

110TH CONGRESS
1ST SESSION

H. R. 3162

[Report No. 110–284, Part I]

To amend titles XVIII, XIX, and XXI of the Social Security Act to extend and improve the children’s health insurance program, to improve beneficiary protections under the Medicare, Medicaid, and the CHIP program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JULY 24, 2007

Mr. DINGELL (for himself, Mr. RANGEL, Mr. STARK, and Mr. PALLONE) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

AUGUST 1 (legislative day, JULY 31), 2007

Additional sponsors: Ms. BALDWIN, Mr. ENGEL, Mr. CUELLAR, Mr. WYNN, Mr. WAXMAN, Ms. HIRONO, Mr. GENE GREEN of Texas, Ms. DEGETTE, and Mr. ALLEN

AUGUST 1 (legislative day, JULY 31), 2007

Reported from the Committee on Ways and Means with an amendment and ordered to be printed

[Strike out all after the enacting clause and insert the part printed in *italie*]

[For text of introduced bill, see copy of bill as introduced on July 24, 2007]

A BILL

To amend titles XVIII, XIX, and XXI of the Social Security Act to extend and improve the children’s health insurance program, to improve beneficiary protections under

the Medicare, Medicaid, and the CHIP program, and for other purposes.

1 *Be it enacted by the Senate and House of Representa-*
 2 *tives of the United States of America in Congress assembled,*

3 **SECTION 1. SHORT TITLE; TABLE OF CONTENTS.**

4 (a) *SHORT TITLE.*—*This Act may be cited as the*
 5 *“Children’s Health and Medicare Protection Act of 2007”.*

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

Sec. 1. Short title; table of contents.

TITLE I—CHILDREN’S HEALTH INSURANCE PROGRAM

Sec. 100. Purpose.

Subtitle A—Funding

Sec. 101. Establishment of new base CHIP allotments.

Sec. 102. 2-year initial availability of CHIP allotments.

Sec. 103. Redistribution of unused allotments to address State funding shortfalls.

Sec. 104. Extension of option for qualifying States.

Subtitle B—Improving Enrollment and Retention of Eligible Children

Sec. 111. CHIP performance bonus payment to offset additional enrollment costs resulting from enrollment and retention efforts.

Sec. 112. State option to rely on findings from an express lane agency to conduct simplified eligibility determinations.

Sec. 113. Application of medicaid outreach procedures to all children and pregnant women.

Sec. 114. Encouraging culturally appropriate enrollment and retention practices.

Subtitle C—Coverage

Sec. 121. Ensuring child-centered coverage.

Sec. 122. Improving benchmark coverage options.

Sec. 123. Premium grace period.

Subtitle D—Populations

Sec. 131. Optional coverage of older children under Medicaid and CHIP.

Sec. 132. Optional coverage of legal immigrants under the Medicaid program and CHIP.

Sec. 133. State option to expand or add coverage of certain pregnant women under CHIP.

Sec. 134. Limitation on waiver authority to cover adults.

Subtitle E—Access

- Sec. 141. Children’s Access, Payment, and Equality Commission.*
- Sec. 142. Model of Interstate coordinated enrollment and coverage process.*
- Sec. 143. Medicaid citizenship documentation requirements.*
- Sec. 144. Access to dental care for children.*
- Sec. 145. Prohibiting initiation of new health opportunity account demonstration programs.*

Subtitle F—Quality and Program Integrity

- Sec. 151. Pediatric health quality measurement program.*
- Sec. 152. Application of certain managed care quality safeguards to CHIP.*
- Sec. 153. Updated Federal evaluation of CHIP.*
- Sec. 154. Access to records for IG and GAO audits and evaluations.*
- Sec. 155. References to title XXI.*
- Sec. 156. Reliance on law; exception for State legislation.*

TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS*Subtitle A—Improvements in Benefits*

- Sec. 201. Coverage and waiver of cost-sharing for preventive services.*
- Sec. 202. Waiver of deductible for colorectal cancer screening tests regardless of coding, subsequent diagnosis, or ancillary tissue removal.*
- Sec. 203. Parity for mental health coinsurance.*

Subtitle B—Improving, Clarifying, and Simplifying Financial Assistance for Low Income Medicare Beneficiaries

- Sec. 211. Improving assets tests for Medicare Savings Program and low-income subsidy program.*
- Sec. 212. Making QI program permanent and expanding eligibility.*
- Sec. 213. Eliminating barriers to enrollment.*
- Sec. 214. Eliminating application of estate recovery.*
- Sec. 215. Elimination of part D cost-sharing for certain non-institutionalized full-benefit dual eligible individuals.*
- Sec. 216. Exemptions from income and resources for determination of eligibility for low-income subsidy.*
- Sec. 217. Cost-sharing protections for low-income subsidy-eligible individuals.*
- Sec. 218. Intelligent assignment in enrollment.*

Subtitle C—Part D Beneficiary Improvements

- Sec. 221. Including costs incurred by AIDS drug assistance programs and Indian Health Service in providing prescription drugs toward the annual out of pocket threshold under Part D.*
- Sec. 222. Permitting mid-year changes in enrollment for formulary changes adversely impact an enrollee.*
- Sec. 223. Removal of exclusion of benzodiazepines from required coverage under the Medicare prescription drug program.*
- Sec. 224. Permitting updating drug compendia under part D using part B update process.*
- Sec. 225. Codification of special protections for six protected drug classifications.*
- Sec. 226. Elimination of Medicare part D late enrollment penalties paid by low-income subsidy-eligible individuals.*
- Sec. 227. Special enrollment period for subsidy eligible individuals.*

Subtitle D—Reducing Health Disparities

- Sec. 231. Medicare data on race, ethnicity, and primary language.*
Sec. 232. Ensuring effective communication in Medicare.
Sec. 233. Demonstration to promote access for Medicare beneficiaries with limited English proficiency by providing reimbursement for culturally and linguistically appropriate services.
Sec. 234. Demonstration to improve care to previously uninsured.
Sec. 235. Office of the Inspector General report on compliance with and enforcement of national standards on culturally and linguistically appropriate services (CLAS) in Medicare.
Sec. 236. IOM report on impact of language access services.
Sec. 237. Definitions.

TITLE III—PHYSICIANS’ SERVICE PAYMENT REFORM

- Sec. 301. Establishment of separate target growth rates for service categories.*
Sec. 302. Improving accuracy of relative values under the Medicare physician fee schedule.
Sec. 303. Feedback mechanism on practice patterns.
Sec. 304. Payments for efficient areas.
Sec. 305. Recommendations on refining the physician fee schedule.
Sec. 306. Improved and expanded medical home demonstration project.
Sec. 307. Repeal of Physician Assistance and Quality Initiative Fund.
Sec. 308. Adjustment to Medicare payment localities.
Sec. 309. Payment for imaging services.
Sec. 310. Reducing frequency of meetings of the Practicing Physicians Advisory Council.

*TITLE IV—MEDICARE ADVANTAGE REFORMS**Subtitle A—Payment Reform*

- Sec. 401. Equalizing payments between Medicare Advantage plans and fee-for-service Medicare.*

Subtitle B—Beneficiary Protections

- Sec. 411. NAIC development of marketing, advertising, and related protections.*
Sec. 412. Limitation on out-of-pocket costs for individual health services.
Sec. 413. MA plan enrollment modifications.
Sec. 414. Information for beneficiaries on MA plan administrative costs.

Subtitle C—Quality and Other Provisions

- Sec. 421. Requiring all MA plans to meet equal standards.*
Sec. 422. Development of new quality reporting measures on racial disparities.
Sec. 423. Strengthening audit authority.
Sec. 424. Improving risk adjustment for MA payments.
Sec. 425. Eliminating special treatment of private fee-for-service plans.
Sec. 426. Renaming of Medicare Advantage program.

Subtitle D—Extension of Authorities

- Sec. 431. Extension and revision of authority for special needs plans (SNPs).*
Sec. 432. Extension and revision of authority for Medicare reasonable cost contracts.

TITLE V—PROVISIONS RELATING TO MEDICARE PART A

- Sec. 501. Inpatient hospital payment updates.*
Sec. 502. Payment for inpatient rehabilitation facility (IRF) services.
Sec. 503. Long-term care hospitals.
Sec. 504. Increasing the DSH adjustment cap.
Sec. 505. PPS-exempt cancer hospitals.
Sec. 506. Skilled nursing facility payment update.
Sec. 507. Revocation of unique deeming authority of the Joint Commission for the Accreditation of Healthcare Organizations.
Sec. 508. Treatment of Medicare hospital reclassifications.
Sec. 509. Medicare critical access hospital designations.

TITLE VI—OTHER PROVISIONS RELATING TO MEDICARE PART B

Subtitle A—Payment and Coverage Improvements

- Sec. 601. Payment for therapy services.*
Sec. 602. Medicare separate definition of outpatient speech-language pathology services.
Sec. 603. Increased reimbursement rate for certified nurse-midwives.
Sec. 604. Adjustment in outpatient hospital fee schedule increase factor.
Sec. 605. Exception to 60-day limit on Medicare substitute billing arrangements in case of physicians ordered to active duty in the Armed Forces.
Sec. 606. Excluding clinical social worker services from coverage under the medicare skilled nursing facility prospective payment system and consolidated payment.
Sec. 607. Coverage of marriage and family therapist services and mental health counselor services.
Sec. 608. Rental and purchase of power-driven wheelchairs.
Sec. 609. Rental and purchase of oxygen equipment.
Sec. 610. Adjustment for Medicare mental health services.
Sec. 611. Extension of brachytherapy special rule.
Sec. 612. Payment for part B drugs.

Subtitle B—Extension of Medicare Rural Access Protections

- Sec. 621. 2-year extension of floor on medicare work geographic adjustment.*
Sec. 622. 2-year extension of special treatment of certain physician pathology services under Medicare.
Sec. 623. 2-year extension of medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas.
Sec. 624. 2-year extension of Medicare incentive payment program for physician scarcity areas .
Sec. 625. 2-year extension of medicare increase payments for ground ambulance services in rural areas.
Sec. 626. Extending hold harmless for small rural hospitals under the HOPD prospective payment system.

Subtitle C—End Stage Renal Disease Program

- Sec. 631. Chronic kidney disease demonstration projects.*
Sec. 632. Medicare coverage of kidney disease patient education services.
Sec. 633. Required training for patient care dialysis technicians.
Sec. 634. MedPAC report on treatment modalities for patients with kidney failure.

- Sec. 635. Adjustment for erythropoietin stimulating agents (ESAs).*
Sec. 636. Site neutral composite rate.
Sec. 637. Development of ESRD bundling system and quality incentive payments.
Sec. 638. MedPAC report on ESRD bundling system.
Sec. 639. OIG study and report on erythropoietin.

Subtitle D—Miscellaneous

- Sec. 651. Limitation on exception to the prohibition on certain physician referrals for hospitals.*

TITLE VII—PROVISIONS RELATING TO MEDICARE PARTS A AND B

- Sec. 701. Home health payment update for 2008.*
Sec. 702. 2-year extension of temporary Medicare payment increase for home health services furnished in a rural area.
Sec. 703. Extension of Medicare secondary payer for beneficiaries with end stage renal disease for large group plans.
Sec. 704. Plan for Medicare payment adjustments for never events.
Sec. 705. Reinstatement of residency slots.

TITLE VIII—MEDICAID

Subtitle A—Protecting Existing Coverage

- Sec. 801. Modernizing transitional Medicaid.*
Sec. 802. Family planning services.
Sec. 803. Authority to continue providing adult day health services approved under a State Medicaid plan.
Sec. 804. State option to protect community spouses of individuals with disabilities.
Sec. 805. County medicaid health insuring organizations .

Subtitle B—Payments

- Sec. 811. Payments for Puerto Rico and territories.*
Sec. 812. Medicaid drug rebate.
Sec. 813. Adjustment in computation of Medicaid FMAP to disregard an extraordinary employer pension contribution.
Sec. 814. Moratorium on certain payment restrictions.
Sec. 815. Tennessee DSH.
Sec. 816. Clarification treatment of regional medical center.

Subtitle C—Miscellaneous

- Sec. 821. Demonstration project for employer buy-in.*
Sec. 822. Diabetes grants.
Sec. 823. Technical correction.

TITLE IX—MISCELLANEOUS

- Sec. 901. Medicare Payment Advisory Commission status.*
Sec. 902. Repeal of trigger provision.
Sec. 903. Repeal of comparative cost adjustment (CCA) program.
Sec. 904. Comparative effectiveness research.
Sec. 905. Implementation of Health information technology (IT) under Medicare.
Sec. 906. Development, reporting, and use of health care measures.

Sec. 907. Improvements to the Medigap program.

Sec. 908. Implementation funding.

TITLE X—REVENUES

Sec. 1001. Increase in rate of excise taxes on tobacco products and cigarette papers and tubes.

Sec. 1002. Exemption for emergency medical services transportation.

1 ***TITLE I—CHILDREN’S HEALTH***
 2 ***INSURANCE PROGRAM***

3 ***SEC. 100. PURPOSE.***

4 *It is the purpose of this title to provide dependable and*
 5 *stable funding for children’s health insurance under titles*
 6 *XXI and XIX of the Social Security Act in order to enroll*
 7 *all six million uninsured children who are eligible, but not*
 8 *enrolled, for coverage today through such titles.*

9 ***Subtitle A—Funding***

10 ***SEC. 101. ESTABLISHMENT OF NEW BASE CHIP ALLOT-***
 11 ***MENTS.***

12 *Section 2104 of the Social Security Act (42 U.S.C.*
 13 *1397dd) is amended—*

14 *(1) in subsection (a)—*

15 *(A) in paragraph (9), by striking “and” at*
 16 *the end;*

17 *(B) in paragraph (10), by striking the pe-*
 18 *riod at the end and inserting “; and”; and*

19 *(C) by adding at the end the following new*
 20 *paragraph:*

1 “(11) for fiscal year 2008 and each succeeding
2 fiscal year, the sum of the State allotments provided
3 under subsection (i) for such fiscal year.”;

4 (2) in subsections (b)(1) and (c)(1), by striking
5 “subsection (d)” and inserting “subsections (d) and
6 (i)”; and

7 (3) by adding at the end the following new sub-
8 section:

9 “(i) ALLOTMENTS FOR STATES AND TERRITORIES BE-
10 GINNING WITH FISCAL YEAR 2008.—

11 “(1) GENERAL ALLOTMENT COMPUTATION.—Sub-
12 ject to the succeeding provisions of this subsection, the
13 Secretary shall compute a State allotment for each
14 State for each fiscal year as follows:

15 “(A) FOR FISCAL YEAR 2008.—For fiscal
16 year 2008, the allotment of a State is equal to
17 the greater of—

18 “(i) the State projection (in its submis-
19 sion on forms CMS—21B and CMS—37 for
20 May 2007) of Federal payments to the State
21 under this title for such fiscal year, except
22 that, in the case of a State that has enacted
23 legislation to modify its State child health
24 plan during 2007, the State may substitute
25 its projection in its submission on forms

1 *CMS—21B and CMS—37 for August 2007,*
2 *instead of such forms for May 2007; or*

3 *“(ii) the allotment of the State under*
4 *this section for fiscal year 2007 multiplied*
5 *by the allotment increase factor under para-*
6 *graph (2) for fiscal year 2008.*

7 *“(B) INFLATION UPDATE FOR FISCAL YEAR*
8 *2009 AND EACH SECOND SUCCEEDING FISCAL*
9 *YEAR.—For fiscal year 2009 and each second*
10 *succeeding fiscal year, the allotment of a State is*
11 *equal to the amount of the State allotment under*
12 *this paragraph for the previous fiscal year mul-*
13 *tiplied by the allotment increase factor under*
14 *paragraph (2) for the fiscal year involved.*

15 *“(C) REBASING IN FISCAL YEAR 2010 AND*
16 *EACH SECOND SUCCEEDING FISCAL YEAR.—For*
17 *fiscal year 2010 and each second succeeding fis-*
18 *cal year, the allotment of a State is equal to the*
19 *Federal payments to the State that are attrib-*
20 *utable to (and countable towards) the total*
21 *amount of allotments available under this section*
22 *to the State (including allotments made avail-*
23 *able under paragraph (3) as well as amounts re-*
24 *distributed to the State) in the previous fiscal*

1 year multiplied by the allotment increase factor
2 under paragraph (2) for the fiscal year involved.

3 “(D) *SPECIAL RULES FOR TERRITORIES.*—
4 Notwithstanding the previous subparagraphs, the
5 allotment for a State that is not one of the 50
6 States or the District of Columbia for fiscal year
7 2008 and for a succeeding fiscal year is equal to
8 the Federal payments provided to the State
9 under this title for the previous fiscal year mul-
10 tiplied by the allotment increase factor under
11 paragraph (2) for the fiscal year involved (but
12 determined by applying under paragraph (2)(B)
13 as if the reference to ‘in the State’ were a ref-
14 erence to ‘in the United States’).

15 “(2) *ALLOTMENT INCREASE FACTOR.*—The allot-
16 ment increase factor under this paragraph for a fiscal
17 year is equal to the product of the following:

18 “(A) *PER CAPITA HEALTH CARE GROWTH*
19 *FACTOR.*—1 plus the percentage increase in the
20 projected per capita amount of National Health
21 Expenditures from the calendar year in which
22 the previous fiscal year ends to the calendar year
23 in which the fiscal year involved ends, as most
24 recently published by the Secretary before the be-
25 ginning of the fiscal year.

1 “(B) *CHILD POPULATION GROWTH FAC-*
2 *TOR.—1 plus the percentage increase (if any) in*
3 *the population of children under 19 years of age*
4 *in the State from July 1 in the previous fiscal*
5 *year to July 1 in the fiscal year involved, as de-*
6 *termined by the Secretary based on the most re-*
7 *cent published estimates of the Bureau of the*
8 *Census before the beginning of the fiscal year in-*
9 *olved, plus 1 percentage point*

10 “(3) *PERFORMANCE-BASED SHORTFALL ADJUST-*
11 *MENT.—*

12 “(A) *IN GENERAL.—If a State’s expendi-*
13 *tures under this title in a fiscal year (beginning*
14 *with fiscal year 2008) exceed the total amount of*
15 *allotments available under this section to the*
16 *State in the fiscal year (determined without re-*
17 *gard to any redistribution it receives under sub-*
18 *section (f) that is available for expenditure dur-*
19 *ing such fiscal year, but including any carryover*
20 *from a previous fiscal year) and if the average*
21 *monthly unduplicated number of children en-*
22 *rolled under the State plan under this title (in-*
23 *cluding children receiving health care coverage*
24 *through funds under this title pursuant to a*
25 *waiver under section 1115) during such fiscal*

1 year exceeds its target average number of such
2 enrollees (as determined under subparagraph
3 (B)) for that fiscal year, the allotment under this
4 section for the State for the subsequent fiscal
5 year (or, pursuant to subparagraph (F), for the
6 fiscal year involved) shall be increased by the
7 product of—

8 “(i) the amount by which such average
9 monthly caseload exceeds such target num-
10 ber of enrollees; and

11 “(ii) the projected per capita expendi-
12 tures under the State child health plan (as
13 determined under subparagraph (C) for the
14 original fiscal year involved), multiplied by
15 the enhanced FMAP (as defined in section
16 2105(b)) for the State and fiscal year in-
17 volved

18 “(B) *TARGET AVERAGE NUMBER OF CHILD*
19 *ENROLLEES.*—In this subsection, the target aver-
20 age number of child enrollees for a State—

21 “(i) for fiscal year 2008 is equal to the
22 monthly average unduplicated number of
23 children enrolled in the State child health
24 plan under this title (including such chil-
25 dren receiving health care coverage through

1 *funds under this title pursuant to a waiver*
2 *under section 1115) during fiscal year 2007*
3 *increased by the population growth for chil-*
4 *dren in that State for the year ending on*
5 *June 30, 2006 (as estimated by the Bureau*
6 *of the Census) plus 1 percentage point; or*

7 *“(i) for a subsequent fiscal year is*
8 *equal to the target average number of child*
9 *enrollees for the State for the previous fiscal*
10 *year increased by the population growth for*
11 *children in that State for the year ending*
12 *on June 30 before the beginning of the fiscal*
13 *year (as estimated by the Bureau of the*
14 *Census) plus 1 percentage point.*

15 *“(C) PROJECTED PER CAPITA EXPENDI-*
16 *TURES.—For purposes of subparagraph (A)(i),*
17 *the projected per capita expenditures under a*
18 *State child health plan—*

19 *“(i) for fiscal year 2008 is equal to the*
20 *average per capita expenditures (including*
21 *both State and Federal financial participa-*
22 *tion) under such plan for the targeted low-*
23 *income children counted in the average*
24 *monthly caseload for purposes of this para-*
25 *graph during fiscal year 2007, increased by*

1 *the annual percentage increase in the per*
2 *capita amount of National Health Expendi-*
3 *tures (as estimated by the Secretary) for*
4 *2008; or*

5 *“(ii) for a subsequent fiscal year is*
6 *equal to the projected per capita expendi-*
7 *tures under such plan for the previous fiscal*
8 *year (as determined under clause (i) or this*
9 *clause) increased by the annual percentage*
10 *increase in the per capita amount of Na-*
11 *tional Health Expenditures (as estimated*
12 *by the Secretary) for the year in which such*
13 *subsequent fiscal year ends.*

14 *“(D) AVAILABILITY.—Notwithstanding sub-*
15 *section (e), an increase in allotment under this*
16 *paragraph shall only be available for expendi-*
17 *ture during the fiscal year in which it is pro-*
18 *vided.*

19 *“(E) NO REDISTRIBUTION OF PERFORM-*
20 *ANCE-BASED SHORTFALL ADJUSTMENT.—In no*
21 *case shall any increase in allotment under this*
22 *paragraph for a State be subject to redistribution*
23 *to other States.*

24 *“(F) INTERIM ALLOTMENT ADJUSTMENT.—*
25 *The Secretary shall develop a process to admin-*

1 *ister the performance-based shortfall adjustment*
 2 *in a manner so it is applied to (and before the*
 3 *end of) the fiscal year (rather than the subse-*
 4 *quent fiscal year) involved for a State that the*
 5 *Secretary estimates will be in shortfall and will*
 6 *exceed its enrollment target for that fiscal year.*

7 “(G) *PERIODIC AUDITING.*—*The Comp-*
 8 *troller General of the United States shall periodi-*
 9 *cally audit the accuracy of data used in the com-*
 10 *putation of allotment adjustments under this*
 11 *paragraph. Based on such audits, the Comp-*
 12 *troller General shall make such recommendations*
 13 *to the Congress and the Secretary as the Comp-*
 14 *troller General deems appropriate.*

15 “(4) *CONTINUED REPORTING.*—*For purposes of*
 16 *paragraph (3) and subsection (f), the State shall sub-*
 17 *mit to the Secretary the State’s projected Federal ex-*
 18 *penditures, even if the amount of such expenditures*
 19 *exceeds the total amount of allotments available to the*
 20 *State in such fiscal year.”.*

21 **SEC. 102. 2-YEAR INITIAL AVAILABILITY OF CHIP ALLOT-**
 22 **MENTS.**

23 *Section 2104(e) of the Social Security Act (42 U.S.C.*
 24 *1397dd(e)) is amended to read as follows:*

25 “(e) *AVAILABILITY OF AMOUNTS ALLOTTED.*—

1 “(1) *IN GENERAL.*—*Except as provided in para-*
2 *graph (2) and subsection (i)(3)(D), amounts allotted*
3 *to a State pursuant to this section—*

4 “(A) *for each of fiscal years 1998 through*
5 *2007, shall remain available for expenditure by*
6 *the State through the end of the second suc-*
7 *ceeding fiscal year; and*

8 “(B) *for fiscal year 2008 and each fiscal*
9 *year thereafter, shall remain available for ex-*
10 *penditure by the State through the end of the*
11 *succeeding fiscal year.*

12 “(2) *AVAILABILITY OF AMOUNTS REDISTRIB-*
13 *UTED.*—*Amounts redistributed to a State under sub-*
14 *section (f) shall be available for expenditure by the*
15 *State through the end of the fiscal year in which they*
16 *are redistributed, except that funds so redistributed to*
17 *a State that are not expended by the end of such fis-*
18 *cal year shall remain available after the end of such*
19 *fiscal year and shall be available in the following fis-*
20 *cal year for subsequent redistribution under such sub-*
21 *section.”.*

22 **SEC. 103. REDISTRIBUTION OF UNUSED ALLOTMENTS TO**
23 **ADDRESS STATE FUNDING SHORTFALLS.**

24 *Section 2104(f) of the Social Security Act (42 U.S.C.*
25 *1397dd(f)) is amended—*

1 (1) by striking “The Secretary” and inserting
2 the following:

3 “(1) *IN GENERAL.—The Secretary*”;

4 (2) by striking “States that have fully expended
5 the amount of their allotments under this section.”
6 and inserting “States that the Secretary determines
7 with respect to the fiscal year for which unused allot-
8 ments are available for redistribution under this sub-
9 section, are shortfall States described in paragraph
10 (2) for such fiscal year, but not to exceed the amount
11 of the shortfall described in paragraph (2)(A) for each
12 such State (as may be adjusted under paragraph
13 (2)(C)). The amount of allotments not expended or re-
14 distributed under the previous sentence shall remain
15 available for redistribution in the succeeding fiscal
16 year.”; and

17 (3) by adding at the end the following new para-
18 graph:

19 “(2) *SHORTFALL STATES DESCRIBED.—*

20 “(A) *IN GENERAL.—For purposes of para-*
21 *graph (1), with respect to a fiscal year, a short-*
22 *fall State described in this subparagraph is a*
23 *State with a State child health plan approved*
24 *under this title for which the Secretary estimates*
25 *on the basis of the most recent data available to*

1 *the Secretary, that the projected expenditures*
2 *under such plan for the State for the fiscal year*
3 *will exceed the sum of—*

4 “(i) *the amount of the State’s allot-*
5 *ments for any preceding fiscal years that*
6 *remains available for expenditure and that*
7 *will not be expended by the end of the im-*
8 *mediately preceding fiscal year;*

9 “(ii) *the amount (if any) of the per-*
10 *formance based adjustment under subsection*
11 *(i)(3)(A); and*

12 “(iii) *the amount of the State’s allot-*
13 *ment for the fiscal year.*

14 “(B) *PRORATION RULE.—If the amounts*
15 *available for redistribution under paragraph (1)*
16 *for a fiscal year are less than the total amounts*
17 *of the estimated shortfalls determined for the*
18 *year under subparagraph (A), the amount to be*
19 *redistributed under such paragraph for each*
20 *shortfall State shall be reduced proportionally.*

