding requirements imposed under title XIX of the Social Security Act with respect to a State shall have any application to the State plan of the State under title XV of such Act. A State may, pursuant to the previous sentence, seek

the abrogation or modification of any such decision after the date of termination of the State medicaid plan under title XIX of such Act.

(4) No cause of action under title XIX of the Social Security Act which seeks to require a State to establish or maintain minimum payment rates under such title or claim which seeks reimbursement for any period before the date of the enactment of this Act based on the alleged failure of the State to comply with such title and which has not become final as of such date shall be brought or continued.

(5) Section 6408(a)(3) of the Omnibus Budget Reconciliation Act of 1989 (as amended by section 13642 of the Omnibus Budget Reconciliation Act of 1993) and section 2 of Public Law 102–276 (as amended by section 13644 of the Omnibus Budget Reconciliation Act of 1993) are each amended by striking "December 31, 1995" and inserting "October 1, 1997".

(c) ANTI-FRAUD PROVISIONS.—Section 1128(h)(1) of the Social Security Act (42 U.S.C. 1320a–7(h)(1)) is amended by inserting "or a State plan under title XV" after "title XIX".

(d) TECHNICAL AND CONFORMING AMENDMENTS.—

(1) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 90 days after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation, as appropriate, with heads of other Federal agencies and the States (as defined in section 1101(a)(8) of the Social Security Act for purposes of title XIX of such Act), shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of, and amendments made by, this title.

(2) TRANSITIONAL RULE.—Any reference in any provision of law to title XIX of the Social Security Act or any provision thereof shall be deemed to be a reference to such

title or provision as in effect on the day before the date of the enactment of this Act.

SEC. 2005. INTEGRATION DEMONSTRATION PROJECT.

(a) DESCRIPTION OF PROJECTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") may waive such requirements of titles XVIII and XV of the Social Security Act as may be necessary for States to conduct demonstration projects under this section. Such projects shall demonstrate the manner in which States may use funds from the programs under such titles to develop and implement innovative programs for individuals dually eligible for benefits under both titles, including such individuals who are chronically ill. The Secretary shall grant waivers in a manner that permits States flexibility in contracting with medicare risk providers and other providers for services, oversight of contract administration and quality management, and administration of a single enrollment process. Such a waiver may restrict time period during which project participants may disenroll without cause from capitated health plans under the medicare program.

(2) VOLUNTARY PARTICIPATION.—A State may not require an individual eligible to receive items and services under the medicare and title XV programs to participate in a demonstration project under this section.

(b) BUDGET NEUTRALITY AND REINVESTMENT OF SAVINGS.—

(1) BUDGET NEUTRALITY.—The Secretary shall not approve a demonstration project under this section for a State unless the State demonstrates that the amount of the Federal expenditures under the program will not exceed the amount of the Federal expenditures that would have been made if the project had not been approve.

(2) USE OF SAVINGS.—The Secretary shall permit a State to retain any savings achieved under a project and to use such savings for—

(A) expanding eligibility for low income medicare beneficiaries who are risk of institutionalization and who, if institionalized, are likely to qualify for benefits under title XV of the Social Security Act, and

(B) providing a scope of services under the project that exceeds the scope of services normally covered under such title.

(c) LIMITATION ON NUMBER OF PROJECTS.—Not more than 10 demonstration projects shall be conducted under this section.

(d) DURATION.—

(1) IN GENERAL.—Subject to paragraph (2), a demonstration project conducted under this section shall be conducted for an initial period of 5 years and, upon the request of a State and a finding by the Secretary that the project has been successful, shall be extended indefinitely.

(2) TERMINATION.—The Secretary may, with 90 days' notice, terminate any demonstration project conducted under this section that is not in substantial compliance with the terms of the application approved by the Secretary under this section.

(e) APPLICATIONS.—Each State, or a coalition of States, desiring to conduct a demonstration project under this section shall prepare and submit to the Secretary an application at such time, in such manner, and containing such information as the Secretary may require, including an explanation of a plan for evaluating the project. The Secretary shall approve or deny an application not later than 90 days after the receipt of such application.

(f) PAYMENTS.—For each calendar quarter occurring during a demonstration project conducted under this section, the Secretary shall provide for payments to the State in a manner consistent with subsection (b)(1).

(g) OVERSIGHT.—The Secretary shall establish quality standards for evaluating and monitoring the demonstration projects conducted under this section. Such quality standards

shall include reporting requirements which contain the following:

(1) A description of the demonstration project.

(2) An analysis of beneficiary satisfaction under such project.

(3) An analysis of the quality of the services delivered under the project.

(4) A description of the savings to the medicare and title XV programs as a result of the demonstration project.