21 “(C) *RETROSPECTIVE ADJUSTMENT.—The*
22 *Secretary may adjust the estimates and deter-*
23 *minations made under paragraph (1) and this*
24 *paragraph with respect to a fiscal year as nec-*
25 *essary on the basis of the amounts reported by*

1 *States not later than November 30 of the suc-*
 2 *ceeding fiscal year, as approved by the Sec-*
 3 *retary.”.*

4 **SEC. 104. EXTENSION OF OPTION FOR QUALIFYING STATES.**

5 *Section 2105(g)(1)(A) of the Social Security Act (42*
 6 *U.S.C. 1397ee(g)(1)(A)) is amended by inserting after “or*
 7 *2007” the following: “or 30 percent of any allotment under*
 8 *section 2104 for any subsequent fiscal year”.*

9 ***Subtitle B—Improving Enrollment***
 10 ***and Retention of Eligible Children***

11 **SEC. 111. CHIP PERFORMANCE BONUS PAYMENT TO OFFSET**

12 ***ADDITIONAL ENROLLMENT COSTS RESULT-***
 13 ***ING FROM ENROLLMENT AND RETENTION EF-***
 14 ***FORTS.***

15 *Section 2105(a) of the Social Security Act (42 U.S.C.*
 16 *1397ee(a)) is amended by adding at the end the following*
 17 *new paragraphs:*

18 ***“(3) PERFORMANCE BONUS PAYMENT TO OFFSET***
 19 ***ADDITIONAL MEDICAID AND CHIP CHILD ENROLLMENT***
 20 ***COSTS RESULTING FROM ENROLLMENT AND RETEN-***
 21 ***TION EFFORTS.—***

22 ***“(A) IN GENERAL.—In addition to the pay-***
 23 ***ments made under paragraph (1), for each fiscal***
 24 ***year (beginning with fiscal year 2008) the Sec-***
 25 ***retary shall pay to each State that meets the con-***

1 *dition under paragraph (4) for the fiscal year,*
 2 *an amount equal to the amount described in sub-*
 3 *paragraph (B) for the State and fiscal year. The*
 4 *payment under this paragraph shall be made, to*
 5 *a State for a fiscal year, as a single payment not*
 6 *later than the last day of the first calendar quar-*
 7 *ter of the following fiscal year.*

8 *“(B) AMOUNT.—The amount described in*
 9 *this subparagraph for a State for a fiscal year*
 10 *is equal to the sum of the following amounts:*

11 *“(i) FOR ABOVE BASELINE MEDICAID*
 12 *CHILD ENROLLMENT COSTS.—*

13 *“(I) FIRST TIER ABOVE BASELINE*
 14 *MEDICAID ENROLLEES.—An amount*
 15 *equal to the number of first tier above*
 16 *baseline child enrollees (as determined*
 17 *under subparagraph (C)(i)) under title*
 18 *XIX for the State and fiscal year mul-*
 19 *tiplied by 35 percent of the projected*
 20 *per capita State Medicaid expenditures*
 21 *(as determined under subparagraph*
 22 *(D)(i)) for the State and fiscal year*
 23 *under title XIX.*

24 *“(II) SECOND TIER ABOVE BASE-*
 25 *LINE MEDICAID ENROLLEES.—An*

1 *amount equal to the number of second*
2 *tier above baseline child enrollees (as*
3 *determined under subparagraph*
4 *(C)(ii)) under title XIX for the State*
5 *and fiscal year multiplied by 90 per-*
6 *cent of the projected per capita State*
7 *Medicaid expenditures (as determined*
8 *under subparagraph (D)(i)) for the*
9 *State and fiscal year under title XIX.*

10 *“(i) FOR ABOVE BASELINE CHIP EN-*
11 *ROLLMENT COSTS.—*

12 *“(I) FIRST TIER ABOVE BASELINE*
13 *CHIP ENROLLEES.—An amount equal*
14 *to the number of first tier above base-*
15 *line child enrollees under this title (as*
16 *determined under subparagraph (C)(i))*
17 *for the State and fiscal year multiplied*
18 *by 5 percent of the projected per capita*
19 *State CHIP expenditures (as deter-*
20 *mined under subparagraph (D)(ii)) for*
21 *the State and fiscal year under this*
22 *title.*

23 *“(II) SECOND TIER ABOVE BASE-*
24 *LINE CHIP ENROLLEES.—An amount*
25 *equal to the number of second tier*

1 *above baseline child enrollees under*
 2 *this title (as determined under sub-*
 3 *paragraph (C)(ii)) for the State and*
 4 *fiscal year multiplied by 75 percent of*
 5 *the projected per capita State CHIP*
 6 *expenditures (as determined under sub-*
 7 *paragraph (D)(ii)) for the State and*
 8 *fiscal year under this title.*

9 “(C) *NUMBER OF FIRST AND SECOND TIER*
 10 *ABOVE BASELINE CHILD ENROLLEES; BASELINE*
 11 *NUMBER OF CHILD ENROLLEES.—For purposes*
 12 *of this paragraph:*

13 “(i) *FIRST TIER ABOVE BASELINE*
 14 *CHILD ENROLLEES.—The number of first*
 15 *tier above baseline child enrollees for a*
 16 *State for a fiscal year under this title or*
 17 *title XIX is equal to the number (if any, as*
 18 *determined by the Secretary) by which—*

19 “(I) *the monthly average*
 20 *unduplicated number of qualifying*
 21 *children (as defined in subparagraph*
 22 *(E)) enrolled during the fiscal year*
 23 *under the State child health plan*
 24 *under this title or under the State plan*
 25 *under title XIX, respectively; exceeds*

1 “(II) the baseline number of en-
2 rollees described in clause (iii) for the
3 State and fiscal year under this title or
4 title XIX, respectively;

5 but not to exceed 3 percent (in the case of
6 title XIX) or 7.5 percent (in the case of this
7 title) of the baseline number of enrollees de-
8 scribed in subclause (II).

9 “(ii) SECOND TIER ABOVE BASELINE
10 CHILD ENROLLEES.—The number of second
11 tier above baseline child enrollees for a
12 State for a fiscal year under this title or
13 title XIX is equal to the number (if any, as
14 determined by the Secretary) by which—

15 “(I) the monthly average
16 unduplicated number of qualifying
17 children (as defined in subparagraph
18 (E)) enrolled during the fiscal year
19 under this title or under title XIX, re-
20 spectively, as described in clause (i)(I);
21 exceeds

22 “(II) the sum of the baseline num-
23 ber of child enrollees described in
24 clause (iii) for the State and fiscal
25 year under this title or title XIX, re-

1 *spectively, as described in clause*
2 *(i)(II), and the maximum number of*
3 *first tier above baseline child enrollees*
4 *for the State and fiscal year under this*
5 *title or title XIX, respectively, as deter-*
6 *mined under clause (i).*

7 “*(iii) BASELINE NUMBER OF CHILD*
8 *ENROLLEES.—The baseline number of child*
9 *enrollees for a State under this title or title*
10 *XIX—*

11 “*(I) for fiscal year 2008 is equal*
12 *to the monthly average unduplicated*
13 *number of qualifying children enrolled*
14 *in the State child health plan under*
15 *this title or in the State plan under*
16 *title XIX, respectively, during fiscal*
17 *year 2007 increased by the population*
18 *growth for children in that State for*
19 *the year ending on June 30, 2006 (as*
20 *estimated by the Bureau of the Census)*
21 *plus 1 percentage point; or*

22 “*(II) for a subsequent fiscal year*
23 *is equal to the baseline number of child*
24 *enrollees for the State for the previous*
25 *fiscal year under this title or title XIX,*

1 *respectively, increased by the popu-*
2 *lation growth for children in that State*
3 *for the year ending on June 30 before*
4 *the beginning of the fiscal year (as es-*
5 *timated by the Bureau of the Census)*
6 *plus 1 percentage point.*

7 “(D) *PROJECTED PER CAPITA STATE EX-*
8 *PENDITURES.—For purposes of subparagraph*
9 *(B)—*

10 “(i) *PROJECTED PER CAPITA STATE*
11 *MEDICAID EXPENDITURES.—The projected*
12 *per capita State Medicaid expenditures for*
13 *a State and fiscal year under title XIX is*
14 *equal to the average per capita expenditures*
15 *(including both State and Federal financial*
16 *participation) for children under the State*
17 *plan under such title, including under*
18 *waivers but not including such children eli-*
19 *gible for assistance by virtue of the receipt*
20 *of benefits under title XVI, for the most re-*
21 *cent fiscal year for which actual data are*
22 *available (as determined by the Secretary),*
23 *increased (for each subsequent fiscal year up*
24 *to and including the fiscal year involved)*
25 *by the annual percentage increase in per*

1 *capita amount of National Health Expendi-*
2 *tures (as estimated by the Secretary) for the*
3 *calendar year in which the respective subse-*
4 *quent fiscal year ends and multiplied by a*
5 *State matching percentage equal to 100 per-*
6 *cent minus the Federal medical assistance*
7 *percentage (as defined in section 1905(b))*
8 *for the fiscal year involved.*

9 “(ii) *PROJECTED PER CAPITA STATE*
10 *CHIP EXPENDITURES.—The projected per*
11 *capita State CHIP expenditures for a State*
12 *and fiscal year under this title is equal to*
13 *the average per capita expenditures (includ-*
14 *ing both State and Federal financial par-*
15 *ticipation) for children under the State*
16 *child health plan under this title, including*
17 *under waivers, for the most recent fiscal*
18 *year for which actual data are available (as*
19 *determined by the Secretary), increased (for*
20 *each subsequent fiscal year up to and in-*
21 *cluding the fiscal year involved) by the an-*
22 *ual percentage increase in per capita*
23 *amount of National Health Expenditures*
24 *(as estimated by the Secretary) for the cal-*
25 *endar year in which the respective subse-*

1 quent fiscal year ends and multiplied by a
2 State matching percentage equal to 100 per-
3 cent minus the enhanced FMAP (as defined
4 in section 2105(b)) for the fiscal year in-
5 volved.

6 “(E) *QUALIFYING CHILDREN DEFINED.*—
7 For purposes of this subsection, the term ‘quali-
8 fying children’ means, with respect to this title
9 or title XIX, children who meet the eligibility
10 criteria (including income, categorical eligibility,
11 age, and immigration status criteria) in effect as
12 of July 1, 2007, for enrollment under this title
13 or title XIX, respectively, taking into account
14 criteria applied as of such date under this title
15 or title XIX, respectively, pursuant to a waiver
16 under section 1115.

17 “(4) *ENROLLMENT AND RETENTION PROVISIONS*
18 *FOR CHILDREN.*—For purposes of paragraph (3)(A),
19 a State meets the condition of this paragraph for a
20 fiscal year if it is implementing at least 4 of the fol-
21 lowing enrollment and retention provisions (treating
22 each subparagraph as a separate enrollment and re-
23 tention provision) throughout the entire fiscal year:

24 “(A) *CONTINUOUS ELIGIBILITY.*—The State
25 has elected the option of continuous eligibility for

1 *a full 12 months for all children described in sec-*
2 *tion 1902(e)(12) under title XIX under 19 years*
3 *of age, as well as applying such policy under its*
4 *State child health plan under this title.*

5 “(B) *LIBERALIZATION OF ASSET REQUIRE-*
6 *MENTS.—The State meets the requirement speci-*
7 *fied in either of the following clauses:*

8 “(i) *ELIMINATION OF ASSET TEST.—*
9 *The State does not apply any asset or re-*
10 *source test for eligibility for children under*
11 *title XIX or this title.*

12 “(ii) *ADMINISTRATIVE VERIFICATION*
13 *OF ASSETS.—The State—*

14 “(I) *permits a parent or caretaker*
15 *relative who is applying on behalf of a*
16 *child for medical assistance under title*
17 *XIX or child health assistance under*
18 *this title to declare and certify by sig-*
19 *nature under penalty of perjury infor-*
20 *mation relating to family assets for*
21 *purposes of determining and redeter-*
22 *mining financial eligibility; and*

23 “(II) *takes steps to verify assets*
24 *through means other than by requiring*
25 *documentation from parents and ap-*

1 *plicants except in individual cases of*
2 *discrepancies or where otherwise justi-*
3 *fied.*

4 “(C) *ELIMINATION OF IN-PERSON INTER-*
5 *VIEW REQUIREMENT.*—*The State does not require*
6 *an application of a child for medical assistance*
7 *under title XIX (or for child health assistance*
8 *under this title), including an application for re-*
9 *newal of such assistance, to be made in person*
10 *nor does the State require a face-to-face inter-*
11 *view, unless there are discrepancies or individual*
12 *circumstances justifying an in-person applica-*
13 *tion or face-to-face interview.*

14 “(D) *USE OF JOINT APPLICATION FOR MED-*
15 *ICAID AND CHIP.*—*The application form and*
16 *supplemental forms (if any) and information*
17 *verification process is the same for purposes of*
18 *establishing and renewing eligibility for children*
19 *for medical assistance under title XIX and child*
20 *health assistance under this title.*

21 “(E) *AUTOMATIC RENEWAL (USE OF ADMIN-*
22 *ISTRATIVE RENEWAL).*—

23 “(i) *IN GENERAL.*—*The State provides,*
24 *in the case of renewal of a child’s eligibility*
25 *for medical assistance under title XIX or*

1 *child health assistance under this title, a*
2 *pre-printed form completed by the State*
3 *based on the information available to the*
4 *State and notice to the parent or caretaker*
5 *relative of the child that eligibility of the*
6 *child will be renewed and continued based*
7 *on such information unless the State is pro-*
8 *vided other information. Nothing in this*
9 *clause shall be construed as preventing a*
10 *State from verifying, through electronic and*
11 *other means, the information so provided.*

12 *“(ii) SATISFACTION THROUGH DEM-*
13 *ONSTRATED USE OF EX PARTE PROCESS.—*
14 *A State shall be treated as satisfying the re-*
15 *quirement of clause (i) if renewal of eligi-*
16 *bility of children under title XIX or this*
17 *title is determined without any requirement*
18 *for an in-person interview, unless sufficient*
19 *information is not in the State’s possession*
20 *and cannot be acquired from other sources*
21 *(including other State agencies) without the*
22 *participation of the applicant or the appli-*
23 *cant’s parent or caretaker relative.*

24 *“(F) PRESUMPTIVE ELIGIBILITY FOR CHIL-*
25 *DREN.—The State is implementing section*

1 1920A under title XIX as well as, pursuant to
2 section 2107(e)(1), under this title .

3 “(G) *EXPRESS LANE*.—The State is imple-
4 menting the option described in section
5 1902(e)(13) under title XIX as well as, pursuant
6 to section 2107(e)(1), under this title.”.

7 **SEC. 112. STATE OPTION TO RELY ON FINDINGS FROM AN**
8 **EXPRESS LANE AGENCY TO CONDUCT SIM-**
9 **PLIFIED ELIGIBILITY DETERMINATIONS.**

10 (a) *MEDICAID*.—Section 1902(e) of the Social Security
11 Act (42 U.S.C. 1396a(e)) is amended by adding at the end
12 the following:

13 “(13) *EXPRESS LANE OPTION*.—

14 “(A) *IN GENERAL*.—

15 “(i) *OPTION TO USE A FINDING FROM AN*
16 *EXPRESS LANE AGENCY*.—At the option of the
17 State, the State plan may provide that in deter-
18 mining eligibility under this title for a child (as
19 defined in subparagraph (F)), the State may
20 rely on a finding made within a reasonable pe-
21 riod (as determined by the State) from an Ex-
22 press Lane agency (as defined in subparagraph
23 (E)) when it determines whether a child satisfies
24 one or more components of eligibility for medical
25 assistance under this title. The State may rely

1 on a finding from an *Express Lane* agency not-
2 withstanding sections 1902(a)(46)(B), 1903(x),
3 and 1137(d) and any differences in budget unit,
4 disregard, deeming or other methodology, if the
5 following requirements are met:

6 “(I) *PROHIBITION ON DETERMINING*
7 *CHILDREN INELIGIBLE FOR COVERAGE.—If*
8 *a finding from an Express Lane agency*
9 *would result in a determination that a*
10 *child does not satisfy an eligibility require-*
11 *ment for medical assistance under this title*
12 *and for child health assistance under title*
13 *XXI, the State shall determine eligibility for*
14 *assistance using its regular procedures.*

15 “(II) *NOTICE REQUIREMENT.—For*
16 *any child who is found eligible for medical*
17 *assistance under the State plan under this*
18 *title or child health assistance under title*
19 *XXI and who is subject to premiums based*
20 *on an Express Lane agency’s finding of*
21 *such child’s income level, the State shall*
22 *provide notice that the child may qualify*
23 *for lower premium payments if evaluated*
24 *by the State using its regular policies and*

1 of the procedures for requesting such an
2 evaluation.

3 “(III) COMPLIANCE WITH SCREEN AND
4 ENROLL REQUIREMENT.—The State shall
5 satisfy the requirements under (A) and (B)
6 of section 2102(b)(3) (relating to screen and
7 enroll) before enrolling a child in child
8 health assistance under title XXI. At its op-
9 tion, the State may fulfill such requirements
10 in accordance with either option provided
11 under subparagraph (C) of this paragraph.

12 “(i) OPTION TO APPLY TO RENEWALS AND
13 REDETERMINATIONS.—The State may apply the
14 provisions of this paragraph when conducting
15 initial determinations of eligibility, redetermina-
16 tions of eligibility, or both, as described in the
17 State plan.

18 “(B) RULES OF CONSTRUCTION.—Nothing in
19 this paragraph shall be construed—

20 “(i) to limit or prohibit a State from taking
21 any actions otherwise permitted under this title
22 or title XXI in determining eligibility for or en-
23 rolling children into medical assistance under
24 this title or child health assistance under title
25 XXI; or

1 “(ii) to modify the limitations in section
2 1902(a)(5) concerning the agencies that may
3 make a determination of eligibility for medical
4 assistance under this title.

5 “(C) *OPTIONS FOR SATISFYING THE SCREEN AND*
6 *ENROLL REQUIREMENT.*—

7 “(i) *IN GENERAL.*—With respect to a child
8 whose eligibility for medical assistance under
9 this title or for child health assistance under title
10 XXI has been evaluated by a State agency using
11 an income finding from an Express Lane agen-
12 cy, a State may carry out its duties under sub-
13 paragraphs (A) and (B) of section 2102(b)(3)
14 (relating to screen and enroll) in accordance
15 with either clause (ii) or clause (iii).

16 “(ii) *ESTABLISHING A SCREENING THRESH-*
17 *OLD.*—

18 “(I) *IN GENERAL.*—Under this clause,
19 the State establishes a screening threshold
20 set as a percentage of the Federal poverty
21 level that exceeds the highest income thresh-
22 old applicable under this title to the child
23 by a minimum of 30 percentage points or,
24 at State option, a higher number of percent-
25 age points that reflects the value (as deter-

1 *mined by the State and described in the*
2 *State plan) of any differences between in-*
3 *come methodologies used by the program ad-*
4 *ministered by the Express Lane agency and*
5 *the methodologies used by the State in deter-*
6 *mining eligibility for medical assistance*
7 *under this title.*

8 *“(II) CHILDREN WITH INCOME NOT*
9 *ABOVE THRESHOLD.—If the income of a*
10 *child does not exceed the screening threshold,*
11 *the child is deemed to satisfy the income eli-*
12 *gibility criteria for medical assistance*
13 *under this title regardless of whether such*
14 *child would otherwise satisfy such criteria.*

15 *“(III) CHILDREN WITH INCOME ABOVE*
16 *THRESHOLD.—If the income of a child ex-*
17 *ceeds the screening threshold, the child shall*
18 *be considered to have an income above the*
19 *Medicaid applicable income level described*
20 *in section 2110(b)(4) and to satisfy the re-*
21 *quirement under section 2110(b)(1)(C) (re-*
22 *lating to the requirement that CHIP match-*
23 *ing funds be used only for children not eli-*
24 *gible for Medicaid). If such a child is en-*
25 *rolled in child health assistance under title*

1 *XXI, the State shall provide the parent,*
2 *guardian, or custodial relative with the fol-*
3 *lowing:*

4 “(aa) *Notice that the child may be*
5 *eligible to receive medical assistance*
6 *under the State plan under this title if*
7 *evaluated for such assistance under the*
8 *State’s regular procedures and notice*
9 *of the process through which a parent,*
10 *guardian, or custodial relative can re-*
11 *quest that the State evaluate the child’s*
12 *eligibility for medical assistance under*
13 *this title using such regular procedures.*

14 “(bb) *A description of differences*
15 *between the medical assistance pro-*
16 *vided under this title and child health*
17 *assistance under title XXI, including*
18 *differences in cost-sharing requirements*
19 *and covered benefits.*

20 “(iii) *TEMPORARY ENROLLMENT IN CHIP*
21 *PENDING SCREEN AND ENROLL.—*

22 “(I) *IN GENERAL.—Under this clause,*
23 *a State enrolls a child in child health as-*
24 *sistance under title XXI for a temporary*
25 *period if the child appears eligible for such*

1 assistance based on an income finding by
2 an Express Lane agency.

3 “(II) DETERMINATION OF ELIGI-
4 BILITY.—During such temporary enrollment
5 period, the State shall determine the child’s
6 eligibility for child health assistance under
7 title XXI or for medical assistance under
8 this title in accordance with this clause.

9 “(III) PROMPT FOLLOW UP.—In mak-
10 ing such a determination, the State shall
11 take prompt action to determine whether the
12 child should be enrolled in medical assist-
13 ance under this title or child health assist-
14 ance under title XXI pursuant to subpara-
15 graphs (A) and (B) of section 2102(b)(3)
16 (relating to screen and enroll).

17 “(IV) REQUIREMENT FOR SIMPLIFIED
18 DETERMINATION.—In making such a deter-
19 mination, the State shall use procedures
20 that, to the maximum feasible extent, reduce
21 the burden imposed on the individual of
22 such determination. Such procedures may
23 not require the child’s parent, guardian, or
24 custodial relative to provide or verify infor-
25 mation that already has been provided to

1 *the State agency by an Express Lane agen-*
2 *cy or another source of information unless*
3 *the State agency has reason to believe the*
4 *information is erroneous.*

5 “(V) *AVAILABILITY OF CHIP MATCHING*
6 *FUNDS DURING TEMPORARY ENROLLMENT*
7 *PERIOD.—Medical assistance for items and*
8 *services that are provided to a child enrolled*
9 *in title XXI during a temporary enrollment*
10 *period under this clause shall be treated as*
11 *child health assistance under such title.*

12 “(D) *OPTION FOR AUTOMATIC ENROLLMENT.—*

13 “(i) *IN GENERAL.—At its option, a State*
14 *may initiate an evaluation of an individual’s*
15 *eligibility for medical assistance under this title*
16 *without an application and determine the indi-*
17 *vidual’s eligibility for such assistance using find-*
18 *ings from one or more Express Lane agencies*
19 *and information from sources other than a child,*
20 *if the requirements of clauses (ii) and (iii) are*
21 *met.*

22 “(ii) *INDIVIDUAL CHOICE REQUIREMENT.—*
23 *The requirement of this clause is that the child*
24 *is enrolled in medical assistance under this title*
25 *or child health assistance under title XXI only if*

1 *the child (or a parent, caretaker relative, or*
2 *guardian on the behalf of the child) has affirma-*
3 *tively assented to such enrollment.*

4 “(iii) *INFORMATION REQUIREMENT.—The*
5 *requirement of this clause is that the State in-*
6 *forms the parent, guardian, or custodial relative*
7 *of the child of the services that will be covered,*
8 *appropriate methods for using such services, pre-*
9 *mium or other cost sharing charges (if any) that*
10 *apply, medical support obligations (under sec-*
11 *tion 1912(a)) created by enrollment (if applica-*
12 *ble), and the actions the parent, guardian, or rel-*
13 *ative must take to maintain enrollment and*
14 *renew coverage.*

15 “(E) *EXPRESS LANE AGENCY DEFINED.—In this*
16 *paragraph, the term ‘express lane agency’ means an*
17 *agency that meets the following requirements:*

18 “(i) *The agency determines eligibility for*
19 *assistance under the Food Stamp Act of 1977,*
20 *the Richard B. Russell National School Lunch*
21 *Act, the Child Nutrition Act of 1966, or the*
22 *Child Care and Development Block Grant Act of*
23 *1990.*

1 “(ii) The agency notifies the child (or a
2 parent, caretaker relative, or guardian on the be-
3 half of the child)—

4 “(I) of the information which shall be
5 disclosed;

6 “(II) that the information will be used
7 by the State solely for purposes of deter-
8 mining eligibility for and for providing
9 medical assistance under this title or child
10 health assistance under title XXI; and

11 “(III) that the child, or parent, care-
12 taker relative, or guardian, may elect to not
13 have the information disclosed for such pur-
14 poses.

15 “(iii) The agency and the State agency are
16 subject to an interagency agreement limiting the
17 disclosure and use of such information to such
18 purposes.

19 “(iv) The agency is determined by the State
20 agency to be capable of making the determina-
21 tions described in this paragraph and is identi-
22 fied in the State plan under this title or title
23 XXI.

24 For purposes of this subparagraph, the term ‘State
25 agency’ refers to the agency determining eligibility for

1 *medical assistance under this title or child health as-*
2 *sistance under title XXI.*

3 “(F) *CHILD DEFINED.*—*For purposes of this*
4 *paragraph, the term ‘child’ means an individual*
5 *under 19 years of age, or, at the option of a State,*
6 *such higher age, not to exceed 21 years of age, as the*
7 *State may elect.”.*

8 (b) *CHIP.*—*Section 2107(e)(1) of such Act (42 U.S.C.*
9 *1397gg(e)(1)) is amended by redesignating subparagraphs*
10 *(B), (C), and (D) as subparagraphs (E), (H), and (I), re-*
11 *spectively, and by inserting after subparagraph (A) the fol-*
12 *lowing new subparagraph:*

13 “(C) *Section 1902(e)(13) (relating to the*
14 *State option to rely on findings from an Express*
15 *Lane agency to help evaluate a child’s eligibility*
16 *for medical assistance).”.*

17 (c) *ELECTRONIC TRANSMISSION OF INFORMATION.*—
18 *Section 1902 of such Act (42 U.S.C. 1396a) is amended by*
19 *adding at the end the following new subsection:*

20 “(dd) *ELECTRONIC TRANSMISSION OF INFORMA-*
21 *TION.*—*If the State agency determining eligibility for med-*
22 *ical assistance under this title or child health assistance*
23 *under title XXI verifies an element of eligibility based on*
24 *information from an Express Lane Agency (as defined in*
25 *subsection (e)(13)(F)), or from another public agency, then*

1 *the applicant’s signature under penalty of perjury shall not*
 2 *be required as to such element. Any signature requirement*
 3 *for an application for medical assistance may be satisfied*
 4 *through an electronic signature, as defined in section*
 5 *1710(1) of the Government Paperwork Elimination Act (44*
 6 *U.S.C. 3504 note). The requirements of subparagraphs (A)*
 7 *and (B) of section 1137(d)(2) may be met through evidence*
 8 *in digital or electronic form.”.*

9 *(d) AUTHORIZATION OF INFORMATION DISCLOSURE.—*

10 *(1) IN GENERAL.—Title XIX of the Social Secu-*
 11 *rity Act is amended—*

12 *(A) by redesignating section 1939 as section*
 13 *1940; and*

14 *(B) by inserting after section 1938 the fol-*
 15 *lowing new section:*

16 **“SEC. 1939. AUTHORIZATION TO RECEIVE PERTINENT IN-**
 17 **FORMATION.**

18 *“(a) IN GENERAL.—Notwithstanding any other provi-*
 19 *sion of law, a Federal or State agency or private entity*
 20 *in possession of the sources of data potentially pertinent*
 21 *to eligibility determinations under this title (including eli-*
 22 *gibility files maintained by Express Lane agencies de-*
 23 *scribed in section 1902(e)(13)(F), information described in*
 24 *paragraph (2) or (3) of section 1137(a), vital records infor-*
 25 *mation about births in any State, and information de-*

1 *scribed in sections 453(i) and 1902(a)(25)(I)) is authorized*
2 *to convey such data or information to the State agency ad-*
3 *ministering the State plan under this title, to the extent*
4 *such conveyance meets the requirements of subsection (b).*

5 “(b) *REQUIREMENTS FOR CONVEYANCE.—Data or in-*
6 *formation may be conveyed pursuant to subsection (a) only*
7 *if the following requirements are met:*

8 “(1) *The individual whose circumstances are de-*
9 *scribed in the data or information (or such individ-*
10 *ual’s parent, guardian, caretaker relative, or author-*
11 *ized representative) has either provided advance con-*
12 *sent to disclosure or has not objected to disclosure*
13 *after receiving advance notice of disclosure and a rea-*
14 *sonable opportunity to object.*

15 “(2) *Such data or information are used solely for*
16 *the purposes of—*

17 “(A) *identifying individuals who are eligi-*
18 *ble or potentially eligible for medical assistance*
19 *under this title and enrolling or attempting to*
20 *enroll such individuals in the State plan; and*

21 “(B) *verifying the eligibility of individuals*
22 *for medical assistance under the State plan.*

23 “(3) *An interagency or other agreement, con-*
24 *sistent with standards developed by the Secretary—*

1 “(A) prevents the unauthorized use, disclo-
2 sure, or modification of such data and otherwise
3 meets applicable Federal requirements safe-
4 guarding privacy and data security; and

5 “(B) requires the State agency admin-
6 istering the State plan to use the data and infor-
7 mation obtained under this section to seek to en-
8 roll individuals in the plan.

9 “(c) *CRIMINAL PENALTY.*—A private entity described
10 in the subsection (a) that publishes, discloses, or makes
11 known in any manner, or to any extent not authorized by
12 Federal law, any information obtained under this section
13 shall be fined not more than \$1,000 or imprisoned not more
14 than 1 year, or both, for each such unauthorized publication
15 or disclosure.

16 “(d) *RULE OF CONSTRUCTION.*—The limitations and
17 requirements that apply to disclosure pursuant to this sec-
18 tion shall not be construed to prohibit the conveyance or
19 disclosure of data or information otherwise permitted under
20 Federal law (without regard to this section).”.

21 (2) *CONFORMING AMENDMENT TO TITLE XXI.*—
22 Section 2107(e)(1) of such Act (42 U.S.C.
23 1397gg(e)(1)), as amended by subsection (b), is
24 amended by adding at the end the following new sub-
25 paragraph:

1 “(J) Section 1939 (relating to authorization
2 to receive data potentially pertinent to eligibility
3 determinations).”.

4 (3) *CONFORMING AMENDMENT TO PROVIDE AC-*
5 *CESS TO DATA ABOUT ENROLLMENT IN INSURANCE*
6 *FOR PURPOSES OF EVALUATING APPLICATIONS AND*
7 *FOR CHIP.—Section 1902(a)(25)(I)(i) of such Act (42*
8 *U.S.C. 1396a(a)(25)(I)(i) is amended—*

9 (A) by inserting “(and, at State option, in-
10 dividuals who are potentially eligible or who
11 apply)” after “with respect to individuals who
12 are eligible”; and

13 (B) by inserting “under this title (and, at
14 State option, child health assistance under title
15 XXI)” after “the State plan”.

16 (e) *EFFECTIVE DATE.—The amendments made by this*
17 *section are effective on January 1, 2008.*

18 **SEC. 113. APPLICATION OF MEDICAID OUTREACH PROCE-**
19 **DURES TO ALL CHILDREN AND PREGNANT**
20 **WOMEN.**

21 (a) *IN GENERAL.—Section 1902(a)(55) of the Social*
22 *Security Act (42 U.S.C. 1396a(a)(55)) is amended—*

23 (1) *in the matter before subparagraph (A), by*
24 *striking “individuals for medical assistance under*
25 *subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI),*

1 (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX)” and insert-
2 ing “children and pregnant women for medical assist-
3 ance under any provision of this title”; and

4 (2) in subparagraph (B), by inserting before the
5 semicolon at the end the following: “, which need not
6 be the same application form for all such individ-
7 uals”.

8 (b) *EFFECTIVE DATE.*—The amendments made by sub-
9 section (a) take effect on January 1, 2008.

10 **SEC. 114. ENCOURAGING CULTURALLY APPROPRIATE EN-**
11 **ROLLMENT AND RETENTION PRACTICES.**

12 (a) *USE OF MEDICAID FUNDS.*—Section 1903(a)(2) of
13 the Social Security Act (42 U.S.C. 1396b(a)(2)) is amended
14 by adding at the end the following new subparagraph:

15 “(E) an amount equal to 75 percent of so much
16 of the sums expended during such quarter (as found
17 necessary by the Secretary for the proper and efficient
18 administration of the State plan) as are attributable
19 to translation or interpretation services in connection
20 with the enrollment and retention under this title of
21 children of families for whom English is not the pri-
22 mary language; plus”.

23 (b) *USE OF COMMUNITY HEALTH WORKERS FOR OUT-*
24 *REACH ACTIVITIES.*—

1 (1) *IN GENERAL*.—Section 2102(c)(1) of such Act
 2 (42 U.S.C. 1397bb(c)(1)) is amended by inserting
 3 “(through community health workers and others)”
 4 after “Outreach”.

5 (2) *IN FEDERAL EVALUATION*.—Section
 6 2108(c)(3)(B) of such Act (42 U.S.C.
 7 1397hh(c)(3)(B)) is amended by inserting “(such as
 8 through community health workers and others)” after
 9 “including practices”.

10 ***Subtitle C—Coverage***

11 ***SEC. 121. ENSURING CHILD-CENTERED COVERAGE.***

12 (a) *ADDITIONAL REQUIRED SERVICES*.—

13 (1) *CHILD-CENTERED COVERAGE*.—Section 2103
 14 of the Social Security Act (42 U.S.C. 1397ec) is
 15 amended—

16 (A) in subsection (a)—

17 (i) in the matter before paragraph (1),
 18 by striking “subsection (c)(5)” and insert-
 19 ing “paragraphs (5) and (6) of subsection
 20 (c)”; and

21 (ii) in paragraph (1), by inserting “at
 22 least” after “that is”; and

23 (B) in subsection (c)—

24 (i) by redesignating paragraph (5) as
 25 paragraph (6); and

1 (ii) by inserting after paragraph (4),
2 the following:

3 “(5) *DENTAL, FQHC, AND RHC SERVICES.*—The
4 child health assistance provided to a targeted low-in-
5 come child (whether through benchmark coverage or
6 benchmark-equivalent coverage or otherwise) shall in-
7 clude coverage of the following:

8 “(A) *Dental services necessary to prevent*
9 *disease and promote oral health, restore oral*
10 *structures to health and function, and treat*
11 *emergency conditions.*

12 “(B) *Federally-qualified health center serv-*
13 *ices (as defined in section 1905(l)(2)) and rural*
14 *health clinic services (as defined in section*
15 *1905(l)(1)).*

16 *Nothing in this section shall be construed as pre-*
17 *venting a State child health plan from providing such*
18 *services as part of benchmark coverage or in addition*
19 *to the benefits provided through benchmark coverage.”.*

20 (2) *REQUIRED PAYMENT FOR FQHC AND RHC*
21 *SERVICES.*—Section 2107(e)(1) of such Act (42 U.S.C.
22 1397gg(e)(1)), as amended by sections 112(b) and
23 112(d)(2), is amended by inserting after subpara-
24 graph (C) the following new subparagraph:

1 “(D) Section 1902(bb) (relating to payment
2 for services provided by Federally-qualified
3 health centers and rural health clinics).”.

4 (3) *MENTAL HEALTH PARITY*.—Section
5 2103(a)(2)(C) of such Act (42 U.S.C.
6 1397aa(a)(2)(C)) is amended by inserting “(or 100
7 percent in the case of the category of services described
8 in subparagraph (B) of such subsection)” after “75
9 percent”.

10 (4) *EFFECTIVE DATE*.—The amendments made
11 by this subsection and subsection (d) shall apply to
12 health benefits coverage provided on or after October
13 1, 2008.

14 (b) *CLARIFICATION OF REQUIREMENT TO PROVIDE*
15 *EPSDT SERVICES FOR ALL CHILDREN IN BENCHMARK*
16 *BENEFIT PACKAGES UNDER MEDICAID* .—

17 (1) *IN GENERAL*.—Section 1937(a)(1) of the So-
18 cial Security Act (42 U.S.C. 1396u–7(a)(1)) is
19 amended—

20 (A) in subparagraph (A)—

21 (i) in the matter before clause (i), by
22 striking “Notwithstanding any other provi-
23 sion of this title” and inserting “Subject to
24 subparagraph (E)”; and

1 (ii) by striking “enrollment in coverage
2 that provides” and all that follows and in-
3 serting “benchmark coverage described in
4 subsection (b)(1) or benchmark equivalent
5 coverage described in subsection (b)(2).”;

6 (B) by striking subparagraph (C) and in-
7 serting the following new subparagraph:

8 “(C) *STATE OPTION TO PROVIDE ADDI-*
9 *TIONAL BENEFITS.—A State, at its option, may*
10 *provide such additional benefits to benchmark*
11 *coverage described in subsection (b)(1) or bench-*
12 *mark equivalent coverage described in subsection*
13 *(b)(2) as the State may specify.”; and*

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

16 “(E) *REQUIRING COVERAGE OF EPSDT*
17 *SERVICES.—Nothing in this paragraph shall be*
18 *construed as affecting a child’s entitlement to*
19 *care and services described in subsections*
20 *(a)(4)(B) and (r) of section 1905 and provided*
21 *in accordance with section 1902(a)(43) whether*
22 *provided through benchmark coverage, bench-*
23 *mark equivalent coverage, or otherwise.”.*

24 (2) *EFFECTIVE DATE.—The amendments made*
25 *by paragraph (1) shall take effect as if included in*

1 *the amendment made by section 6044(a) of the Deficit*
2 *Reduction Act of 2005.*

3 (c) *CLARIFICATION OF COVERAGE OF SERVICES IN*
4 *SCHOOL-BASED HEALTH CENTERS INCLUDED AS CHILD*
5 *HEALTH ASSISTANCE.—*

6 (1) *IN GENERAL.—Section 2110(a)(5) of such*
7 *Act (42 U.S.C. 1397jj(a)(5)) is amended by inserting*
8 *after “health center services” the following: “and*
9 *school-based health center services for which coverage*
10 *is otherwise provided under this title when furnished*
11 *by a school-based health center that is authorized to*
12 *furnish such services under State law”.*

13 (2) *EFFECTIVE DATE.—The amendment made by*
14 *paragraph (1) shall apply to child health assistance*
15 *furnished on or after the date of the enactment of this*
16 *Act.*

17 (d) *ASSURING ACCESS TO CARE.—*

18 (1) *STATE CHILD HEALTH PLAN REQUIRE-*
19 *MENT.—Section 2102(a)(7)(B) of such Act (42 U.S.C.*
20 *1397bb(c)(2)) is amended by inserting “and services*
21 *described in section 2103(c)(5)” after “emergency*
22 *services”.*

23 (2) *REFERENCE TO EFFECTIVE DATE.—For the*
24 *effective date for the amendments made by this sub-*
25 *section, see subsection (a)(5).*

1 **SEC. 122. IMPROVING BENCHMARK COVERAGE OPTIONS.**

2 (a) *LIMITATION ON SECRETARY-APPROVED COV-*
3 *ERAGE.—*

4 (1) *UNDER CHIP.—Section 2103(a)(4) of the So-*
5 *cial Security Act (42 U.S.C. 1397cc(a)(4)) is amend-*
6 *ed by inserting before the period at the end the fol-*
7 *lowing: “if the health benefits coverage is at least*
8 *equivalent to the benefits coverage in a benchmark*
9 *benefit package described in subsection (b)”.*

10 (2) *UNDER MEDICAID.—Section 1937(b)(1)(D) of*
11 *the Social Security Act (42 U.S.C. 1396u–7(b)(1)(D))*
12 *is amended by inserting before the period at the end*
13 *the following: “if the health benefits coverage is at*
14 *least equivalent to the benefits coverage in benchmark*
15 *coverage described in subparagraph (A), (B), or (C)”.*

16 (b) *REQUIREMENT FOR MOST POPULAR FAMILY COV-*
17 *ERAGE FOR STATE EMPLOYEE COVERAGE BENCHMARK.—*

18 (1) *CHIP.—Section 2103(b)(2) of such Act (42*
19 *U.S.C. 1397(b)(2)) is amended by inserting “and that*
20 *has been selected most frequently by employees seeking*
21 *dependent coverage, among such plans that provide*
22 *such dependent coverage, in either of the previous 2*
23 *plan years” before the period at the end.*

24 (2) *MEDICAID.—Section 1937(b)(1)(B) of such*
25 *Act is amended by inserting “and that has been se-*
26 *lected most frequently, by employees seeking depend-*

1 ent coverage, among such plans that provide such de-
 2 pendent coverage, in either of the previous 2 plan
 3 years” before the period at the end.

4 (c) *EFFECTIVE DATE.*—The amendments made by this
 5 section shall apply to health benefits coverage provided on
 6 or after October 1, 2008.

7 **SEC. 123. PREMIUM GRACE PERIOD.**

8 (a) *IN GENERAL.*—Section 2103(e)(3) of the Social Se-
 9 curity Act (42 U.S.C. 1397cc(e)(3)) is amended by adding
 10 at the end the following new subparagraph:

11 “(C) *PREMIUM GRACE PERIOD.*—The State
 12 child health plan—

13 “(i) shall afford individuals enrolled
 14 under the plan a grace period of at least 30
 15 days from the beginning of a new coverage
 16 period to make premium payments before
 17 the individual’s coverage under the plan
 18 may be terminated; and

19 “(ii) shall provide to such an indi-
 20 vidual, not later than 7 days after the first
 21 day of such grace period, notice—

22 “(I) that failure to make a pre-
 23 mium payment within the grace period
 24 will result in termination of coverage
 25 under the State child health plan; and

1 (A) Section 1902(e)(3)(A) of such Act (42
2 U.S.C. 1396a(e)(3)(A)) is amended by striking
3 “18 years of age or younger” and inserting
4 “under 19 years of age (or under such higher age
5 as the State has elected under subsection
6 (l)(1)(D))”.

7 (B) Section 1902(e)(12) of such Act (42
8 U.S.C. 1396a(e)(12)) is amended by inserting
9 “or such higher age as the State has elected
10 under subsection (l)(1)(D)” after “19 years of
11 age”.

12 (C) Section 1905(a) of such Act (42 U.S.C.
13 1396d(a)) is amended, in clause (i), by inserting
14 “or under such higher age as the State has elect-
15 ed under subsection (l)(1)(D)” after “as the State
16 may choose”.

17 (D) Section 1920A(b)(1) of such Act (42
18 U.S.C. 1396r-1a(b)(1)) is amended by inserting
19 “or under such higher age as the State has elect-
20 ed under section 1902(l)(1)(D)” after “19 years
21 of age”.

22 (E) Section 1928(h)(1) of such Act (42
23 U.S.C. 1396s(h)(1)) is amended by striking “18
24 years of age or younger” and inserting “under

1 19 years of age or under such higher age as the
2 State has elected under section 1902(l)(1)(D))”.

3 (F) Section 1932(a)(2)(A) of such Act (42
4 U.S.C. 1396u–2(a)(2)(A)) is amended by insert-
5 ing “(or under such higher age as the State has
6 elected under section 1902(l)(1)(D))” after “19
7 years of age”.

8 (b) TITLE XXI.—Section 2110(c)(1) of such Act (42
9 U.S.C. 1397jj(c)(1)) is amended by inserting “(or, at the
10 option of the State and subject to section 131(d) of the Chil-
11 dren’s Health and Medicare Protection Act of 2007, under
12 such higher age as the State has elected under section
13 1902(l)(1)(D))” after “19 years of age”.

14 (c) EFFECTIVE DATE.—Subject to subsection (d), the
15 amendments made by this section take effect on January
16 1, 2010.

17 (d) TRANSITION.—In carrying out the amendments
18 made by subsections (a) and (b)—

19 (1) for 2010, a State election under section
20 1902(l)(1)(D) shall only apply with respect to title
21 XXI of such Act and the age elected may not exceed
22 21 years of age;

23 (2) for 2011, a State election under section
24 1902(l)(1)(D) may apply under titles XIX and XXI

1 of such Act and the age elected may not exceed 23
2 years of age;

3 (3) for 2012, a State election under section
4 1902(l)(1)(D) may apply under titles XIX and XXI
5 of such Act and the age elected may not exceed 24
6 years of age; and

7 (4) for 2013 and each subsequent year, a State
8 election under section 1902(l)(1)(D) may apply under
9 titles XIX and XXI of such Act and the age elected
10 may not exceed 25 years of age.

11 **SEC. 132. OPTIONAL COVERAGE OF LEGAL IMMIGRANTS**

12 **UNDER THE MEDICAID PROGRAM AND CHIP.**

13 (a) *MEDICAID PROGRAM.*—Section 1903(v) of the So-
14 cial Security Act (42 U.S.C. 1396b(v)) is amended—

15 (1) in paragraph (1), by striking “paragraph
16 (2)” and inserting “paragraphs (2) and (4)”; and

17 (2) by adding at the end the following new para-
18 graph:

19 “(4)(A) A State may elect (in a plan amendment
20 under this title) to provide medical assistance under this
21 title, notwithstanding sections 401(a), 402(b), 403, and 421
22 of the Personal Responsibility and Work Opportunity Rec-
23 onciliation Act of 1996, for aliens who are lawfully residing
24 in the United States (including battered aliens described
25 in section 431(c) of such Act) and who are otherwise eligible

1 *for such assistance, within either or both of the following*
2 *eligibility categories:*

3 “(i) *PREGNANT WOMEN.*—*Women during preg-*
4 *nancy (and during the 60-day period beginning on*
5 *the last day of the pregnancy).*

6 “(ii) *CHILDREN.*—*Individuals under age 19 (or*
7 *such higher age as the State has elected under section*
8 *1902(l)(1)(D)), including optional targeted low-in-*
9 *come children described in section 1905(u)(2)(B).*

10 “(B) *In the case of a State that has elected to provide*
11 *medical assistance to a category of aliens under subpara-*
12 *graph (A), no debt shall accrue under an affidavit of sup-*
13 *port against any sponsor of such an alien on the basis of*
14 *provision of medical assistance to such category and the cost*
15 *of such assistance shall not be considered as an unreim-*
16 *bursed cost.”.*

17 “(b) *CHIP.*—*Section 2107(e)(1) of such Act (42 U.S.C.*
18 *1397gg(e)(1)), as amended by section 112(b), 112(d)(2), and*
19 *121(a)(2), is amended by inserting after subparagraph (E)*
20 *the following new subparagraphs:*

21 “(F) *Section 1903(v)(4)(A) (relating to op-*
22 *tional coverage of certain categories of lawfully*
23 *residing immigrants), insofar as it relates to the*
24 *category of pregnant women described in clause*
25 *(i) of such section, but only if the State has elect-*

1 *ed to apply such section with respect to such*
 2 *women under title XIX and the State has elected*
 3 *the option under section 2111 to provide assist-*
 4 *ance for pregnant women under this title.*

5 *“(G) Section 1903(v)(4)(A) (relating to op-*
 6 *tional coverage of categories of lawfully residing*
 7 *immigrants), insofar as it relates to the category*
 8 *of children described in clause (ii) of such sec-*
 9 *tion, but only if the State has elected to apply*
 10 *such section with respect to such children under*
 11 *title XIX.”.*

12 *(c) EFFECTIVE DATE.—The amendments made by this*
 13 *section take effect on the date of the enactment of this Act.*

14 **SEC. 133. STATE OPTION TO EXPAND OR ADD COVERAGE OF**
 15 **CERTAIN PREGNANT WOMEN UNDER CHIP.**

16 *(a) CHIP.—*

17 *(1) COVERAGE.—Title XXI (42 U.S.C. 1397aa et*
 18 *seq.) of the Social Security Act is amended by adding*
 19 *at the end the following new section:*

20 **“SEC. 2111. OPTIONAL COVERAGE OF TARGETED LOW-IN-**
 21 **COME PREGNANT WOMEN.**

22 *“(a) OPTIONAL COVERAGE.—Notwithstanding any*
 23 *other provision of this title, a State may provide for cov-*
 24 *erage, through an amendment to its State child health plan*
 25 *under section 2102, of assistance for pregnant women for*

1 *targeted low-income pregnant women in accordance with*
2 *this section, but only if—*

3 “(1) *the State has established an income eligi-*
4 *bility level—*

5 “(A) *for pregnant women, under any of*
6 *clauses (i)(III), (i)(IV), or (ii)(IX) of section*
7 *1902(a)(10)(A), that is at least 185 percent (or*
8 *such higher percent as the State has in effect for*
9 *pregnant women under this title) of the poverty*
10 *line applicable to a family of the size involved,*
11 *but in no case a percent lower than the percent*
12 *in effect under any such clause as of July 1,*
13 *2007; and*

14 “(B) *for children under 19 years of age*
15 *under this title (or title XIX) that is at least 200*
16 *percent of the poverty line applicable to a family*
17 *of the size involved; and*

18 “(2) *the State does not impose, with respect to*
19 *the enrollment under the State child health plan of*
20 *targeted low-income children during the quarter, any*
21 *enrollment cap or other numerical limitation on en-*
22 *rollment, any waiting list, any procedures designed to*
23 *delay the consideration of applications for enrollment,*
24 *or similar limitation with respect to enrollment.*

25 “(b) *DEFINITIONS.—For purposes of this title:*

1 “(1) *ASSISTANCE FOR PREGNANT WOMEN.*—*The*
2 *term ‘assistance for pregnant women’ has the mean-*
3 *ing given the term child health assistance in section*
4 *2110(a) as if any reference to targeted low-income*
5 *children were a reference to targeted low-income preg-*
6 *nant women.*

7 “(2) *TARGETED LOW-INCOME PREGNANT*
8 *WOMAN.*—*The term ‘targeted low-income pregnant*
9 *woman’ means a woman—*

10 “(A) *during pregnancy and through the end*
11 *of the month in which the 60-day period (begin-*
12 *ning on the last day of her pregnancy) ends;*

13 “(B) *whose family income exceeds 185 per-*
14 *cent (or, if higher, the percent applied under sub-*
15 *section (a)(1)(A)) of the poverty level applicable*
16 *to a family of the size involved, but does not ex-*
17 *ceed the income eligibility level established under*
18 *the State child health plan under this title for a*
19 *targeted low-income child; and*

20 “(C) *who satisfies the requirements of para-*
21 *graphs (1)(A), (1)(C), (2), and (3) of section*
22 *2110(b), applied as if any reference to a child*
23 *was a reference to a pregnant woman.*

24 “(c) *REFERENCES TO TERMS AND SPECIAL RULES.*—
25 *In the case of, and with respect to, a State providing for*

1 *coverage of assistance for pregnant women to targeted low-*
2 *income pregnant women under subsection (a), the following*
3 *special rules apply:*

4 “(1) *Any reference in this title (other than in*
5 *subsection (b)) to a targeted low-income child is*
6 *deemed to include a reference to a targeted low-in-*
7 *come pregnant woman.*

8 “(2) *Any reference in this title to child health as-*
9 *sistance (other than with respect to the provision of*
10 *early and periodic screening, diagnostic, and treat-*
11 *ment services) with respect to such women is deemed*
12 *a reference to assistance for pregnant women.*

13 “(3) *Any such reference (other than in section*
14 *2105(d)) to a child is deemed a reference to a woman*
15 *during pregnancy and the period described in sub-*
16 *section (b)(2)(A).*

17 “(4) *In applying section 2102(b)(3)(B), any ref-*
18 *erence to children found through screening to be eligi-*
19 *ble for medical assistance under the State medicaid*
20 *plan under title XIX is deemed a reference to preg-*
21 *nant women.*

22 “(5) *There shall be no exclusion of benefits for*
23 *services described in subsection (b)(1) based on any*
24 *preexisting condition and no waiting period (includ-*

1 *ing any waiting period imposed to carry out section*
2 *2102(b)(3)(C)) shall apply.*

3 *“(6) In applying section 2103(e)(3)(B) in the*
4 *case of a pregnant woman provided coverage under*
5 *this section, the limitation on total annual aggregate*
6 *cost-sharing shall be applied to such pregnant*
7 *woman.*

8 *“(7) In applying section 2104(i)—*

9 *“(A) in the case of a State which did not*
10 *provide for coverage for pregnant women under*
11 *this title (under a waiver or otherwise) during*
12 *fiscal year 2007, the allotment amount otherwise*
13 *computed for the first fiscal year in which the*
14 *State elects to provide coverage under this section*
15 *shall be increased by an amount (determined by*
16 *the Secretary) equal to the enhanced FMAP of*
17 *the expenditures under this title for such cov-*
18 *erage, based upon projected enrollment and per*
19 *capita costs of such enrollment; and*

20 *“(B) in the case of a State which provided*
21 *for coverage of pregnant women under this title*
22 *for the previous fiscal year—*

23 *“(i) in applying paragraph (2)(B) of*
24 *such section, there shall also be taken into*
25 *account (in an appropriate proportion) the*

1 percentage increase in births in the State
2 for the relevant period; and

3 “(ii) in applying paragraph (3), preg-
4 nant women (and per capita expenditures
5 for such women) shall be accounted for sepa-
6 rately from children, but shall be included
7 in the total amount of any allotment adjust-
8 ment under such paragraph.

9 “(d) *AUTOMATIC ENROLLMENT FOR CHILDREN BORN*
10 *TO WOMEN RECEIVING ASSISTANCE FOR PREGNANT*
11 *WOMEN.—If a child is born to a targeted low-income preg-*
12 *nant woman who was receiving assistance for pregnant*
13 *women under this section on the date of the child’s birth,*
14 *the child shall be deemed to have applied for child health*
15 *assistance under the State child health plan and to have*
16 *been found eligible for such assistance under such plan or*
17 *to have applied for medical assistance under title XIX and*
18 *to have been found eligible for such assistance under such*
19 *title on the date of such birth, based on the mother’s reported*
20 *income as of the time of her enrollment under this section*
21 *and applicable income eligibility levels under this title and*
22 *title XIX, and to remain eligible for such assistance until*
23 *the child attains 1 year of age. During the period in which*
24 *a child is deemed under the preceding sentence to be eligible*
25 *for child health or medical assistance, the assistance for*

1 *pregnant women or medical assistance eligibility identifica-*
2 *tion number of the mother shall also serve as the identifica-*
3 *tion number of the child, and all claims shall be submitted*
4 *and paid under such number (unless the State issues a sep-*
5 *arate identification number for the child before such period*
6 *expires).”.*

7 (2) *ADDITIONAL AMENDMENT.—Section*
8 *2107(e)(1)(I) of such Act (42 U.S.C.*
9 *1397gg(e)(1)(H)), as redesignated by section 112(b),*
10 *is amended to read as follows:*

11 *“(I) Sections 1920 and 1920A (relating to*
12 *presumptive eligibility for pregnant women and*
13 *children).”.*

14 (b) *AMENDMENTS TO MEDICAID.—*

15 (1) *ELIGIBILITY OF A NEWBORN.—Section*
16 *1902(e)(4) of the Social Security Act (42 U.S.C.*
17 *1396a(e)(4)) is amended in the first sentence by strik-*
18 *ing “so long as the child is a member of the woman’s*
19 *household and the woman remains (or would remain*
20 *if pregnant) eligible for such assistance”.*

21 (2) *APPLICATION OF QUALIFIED ENTITIES TO*
22 *PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN*
23 *UNDER MEDICAID.—Section 1920(b) of the Social Se-*
24 *curity Act (42 U.S.C. 1396r-1(b)) is amended by*

1 *adding after paragraph (2) the following flush sen-*
2 *tence:*

3 *“The term ‘qualified provider’ also includes a qualified en-*
4 *tity, as defined in section 1920A(b)(3).”.*

5 **SEC. 134. LIMITATION ON WAIVER AUTHORITY TO COVER**
6 **ADULTS.**

7 *Section 2102 of the Social Security Act (42 U.S.C.*
8 *1397bb) is amended by adding at the end the following new*
9 *subsection:*

10 *“(d) LIMITATION ON COVERAGE OF ADULTS.—Not-*
11 *withstanding any other provision of this title, the Secretary*
12 *may not, through the exercise of any waiver authority on*
13 *or after January 1, 2008, provide for Federal financial par-*
14 *ticipation to a State under this title for health care services*
15 *for individuals who are not targeted low-income children*
16 *or pregnant women unless the Secretary determines that no*
17 *eligible targeted low-income child in the State would be de-*
18 *nied coverage under this title for health care services because*
19 *of such eligibility. In making such determination, the Sec-*
20 *retary must receive assurances that—*

21 *“(1) there is no waiting list under this title in*
22 *the State for targeted low-income children to receive*
23 *child health assistance under this title; and*

24 *“(2) the State has in place an outreach program*
25 *to reach all targeted low-income children in families*

1 *with incomes less than 200 percent of the poverty*
2 *line.”.*

3 ***Subtitle E—Access***

4 ***SEC. 141. CHILDREN’S ACCESS, PAYMENT, AND EQUALITY*** 5 ***COMMISSION.***

6 *Title XIX of the Social Security Act is amended by*
7 *inserting before section 1901 the following new section:*

8 *“CHILDREN’S ACCESS, PAYMENT, AND EQUALITY*
9 *COMMISSION*

10 *“SEC. 1900. (a) ESTABLISHMENT.—There is hereby es-*
11 *tablished as an agency of Congress the Children’s Access,*
12 *Payment, and Equality Commission (in this section re-*
13 *ferred to as the ‘Commission’).*

14 *“(b) DUTIES.—*

15 *“(1) REVIEW OF PAYMENT POLICIES AND ANNUAL*
16 *REPORTS.—The Commission shall—*

17 *“(A) review Federal and State payment*
18 *policies of the Medicaid program established*
19 *under this title (in this section referred to as*
20 *‘Medicaid’) and the State Children’s Health In-*
21 *surance Program established under title XXI (in*
22 *this section referred to as ‘CHIP’), including*
23 *topics described in paragraph (2);*

24 *“(B) review access to, and affordability of,*
25 *coverage and services for enrollees under Med-*
26 *icaid and CHIP;*

1 “(C) *make recommendations to Congress*
2 *concerning such policies;*

3 “(D) *by not later than March 1 of each*
4 *year, submit to Congress a report containing the*
5 *results of such reviews and its recommendations*
6 *concerning such policies; and*

7 “(E) *by not later than June 1 of each year,*
8 *submit to Congress a report containing an exam-*
9 *ination of issues affecting Medicaid and CHIP,*
10 *including the implications of changes in health*
11 *care delivery in the United States and in the*
12 *market for health care services on such programs.*

13 “(2) *SPECIFIC TOPICS TO BE REVIEWED.—Spe-*
14 *cifically, the Commission shall review the following:*

15 “(A) *The factors affecting expenditures for*
16 *services in different sectors (such as physician,*
17 *hospital and other sectors), payment methodolo-*
18 *gies, and their relationship to access and quality*
19 *of care for Medicaid and CHIP beneficiaries.*

20 “(B) *The impact of Federal and State Med-*
21 *icaid and CHIP payment policies on access to*
22 *services (including dental services) for children*
23 *(including children with disabilities) and other*
24 *Medicaid and CHIP populations.*

1 “(C) *The impact of Federal and State Med-*
2 *icaid and CHIP policies on reducing health dis-*
3 *parities, including geographic disparities and*
4 *disparities among minority populations.*

5 “(D) *The overall financial stability of the*
6 *health care safety net, including Federally-quali-*
7 *fied health centers, rural health centers, school-*
8 *based clinics, disproportionate share hospitals,*
9 *public hospitals, providers and grantees under*
10 *section 2612(a)(5) of the Public Health Service*
11 *Act (popularly known as the Ryan White CARE*
12 *Act), and other providers that have a patient*
13 *base which includes a disproportionate number*
14 *of uninsured or low-income individuals and the*
15 *impact of CHIP and Medicaid policies on such*
16 *stability.*

17 “(E) *The relation (if any) between payment*
18 *rates for providers and improvement in care for*
19 *children as measured under the children’s health*
20 *quality measurement program established under*
21 *section 151 of the Children’s Health and Medi-*
22 *care Protection Act of 2007.*

23 “(F) *The affordability, cost effectiveness,*
24 *and accessibility of services needed by special*

1 *populations under Medicaid and CHIP as com-*
2 *pared with private-sector coverage.*

3 “(G) *The extent to which the operation of*
4 *Medicaid and CHIP ensures access, comparable*
5 *to access under employer-sponsored or other pri-*
6 *ivate health insurance coverage (or in the case of*
7 *federally-qualified health center services (as de-*
8 *fined in section 1905(l)(2)) and rural health*
9 *clinic services (as defined in section 1905(l)(1)),*
10 *access comparable to the access to such services*
11 *under title XIX), for targeted low-income chil-*
12 *dren.*

13 “(H) *The effect of demonstrations under sec-*
14 *tion 1115, benchmark coverage under section*
15 *1937, and other coverage under section 1938, on*
16 *access to care, affordability of coverage, provider*
17 *ability to achieve children’s health quality per-*
18 *formance measures, and access to safety net serv-*
19 *ices.*

20 “(3) *COMMENTS ON CERTAIN SECRETARIAL RE-*
21 *PORTS.—If the Secretary submits to Congress (or a*
22 *committee of Congress) a report that is required by*
23 *law and that relates to payment policies under Med-*
24 *icaid or CHIP, the Secretary shall transmit a copy*
25 *of the report to the Commission. The Commission*

1 *shall review the report and, not later than 6 months*
2 *after the date of submittal of the Secretary’s report to*
3 *Congress, shall submit to the appropriate committees*
4 *of Congress written comments on such report. Such*
5 *comments may include such recommendations as the*
6 *Commission deems appropriate.*

7 “(4) *AGENDA AND ADDITIONAL REVIEWS.*—*The*
8 *Commission shall consult periodically with the Chair-*
9 *men and Ranking Minority Members of the appro-*
10 *priate committees of Congress regarding the Commis-*
11 *sion’s agenda and progress towards achieving the*
12 *agenda. The Commission may conduct additional re-*
13 *views, and submit additional reports to the appro-*
14 *priate committees of Congress, from time to time on*
15 *such topics relating to the program under this title or*
16 *title XXI as may be requested by such Chairmen and*
17 *Members and as the Commission deems appropriate.*

18 “(5) *AVAILABILITY OF REPORTS.*—*The Commis-*
19 *sion shall transmit to the Secretary a copy of each re-*
20 *port submitted under this subsection and shall make*
21 *such reports available to the public.*

22 “(6) *APPROPRIATE COMMITTEE OF CONGRESS.*—
23 *For purposes of this section, the term ‘appropriate*
24 *committees of Congress’ means the Committees on En-*

1 *ergy and Commerce of the House of Representatives*
2 *and the Committee on Finance of the Senate.*

3 “(7) *VOTING AND REPORTING REQUIREMENTS.—*
4 *With respect to each recommendation contained in a*
5 *report submitted under paragraph (1), each member*
6 *of the Commission shall vote on the recommendation,*
7 *and the Commission shall include, by member, the re-*
8 *sults of that vote in the report containing the rec-*
9 *ommendation.*

10 “(8) *EXAMINATION OF BUDGET CON-*
11 *SEQUENCES.—Before making any recommendations,*
12 *the Commission shall examine the budget con-*
13 *sequences of such recommendations, directly or*
14 *through consultation with appropriate expert entities.*

15 “(c) *APPLICATION OF PROVISIONS.—The following*
16 *provisions of section 1805 shall apply to the Commission*
17 *in the same manner as they apply to the Medicare Payment*
18 *Advisory Commission:*

19 “(1) *Subsection (c) (relating to membership), ex-*
20 *cept that the membership of the Commission shall also*
21 *include representatives of children, pregnant women,*
22 *individuals with disabilities, seniors, low-income fam-*
23 *ilies, and other groups of CHIP and Medicaid bene-*
24 *ficiaries.*

1 “(2) Subsection (d) (relating to staff and con-
2 sultants).

3 “(3) Subsection (e) (relating to powers).

4 “(d) *AUTHORIZATION OF APPROPRIATIONS.—*

5 “(1) *REQUEST FOR APPROPRIATIONS.—The*
6 *Commission shall submit requests for appropriations*
7 *in the same manner as the Comptroller General sub-*
8 *mits requests for appropriations, but amounts appro-*
9 *propriated for the Commission shall be separate from*
10 *amounts appropriated for the Comptroller General.*

11 “(2) *AUTHORIZATION.—There are authorized to*
12 *be appropriated such sums as may be necessary to*
13 *carry out the provisions of this section.”.*

14 **SEC. 142. MODEL OF INTERSTATE COORDINATED ENROLL-**
15 **MENT AND COVERAGE PROCESS.**

16 “(a) *IN GENERAL.—In order to assure continuity of*
17 *coverage of low-income children under the Medicaid pro-*
18 *gram and the State Children’s Health Insurance Program*
19 *(CHIP), not later than 18 months after the date of the en-*
20 *actment of this Act, the Comptroller General of the United*
21 *States, in consultation with State Medicaid and CHIP di-*
22 *rectors and organizations representing program bene-*
23 *ficiaries, shall develop a model process for the coordination*
24 *of the enrollment, retention, and coverage under such pro-*
25 *grams of children who, because of migration of families,*

1 *emergency evacuations, educational needs, or otherwise, fre-*
 2 *quently change their State of residency or otherwise are*
 3 *temporarily located outside of the State of their residency.*

4 *(b) REPORT TO CONGRESS.—After development of such*
 5 *model process, the Comptroller General shall submit to Con-*
 6 *gress a report describing additional steps or authority need-*
 7 *ed to make further improvements to coordinate the enroll-*
 8 *ment, retention, and coverage under CHIP and Medicaid*
 9 *of children described in subsection (a).*

10 **SEC. 143. MEDICAID CITIZENSHIP DOCUMENTATION RE-**
 11 **QUIREMENTS.**

12 *(a) STATE OPTION TO REQUIRE CHILDREN TO*
 13 *PRESENT SATISFACTORY DOCUMENTARY EVIDENCE OF*
 14 *PROOF OF CITIZENSHIP OR NATIONALITY FOR PURPOSES*
 15 *OF ELIGIBILITY FOR MEDICAID; REQUIREMENT FOR AUDIT-*
 16 *ING.—*

17 *(1) IN GENERAL.—Section 1902 of the Social Se-*
 18 *curity Act (42 U.S.C. 1396a) is amended—*

19 *(A) in subsection (a)(46)—*

20 *(i) by inserting “(A)” after “(46)”;*

21 *and*

22 *(ii) by adding at the end the following*
 23 *new subparagraphs:*

24 *“(B) at the option of the State, require that,*
 25 *with respect to a child under 21 years of age (other*

1 *than an individual described in section 1903(x)(2))*
2 *who declares to be a citizen or national of the United*
3 *States for purposes of establishing initial eligibility*
4 *for medical assistance under this title (or, at State*
5 *option, for purposes of renewing or redetermining*
6 *such eligibility to the extent that such satisfactory*
7 *documentary evidence of citizenship or nationality*
8 *has not yet been presented), there is presented satis-*
9 *factory documentary evidence of citizenship or na-*
10 *tionality of the individual (using criteria determined*
11 *by the State, which shall be no more restrictive than*
12 *the documentation specified in section 1903(x)(3));*
13 *and*

14 *“(C) comply with the auditing requirements of*
15 *section 1903(x)(4);”;* and

16 *(B) in subsection (b)(3), by inserting “or*
17 *any citizenship documentation requirement for a*
18 *child under 21 years of age that is more restric-*
19 *tive than what a State may provide under sec-*
20 *tion 1903(x)” before the period at the end.*

21 *(2) AUDITING REQUIREMENT.—Section 1903(x)*
22 *of such Act (as amended by section 405(c)(1)(A) of di-*
23 *vision B of the Tax Relief and Health Care Act of*
24 *2006 (Public Law 109–432)) is amended by adding*
25 *at the end the following new paragraph:*

1 “(4)(A) *Regardless of whether a State has chosen to*
2 *take the option specified in section 1902(a)(46)(B), each*
3 *State shall audit a statistically-based sample of cases of*
4 *children under 21 years of age in order to demonstrate to*
5 *the satisfaction of the Secretary that the percentage of Fed-*
6 *eral Medicaid funds being spent for non-emergency benefits*
7 *for aliens described in subsection (v)(1) who are under 21*
8 *years of age does not exceed 3 percent of total expenditures*
9 *for medical assistance under the plan for items and services*
10 *for individuals under 21 years of age for the period for*
11 *which the sample is taken. In conducting such audits, a*
12 *State may rely on case reviews regularly conducted pursu-*
13 *ant to their Medicaid Quality Control or Payment Error*
14 *Rate Measurement (PERM) eligibility reviews under sub-*
15 *section (u).*

16 “(B) *In conducting audits under subparagraph (A),*
17 *payments for non-emergency benefits shall be treated as er-*
18 *roneous if the audit could not confirm the citizenship of*
19 *the individual based either on documentation in the case*
20 *file or on documentation obtained independently during the*
21 *audit.*

22 “(C) *If the erroneous error rate described in subpara-*
23 *graph (A)—*

24 “(i) *exceeds 3 percent, the State shall—*

1 “(I) remit to the Secretary the Federal
2 share of improper expenditures in excess of the
3 3 percent level described in such subparagraph;

4 “(II) shall develop a corrective action plan;
5 and

6 “(III) shall conduct another audit the fol-
7 lowing fiscal year, after the corrective action
8 plan is implemented; or

9 “(ii) does not exceed 3 percent, the State is not
10 required to conduct another audit under subpara-
11 graph (A) until the third fiscal year succeeding the
12 fiscal year for which the audit was conducted.”.

13 (3) *ELIMINATION OF DENIAL OF PAYMENTS FOR*
14 *CHILDREN.*—Section 1903(i)(22) of such Act (42
15 U.S.C. 1396b(i)(22)) is amended by inserting “(other
16 than a child under the age of 21)” after “for an indi-
17 vidual”.

18 (b) *CLARIFICATION OF RULES FOR CHILDREN BORN*
19 *IN THE UNITED STATES TO MOTHERS ELIGIBLE FOR MED-*
20 *ICAID.*—Section 1903(x)(2) of such Act (42 U.S.C.
21 1396b(x)(2)) is amended—

22 (1) in subparagraph (C), by striking “or” at the
23 end;

24 (2) by redesignating subparagraph (D) as sub-
25 paragraph (E); and

1 (3) by inserting after subparagraph (C) the fol-
2 lowing new subparagraph:

3 “(D) pursuant to the application of section
4 1902(e)(4) (and, in the case of an individual who is
5 eligible for medical assistance on such basis, the indi-
6 vidual shall be deemed to have provided satisfactory
7 documentary evidence of citizenship or nationality
8 and shall not be required to provide further documen-
9 tary evidence on any date that occurs during or after
10 the period in which the individual is eligible for med-
11 ical assistance on such basis; or”.

12 (c) *DOCUMENTATION FOR NATIVE AMERICANS* .—Sec-
13 tion 1903(x)(3)(B) of such Act is amended—

14 (1) by redesignating clause (v) as clause (vi);
15 and

16 (2) by inserting after clause (iv) the following
17 new clause:

18 “(v) For an individual who is a member of, or
19 enrolled in or affiliated with, a federally-recognized
20 Indian tribe, a document issued by such tribe evidenc-
21 ing such membership, enrollment, or affiliation with
22 the tribe (such as a tribal enrollment card or certifi-
23 cate of degree of Indian blood), and, only with respect
24 to those federally-recognized Indian tribes located
25 within States having an international border whose

1 membership includes individuals who are not citizens
2 of the United States, such other forms of documenta-
3 tion (including tribal documentation, if appropriate)
4 as the Secretary, after consulting with such tribes, de-
5 termines to be satisfactory documentary evidence of
6 citizenship or nationality for purposes of satisfying
7 the requirement of this subparagraph.”.

8 (d) *REASONABLE OPPORTUNITY*.—Section 1903(x) of
9 such Act, as amended by subsection (a)(2), is further
10 amended by adding at the end the following new paragraph:

11 “(5) In the case of an individual declaring to be a
12 citizen or national of the United States with respect to
13 whom a State requires the presentation of satisfactory docu-
14 mentary evidence of citizenship or nationality under section
15 1902(a)(46)(B), the individual shall be provided at least the
16 reasonable opportunity to present satisfactory documentary
17 evidence of citizenship or nationality under this subsection
18 as is provided under clauses (i) and (ii) of section
19 1137(d)(4)(A) to an individual for the submittal to the
20 State of evidence indicating a satisfactory immigration sta-
21 tus and shall not be denied medical assistance on the basis
22 of failure to provide such documentation until the indi-
23 vidual has had such an opportunity.”.

24 (e) *EFFECTIVE DATE*.—

1 (1) *RETROACTIVE APPLICATION.*—*The amend-*
2 *ments made by this section shall take effect as if in-*
3 *cluded in the enactment of the Deficit Reduction Act*
4 *of 2005 (Public Law 109–171; 120 Stat. 4).*

5 (2) *RESTORATION OF ELIGIBILITY.*—*In the case*
6 *of an individual who, during the period that began*
7 *on July 1, 2006, and ends on the date of the enact-*
8 *ment of this Act, was determined to be ineligible for*
9 *medical assistance under a State Medicaid program*
10 *solely as a result of the application of subsections*
11 *(i)(22) and (x) of section 1903 of the Social Security*
12 *Act (as in effect during such period), but who would*
13 *have been determined eligible for such assistance if*
14 *such subsections, as amended by this section, had ap-*
15 *plied to the individual, a State may deem the indi-*
16 *vidual to be eligible for such assistance as of the date*
17 *that the individual was determined to be ineligible for*
18 *such medical assistance on such basis.*

19 **SEC. 144. ACCESS TO DENTAL CARE FOR CHILDREN.**

20 (a) *DENTAL EDUCATION FOR PARENTS OF*
21 *NEWBORNS.*—*The Secretary of Health and Human Services*
22 *shall develop and implement, through entities that fund or*
23 *provide perinatal care services to targeted low-income chil-*
24 *dren under a State child health plan under title XXI of*
25 *the Social Security Act, a program to deliver oral health*

1 *educational materials that inform new parents about risks*
2 *for, and prevention of, early childhood caries and the need*
3 *for a dental visit within their newborn’s first year of life.*

4 (b) *PROVISION OF DENTAL SERVICES THROUGH*
5 *FQHCs.—*

6 (1) *MEDICAID.—Section 1902(a) of the Social*
7 *Security Act (42 U.S.C. 1396a(a)) is amended—*

8 (A) *by striking “and” at the end of para-*
9 *graph (69);*

10 (B) *by striking the period at the end of*
11 *paragraph (70) and inserting “; and”; and*

12 (C) *by inserting after paragraph (70) the*
13 *following new paragraph:*

14 “(71) *provide that the State will not prevent a*
15 *Federally-qualified health center from entering into*
16 *contractual relationships with private practice dental*
17 *providers in the provision of Federally-qualified*
18 *health center services.”.*

19 (2) *CHIP.—Section 2107(e)(1) of such Act (42*
20 *U.S.C. 1397g(e)(1)), as amended by section 112(b), is*
21 *amended by inserting after subparagraph (A) the fol-*
22 *lowing new subparagraph:*

23 “(B) *Section 1902(a)(71) (relating to lim-*
24 *iting FQHC contracting for provision of dental*
25 *services).”.*

1 (3) *EFFECTIVE DATE.*—*The amendments made*
2 *by this subsection shall take effect on January 1,*
3 *2008.*

4 (c) *REPORTING INFORMATION ON DENTAL HEALTH.*—

5 (1) *MEDICAID.*—*Section 1902(a)(43)(D)(iii) of*
6 *such Act (42 U.S.C. 1396a(a)(43)(D)(iii)) is amended*
7 *by inserting “and other information relating to the*
8 *provision of dental services to such children described*
9 *in section 2108(e)” after “receiving dental services,”.*

10 (2) *CHIP.*—*Section 2108 of such Act (42 U.S.C.*
11 *1397hh) is amended by adding at the end the fol-*
12 *lowing new subsection:*

13 “(e) *INFORMATION ON DENTAL CARE FOR CHIL-*
14 *DREN.*—

15 “(1) *IN GENERAL.*—*Each annual report under*
16 *subsection (a) shall include the following information*
17 *with respect to care and services described in section*
18 *1905(r)(3) provided to targeted low-income children*
19 *enrolled in the State child health plan under this title*
20 *at any time during the year involved:*

21 “(A) *The number of enrolled children by age*
22 *grouping used for reporting purposes under sec-*
23 *tion 1902(a)(43).*

24 “(B) *For children within each such age*
25 *grouping, information of the type contained in*

1 *questions 12(a)–(c) of CMS Form 416 (that con-*
2 *sists of the number of enrolled targeted low in-*
3 *come children who receive any, preventive, or re-*
4 *storative dental care under the State plan).*

5 *“(C) For the age grouping that includes*
6 *children 8 years of age, the number of such chil-*
7 *dren who have received a protective sealant on at*
8 *least one permanent molar tooth.*

9 *“(2) INCLUSION OF INFORMATION ON ENROLLEES*
10 *IN MANAGED CARE PLANS.—The information under*
11 *paragraph (1) shall include information on children*
12 *who are enrolled in managed care plans and other*
13 *private health plans and contracts with such plans*
14 *under this title shall provide for the reporting of such*
15 *information by such plans to the State.”.*

16 *(3) EFFECTIVE DATE.—The amendments made*
17 *by this subsection shall be effective for annual reports*
18 *submitted for years beginning after date of enactment.*

19 *(d) GAO STUDY AND REPORT.—*

20 *(1) STUDY.—The Comptroller General of the*
21 *United States shall provide for a study that exam-*
22 *ines—*

23 *(A) access to dental services by children in*
24 *underserved areas; and*

1 (B) *the feasibility and appropriateness of*
 2 *using qualified mid-level dental health providers,*
 3 *in coordination with dentists, to improve access*
 4 *for children to oral health services and public*
 5 *health overall.*

6 (2) *REPORT.—Not later than 1 year after the*
 7 *date of the enactment of this Act, the Comptroller*
 8 *General shall submit to Congress a report on the*
 9 *study conducted under paragraph (1).*

10 **SEC. 145. PROHIBITING INITIATION OF NEW HEALTH OP-**
 11 **PORTUNITY ACCOUNT DEMONSTRATION PRO-**
 12 **GRAMS.**

13 *After the date of the enactment of this Act, the Sec-*
 14 *retary of Health and Human Services may not approve any*
 15 *new demonstration programs under section 1938 of the So-*
 16 *cial Security Act (42 U.S.C. 1396u–8).*

17 **Subtitle F—Quality and Program**
 18 **Integrity**

19 **SEC. 151. PEDIATRIC HEALTH QUALITY MEASUREMENT**
 20 **PROGRAM.**

21 (a) *QUALITY MEASUREMENT OF CHILDREN’S*
 22 *HEALTH.—*

23 (1) *ESTABLISHMENT OF PROGRAM TO DEVELOP*
 24 *QUALITY MEASURES FOR CHILDREN’S HEALTH.—The*
 25 *Secretary of Health and Human Services (in this sec-*

1 *tion referred to as the “Secretary”) shall establish a*
2 *child health care quality measurement program (in*
3 *this subsection referred to as the “children’s health*
4 *quality measurement program”) to develop and im-*
5 *plement—*

6 *(A) pediatric quality measures on children’s*
7 *health care that may be used by public and pri-*
8 *vate health care purchasers (and a system for re-*
9 *porting such measures); and*

10 *(B) measures of overall program perform-*
11 *ance that may be used by public and private*
12 *health care purchasers.*

13 *The Secretary shall publish, not later than September*
14 *30, 2009, the recommended measures under the pro-*
15 *gram for application under the amendments made by*
16 *subsection (b) for years beginning with 2010.*

17 *(2) MEASURES.—*

18 *(A) SCOPE.—The measures developed under*
19 *the children’s health quality measurement pro-*
20 *gram shall—*

21 *(i) provide comprehensive information*
22 *with respect to the provision and outcomes*
23 *of health care for young children, school age*
24 *children, and older children;*

1 (ii) be designed to identify disparities
2 by pediatric characteristics (including, at a
3 minimum, those specified in subparagraph
4 (C)) in child health and the provision of
5 health care;

6 (iii) be designed to ensure that the
7 data required for such measures is collected
8 and reported in a standard format that per-
9 mits comparison at a State, plan, and pro-
10 vider level, and between insured and unin-
11 sured children;

12 (iv) take into account existing meas-
13 ures of child health quality and be periodi-
14 cally updated;

15 (v) include measures of clinical health
16 care quality which meet the requirements
17 for pediatric quality measures in paragraph
18 (1);

19 (vi) improve and augment existing
20 measures of clinical health care quality for
21 children's health care and develop new and
22 emerging measures; and

23 (vii) increase the portfolio of evidence-
24 based pediatric quality measures available

1 to public and private purchasers, providers,
2 and consumers.

3 (B) *SPECIFIC MEASURES.*—Such measures
4 shall include measures relating to at least the fol-
5 lowing aspects of health care for children:

6 (i) *The proportion of insured (and un-*
7 *insured) children who receive age-appro-*
8 *priate preventive health and dental care*
9 *(including age appropriate immunizations)*
10 *at each stage of child health development.*

11 (ii) *The proportion of insured (and*
12 *uninsured) children who receive dental care*
13 *for restoration of teeth, relief of pain and*
14 *infection, and maintenance of dental health.*

15 (iii) *The effectiveness of early health*
16 *care interventions for children whose assess-*
17 *ments indicate the presence or risk of phys-*
18 *ical or mental conditions that could ad-*
19 *versely affect growth and development.*

20 (iv) *The effectiveness of treatment to*
21 *ameliorate the effects of diagnosed physical*
22 *and mental health conditions, including*
23 *chronic conditions.*

1 (v) *The proportion of children under*
2 *age 21 who are continuously insured for a*
3 *period of 12 months or longer.*

4 (vi) *The effectiveness of health care for*
5 *children with disabilities.*

6 *In carrying out clause (vi), the Secretary shall*
7 *develop quality measures and best practices re-*
8 *lating to cystic fibrosis.*

9 (C) *REPORTING METHODOLOGY FOR ANAL-*
10 *YSIS BY PEDIATRIC CHARACTERISTICS.—The*
11 *children’s health quality measurement program*
12 *shall describe with specificity such measures and*
13 *the process by which such measures will be re-*
14 *ported in a manner that permits analysis based*
15 *on each of the following pediatric characteristics:*

16 (i) *Age.*

17 (ii) *Gender.*

18 (iii) *Race.*

19 (iv) *Ethnicity.*

20 (v) *Primary language of the child’s*
21 *parents (or caretaker relative).*

22 (vi) *Disability or chronic condition*
23 *(including cystic fibrosis).*

24 (vii) *Geographic location.*

1 (viii) Coverage status under public and
2 private health insurance programs.

3 (D) *PEDIATRIC QUALITY MEASURE*.—In this
4 subsection, the term “pediatric quality measure”
5 means a measurement of clinical care that as-
6 sesses one or more aspects of pediatric health
7 care quality (in various settings) including the
8 structure of the clinical care system, the process
9 and outcome of care, or patient experience in
10 such care.

11 (3) *CONSULTATION IN DEVELOPING QUALITY*
12 *MEASURES FOR CHILDREN’S HEALTH SERVICES*.—In
13 developing and implementing the children’s health
14 quality measurement program, the Secretary shall
15 consult with—

16 (A) States;

17 (B) pediatric hospitals, pediatricians, and
18 other primary and specialized pediatric health
19 care professionals (including members of the al-
20 lied health professions) who specialize in the care
21 and treatment of children, particularly children
22 with special physical, mental, and developmental
23 health care needs;

24 (C) dental professionals;

1 (D) health care providers that furnish pri-
2 mary health care to children and families who
3 live in urban and rural medically underserved
4 communities or who are members of distinct
5 population sub-groups at heightened risk for
6 poor health outcomes;

7 (E) national organizations representing
8 children, including children with disabilities and
9 children with chronic conditions;

10 (F) national organizations and individuals
11 with expertise in pediatric health quality per-
12 formance measurement; and

13 (G) voluntary consensus standards setting
14 organizations and other organizations involved
15 in the advancement of evidence based measures of
16 health care.

17 (4) *USE OF GRANTS AND CONTRACTS.*—*In car-*
18 *rying out the children’s health quality measurement*
19 *program, the Secretary may award grants and con-*
20 *tracts to develop, test, validate, update, and dissemi-*
21 *nate quality measures under the program.*

22 (5) *TECHNICAL ASSISTANCE.*—*The Secretary*
23 *shall provide technical assistance to States to estab-*
24 *lish for the reporting of quality measures under titles*
25 *XIX and XXI of the Social Security Act in accord-*

1 *ance with the children’s health quality measurement*
2 *program.*

3 *(b) DISSEMINATION OF INFORMATION ON THE QUALITY*
4 *OF PROGRAM PERFORMANCE.—Not later than January 1,*
5 *2009, and annually thereafter, the Secretary shall collect,*
6 *analyze, and make publicly available on a public website*
7 *of the Department of Health and Human Services in an*
8 *online format—*

9 *(1) a complete list of all measures in use by*
10 *States as of such date and used to measure the qual-*
11 *ity of medical and dental health services furnished to*
12 *children enrolled under title XIX of XXI of the Social*
13 *Security Act by participating providers, managed*
14 *care entities, and plan issuers; and*

15 *(2) information on health care quality for chil-*
16 *dren contained in external quality review reports re-*
17 *quired under section 1932(c)(2) of such Act (42*
18 *U.S.C. 1396u–2) or produced by States that admin-*
19 *ister separate plans under title XXI of such Act.*

20 *(c) REPORTS TO CONGRESS ON PROGRAM PERFORM-*
21 *ANCE.—Not later than January 1, 2010, and every 2 years*
22 *thereafter, the Secretary shall report to Congress on—*

23 *(1) the quality of health care for children en-*
24 *rolled under title XIX and XXI of the Social Security*

1 *Act under the children’s health quality measurement*
2 *program; and*

3 *(2) patterns of health care utilization with re-*
4 *spect to the measures specified in subsection (a)(2)(B)*
5 *among children by the pediatric characteristics listed*
6 *in subsection (a)(2)(C).*

7 **SEC. 152. APPLICATION OF CERTAIN MANAGED CARE QUAL-**
8 **ITY SAFEGUARDS TO CHIP.**

9 *(a) IN GENERAL.—Section 2103(f) of Social Security*
10 *Act (42 U.S.C. 1397bb(f)) is amended by adding at the end*
11 *the following new paragraph:*

12 *“(3) COMPLIANCE WITH MANAGED CARE RE-*
13 *QUIREMENTS.—The State child health plan shall pro-*
14 *vide for the application of subsections (a)(4), (a)(5),*
15 *(b), (c), (d), and (e) of section 1932 (relating to re-*
16 *quirements for managed care) to coverage, State agen-*
17 *cies, enrollment brokers, managed care entities, and*
18 *managed care organizations under this title in the*
19 *same manner as such subsections apply to coverage*
20 *and such entities and organizations under title*
21 *XIX.”.*

22 *(b) EFFECTIVE DATE.—The amendment made by sub-*
23 *section (a) shall apply to contract years for health plans*
24 *beginning on or after July 1, 2008.*

1 **SEC. 153. UPDATED FEDERAL EVALUATION OF CHIP.**

2 *Section 2108(c) of the Social Security Act (42 U.S.C.*
3 *1397hh(c)) is amended by striking paragraph (5) and in-*
4 *serting the following:*

5 *“(5) SUBSEQUENT EVALUATION USING UPDATED*
6 *INFORMATION.—*

7 *“(A) IN GENERAL.—The Secretary, directly*
8 *or through contracts or interagency agreements,*
9 *shall conduct an independent subsequent evalua-*
10 *tion of 10 States with approved child health*
11 *plans.*

12 *“(B) SELECTION OF STATES AND MATTERS*
13 *INCLUDED.—Paragraphs (2) and (3) shall apply*
14 *to such subsequent evaluation in the same man-*
15 *ner as such provisions apply to the evaluation*
16 *conducted under paragraph (1).*

17 *“(C) SUBMISSION TO CONGRESS.—Not later*
18 *than December 31, 2010, the Secretary shall sub-*
19 *mit to Congress the results of the evaluation con-*
20 *ducted under this paragraph.*

21 *“(D) FUNDING.—Out of any money in the*
22 *Treasury of the United States not otherwise ap-*
23 *propriated, there are appropriated \$10,000,000*
24 *for fiscal year 2009 for the purpose of conducting*
25 *the evaluation authorized under this paragraph.*
26 *Amounts appropriated under this subparagraph*

1 *shall remain available for expenditure through*
2 *fiscal year 2011.”.*

3 **SEC. 154. ACCESS TO RECORDS FOR IG AND GAO AUDITS**
4 **AND EVALUATIONS.**

5 *Section 2108(d) of the Social Security Act (42 U.S.C.*
6 *1397hh(d)) is amended to read as follows:*

7 “(d) **ACCESS TO RECORDS FOR IG AND GAO AUDITS**
8 **AND EVALUATIONS.**—*For the purpose of evaluating and au-*
9 *diting the program established under this title, the Sec-*
10 *retary, the Office of Inspector General, and the Comptroller*
11 *General shall have access to any books, accounts, records,*
12 *correspondence, and other documents that are related to the*
13 *expenditure of Federal funds under this title and that are*
14 *in the possession, custody, or control of States receiving*
15 *Federal funds under this title or political subdivisions*
16 *thereof, or any grantee or contractor of such States or polit-*
17 *ical subdivisions.”.*

18 **SEC. 155. REFERENCES TO TITLE XXI.**

19 *Section 704 of the Medicare, Medicaid, and SCHIP*
20 *Balanced Budget Refinement Act of 1999 (Appendix F, 113*
21 *Stat. 1501A–321), as enacted into law by section*
22 *1000(a)(6) of Public Law 106–113) is repealed and the item*
23 *relating to such section in the table of contents of such Act*
24 *is repealed.*

1 **SEC. 156. RELIANCE ON LAW; EXCEPTION FOR STATE LEGIS-**
2 **LATION.**

3 (a) *RELIANCE ON LAW.*—With respect to amendments
4 made by this title or title VIII that become effective as of
5 a date—

6 (1) *such amendments are effective as of such date*
7 *whether or not regulations implementing such amend-*
8 *ments have been issued; and*

9 (2) *Federal financial participation for medical*
10 *assistance or child health assistance furnished under*
11 *title XIX or XXI, respectively, of the Social Security*
12 *Act on or after such date by a State in good faith re-*
13 *liance on such amendments before the date of promul-*
14 *gation of final regulations, if any, to carry out such*
15 *amendments (or before the date of guidance, if any,*
16 *regarding the implementation of such amendments)*
17 *shall not be denied on the basis of the State's failure*
18 *to comply with such regulations or guidance.*

19 (b) *EXCEPTION FOR STATE LEGISLATION.*—In the case
20 of a State plan under title XIX or State child health plan
21 under XXI of the Social Security Act, which the Secretary
22 of Health and Human Services determines requires State
23 legislation in order for respective plan to meet one or more
24 additional requirements imposed by amendments made by
25 this title or title VIII, the respective State plan shall not
26 be regarded as failing to comply with the requirements of

1 *such title solely on the basis of its failure to meet such an*
 2 *additional requirement before the first day of the first cal-*
 3 *endar quarter beginning after the close of the first regular*
 4 *session of the State legislature that begins after the date of*
 5 *enactment of this Act. For purposes of the previous sentence,*
 6 *in the case of a State that has a 2-year legislative session,*
 7 *each year of the session shall be considered to be a separate*
 8 *regular session of the State legislature.*

9 **TITLE II—MEDICARE**
 10 **BENEFICIARY IMPROVEMENTS**
 11 **Subtitle A—Improvements in**
 12 **Benefits**

13 **SEC. 201. COVERAGE AND WAIVER OF COST-SHARING FOR**
 14 **PREVENTIVE SERVICES.**

15 *(a) PREVENTIVE SERVICES DEFINED; COVERAGE OF*
 16 *ADDITIONAL PREVENTIVE SERVICES.—Section 1861 of the*
 17 *Social Security Act (42 U.S.C. 1395x) is amended—*

18 *(1) in subsection (s)(2)—*

19 *(A) in subparagraph (Z), by striking “and”*
 20 *after the semicolon at the end;*

21 *(B) in subparagraph (AA), by adding*
 22 *“and” after the semicolon at the end; and*

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

1 “(BB) additional pre-
2 ventive services (described in
3 subsection (ccc)(1)(M));”;
4 and

5 (2) by adding at the end the following new sub-
6 section:

7 “Preventive Services

8 “(ccc)(1) The term ‘preventive services’ means the fol-
9 lowing:

10 “(A) Prostate cancer screening tests (as defined
11 in subsection (oo)).

12 “(B) Colorectal cancer screening tests (as defined
13 in subsection (pp)).

14 “(C) Diabetes outpatient self-management train-
15 ing services (as defined in subsection (qq)).

16 “(D) Screening for glaucoma for certain individ-
17 uals (as described in subsection (s)(2)(U)).

18 “(E) Medical nutrition therapy services for cer-
19 tain individuals (as described in subsection
20 (s)(2)(V)).

21 “(F) An initial preventive physical examination
22 (as defined in subsection (ww)).

23 “(G) Cardiovascular screening blood tests (as de-
24 fined in subsection (xx)(1)).

1 “(H) *Diabetes screening tests (as defined in sub-*
2 *section described in subsection (s)(2)(Y)).*

3 “(I) *Ultrasound screening for abdominal aortic*
4 *aneurysm for certain individuals (as described in de-*
5 *scribed in subsection (s)(2)(AA)).*

6 “(J) *Pneumococcal and influenza vaccine and*
7 *their administration (as described in subsection*
8 *(s)(10)(A)).*

9 “(K) *Hepatitis B vaccine and its administration*
10 *for certain individuals (as described in subsection*
11 *(s)(10)(B)).*

12 “(L) *Screening mammography (as defined in*
13 *subsection (jj)).*

14 “(M) *Screening pap smear and screening pelvic*
15 *exam (as described in subsection (s)(14)).*

16 “(N) *Bone mass measurement (as defined in sub-*
17 *section (rr)).*

18 “(O) *Additional preventive services (as deter-*
19 *mined under paragraph (2)).*

20 “(2)(A) *The term ‘additional preventive services’*
21 *means items and services, including mental health services,*
22 *not described in subparagraphs (A) through (N) of para-*
23 *graph (1) that the Secretary determines to be reasonable*
24 *and necessary for the prevention or early detection of an*
25 *illness or disability.*

1 “(B) In making determinations under subparagraph
2 (1), the Secretary shall—

3 “(i) take into account evidence-based rec-
4 ommendations by the United States Preventive Serv-
5 ices Task Force and other appropriate organizations;
6 and

7 “(ii) use the process for making national cov-
8 erage determinations (as defined in section
9 1869(f)(1)(B)) under this title.”.

10 (b) PAYMENT AND ELIMINATION OF COST-SHARING.—

11 (1) IN GENERAL.—

12 (A) IN GENERAL.—Section 1833(a)(1) of the
13 Social Security Act (42 U.S.C. 1395l(a)(1)) is
14 amended—

15 (i) in clause (T), by striking “80 per-
16 cent” and inserting “100 percent”;

17 (ii) by striking “and” before “(V)”;
18 and

19 (iii) by inserting before the semicolon
20 at the end the following: “, and (W) with
21 respect to additional preventive services (as
22 defined in section 1861(ccc)(2)) and other
23 preventive services for which a payment
24 rate is not otherwise established under this
25 section, the amount paid shall be 100 per-

1 *cent of the lesser of the actual charge for the*
2 *services or the amount determined under a*
3 *fee schedule established by the Secretary for*
4 *purposes of this clause”.*

5 *(B) APPLICATION TO SIGMOIDOSCOPIES AND*
6 *COLONOSCOPIES.—Section 1834(d) of such Act*
7 *(42 U.S.C. 1395m(d)) is amended—*

8 *(i) in paragraph (2)(C), by amending*
9 *clause (i) to read as follows:*

10 *“(i) NO COINSURANCE.—In the case of*
11 *a beneficiary who receives services described*
12 *in clause (i), there shall be no coinsurance*
13 *applied.”; and*

14 *(ii) in paragraph (3)(C), by amending*
15 *clause (i) to read as follows:*

16 *“(i) NO COINSURANCE.—In the case of*
17 *a beneficiary who receives services described*
18 *in clause (i), there shall be no coinsurance*
19 *applied.”.*

20 *(2) ELIMINATION OF COINSURANCE IN OUT-*
21 *PATIENT HOSPITAL SETTINGS.—*

22 *(A) EXCLUSION FROM OPD FEE SCHED-*
23 *ULE.—Section 1833(t)(1)(B)(iv) of the Social*
24 *Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is*
25 *amended by striking “screening mammography*

1 *(as defined in section 1861(jj)) and diagnostic*
2 *mammography” and inserting “diagnostic mam-*
3 *mography and preventive services (as defined in*
4 *section 1861(ccc)(1))”.*

5 *(B) CONFORMING AMENDMENTS.—Section*
6 *1833(a)(2) of the Social Security Act (42 U.S.C.*
7 *1395l(a)(2)) is amended—*

8 *(i) in subparagraph (F), by striking*
9 *“and” after the semicolon at the end;*

10 *(ii) in subparagraph (G)(ii), by add-*
11 *ing “and” at the end; and*

12 *(iii) by adding at the end the following*
13 *new subparagraph:*

14 *“(H) with respect to additional preventive*
15 *services (as defined in section 1861(ccc)(2)) fur-*
16 *nished by an outpatient department of a hos-*
17 *pital, the amount determined under paragraph*
18 *(1)(W);”.*

19 *(3) WAIVER OF APPLICATION OF DEDUCTIBLE*
20 *FOR ALL PREVENTIVE SERVICES.—The first sentence*
21 *of section 1833(b) of the Social Security Act (42*
22 *U.S.C. 1395l(b)) is amended —*

23 *(A) in clause (1), by striking “items and*
24 *services described in section 1861(s)(10)(A)” and*

1 inserting “preventive services (as defined in sec-
2 tion 1861(ccc)(1))”;

3 (B) by inserting “and” before “(4)”; and

4 (C) by striking clauses (5) through (8).

5 (c) *INCLUSION AS PART OF INITIAL PREVENTIVE*
6 *PHYSICAL EXAMINATION.*—Section 1861(*ww*)(2) of the So-
7 cial Security Act (42 U.S.C. 1395x(*ww*)(2)) is amended by
8 adding at the end the following new subparagraph:

9 “(M) Additional preventive services (as de-
10 fined in subsection (ccc)(2)).”.

11 (d) *EFFECTIVE DATE.*—The amendments made by this
12 section shall apply to services furnished on or after January
13 1, 2008.

14 **SEC. 202. WAIVER OF DEDUCTIBLE FOR COLORECTAL CAN-**
15 **CER SCREENING TESTS REGARDLESS OF**
16 **CODING, SUBSEQUENT DIAGNOSIS, OR ANCIL-**
17 **LARY TISSUE REMOVAL.**

18 (a) *IN GENERAL.*—Section 1833(b) of the Social Secu-
19 rity Act (42 U.S.C. 1395l(b)), as amended by section
20 201(b), is amended by adding at the end the following new
21 sentence: “Clause (1) of the first sentence of this subsection
22 shall apply with respect to a colorectal cancer screening test
23 regardless of the code applied, of the establishment of a diag-
24 nosis as a result of the test, or of the removal of tissue or

1 *other matter or other procedure that is performed in connec-*
 2 *tion with and as a result of the screening test.”.*

3 (b) *EFFECTIVE DATE.*—*The amendment made by sub-*
 4 *section (a) shall apply to items and services furnished on*
 5 *or after January 1, 2008.*

6 **SEC. 203. PARITY FOR MENTAL HEALTH COINSURANCE.**

7 *Section 1833(c) of the Social Security Act (42 U.S.C.*
 8 *1395l(c)) is amended by inserting “before 2008” after “in*
 9 *any calendar year”.*

10 ***Subtitle B—Improving, Clarifying,***
 11 ***and Simplifying Financial As-***
 12 ***sistance for Low Income Medi-***
 13 ***care Beneficiaries***

14 **SEC. 211. IMPROVING ASSETS TESTS FOR MEDICARE SAV-**
 15 **INGS PROGRAM AND LOW-INCOME SUBSIDY**
 16 **PROGRAM.**

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

19 (1) *TO FULL-PREMIUM SUBSIDY ELIGIBLE INDI-*
 20 *VIDUALS.*—*Section 1860D–14(a) of the Social Secu-*
 21 *rity Act (42 U.S.C. 1395w–114(a)) is amended—*

22 (A) *in paragraph (1), in the matter before*
 23 *subparagraph (A), by inserting “(or, beginning*
 24 *with 2009, paragraph (3)(E))” after “paragraph*
 25 *(3)(D)”;* and

1 (B) in paragraph (3)(A)(iii), by striking
2 “(D) or”.

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

6 (A) by striking “and” at the end of sub-
7 clause (I);

8 (B) in subclause (II), by inserting “(before
9 2009)” after “subsequent year”;

10 (C) by striking the period at the end of sub-
11 clause (II) and inserting a semicolon; and

12 (D) by inserting after subclause (II) the fol-
13 lowing new subclauses:

14 “(III) for 2009, \$17,000 (or
15 \$34,000 in the case of the combined
16 value of the individual’s assets or re-
17 sources and the assets or resources of
18 the individual’s spouse); and

19 “(IV) for a subsequent year, the
20 dollar amounts specified in this sub-
21 clause (or subclause (III)) for the pre-
22 vious year increased by \$1,000 (or
23 \$2,000 in the case of the combined
24 value referred to in subclause (III)).”.

1 (3) *APPLICATION OF LIS TEST UNDER MEDICARE*
2 *SAVINGS PROGRAM.*—Section 1905(p)(1)(C) of such
3 Act (42 U.S.C. 1396d(p)(1)(C)) is amended by insert-
4 ing before the period at the end the following: “or, ef-
5 fective beginning with January 1, 2009, whose re-
6 sources (as so determined) do not exceed the max-
7 imum resource level applied for the year under sec-
8 tion 1860D–14(a)(3)(E) applicable to an individual
9 or to the individual and the individual’s spouse (as
10 the case may be)”.

11 (b) *EFFECTIVE DATE.*—The amendments made by sub-
12 section (a) shall apply to eligibility determinations for in-
13 come-related subsidies and medicare cost-sharing furnished
14 for periods beginning on or after January 1, 2009.

15 **SEC. 212. MAKING QI PROGRAM PERMANENT AND EXPAND-**
16 **ING ELIGIBILITY.**

17 (a) *MAKING PROGRAM PERMANENT.*—

18 (1) *IN GENERAL.*—Section 1902(a)(10)(E)(iv) of
19 the Social Security Act (42 U.S.C.
20 1396b(a)(10)(E)(iv)) is amended—

21 (A) by striking “sections 1933 and” and by
22 inserting “section”; and

23 (B) by striking “(but only for” and all that
24 follows through “September 2007)”.

25 (2) *ELIMINATION OF FUNDING LIMITATION.*—

1 (A) *IN GENERAL.*—Section 1933 of such Act
2 (42 U.S.C. 1396u–3) is amended—

3 (i) in subsection (a), by striking “who
4 are selected to receive such assistance under
5 subsection (b)”;

6 (ii) by striking subsections (b), (c), (e),
7 and (g);

8 (iii) in subsection (d), by striking
9 “furnished in a State” and all that follows
10 and inserting “the Federal medical assist-
11 ance percentage shall be equal to 100 per-
12 cent.”; and

13 (iv) by redesignating subsections (d)
14 and (f) as subsections (b) and (c), respec-
15 tively.

16 (B) *CONFORMING AMENDMENT.*—Section
17 1905(b) of such Act (42 U.S.C. 1396d(b)) is
18 amended by striking “1933(d)” and inserting
19 “1933(b)”.

20 (C) *EFFECTIVE DATE.*—The amendments
21 made by subparagraph (A) shall take effect on
22 October 1, 2007.

23 (b) *INCREASE IN ELIGIBILITY TO 150 PERCENT OF*
24 *THE FEDERAL POVERTY LEVEL.*—Section
25 1902(a)(10)(E)(iv) of such Act is further amended by in-

1 *serting “(or, effective January 1, 2008, 150 percent)” after*
2 *“135 percent”.*

3 **SEC. 213. ELIMINATING BARRIERS TO ENROLLMENT.**

4 *(a) ADMINISTRATIVE VERIFICATION OF INCOME AND*
5 *RESOURCES UNDER THE LOW-INCOME SUBSIDY PRO-*
6 *GRAM.—Section 1860D–14(a)(3) of the Social Security Act*
7 *(42 U.S.C. 1395w–114(a)(3)) is amended by adding at the*
8 *end the following new subparagraph:*

9 *“(G) SELF-CERTIFICATION OF INCOME AND*
10 *RESOURCES.—For purposes of applying this sec-*
11 *tion, an individual shall be permitted to qualify*
12 *on the basis of self-certification of income and re-*
13 *sources without the need to provide additional*
14 *documentation.”.*

15 *(b) AUTOMATIC REENROLLMENT WITHOUT NEED TO*
16 *REAPPLY UNDER LOW-INCOME SUBSIDY PROGRAM.—Sec-*
17 *tion 1860D–14(a)(3) of such Act (42 U.S.C. 1395w–*
18 *114(a)(3)), as amended by subsection (a), is further amend-*
19 *ed by adding at the end the following new subparagraph:*

20 *“(H) AUTOMATIC REENROLLMENT.—For*
21 *purposes of applying this section, in the case of*
22 *an individual who has been determined to be a*
23 *subsidy eligible individual (and within a par-*
24 *ticular class of such individuals, such as a full-*
25 *subsidy eligible individual or a partial subsidy*

1 *eligible individual), the individual shall be*
2 *deemed to continue to be so determined without*
3 *the need for any annual or periodic application*
4 *unless and until the individual notifies a Fed-*
5 *eral or State official responsible for such deter-*
6 *minations that the individual's eligibility condi-*
7 *tions have changed so that the individual is no*
8 *longer a subsidy eligible individual (or is no*
9 *longer within such class of such individuals).”.*

10 *(c) ENCOURAGING APPLICATION OF PROCEDURES*
11 *UNDER MEDICARE SAVINGS PROGRAM.—Section 1905(p) of*
12 *such Act (42 U.S.C. 1396d(p)) is amended by adding at*
13 *the end the following new paragraph:*

14 *“(7) The Secretary shall take all reasonable steps to*
15 *encourage States to provide for administrative verification*
16 *of income and automatic reenrollment (as provided under*
17 *clauses (iii) and (iv) of section 1860D–14(a)(3)(C) in the*
18 *case of the low-income subsidy program).”.*

19 *(d) SSA ASSISTANCE WITH MEDICARE SAVINGS PRO-*
20 *GRAM AND LOW-INCOME SUBSIDY PROGRAM APPLICA-*
21 *TIONS.—Section 1144 of such Act (42 U.S.C. 1320b–14) is*
22 *amended by adding at the end the following new subsection:*

23 *“(c) ASSISTANCE WITH MEDICARE SAVINGS PROGRAM*
24 *AND LOW-INCOME SUBSIDY PROGRAM APPLICATIONS.—*

1 “(1) *DISTRIBUTION OF APPLICATIONS TO APPLI-*
2 *CANTS FOR MEDICARE.—In the case of each indi-*
3 *vidual applying for hospital insurance benefits under*
4 *section 226 or 226A, the Commissioner shall provide*
5 *the following:*

6 “(A) *Information describing the low-income*
7 *subsidy program under section 1860D–14 and*
8 *the medicare savings program under title XIX.*

9 “(B) *An application for enrollment under*
10 *such low-income subsidy program as well as an*
11 *application form (developed under section*
12 *1905(p)(5)) for medical assistance for medicare*
13 *cost-sharing under title XIX.*

14 “(C) *Information on how the individual*
15 *may obtain assistance in completing such appli-*
16 *cations, including information on how the indi-*
17 *vidual may contact the State health insurance*
18 *assistance program (SHIP) for the State in*
19 *which the individual is located.*

20 *The Commissioner shall make such application forms*
21 *available at local offices of the Social Security Ad-*
22 *ministration.*

23 “(2) *TRAINING PERSONNEL IN ASSISTING IN*
24 *COMPLETING APPLICATIONS.—The Commissioner shall*
25 *provide training to those employees of the Social Se-*

1 *curity Administration who are involved in receiving*
2 *applications for benefits described in paragraph (1)*
3 *in assisting applicants in completing a medicare sav-*
4 *ings program application described in paragraph (1).*
5 *Such employees who are so trained shall provide such*
6 *assistance upon request.*

7 “(3) *TRANSMITTAL OF COMPLETED APPLICA-*
8 *TION.—If such an employee assists in completing such*
9 *an application, the employee, with the consent of the*
10 *applicant, shall transmit the completed application to*
11 *the appropriate State medicaid agency for processing.*

12 “(4) *COORDINATION WITH OUTREACH.—The*
13 *Commissioner shall coordinate outreach activities*
14 *under this subsection with outreach activities con-*
15 *ducted by States in connection with the low-income*
16 *subsidy program and the medicare savings pro-*
17 *gram.”.*

18 (e) *MEDICAID AGENCY CONSIDERATION OF APPLICA-*
19 *TIONS.—Section 1935(a) of such Act (42 U.S.C. 1396u-*
20 *5(a)) is amended by adding at the end the following new*
21 *paragraph:*

22 “(4) *CONSIDERATION OF MSP APPLICATIONS.—*
23 *The State shall accept medicare savings program ap-*
24 *plications transmitted under section 1144(c)(3) and*
25 *act on such applications in the same manner and*

1 *deadlines as if they had been submitted directly by*
 2 *the applicant.”.*

3 (f) *TRANSLATION OF MODEL FORM.—Section*
 4 *1905(p)(5)(A) of the Social Security Act (42 U.S.C.*
 5 *1396d(p)(5)(A)) is amended by adding at the end the fol-*
 6 *lowing: “The Secretary shall provide for the translation of*
 7 *such application form into at least the 10 languages (other*
 8 *than English) that are most often used by individuals ap-*
 9 *plying for hospital insurance benefits under section 226 or*
 10 *226A and shall make the translated forms available to the*
 11 *States and to the Commissioner of Social Security.”.*

12 (g) *DISCLOSURE OF TAX RETURN INFORMATION FOR*
 13 *PURPOSES OF PROVIDING LOW-INCOME SUBSIDIES UNDER*
 14 *MEDICARE.—*

15 (1) *IN GENERAL.—Subsection (l) of section 6103*
 16 *of the Internal Revenue Code of 1986 is amended by*
 17 *adding at the end the following new paragraph:*

18 “(21) *DISCLOSURE OF RETURN INFORMATION*
 19 *FOR PURPOSES OF PROVIDING LOW-INCOME SUB-*
 20 *SIDIES UNDER MEDICARE.—*

21 “(A) *RETURN INFORMATION FROM INTER-*
 22 *NAL REVENUE SERVICE TO SOCIAL SECURITY AD-*
 23 *MINISTRATION.—The Secretary, upon written re-*
 24 *quest from the Commissioner of Social Security,*
 25 *shall disclose to the officers and employees of the*

1 *Social Security Administration with respect to*
2 *any individual identified by the Commissioner*
3 *as potentially eligible (based on information*
4 *other than return information) for low-income*
5 *subsidies under section 1860D-14 of the Social*
6 *Security Act—*

7 “(i) *whether the adjusted gross income*
8 *for the applicable year is less than 135 per-*
9 *cent of the poverty line (as specified by the*
10 *Commissioner in such request),*

11 “(ii) *whether such adjusted gross in-*
12 *come is between 135 percent and 150 per-*
13 *cent of the poverty line (as so specified),*

14 “(iii) *whether any designated distribu-*
15 *tions (as defined in section 3405(e)(1)) were*
16 *reported with respect to such individual*
17 *under section 6047(d) for the applicable*
18 *year, and the amount (if any) of the dis-*
19 *tributions so reported,*

20 “(iv) *whether the return was a joint re-*
21 *turn for the applicable year, and*

22 “(v) *the applicable year.*

23 “(B) *APPLICABLE YEAR.—*

24 “(i) *IN GENERAL.—For the purposes of*
25 *this paragraph, the term ‘applicable year’*

1 means the most recent taxable year for
2 which information is available in the Inter-
3 nal Revenue Service's taxpayer data infor-
4 mation systems, or, if there is no return
5 filed for the individual for such year, the
6 prior taxable year.

7 “(ii) NO RETURN.—If no return is
8 filed for such individual for both taxable
9 years referred to in clause (i), the Secretary
10 shall disclose the fact that there is no return
11 filed for such individual for the applicable
12 year in lieu of the information described in
13 subparagraph (A).

14 “(C) RESTRICTION ON USE OF DISCLOSED
15 INFORMATION.—Return information disclosed
16 under this paragraph may be used only for the
17 purpose of improving the efforts of the Social Se-
18 curity Administration to contact and assist eli-
19 gible individuals for, and administering, low-in-
20 come subsidies under section 1860D–14 of the
21 Social Security Act.

22 “(D) TERMINATION.—No disclosure shall be
23 made under this paragraph after the 2-year pe-
24 riod beginning on the date of the enactment of
25 this paragraph.”.

1 (2) *PROCEDURES AND RECORDKEEPING RE-*
2 *LATED TO DISCLOSURES.*—Paragraph (4) of section
3 6103(p) of such Code is amended by striking “or
4 (17)” each place it appears and inserting “(17), or
5 (21)”.

6 (3) *REPORT.*—Not later than 18 months after the
7 date of the enactment of this Act, the Secretary of the
8 Treasury, after consultation with the Commissioner of
9 Social Security, shall submit a written report to Con-
10 gress regarding the use of disclosures made under sec-
11 tion 6103(l)(21) of the Internal Revenue Code of
12 1986, as added by this subsection, in identifying indi-
13 viduals eligible for the low-income subsidies under
14 section 1860D–14 of the Social Security Act.

15 (4) *EFFECTIVE DATE.*—The amendment made by
16 this subsection shall apply to disclosures made after
17 the date of the enactment of this Act.

18 (h) *EFFECTIVE DATE.*—Except as otherwise provided,
19 the amendments made by this section shall take effect on
20 January 1, 2009.

21 **SEC. 214. ELIMINATING APPLICATION OF ESTATE RECOV-**
22 **ERY.**

23 (a) *IN GENERAL.*—Section 1917(b)(1)(B)(ii) of the So-
24 cial Security Act (42 U.S.C. 1396p(b)(1)(B)(ii)) is amend-
25 ed by inserting “(but not including medical assistance for

1 *medicare cost-sharing or for benefits described in section*
 2 *1902(a)(10)(E))” before the period at the end.*

3 *(b) EFFECTIVE DATE.—The amendment made by sub-*
 4 *section (a) shall take effect as of January 1, 2008.*

5 **SEC. 215. ELIMINATION OF PART D COST-SHARING FOR**
 6 **CERTAIN NON-INSTITUTIONALIZED FULL-**
 7 **BENEFIT DUAL ELIGIBLE INDIVIDUALS.**

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

11 *(1) by striking “INSTITUTIONALIZED INDIVID-*
 12 *UALS.—In” and inserting “ELIMINATION OF COST-*
 13 *SHARING FOR CERTAIN FULL-BENEFIT DUAL ELIGIBLE*
 14 *INDIVIDUALS.—*

15 *“(I) INSTITUTIONALIZED INDIVID-*
 16 *UALS.—In”; and*

17 *(2) by adding at the end the following new sub-*
 18 *clause:*

19 *“(II) CERTAIN OTHER INDIVID-*
 20 *UALS.—In the case of an individual*
 21 *who is a full-benefit dual eligible indi-*
 22 *vidual and with respect to whom there*
 23 *has been a determination that but for*
 24 *the provision of home and community*
 25 *based care (whether under section 1915*

1 or under a waiver under section 1115)
2 the individual would require the level
3 of care provided in a hospital or a
4 nursing facility or intermediate care
5 facility for the mentally retarded the
6 cost of which could be reimbursed
7 under the State plan under title XIX,
8 the elimination of any beneficiary co-
9 insurance described in section 1860D-
10 2(b)(2) (for all amounts through the
11 total amount of expenditures at which
12 benefits are available under section
13 1860D-2(b)(4)).”.

14 (b) *EFFECTIVE DATE.*—The amendments made by sub-
15 section (a) shall apply to drugs dispensed on or after Janu-
16 ary 1, 2009.

17 **SEC. 216. EXEMPTIONS FROM INCOME AND RESOURCES**
18 **FOR DETERMINATION OF ELIGIBILITY FOR**
19 **LOW-INCOME SUBSIDY.**

20 (a) *IN GENERAL.*—Section 1860D-14(a)(3) of the So-
21 cial Security Act (42 U.S.C. 1395w-114(a)(3)), as amended
22 by subsections (a) and (b) of section 213, is further amend-
23 ed—

24 (1) in subparagraph (C)(i), by inserting “and
25 except that support and maintenance furnished in

1 *kind shall not be counted as income” after “section*
2 *1902(r)(2)”;*

3 *(2) in subparagraph (D), in the matter before*
4 *clause (i), by inserting “subject to the additional ex-*
5 *clusions provided under subparagraph (G)” before*
6 *“);”;*

7 *(3) in subparagraph (E)(i), in the matter before*
8 *subclause (I), by inserting “subject to the additional*
9 *exclusions provided under subparagraph (G)” before*
10 *“);”;* and

11 *(4) by adding at the end the following new sub-*
12 *paragraph:*

13 *“(I) ADDITIONAL EXCLUSIONS.—In deter-*
14 *mining the resources of an individual (and the*
15 *eligible spouse of the individual, if any) under*
16 *section 1613 for purposes of subparagraphs (D)*
17 *and (E) the following additional exclusions shall*
18 *apply:*

19 *“(i) LIFE INSURANCE POLICY.—No*
20 *part of the value of any life insurance pol-*
21 *icy shall be taken into account.*

22 *“(ii) PENSION OR RETIREMENT*
23 *PLAN.—No balance in any pension or re-*
24 *tirement plan shall be taken into account.”.*

1 (b) *EFFECTIVE DATE.*—*The amendments made by this*
2 *section shall take effect on January 1, 2009, and shall apply*
3 *to determinations of eligibility for months beginning with*
4 *January 2009.*

5 **SEC. 217. COST-SHARING PROTECTIONS FOR LOW-INCOME**
6 **SUBSIDY-ELIGIBLE INDIVIDUALS.**

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

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

11 “(iv) *OVERALL LIMITATION ON COST-*
12 *SHARING.*—*In the case of all such individ-*
13 *uals, a limitation on aggregate cost-sharing*
14 *under this part for a year not to exceed 2.5*
15 *percent of income.”; and*

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

18 “(F) *OVERALL LIMITATION ON COST-SHAR-*
19 *ING.*—*A limitation on aggregate cost-sharing*
20 *under this part for a year not to exceed 2.5 per-*
21 *cent of income.”.*

22 (b) *EFFECTIVE DATE.*—*The amendments made by sub-*
23 *section (a) shall apply as of January 1, 2009.*

1 **SEC. 218. INTELLIGENT ASSIGNMENT IN ENROLLMENT.**

2 (a) *IN GENERAL.*—Section 1860D–1(b)(1) of the So-
3 cial Security Act (42 U.S.C. 1395w–101(b)(1)) is amend-
4 ed—

5 (1) *in the second sentence of subparagraph (C),*
6 *by inserting “, subject to subparagraph (D),” before*
7 *“on a random basis”; and*

8 (2) *by adding at the end the following new sub-*
9 *paragraph:*

10 “(D) *INTELLIGENT ASSIGNMENT.*—*In the*
11 *case of any auto-enrollment under subparagraph*
12 *(C), no part D eligible individual described in*
13 *such subparagraph shall be enrolled in a pre-*
14 *scription drug plan which does not meet the fol-*
15 *lowing requirements:*

16 “(i) *FORMULARY.*—*The plan has a for-*
17 *mulary that covers at least—*

18 “(I) *95 percent of the 100 most*
19 *commonly prescribed non-duplicative*
20 *generic covered part D drugs for the*
21 *population of individuals entitled to*
22 *benefits under part A or enrolled under*
23 *part B; and*

24 “(II) *95 percent of the 100 most*
25 *commonly prescribed non-duplicative*

1 *brand name covered part D drugs for*
2 *such population.*

3 “(ii) *PHARMACY NETWORK.*—*The plan*
4 *has a network of pharmacies that substan-*
5 *tially exceeds the minimum requirements*
6 *for prescription drug plans in the State and*
7 *that provides access in areas where lower*
8 *income individuals reside.*

9 “(iii) *QUALITY.*—

10 “(I) *IN GENERAL.*—*Subject to*
11 *subclause (I), the plan has an above*
12 *average score on quality ratings of the*
13 *Secretary of prescription drug plans*
14 *under this part.*

15 “(II) *EXCEPTION.*—*Subclause (I)*
16 *shall not apply to a plan that is a new*
17 *plan (as defined by the Secretary),*
18 *with respect to the plan year involved.*

19 “(iv) *LOW COST.*—*The total cost under*
20 *this title of providing prescription drug cov-*
21 *erage under the plan consistent with the*
22 *previous clauses of this subparagraph is*
23 *among the lowest 25th percentile of pre-*
24 *scription drug plans under this part in the*
25 *State.*

1 *clause (iii), such costs shall be treated as in-*
2 *curring only if”;*

3 *(B) by striking “, under section 1860D–14,*
4 *or under a State Pharmaceutical Assistance Pro-*
5 *gram”;* and

6 *(C) by striking the period at the end and*
7 *inserting “; and”;* and

8 *(3) by inserting after clause (ii) the following*
9 *new clause:*

10 *“(iii) such costs shall be treated as in-*
11 *curring and shall not be considered to be re-*
12 *imbursed under clause (ii) if such costs are*
13 *borne or paid—*

14 *“(I) under section 1860D–14;*

15 *“(II) under a State Pharma-*
16 *ceutical Assistance Program;*

17 *“(III) by the Indian Health Serv-*
18 *ice, an Indian tribe or tribal organiza-*
19 *tion, or an urban Indian organization*
20 *(as defined in section 4 of the Indian*
21 *Health Care Improvement Act); or*

22 *“(IV) under an AIDS Drug As-*
23 *sistance Program under part B of title*
24 *XXVI of the Public Health Service*
25 *Act.”.*

1 (b) *EFFECTIVE DATE.*—*The amendments made by sub-*
 2 *section (a) shall apply to costs incurred on or after January*
 3 *1, 2009.*

4 **SEC. 222. PERMITTING MID-YEAR CHANGES IN ENROLL-**
 5 **MENT FOR FORMULARY CHANGES AD-**
 6 **VERSELY IMPACT AN ENROLLEE.**

7 (a) *IN GENERAL.*—*Section 1860D–1(b)(3) of the So-*
 8 *cial Security Act (42 U.S.C. 1395w–101(b)(3)) is amended*
 9 *by adding at the end the following new subparagraph:*

10 “(F) *CHANGE IN FORMULARY RESULTING IN*
 11 *INCREASE IN COST-SHARING.*—

12 “(i) *IN GENERAL.*—*Except as provided*
 13 *in clause (ii), in the case of an individual*
 14 *enrolled in a prescription drug plan (or*
 15 *MA–PD plan) who has been prescribed a*
 16 *covered part D drug while so enrolled, if the*
 17 *formulary of the plan is materially changed*
 18 *(other than at the end of a contract year)*
 19 *so to reduce the coverage (or increase the*
 20 *cost-sharing) of the drug under the plan.*

21 “(ii) *EXCEPTION.*—*Clause (i) shall not*
 22 *apply in the case that a drug is removed*
 23 *from the formulary of a plan because of a*
 24 *recall or withdrawal of the drug issued by*
 25 *the Food and Drug Administration.”.*

1 (b) *EFFECTIVE DATE.*—*The amendment made by sub-*
 2 *section (a) shall apply to contract years beginning on or*
 3 *after January 1, 2009.*

4 **SEC. 223. REMOVAL OF EXCLUSION OF BENZODIAZEPINES**
 5 **FROM REQUIRED COVERAGE UNDER THE**
 6 **MEDICARE PRESCRIPTION DRUG PROGRAM.**

7 (a) *IN GENERAL.*—*Section 1860D–2(e)(2)(A) of the*
 8 *Social Security Act (42 U.S.C. 1395w–102(e)(2)(A)) is*
 9 *amended—*

10 (1) *by striking “subparagraph (E)” and insert-*
 11 *ing “subparagraphs (E) and (J)”;* and

12 (2) *by inserting “and benzodiazepines, respec-*
 13 *tively” after “smoking cessation agents”.*

14 (b) *EFFECTIVE DATE.*—*The amendments made by sub-*
 15 *section (a) shall apply to prescriptions dispensed on or after*
 16 *January 1, 2009.*

17 **SEC. 224. PERMITTING UPDATING DRUG COMPENDIA**
 18 **UNDER PART D USING PART B UPDATE PROC-**
 19 **ESS.**

20 *Section 1860D–4(b)(3)(C) of the Social Security Act*
 21 *(42 U.S.C. 1395w–104(b)(3)(C)) is amended by adding at*
 22 *the end the following new clause:*

23 “(iv) **UPDATING DRUG COMPENDIA**
 24 **USING PART B PROCESS.**—*The Secretary*
 25 *may apply under this subparagraph the*

1 *same process for updating drug compendia*
 2 *that is used for purposes of section*
 3 *1861(t)(2)(B)(ii).”.*

4 **SEC. 225. CODIFICATION OF SPECIAL PROTECTIONS FOR**
 5 **SIX PROTECTED DRUG CLASSIFICATIONS.**

6 *(a) IN GENERAL.—Section 1860D–4(b)(3) of the So-*
 7 *cial Security Act (42 U.S.C. 1395w–104(b)(3)) is amend-*
 8 *ed—*

9 *(1) in subparagraph (C)(i), by inserting “, ex-*
 10 *cept as provided in subparagraph (G),” after “al-*
 11 *though”; and*

12 *(2) by inserting after subparagraph (F) the fol-*
 13 *lowing new subparagraph:*

14 *“(G) REQUIRED INCLUSION OF DRUGS IN*
 15 *CERTAIN THERAPEUTIC CLASSES.—*

16 *“(i) IN GENERAL.—The formulary*
 17 *must include all or substantially all covered*
 18 *part D drugs in each of the following thera-*
 19 *peutic classes of covered part D drugs:*

20 *“(I) Anticonvulsants.*

21 *“(II) Antineoplastics.*

22 *“(III) Antiretrovirals.*

23 *“(IV) Antidepressants.*

24 *“(V) Antipsychotics.*

25 *“(VI) Immunosuppressants.*

1 “(i) *USE OF UTILIZATION MANAGE-*
2 *MENT TOOLS.*—A PDP sponsor of a pre-
3 *scription drug plan may use prior author-*
4 *ization or step therapy for the initiation of*
5 *medications within one of the classifications*
6 *specified in clause (i) but only when ap-*
7 *proved by the Secretary, except that such*
8 *prior authorization or step therapy may not*
9 *be used in the case of antiretrovirals and in*
10 *the case of individuals who already are sta-*
11 *bilized on a drug treatment regimen.”.*

12 (b) *EFFECTIVE DATE.*—The amendment made by sub-
13 *section (a) shall apply for plan years beginning on or after*
14 *January 1, 2009.*

15 **SEC. 226. ELIMINATION OF MEDICARE PART D LATE EN-**
16 **ROLLMENT PENALTIES PAID BY LOW-INCOME**
17 **SUBSIDY-ELIGIBLE INDIVIDUALS.**

18 (a) *INDIVIDUALS WITH INCOME BELOW 135 PERCENT*
19 *OF POVERTY LINE.*—Paragraph (1)(A)(ii) of section
20 *1860D–14(a) of the Social Security Act (42 U.S.C. 1395w–*
21 *114(a)) is amended to read as follows:*

22 “(i) 100 percent of any late enroll-
23 *ment penalties imposed under section*
24 *1860D–13(b) for such individual.”.*

1 (b) *INDIVIDUALS WITH INCOME BETWEEN 135 AND*
 2 *150 PERCENT OF POVERTY LINE.*—Paragraph (2)(A) of
 3 *such section is amended—*

4 (1) *by inserting “equal to (i) an amount” after*
 5 *“premium subsidy”;*

6 (2) *by striking “paragraph (1)(A)” and insert-*
 7 *ing “clause (i) of paragraph (1)(A)”;* and

8 (3) *by adding at the end before the period the fol-*
 9 *lowing: “, plus (ii) 100 percent of the amount de-*
 10 *scribed in clause (ii) of such paragraph for such indi-*
 11 *vidual”.*

12 (c) *EFFECTIVE DATE.*—*The amendments made by this*
 13 *section shall apply to subsidies for months beginning with*
 14 *January 2008.*

15 **SEC. 227. SPECIAL ENROLLMENT PERIOD FOR SUBSIDY ELI-**
 16 **GIBLE INDIVIDUALS.**

17 (a) *IN GENERAL.*—*Section 1860D–1(b)(3) of the So-*
 18 *cial Security Act (42 U.S.C. 1395w–101(b)(3)), as amended*
 19 *by section 222(a), is further amended by adding at the end*
 20 *the following new subparagraph:*

21 “(G) *ELIGIBILITY FOR LOW-INCOME SUB-*
 22 *SIDY.*—

23 “(i) *IN GENERAL.*—*In the case of an*
 24 *applicable subsidy eligible individual (as*

1 *defined in clause (ii)), the special enroll-*
2 *ment period described in clause (iii).*

3 “(ii) *APPLICABLE SUBSIDY ELIGIBLE*
4 *INDIVIDUAL DEFINED.—For purposes of this*
5 *subparagraph, the term ‘applicable subsidy*
6 *eligible individual’ means a part D eligible*
7 *individual who is determined under sub-*
8 *paragraph (B) of section 1860D–14(a)(3) to*
9 *be a subsidy eligible individual (as defined*
10 *in subparagraph (A) of such section), and*
11 *includes such an individual who was en-*
12 *rolled in a prescription drug plan or an*
13 *MA–PD plan on the date of such deter-*
14 *mination.*

15 “(iii) *SPECIAL ENROLLMENT PERIOD*
16 *DESCRIBED.—The special enrollment period*
17 *described in this clause, with respect to an*
18 *applicable subsidy eligible individual, is the*
19 *90-day period beginning on the date the in-*
20 *dividual receives notification that such in-*
21 *dividual has been determined under section*
22 *1860D–14(a)(3)(B) to be a subsidy eligible*
23 *individual (as so defined).”.*

24 (b) *AUTOMATIC ENROLLMENT PROCESS FOR CERTAIN*
25 *SUBSIDY ELIGIBLE INDIVIDUALS.—Section 1860D–1(b)(1)*

1 *of the Social Security Act (42 U.S.C. 1395w–101(b)(1)), as*
2 *amended by section 218(a)(2), is further amended by add-*
3 *ing at the end the following new subparagraph:*

4 “(E) *SPECIAL RULE FOR SUBSIDY ELIGIBLE*
5 *INDIVIDUALS.—The process established under*
6 *subparagraph (A) shall include, in the case of an*
7 *applicable subsidy eligible individual (as defined*
8 *in clause (ii) of paragraph (3)(F)) who fails to*
9 *enroll in a prescription drug plan or an MA–PD*
10 *plan during the special enrollment period de-*
11 *scribed in clause (iii) of such paragraph applica-*
12 *ble to such individual, a process for the facili-*
13 *tated enrollment of the individual in the pre-*
14 *scription drug plan or MA–PD plan that is most*
15 *appropriate for such individual (as determined*
16 *by the Secretary). Nothing in the previous sen-*
17 *tence shall prevent an individual described in*
18 *such sentence from declining enrollment in a*
19 *plan determined appropriate by the Secretary*
20 *(or in the program under this part) or from*
21 *changing such enrollment.”.*

22 (c) *EFFECTIVE DATE.—The amendments made by this*
23 *section shall apply to subsidy determinations made for*
24 *months beginning with January 2008.*

1 ***Subtitle D—Reducing Health***
2 ***Disparities***

3 **SEC. 231. MEDICARE DATA ON RACE, ETHNICITY, AND PRI-**
4 **MARY LANGUAGE.**

5 (a) *REQUIREMENTS.*—

6 (1) *IN GENERAL.*—*The Secretary of Health and*
7 *Human Services (in this subtitle referred to as the*
8 *“Secretary”)* shall—

9 (A) *collect data on the race, ethnicity, and*
10 *primary language of each applicant for and re-*
11 *cipient of benefits under title XVIII of the Social*
12 *Security Act—*

13 (i) *using, at a minimum, the cat-*
14 *egories for race and ethnicity described in*
15 *the 1997 Office of Management and Budget*
16 *Standards for Maintaining, Collecting, and*
17 *Presenting Federal Data on Race and Eth-*
18 *nicity;*

19 (ii) *using the standards developed*
20 *under subsection (e) for the collection of lan-*
21 *guage data;*

22 (iii) *where practicable, collecting data*
23 *for additional population groups if such*
24 *groups can be aggregated into the minimum*
25 *race and ethnicity categories; and*

1 (iv) where practicable, through self-re-
2 porting;

3 (B) with respect to the collection of the data
4 described in subparagraph (A) for applicants
5 and recipients who are minors or otherwise le-
6 gally incapacitated, require that—

7 (i) such data be collected from the par-
8 ent or legal guardian of such an applicant
9 or recipient; and

10 (ii) the preferred language of the par-
11 ent or legal guardian of such an applicant
12 or recipient be collected;

13 (C) systematically analyze at least annually
14 such data using the smallest appropriate units of
15 analysis feasible to detect racial and ethnic dis-
16 parities in health and health care and when ap-
17 propriate, for men and women separately;

18 (D) report the results of analysis annually
19 to the Director of the Office for Civil Rights, the
20 Committee on Health, Education, Labor, and
21 Pensions and the Committee on Finance of the
22 Senate, and the Committee on Energy and Com-
23 merce and the Committee on Ways and Means of
24 the House of Representatives; and

1 (E) ensure that the provision of assistance
2 to an applicant or recipient of assistance is not
3 denied or otherwise adversely affected because of
4 the failure of the applicant or recipient to pro-
5 vide race, ethnicity, and primary language data.

6 (2) *RULES OF CONSTRUCTION.*—Nothing in this
7 subsection shall be construed—

8 (A) to permit the use of information col-
9 lected under this subsection in a manner that
10 would adversely affect any individual providing
11 any such information; and

12 (B) to require health care providers to col-
13 lect data.

14 (b) *PROTECTION OF DATA.*—The Secretary shall en-
15 sure (through the promulgation of regulations or otherwise)
16 that all data collected pursuant to subsection (a) is pro-
17 tected—

18 (1) under the same privacy protections as the
19 Secretary applies to other health data under the regu-
20 lations promulgated under section 264(c) of the
21 Health Insurance Portability and Accountability Act
22 of 1996 (Public Law 104–191; 110 Stat. 2033) relat-
23 ing to the privacy of individually identifiable health
24 information and other protections; and

1 (2) *from all inappropriate internal use by any*
2 *entity that collects, stores, or receives the data, includ-*
3 *ing use of such data in determinations of eligibility*
4 *(or continued eligibility) in health plans, and from*
5 *other inappropriate uses, as defined by the Secretary.*

6 (c) *COLLECTION PLAN.—In carrying out the duties*
7 *specified in subsection (a), the Secretary shall develop and*
8 *implement a plan to improve the collection, analysis, and*
9 *reporting of racial, ethnic, and primary language data*
10 *within the programs administered under title XVIII of the*
11 *Social Security Act, and, in consultation with the National*
12 *Committee on Vital Health Statistics, the Office of Minority*
13 *Health, and other appropriate public and private entities,*
14 *shall make recommendations on how to—*

15 (1) *implement subsection (a) while minimizing*
16 *the cost and administrative burdens of data collection*
17 *and reporting;*

18 (2) *expand awareness that data collection, anal-*
19 *ysis, and reporting by race, ethnicity, and primary*
20 *language is legal and necessary to assure equity and*
21 *non-discrimination in the quality of health care serv-*
22 *ices;*

23 (3) *ensure that future patient record systems*
24 *have data code sets for racial, ethnic, and primary*
25 *language identifiers and that such identifiers can be*

1 retrieved from clinical records, including records
2 transmitted electronically;

3 (4) improve health and health care data collec-
4 tion and analysis for more population groups if such
5 groups can be aggregated into the minimum race and
6 ethnicity categories;

7 (5) provide researchers with greater access to ra-
8 cial, ethnic, and primary language data, subject to
9 privacy and confidentiality regulations; and

10 (6) safeguard and prevent the misuse of data col-
11 lected under subsection (a).

12 (d) *COMPLIANCE WITH STANDARDS.*—Data collected
13 under subsection (a) shall be obtained, maintained, and
14 presented (including for reporting purposes and at a min-
15 imum) in accordance with the 1997 Office of Management
16 and Budget Standards for Maintaining, Collecting, and
17 Presenting Federal Data on Race and Ethnicity.

18 (e) *LANGUAGE COLLECTION STANDARDS.*—Not later
19 than 1 year after the date of enactment of this Act, the Di-
20 rector of the Office of Minority Health, in consultation with
21 the Office for Civil Rights of the Department of Health and
22 Human Services, shall develop and disseminate Standards
23 for the Classification of Federal Data on Preferred Written
24 and Spoken Language.

1 (f) *TECHNICAL ASSISTANCE FOR THE COLLECTION*
2 *AND REPORTING OF DATA.*—

3 (1) *IN GENERAL.*—*The Secretary may, either di-*
4 *rectly or through grant or contract, provide technical*
5 *assistance to enable a health care provider or plan op-*
6 *erating under the Medicare program to comply with*
7 *the requirements of this section.*

8 (2) *TYPES OF ASSISTANCE.*—*Assistance provided*
9 *under this subsection may include assistance to—*

10 (A) *enhance or upgrade computer tech-*
11 *nology that will facilitate racial, ethnic, and pri-*
12 *mary language data collection and analysis;*

13 (B) *improve methods for health data collec-*
14 *tion and analysis including additional popu-*
15 *lation groups beyond the Office of Management*
16 *and Budget categories if such groups can be ag-*
17 *gregated into the minimum race and ethnicity*
18 *categories;*

19 (C) *develop mechanisms for submitting col-*
20 *lected data subject to existing privacy and con-*
21 *fidentiality regulations; and*

22 (D) *develop educational programs to raise*
23 *awareness that data collection and reporting by*
24 *race, ethnicity, and preferred language are legal*

1 *and essential for eliminating health and health*
2 *care disparities.*

3 *(g) ANALYSIS OF RACIAL AND ETHNIC DATA.—The*
4 *Secretary, acting through the Director of the Agency for*
5 *Health Care Research and Quality and in coordination*
6 *with the Administrator of the Centers for Medicare & Med-*
7 *icaid Services, shall—*

8 *(1) identify appropriate quality assurance mech-*
9 *anisms to monitor for health disparities under the*
10 *Medicare program;*

11 *(2) specify the clinical, diagnostic, or therapeutic*
12 *measures which should be monitored;*

13 *(3) develop new quality measures relating to ra-*
14 *cial and ethnic disparities in health and health care;*

15 *(4) identify the level at which data analysis*
16 *should be conducted; and*

17 *(5) share data with external organizations for re-*
18 *search and quality improvement purposes, in compli-*
19 *ance with applicable Federal privacy laws.*

20 *(h) REPORT.—Not later than 2 years after the date*
21 *of enactment of this Act, and biennially thereafter, the Sec-*
22 *retary shall submit to the appropriate committees of Con-*
23 *gress a report on the effectiveness of data collection, anal-*
24 *ysis, and reporting on race, ethnicity, and primary lan-*
25 *guage under the programs administered through title XVIII*

1 *of the Social Security Act. The report shall evaluate the*
2 *progress made with respect to the plan under subsection (c)*
3 *or subsequent revisions thereto.*

4 (i) *AUTHORIZATION OF APPROPRIATIONS.—There is*
5 *authorized to be appropriated to carry out this section, such*
6 *sums as may be necessary for each of fiscal years 2008*
7 *through 2012.*

8 **SEC. 232. ENSURING EFFECTIVE COMMUNICATION IN MEDI-**
9 **CARE.**

10 (a) *ENSURING EFFECTIVE COMMUNICATION BY THE*
11 *CENTERS FOR MEDICARE & MEDICAID SERVICES.—*

12 (1) *STUDY ON MEDICARE PAYMENTS FOR LAN-*
13 *GUAGE SERVICES.—The Secretary of Health and*
14 *Human Services shall conduct a study that examines*
15 *ways that Medicare should develop payment systems*
16 *for language services using the results of the dem-*
17 *onstration program conducted under section 233.*

18 (2) *ANALYSES.—The study shall include an*
19 *analysis of each of the following:*

20 (A) *How to develop and structure appro-*
21 *priate payment systems for language services for*
22 *all Medicare service providers.*

23 (B) *The feasibility of adopting a payment*
24 *methodology for on-site interpreters, including*
25 *interpreters who work as independent contractors*

1 *and interpreters who work for agencies that pro-*
2 *vide on-site interpretation, pursuant to which*
3 *such interpreters could directly bill Medicare for*
4 *services provided in support of physician office*
5 *services for an LEP Medicare patient.*

6 *(C) The feasibility of Medicare contracting*
7 *directly with agencies that provide off-site inter-*
8 *pretation including telephonic and video inter-*
9 *pretation pursuant to which such contractors*
10 *could directly bill Medicare for the services pro-*
11 *vided in support of physician office services for*
12 *an LEP Medicare patient.*

13 *(D) The feasibility of modifying the existing*
14 *Medicare resource-based relative value scale*
15 *(RBRVS) by using adjustments (such as multi-*
16 *pliers or add-ons) when a patient is LEP.*

17 *(E) How each of options described in a pre-*
18 *vious paragraph would be funded and how such*
19 *funding would affect physician payments, a phy-*
20 *sician's practice, and beneficiary cost-sharing.*

21 (3) VARIATION IN PAYMENT SYSTEM DE-
22 SCRIBED.—*The payment systems described in sub-*
23 *section (b) may allow variations based upon types of*
24 *service providers, available delivery methods, and*

1 *costs for providing language services including such*
2 *factors as—*

3 *(A) the type of language services provided*
4 *(such as provision of health care or health care*
5 *related services directly in a non-English lan-*
6 *guage by a bilingual provider or use of an inter-*
7 *preter);*

8 *(B) type of interpretation services provided*
9 *(such as in-person, telephonic, video interpreta-*
10 *tion);*

11 *(C) the methods and costs of providing lan-*
12 *guage services (including the costs of providing*
13 *language services with internal staff or through*
14 *contract with external independent contractors*
15 *and/or agencies);*

16 *(D) providing services for languages not fre-*
17 *quently encountered in the United States; and*

18 *(E) providing services in rural areas.*

19 *(4) REPORT.—The Secretary shall submit a re-*
20 *port on the study conducted under subsection (a) to*
21 *appropriate committees of Congress not later than 1*
22 *year after the expiration of the demonstration pro-*
23 *gram conducted under section 3.*

24 *(b) HEALTH PLANS.—Section 1857(g)(1) of the Social*
25 *Security Act (42 U.S.C. 1395w–27(g)(1)) is amended—*

1 (1) by striking “or” at the end of subparagraph
2 (F);

3 (2) by adding “or” at the end of subparagraph
4 (G); and

5 (3) by inserting after subparagraph (G) the fol-
6 lowing new subparagraph:

7 “(H) fails substantially to provide language
8 services to limited English proficient bene-
9 ficiaries enrolled in the plan that are required
10 under law;”.

11 **SEC. 233. DEMONSTRATION TO PROMOTE ACCESS FOR**
12 **MEDICARE BENEFICIARIES WITH LIMITED**
13 **ENGLISH PROFICIENCY BY PROVIDING REIM-**
14 **BURSEMENT FOR CULTURALLY AND LINGUIS-**
15 **TICALLY APPROPRIATE SERVICES.**

16 (a) *IN GENERAL.*—Within one year after the date of
17 the enactment of this Act the Secretary, acting through the
18 Centers for Medicare & Medicaid Services, shall award 24
19 3-year demonstration grants to eligible Medicare service
20 providers to improve effective communication between such
21 providers and Medicare beneficiaries who are limited
22 English proficient. The Secretary shall not authorize a
23 grant larger than \$500,000 over three years for any grantee.

24 (b) *ELIGIBILITY; PRIORITY.*—

1 (1) *ELIGIBILITY.*—*To be eligible to receive a*
2 *grant under subsection (1) an entity shall—*

3 (A) *be—*

4 (i) *a provider of services under part A*
5 *of title XVIII of the Social Security Act;*

6 (ii) *a service provider under part B of*
7 *such title;*

8 (iii) *a part C organization offering a*
9 *Medicare part C plan under part C of such*
10 *title; or*

11 (iv) *a PDP sponsor of a prescription*
12 *drug plan under part D of such title; and*

13 (B) *prepare and submit to the Secretary an*
14 *application, at such time, in such manner, and*
15 *accompanied by such additional information as*
16 *the Secretary may require.*

17 (2) *PRIORITY.*—

18 (A) *DISTRIBUTION.*—*To the extent feasible,*
19 *in awarding grants under this section, the Sec-*
20 *retary shall award—*

21 (i) *6 grants to providers of services de-*
22 *scribed in paragraph (1)(A)(i);*

23 (ii) *6 grants to service providers de-*
24 *scribed in paragraph (1)(A)(ii);*

1 (iii) 6 grants to organizations de-
2 scribed in paragraph (1)(A)(iii); and

3 (iv) 6 grants to sponsors described in
4 paragraph (1)(A)(iv).

5 (B) *FOR COMMUNITY ORGANIZATIONS.*—*The*
6 *Secretary shall give priority to applicants that*
7 *have developed partnerships with community or-*
8 *ganizations or with agencies with experience in*
9 *language access.*

10 (C) *VARIATION IN GRANTEES.*—*The Sec-*
11 *retary shall also ensure that the grantees under*
12 *this section represent, among other factors, vari-*
13 *ations in—*

14 (i) *different types of service providers*
15 *and organizations under parts A through D*
16 *of title XVIII of the Social Security Act;*

17 (ii) *languages needed and their fre-*
18 *quency of use;*

19 (iii) *urban and rural settings;*

20 (iv) *at least two geographic regions;*

21 *and*

22 (v) *at least two large metropolitan sta-*
23 *tistical areas with diverse populations.*

24 (c) *USE OF FUNDS.*—

1 (1) *IN GENERAL.*—A grantee shall use grant
2 funds received under this section to pay for the provi-
3 sion of competent language services to Medicare bene-
4 ficiaries who are limited English proficient. Com-
5 petent interpreter services may be provided through
6 on-site interpretation, telephonic interpretation, or
7 video interpretation or direct provision of health care
8 or health care related services by a bilingual health
9 care provider. A grantee may use bilingual providers,
10 staff, or contract interpreters. A grantee may use
11 grant funds to pay for competent translation services.
12 A grantee may use up to 10 percent of the grant
13 funds to pay for administrative costs associated with
14 the provision of competent language services and for
15 reporting required under subsection (E).

16 (2) *ORGANIZATIONS.*—Grantees that are part C
17 organizations or PDP sponsors must ensure that their
18 network providers receive at least 50 percent of the
19 grant funds to pay for the provision of competent lan-
20 guage services to Medicare beneficiaries who are lim-
21 ited English proficient, including physicians and
22 pharmacies.

23 (3) *DETERMINATION OF PAYMENTS FOR LAN-*
24 *GUAGE SERVICES.*—Payments to grantees shall be cal-
25 culated based on the estimated numbers of LEP Medi-

1 *care beneficiaries in a grantee's service area uti-*
2 *lizing—*

3 *(A) data on the numbers of limited English*
4 *proficient individuals who speak English less*
5 *than “very well” from the most recently avail-*
6 *able data from the Bureau of the Census or other*
7 *State-based study the Secretary determines likely*
8 *to yield accurate data regarding the number of*
9 *LEP individuals served by the grantee; or*

10 *(B) the grantee's own data if the grantee*
11 *routinely collects data on Medicare beneficiaries'*
12 *primary language in a manner determined by*
13 *the Secretary to yield accurate data and such*
14 *data shows greater numbers of LEP individuals*
15 *than the data listed in subparagraph (A).*

16 *(4) LIMITATIONS.—*

17 *(A) REPORTING.—Payments shall only be*
18 *provided under this section to grantees that re-*
19 *port their costs of providing language services as*
20 *required under subsection (e). If a grantee fails*
21 *to provide the reports under such section for the*
22 *first year of a grant, the Secretary may termi-*
23 *nate the grant and solicit applications from new*
24 *grantees to participate in the subsequent two*
25 *years of the demonstration program.*

1 (B) *TYPE OF SERVICES.*—

2 (i) *IN GENERAL.*—Subject to clause
3 (ii), payments shall be provided under this
4 section only to grantees that utilize com-
5 petent bilingual staff or competent inter-
6 preter or translation services which—

7 (I) if the grantee operates in a
8 State that has statewide health care in-
9 terpreter standards, meet the State
10 standards currently in effect; or

11 (II) if the grantee operates in a
12 State that does not have statewide
13 health care interpreter standards, uti-
14 lizes competent interpreters who follow
15 the National Council on Interpreting
16 in Health Care’s Code of Ethics and
17 Standards of Practice.

18 (ii) *EXEMPTIONS.*—The requirements
19 of clause (i) shall not apply—

20 (I) in the case of a Medicare bene-
21 ficiary who is limited English pro-
22 ficient (who has been informed in the
23 beneficiary’s primary language of the
24 availability of free interpreter and
25 translation services) and who requests

1 *the use of family, friends, or other per-*
2 *sons untrained in interpretation or*
3 *translation and the grantee documents*
4 *the request in the beneficiary's record;*
5 *and*

6 *(II) in the case of a medical emer-*
7 *gency where the delay directly associ-*
8 *ated with obtaining a competent inter-*
9 *preter or translation services would*
10 *jeopardize the health of the patient.*

11 *Nothing in clause (ii)(II) shall be construed*
12 *to exempt an emergency rooms or similar*
13 *entities that regularly provide health care*
14 *services in medical emergencies from having*
15 *in place systems to provide competent inter-*
16 *preter and translation services without*
17 *undue delay.*

18 *(d) ASSURANCES.—Grantees under this section shall—*

19 *(1) ensure that appropriate clinical and support*
20 *staff receive ongoing education and training in lin-*
21 *guistically appropriate service delivery; ensure the*
22 *linguistic competence of bilingual providers;*

23 *(2) offer and provide appropriate language serv-*
24 *ices at no additional charge to each patient with lim-*

1 *ited English proficiency at all points of contact, in a*
2 *timely manner during all hours of operation;*

3 *(3) notify Medicare beneficiaries of their right to*
4 *receive language services in their primary language;*

5 *(4) post signage in the languages of the com-*
6 *monly encountered group or groups present in the*
7 *service area of the organization; and*

8 *(5) ensure that—*

9 *(A) primary language data are collected for*
10 *recipients of language services; and*

11 *(B) consistent with the privacy protections*
12 *provided under the regulations promulgated pur-*
13 *suant to section 264(c) of the Health Insurance*
14 *Portability and Accountability Act of 1996 (42*
15 *U.S.C. 1320d–2 note), if the recipient of lan-*
16 *guage services is a minor or is incapacitated, the*
17 *primary language of the parent or legal guard-*
18 *ian is collected and utilized.*

19 *(e) REPORTING REQUIREMENTS.—Grantees under this*
20 *section shall provide the Secretary with reports at the con-*
21 *clusion of the each year of a grant under this section. each*
22 *report shall include at least the following information:*

23 *(1) The number of Medicare beneficiaries to*
24 *whom language services are provided.*

25 *(2) The languages of those Medicare beneficiaries.*

1 (3) *The types of language services provided (such*
2 *as provision of services directly in non-English lan-*
3 *guage by a bilingual health care provider or use of an*
4 *interpreter).*

5 (4) *Type of interpretation (such as in-person,*
6 *telephonic, or video interpretation).*

7 (5) *The methods of providing language services*
8 *(such as staff or contract with external independent*
9 *contractors or agencies).*

10 (6) *The length of time for each interpretation en-*
11 *counter.*

12 (7) *The costs of providing language services*
13 *(which may be actual or estimated, as determined by*
14 *the Secretary).*

15 (f) *NO COST SHARING.—LEP Beneficiaries shall not*
16 *have to pay cost-sharing or co-pays for language services*
17 *provided through this demonstration program.*

18 (g) *EVALUATION AND REPORT.—The Secretary shall*
19 *conduct an evaluation of the demonstration program under*
20 *this section and shall submit to the appropriate committees*
21 *of Congress a report not later than 1 year after the comple-*
22 *tion of the program. The report shall include the following:*

23 (1) *An analysis of the patient outcomes and costs*
24 *of furnishing care to the LEP Medicare beneficiaries*
25 *participating in the project as compared to such out-*

1 *comes and costs for limited English proficient Medi-*
2 *care beneficiaries not participating.*

3 (2) *The effect of delivering culturally and lin-*
4 *guistically appropriate services on beneficiary access*
5 *to care, utilization of services, efficiency and cost-ef-*
6 *fectiveness of health care delivery, patient satisfaction,*
7 *and select health outcomes.*

8 (3) *Recommendations regarding the extension of*
9 *such project to the entire Medicare program.*

10 (h) *GENERAL PROVISIONS.—Nothing in this section*
11 *shall be construed to limit otherwise existing obligations of*
12 *recipients of Federal financial assistance under title VI of*
13 *the Civil Rights Act of 1964 (42 U.S.C. 2000(d) et. seq.)*
14 *or any other statute.*

15 (i) *AUTHORIZATION OF APPROPRIATIONS.—There are*
16 *authorized to be appropriated to carry out this section*
17 *\$10,000,000 for each fiscal year of the demonstration.*

18 **SEC. 234. DEMONSTRATION TO IMPROVE CARE TO PRE-**
19 **VIOUSLY UNINSURED.**

20 (a) *ESTABLISHMENT.—Within one year after the date*
21 *of enactment of this Act, the Secretary shall establish a dem-*
22 *onstration project to determine the greatest needs and most*
23 *effective methods of outreach to medicare beneficiaries who*
24 *were previously uninsured.*

1 (b) *SCOPE.*—*The demonstration shall be in no fewer*
2 *than 10 sites, and shall include state health insurance as-*
3 *sistance programs, community health centers, community-*
4 *based organizations, community health workers, and other*
5 *service providers under parts A, B, and C of title XVIII*
6 *of the Social Security Act. Grantees that are plans oper-*
7 *ating under part C shall document that enrollees who were*
8 *previously uninsured receive the “Welcome to Medicare”*
9 *physical exam.*

10 (c) *DURATION.*—*The Secretary shall conduct the dem-*
11 *onstration project for a period of 2 years.*

12 (d) *REPORT AND EVALUATION.*—*The Secretary shall*
13 *conduct an evaluation of the demonstration and not later*
14 *than 1 year after the completion of the project shall submit*
15 *to Congress a report including the following:*

16 (1) *An analysis of the effectiveness of outreach*
17 *activities targeting beneficiaries who were previously*
18 *uninsured, such as revising outreach and enrollment*
19 *materials (including the potential for use of video in-*
20 *formation), providing one-on-one counseling, working*
21 *with community health workers, and amending the*
22 *Medicare and You handbook.*

23 (2) *The effect of such outreach on beneficiary ac-*
24 *cess to care, utilization of services, efficiency and cost-*

1 *effectiveness of health care delivery, patient satisfac-*
2 *tion, and select health outcomes.*

3 **SEC. 235. OFFICE OF THE INSPECTOR GENERAL REPORT ON**
4 **COMPLIANCE WITH AND ENFORCEMENT OF**
5 **NATIONAL STANDARDS ON CULTURALLY AND**
6 **LINGUISTICALLY APPROPRIATE SERVICES**
7 **(CLAS) IN MEDICARE.**

8 *(a) REPORT.—Not later than two years after the date*
9 *of the enactment of this Act, the Inspector General of the*
10 *Department of Health and Human Services shall prepare*
11 *and publish a report on—*

12 *(1) the extent to which Medicare providers and*
13 *plans are complying with the Office for Civil Rights’*
14 *Guidance to Federal Financial Assistance Recipients*
15 *Regarding Title VI Prohibition Against National Ori-*
16 *gin Discrimination Affecting Limited English Pro-*
17 *ficient Persons and the Office of Minority Health’s*
18 *Culturally and Linguistically Appropriate Services*
19 *Standards in health care; and*

20 *(2) a description of the costs associated with or*
21 *savings related to the provision of language services.*

22 *Such report shall include recommendations on improving*
23 *compliance with CLAS Standards and recommendations on*
24 *improving enforcement of CLAS Standards.*

1 (b) *IMPLEMENTATION.*—Not later than one year after
2 the date of publication of the report under subsection (a),
3 the Department of Health and Human Services shall imple-
4 ment changes responsive to any deficiencies identified in
5 the report.

6 **SEC. 236. IOM REPORT ON IMPACT OF LANGUAGE ACCESS**
7 **SERVICES.**

8 (a) *IN GENERAL.*—The Secretary of Health and
9 Human Services shall seek to enter into an arrangement
10 with the Institute of Medicine under which the Institute will
11 prepare and publish, not later than 3 years after the date
12 of the enactment of this Act, a report on the impact of lan-
13 guage access services on the health and health care of lim-
14 ited English proficient populations.

15 (b) *CONTENTS.*—Such report shall include—

16 (1) recommendations on the development and
17 implementation of policies and practices by health
18 care organizations and providers for limited English
19 proficient patient populations;

20 (2) a description of the effect of providing lan-
21 guage access services on quality of health care and ac-
22 cess to care and reduced medical error; and

23 (3) a description of the costs associated with or
24 savings related to provision of language access serv-
25 ices.

1 **SEC. 237. DEFINITIONS.**

2 *In this subtitle:*

3 (1) *BILINGUAL.*—*The term “bilingual” with re-*
4 *spect to an individual means a person who has suffi-*
5 *cient degree of proficiency in two languages and can*
6 *ensure effective communication can occur in both lan-*
7 *guages.*

8 (2) *COMPETENT INTERPRETER SERVICES.*—*The*
9 *term “competent interpreter services” means a trans-*
10 *language rendition of a spoken message in which the*
11 *interpreter comprehends the source language and can*
12 *speak comprehensively in the target language to con-*
13 *vey the meaning intended in the source language. The*
14 *interpreter knows health and health-related termi-*
15 *nology and provides accurate interpretations by*
16 *choosing equivalent expressions that convey the best*
17 *matching and meaning to the source language and*
18 *captures, to the greatest possible extent, all nuances*
19 *intended in the source message.*

20 (3) *COMPETENT TRANSLATION SERVICES.*—*The*
21 *term “competent translation services” means a trans-*
22 *language rendition of a written document in which*
23 *the translator comprehends the source language and*
24 *can write comprehensively in the target language to*
25 *convey the meaning intended in the source language.*
26 *The translator knows health and health-related termi-*

1 *nology and provides accurate translations by choosing*
2 *equivalent expressions that convey the best matching*
3 *and meaning to the source language and captures, to*
4 *the greatest possible extent, all nuances intended in*
5 *the source document.*

6 (4) *EFFECTIVE COMMUNICATION.*—*The term “ef-*
7 *fective communication” means an exchange of infor-*
8 *mation between the provider of health care or health*
9 *care-related services and the limited English pro-*
10 *ficient recipient of such services that enables limited*
11 *English proficient individuals to access, understand,*
12 *and benefit from health care or health care-related*
13 *services.*

14 (5) *INTERPRETING/INTERPRETATION.*—*The terms*
15 *“interpreting” and “interpretation” mean the trans-*
16 *mission of a spoken message from one language into*
17 *another, faithfully, accurately, and objectively.*

18 (6) *HEALTH CARE SERVICES.*—*The term “health*
19 *care services” means services that address physical as*
20 *well as mental health conditions in all care settings.*

21 (7) *HEALTH CARE-RELATED SERVICES.*—*The*
22 *term “health care-related services” means human or*
23 *social services programs or activities that provide ac-*
24 *cess, referrals or links to health care.*

1 (8) *LANGUAGE ACCESS.*—*The term “language ac-*
2 *cess” means the provision of language services to an*
3 *LEP individual designed to enhance that individual’s*
4 *access to, understanding of or benefit from health care*
5 *or health care-related services.*

6 (9) *LANGUAGE SERVICES.*—*The term “language*
7 *services” means provision of health care services di-*
8 *rectly in a non-English language, interpretation,*
9 *translation, and non-English signage.*

10 (10) *LIMITED ENGLISH PROFICIENT.*—*The term*
11 *“limited English proficient” or “LEP” with respect*
12 *to an individual means an individual who speaks a*
13 *primary language other than English and who cannot*
14 *speak, read, write or understand the English language*
15 *at a level that permits the individual to effectively*
16 *communicate with clinical or nonclinical staff at an*
17 *entity providing health care or health care related*
18 *services.*

19 (11) *MEDICARE PROGRAM.*—*The term “Medicare*
20 *program” means the programs under parts A through*
21 *D of title XVIII of the Social Security Act.*

22 (12) *SERVICE PROVIDER.*—*The term “service*
23 *provider” includes all suppliers, providers of services,*
24 *or entities under contract to provide coverage, items*

1 *or services under any part of title XVIII of the Social*
2 *Security Act.*

3 ***TITLE III—PHYSICIANS’ SERVICE***
4 ***PAYMENT REFORM***

5 ***SEC. 301. ESTABLISHMENT OF SEPARATE TARGET GROWTH***
6 ***RATES FOR SERVICE CATEGORIES.***

7 *(a) ESTABLISHMENT OF SERVICE CATEGORIES.—Sub-*
8 *section (j) of section 1848 of the Social Security Act (42*
9 *U.S.C. 1395w-4) is amended by adding at the end the fol-*
10 *lowing new paragraph:*

11 *“(5) SERVICE CATEGORIES.—For services fur-*
12 *nished on or after January 1, 2008, each of the fol-*
13 *lowing categories of physicians’ services shall be treat-*
14 *ed as a separate ‘service category’:*

15 *“(A) Evaluation and management services*
16 *for primary care (including new and established*
17 *patient office visits delivered by physicians who*
18 *the Secretary determines provide accessible, con-*
19 *tinuous, coordinated, and comprehensive care for*
20 *Medicare beneficiaries, emergency department*
21 *visits, and home visits), and for preventive serv-*
22 *ices (including screening mammography,*
23 *colorectal cancer screening, and other services as*
24 *defined by the Secretary, limited to the rec-*

1 *ommendations of the United States Preventive*
2 *Services Task Force).*

3 “(B) *Evaluation and management services*
4 *not described in subparagraph (A).*”

5 “(C) *Imaging services (as defined in sub-*
6 *section (b)(4)(B)) and diagnostic tests (other*
7 *than clinical diagnostic laboratory tests) not de-*
8 *scribed in subparagraph (A).*”

9 “(D) *Procedures that are subject (under reg-*
10 *ulations promulgated to carry out this section)*
11 *to a 10-day or 90-day global period (in this*
12 *paragraph referred to as ‘major procedures’), ex-*
13 *cept that the Secretary may reclassify as minor*
14 *procedures under subparagraph (F) any proce-*
15 *dures that would otherwise be included in this*
16 *category if the Secretary determines that such*
17 *procedures are not major procedures.*”

18 “(E) *Anesthesia services that are paid on*
19 *the basis of the separate conversion factor for an-*
20 *esthesia services determined under subsection*
21 *(d)(1)(D).*”

22 “(F) *Minor procedures and any other phy-*
23 *sicians’ services that are not described in a pre-*
24 *ceding subparagraph.*”

1 (b) *ESTABLISHMENT OF SEPARATE CONVERSION FAC-*
2 *TORS FOR EACH SERVICE CATEGORY.—Subsection (d)(1)*
3 *of section 1848 of the Social Security Act (42 U.S.C.*
4 *1395w-4) is amended—*

5 (1) *in subparagraph (A)—*

6 (A) *by designating the sentence beginning*
7 *“The conversion factor” as clause (i) with the*
8 *heading “APPLICATION OF SINGLE CONVERSION*
9 *FACTOR.—” and with appropriate indentation;*

10 (B) *by striking “The conversion factor” and*
11 *inserting “Subject to clause (ii), the conversion*
12 *factor”;* and

13 (C) *by adding at the end the following new*
14 *clause:*

15 “(ii) *APPLICATION OF MULTIPLE CON-*
16 *VERSION FACTORS BEGINNING WITH 2008.—*

17 “(I) *IN GENERAL.—In applying*
18 *clause (i) for years beginning with*
19 *2008, separate conversion factors shall*
20 *be established for each service category*
21 *of physicians’ services (as defined in*
22 *subsection (j)(5)) and any reference in*
23 *this section to a conversion factor for*
24 *such years shall be deemed to be a ref-*

1 *erence to the conversion factor for each*
2 *of such categories.*

3 “(II) *INITIAL CONVERSION FAC-*
4 *TORS; SPECIAL RULE FOR ANESTHESIA*
5 *SERVICES.—Such factors for 2008 shall*
6 *be based upon the single conversion*
7 *factor for 2007 multiplied by the up-*
8 *date established under paragraph (8)*
9 *for such category for 2008. In the case*
10 *of the service category described in sub-*
11 *section (j)(5)(F) (relating to anesthesia*
12 *services), the conversion factor for 2008*
13 *shall be based on the separate conver-*
14 *sion factor specified in subparagraph*
15 *(D) for 2007 multiplied by the update*
16 *established under paragraph (8) for*
17 *such category for 2008.*

18 “(III) *UPDATING OF CONVERSION*
19 *FACTORS.—Such factor for a service*
20 *category for a subsequent year shall be*
21 *based upon the conversion factor for*
22 *such category for the previous year and*
23 *adjusted by the update established for*
24 *such category under paragraph (8) for*
25 *the year involved.”; and*

1 (2) in subparagraph (D), by inserting “(before
2 2008)” after “for a year”.

3 (c) *ESTABLISHING UPDATES FOR CONVERSION FAC-*
4 *TORS FOR SERVICE CATEGORIES.*—Section 1848(d) of the
5 *Social Security Act (42 U.S.C. 1395w-4(d)) is amended—*

6 (1) in paragraph (4)(B), by striking “and (6)”
7 and inserting “, (6), and (8)”;

8 (2) in paragraph (4)(C)(iii), by striking “The
9 allowed” and inserting “Subject to paragraph (8)(B),
10 the allowed”;

11 (3) in paragraph (4)(D), by striking “The up-
12 date” and inserting “Subject to paragraph (8)(E), the
13 update”; and

14 (4) by adding at the end the following new para-
15 graph:

16 “(8) *UPDATES FOR SERVICE CATEGORIES BEGIN-*
17 *NING WITH 2008.*—

18 “(A) *IN GENERAL.*—In applying paragraph
19 (4) for a year beginning with 2008, the following
20 rules apply:

21 “(i) *APPLICATION OF SEPARATE UP-*
22 *DATE ADJUSTMENTS FOR EACH SERVICE*
23 *CATEGORY.*—Pursuant to paragraph
24 (1)(A)(ii)(I), the update shall be made to
25 the conversion factor for each service cat-

1 egory (as defined in subsection (j)(5)) based
2 upon an update adjustment factor for the
3 respective category and year and the update
4 adjustment factor shall be computed, for a
5 year, separately for each service category.

6 “(ii) *COMPUTATION OF ALLOWED AND*
7 *ACTUAL EXPENDITURES BASED ON SERVICE*
8 *CATEGORIES.—In computing the prior year*
9 *adjustment component and the cumulative*
10 *adjustment component under clauses (i) and*
11 *(ii) of paragraph (4)(B), the following rules*
12 *apply:*

13 “(I) *APPLICATION BASED ON*
14 *SERVICE CATEGORIES.—The allowed*
15 *expenditures and actual expenditures*
16 *shall be the allowed and actual expend-*
17 *itures for the service category, as deter-*
18 *mined under subparagraph (B).*

19 “(II) *LIMITATION TO PHYSICIAN*
20 *FEE-SCHEDULE SERVICES.—Actual ex-*
21 *penditures shall only take into account*
22 *expenditures for services furnished*
23 *under the physician fee schedule.*

24 “(III) *APPLICATION OF CATEGORY*
25 *SPECIFIC TARGET GROWTH RATE.—The*

1 *growth rate applied under clause*
2 *(ii)(II) of such paragraph shall be the*
3 *target growth rate for the service cat-*
4 *egory involved under subsection (f)(5).*

5 “(IV) *ALLOCATION OF CUMU-*
6 *LATIVE OVERHANG.—There shall be*
7 *substituted for the difference described*
8 *in subparagraph (B)(ii)(I) of such*
9 *paragraph the amount described in*
10 *subparagraph (C)(i) for the service cat-*
11 *egory involved.*

12 “(B) *DETERMINATION OF ALLOWED EX-*
13 *PENDITURES.—In applying paragraph (4) for a*
14 *year beginning with 2008, notwithstanding sub-*
15 *paragraph (C)(iii) of such paragraph, the al-*
16 *lowed expenditures for a service category for a*
17 *year is an amount computed by the Secretary as*
18 *follows:*

19 “(i) *FOR 2008.—For 2008:*

20 “(I) *TOTAL 2007 ALLOWED EX-*
21 *PENDITURES.—Compute the total al-*
22 *lowed expenditures for services fur-*
23 *nished under the physician fee schedule*
24 *under such paragraph for 2007.*

1 “(II) *INCREASE BY GROWTH*
2 *RATE.*—Increase the total under sub-
3 *clause (I) by the target growth rate for*
4 *such category under subsection (f) for*
5 *2008.*

6 “(III) *ALLOCATION TO SERVICE*
7 *CATEGORY.*—Multiply the increased
8 *total under subclause (II) by the over-*
9 *hang allocation factor for the service*
10 *category (as defined in subparagraph*
11 *(C)(iii)).*

12 “(ii) *FOR SUBSEQUENT YEARS.*—For a
13 *subsequent year, take the amount of allowed*
14 *expenditures for such category for the pre-*
15 *ceding year (under clause (i) or this clause)*
16 *and increase it by the target growth rate de-*
17 *termined under subsection (f) for such cat-*
18 *egory and year.*

19 “(C) *COMPUTATION AND APPLICATION OF*
20 *CUMULATIVE OVERHANG AMONG CATEGORIES.*—

21 “(i) *IN GENERAL.*—For purposes of ap-
22 *plying paragraph (4)(B)(ii)(II) under*
23 *clause (ii)(IV), the amount described in this*
24 *clause for a year (beginning with 2008) is*
25 *the sum of the following:*

1 “(I) *PRE-2008 CUMULATIVE*
2 *OVERHANG.—The amount of the pre-*
3 *2008 cumulative excess spending (as*
4 *defined in clause (ii)) multiplied by*
5 *the overhang allocation factor for the*
6 *service category (under clause (iii)).*

7 “(II) *POST-2007 CUMULATIVE*
8 *AMOUNTS.—For a year beginning with*
9 *2009, the difference (which may be*
10 *positive or negative) between the*
11 *amount of the allowed expenditures for*
12 *physicians’ services (as determined*
13 *under paragraph (4)(C)) in the service*
14 *category from January 1, 2008,*
15 *through the end of the prior year and*
16 *the amount of the actual expenditures*
17 *for such services in such category dur-*
18 *ing that period.*

19 “(ii) *PRE-2008 CUMULATIVE EXCESS*
20 *SPENDING DEFINED.—For purposes of*
21 *clause (i)(I), the term ‘pre-2008 cumulative*
22 *excess spending’ means the difference de-*
23 *scribed in paragraph (4)(B)(i)(I) as deter-*
24 *mined for the year 2008, taking into ac-*
25 *count expenditures through December 31,*

1 2007. Such difference takes into account ex-
2 penditures included in subsection (f)(4)(A).

3 “(iii) *OVERHANG ALLOCATION FAC-*
4 *TOR.—For purposes of this paragraph, the*
5 *term ‘overhang allocation factor’ means, for*
6 *a service category, the proportion, as deter-*
7 *mined by the Secretary of total actual ex-*
8 *penditures under this part for items and*
9 *services in such category during 2007 to the*
10 *total of such actual expenditures for all the*
11 *service categories. In calculating such pro-*
12 *portion, the Secretary shall only take into*
13 *account services furnished under the physi-*
14 *cian fee schedule.*

15 “(D) *FLOOR FOR UPDATES FOR 2008 AND*
16 *2009.—The update to the conversion factors for*
17 *each service category for each of 2008 and 2009*
18 *shall be not less than 0.5 percent.*

19 “(E) *CHANGE IN RESTRICTION ON UPDATE*
20 *ADJUSTMENT FACTOR FOR 2010 AND 2011.—The*
21 *update adjustment factor determined under sub-*
22 *paragraph (4)(B), as modified by this para-*
23 *graph, for a service category for a year (begin-*
24 *ning with 2010 and ending with 2011) may be*
25 *less than -0.07, but may not be less than -0.14.”.*

1 (d) *APPLICATION OF SEPARATE TARGET GROWTH*
2 *RATES FOR EACH CATEGORY.—*

3 (1) *IN GENERAL.—*Section 1848(f) of the Social
4 *Security Act (42 U.S.C. 1395w-4(f)) is amended by*
5 *adding at the end the following new paragraph:*

6 “(5) *APPLICATION OF SEPARATE TARGET*
7 *GROWTH RATES FOR EACH SERVICE CATEGORY BEGIN-*
8 *NING WITH 2008.—*The target growth rate for a year
9 *beginning with 2008 shall be computed and applied*
10 *separately under this subsection for each service cat-*
11 *egory (as defined in subsection (j)(5)) and shall be*
12 *computed using the same method for computing the*
13 *sustainable growth rate except for the following:*

14 “(A) *The reference in paragraphs (2)(A)*
15 *and (2)(D) to ‘all physicians’ services’ is deemed*
16 *a reference to the physicians’ services included in*
17 *such category but shall not take into account*
18 *items and services included in physicians’ serv-*
19 *ices through the operation of paragraph (4)(A).*

20 “(B) *The factor described in paragraph*
21 *(2)(C) for the service category described in sub-*
22 *section (j)(5)(A) shall be increased by 0.03.*

23 “(C) *A national coverage determination (as*
24 *defined in section 1869(f)(1)(B)) shall be treated*

1 *as a change in regulation described in para-*
2 *graph (2)(D).”.*

3 (2) *USE OF TARGET GROWTH RATES.*—*Section*
4 *1848 of such Act is further amended—*

5 (A) *in subsection (d)—*

6 (i) *in paragraph (1)(E)(ii), by insert-*
7 *ing “or target” after “sustainable”; and*

8 (ii) *in paragraph (4)(B)(ii)(II), by in-*
9 *serting “or target” after “sustainable”; and*

10 (B) *in subsection (f)—*

11 (i) *in the heading by inserting “; TAR-*
12 *GET GROWTH RATE” after “SUSTAINABLE*
13 *GROWTH RATE”*

14 (ii) *in paragraph (1)—*

15 (I) *by striking “and” at the end*
16 *of subparagraph (A);*

17 (II) *in subparagraph (B), by in-*
18 *serting “before 2008” after “each suc-*
19 *ceeding year” and by striking the pe-*
20 *riod at the end and inserting “; and”;*
21 *and*

22 (III) *by adding at the end the fol-*
23 *lowing new subparagraph:*

1 “(C) November 1 of each succeeding year the
2 target growth rate for such succeeding year and
3 each of the 2 preceding years.”; and

4 (iii) in paragraph (2), in the matter
5 before subparagraph (A), by inserting after
6 “beginning with 2000” the following: “and
7 ending with 2007”.

8 (e) *REPORTS ON EXPENDITURES FOR PART B DRUGS*
9 *AND CLINICAL DIAGNOSTIC LABORATORY TESTS.*—

10 (1) *REPORTING REQUIREMENT.*—*The Secretary*
11 *of Health and Human Services shall include informa-*
12 *tion in the annual physician fee schedule proposed*
13 *rule on the change in the annual rate of growth of ac-*
14 *tual expenditures for clinical diagnostic laboratory*
15 *tests or drugs, biologicals, and radiopharmaceuticals*
16 *for which payment is made under part B of title*
17 *XVIII of the Social Security Act.*

18 (2) *RECOMMENDATIONS.*—*The report submitted*
19 *under paragraph (1) shall include an analysis of the*
20 *reasons for such excess expenditures and recommenda-*
21 *tions for addressing them in the future.*

1 **SEC. 302. IMPROVING ACCURACY OF RELATIVE VALUES**
2 **UNDER THE MEDICARE PHYSICIAN FEE**
3 **SCHEDULE.**

4 (a) *USE OF EXPERT PANEL TO IDENTIFY MISVALUED*
5 *PHYSICIANS' SERVICES.*—Section 1848(c) of the Social Se-
6 *curity Act (42 U.S.C. 1395w(c)) is amended by adding at*
7 *the end the following new paragraph:*

8 “(7) *USE OF EXPERT PANEL TO IDENTIFY*
9 *MISVALUED PHYSICIANS' SERVICES.*—

10 “(A) *IN GENERAL.*—*The Secretary shall es-*
11 *tablish an expert panel (in this paragraph re-*
12 *ferred to as the ‘expert panel’)—*

13 “(i) *to identify, through data analysis,*
14 *physicians’ services for which the relative*
15 *value under this subsection is potentially*
16 *misvalued, particularly those services for*
17 *which such relative value may be over-*
18 *valued;*

19 “(ii) *to assess whether those misvalued*
20 *services warrant review using existing proc-*
21 *esses (referred to in paragraph (2)(J)(ii))*
22 *for the consideration of coding changes; and*

23 “(iii) *to advise the Secretary con-*
24 *cerning the exercise of authority under*
25 *clauses (ii)(III) and (vi) of paragraph*
26 *(2)(B).*

1 “(B) *COMPOSITION OF PANEL.*—*The expert*
2 *panel shall be appointed by the Secretary and*
3 *composed of—*

4 “(i) *members with expertise in medical*
5 *economics and technology diffusion;*

6 “(ii) *members with clinical expertise;*

7 “(iii) *physicians, particularly physi-*
8 *cians (such as a physician employed by the*
9 *Veterans Administration or a physician*
10 *who has a full time faculty appointment at*
11 *a medical school) who are not directly af-*
12 *ected by changes in the physician fee sched-*
13 *ule under this section;*

14 “(iv) *carrier medical directors; and*

15 “(v) *representatives of private payor*
16 *health plans.*

17 “(C) *APPOINTMENT CONSIDERATIONS.*—*In*
18 *appointing members to the expert panel, the Sec-*
19 *retary shall assure racial and ethnic diversity on*
20 *the panel and may consider appointing a liaison*
21 *from organizations with experience in the con-*
22 *sideration of coding changes to the panel.”.*

23 (b) *EXAMINATION OF SERVICES WITH SUBSTANTIAL*
24 *CHANGES.*—*Such section is further amended by adding at*
25 *the end the following new paragraph:*

1 “(8) *EXAMINATION OF SERVICES WITH SUBSTAN-*
2 *TIAL CHANGES.—The Secretary, in consultation with*
3 *the expert panel under paragraph (7), shall—*

4 “(A) *conduct a five-year review of physi-*
5 *cians’ services in conjunction with the RUC 5-*
6 *year review, particularly for services that have*
7 *experienced substantial changes in length of stay,*
8 *site of service, volume, practice expense, or other*
9 *factors that may indicate changes in physician*
10 *work;*

11 “(B) *identify new services to determine if*
12 *they are likely to experience a reduction in rel-*
13 *ative value over time and forward a list of the*
14 *services so identified for such five-year review;*
15 *and*

16 “(C) *for physicians’ services that are other-*
17 *wise unreviewed under the process the Secretary*
18 *has established, periodically review a sample of*
19 *relative value units within different types of*
20 *services to assess the accuracy of the relative val-*
21 *ues contained in the Medicare physician fee*
22 *schedule.”.*

23 (c) *AUTHORITY TO REDUCE WORK COMPONENT FOR*
24 *SERVICES WITH ACCELERATED VOLUME GROWTH.—*

1 (1) *IN GENERAL.*—*Paragraph (2)(B) of such sec-*
2 *tion is amended—*

3 (A) *in clause (v), by adding at the end the*
4 *following new subclause:*

5 “(III) *REDUCTIONS IN WORK*
6 *VALUE UNITS FOR SERVICES WITH AC-*
7 *CELERATED VOLUME GROWTH.*—*Effec-*
8 *tive January 1, 2009, reduced expendi-*
9 *tures attributable to clause (vi).”;* and

10 (B) *by adding at the end the following new*
11 *clauses:*

12 “(vi) *AUTHORIZING REDUCTION IN*
13 *WORK VALUE UNITS FOR SERVICES WITH*
14 *ACCELERATED VOLUME GROWTH.*—*The Sec-*
15 *retary may provide (without using existing*
16 *processes the Secretary has established for*
17 *review of relative value) for a reduction in*
18 *the work value units for a particular physi-*
19 *cian’s service if the annual rate of growth*
20 *in the expenditures for such service for*
21 *which payment is made under this part for*
22 *individuals for 2006 or a subsequent year*
23 *exceeds the average annual rate of growth in*
24 *expenditures of all physicians’ services for*
25 *which payment is made under this part by*

1 more than 10 percentage points for such
2 year.

3 “(vii) *CONSULTATION WITH EXPERT*
4 *PANEL AND BASED ON CLINICAL EVI-*
5 *DENCE.—The Secretary shall exercise au-*
6 *thority under clauses (ii)(III) and (vi) in*
7 *consultation with the expert panel estab-*
8 *lished under paragraph (7) and shall take*
9 *into account clinical evidence supporting or*
10 *refuting the merits of such accelerated*
11 *growth.”.*

12 (2) *EFFECTIVE DATE.—The amendments made*
13 *by paragraph (1) shall apply with respect to payment*
14 *for services furnished on or after January 1, 2009.*

15 (d) *ADJUSTMENT AUTHORITY FOR EFFICIENCY GAINS*
16 *FOR NEW PROCEDURES.—Paragraph (2)(B)(ii) of such sec-*
17 *tion is amended by adding at the end the following new*
18 *subclause:*

19 “(III) *ADJUSTMENT AUTHORITY*
20 *FOR EFFICIENCY GAINS FOR NEW PRO-*
21 *CEDURES.—In carrying out subclauses*
22 *(I) and (II), the Secretary may apply*
23 *a methodology, based on supporting*
24 *evidence, under which there is imposed*
25 *a reduction over a period of years in*

1 *specified relative value units in the*
2 *case of a new (or newer) procedure to*
3 *take into account inherent efficiencies*
4 *that are typically or likely to be gained*
5 *during the period of initial increased*
6 *application of the procedure.”.*

7 **SEC. 303. FEEDBACK MECHANISM ON PRACTICE PATTERNS.**

8 *By not later than July 1, 2008, the Secretary of Health*
9 *and Human Services shall develop and implement a mecha-*
10 *nism to measure resource use on a per capita and an epi-*
11 *sode basis in order to provide confidential feedback to physi-*
12 *cians in the Medicare program on how their practice pat-*
13 *terns compare to physicians generally, both in the same lo-*
14 *cality as well as nationally. Such feedback shall not be sub-*
15 *ject to disclosure under section 552 of title 5, United States*
16 *Code). The Secretary shall consider extending such mecha-*
17 *nism to other suppliers as necessary.*

18 **SEC. 304. PAYMENTS FOR EFFICIENT AREAS.**

19 *Section 1833 of the Social Security Act (42 U.S.C.*
20 *1395l) is amended by adding at the end the following new*
21 *subsection:*

22 “(v) *INCENTIVE PAYMENTS FOR EFFICIENT AREAS.—*
23 “(1) *IN GENERAL.—In the case of services fur-*
24 *nished under the physician fee schedule under section*
25 *1848 on or after January 1, 2009, and before Janu-*

1 *ary 1, 2011, by a supplier that is paid under such*
2 *fee schedule in an efficient area (as identified under*
3 *paragraph (2)), in addition to the amount of pay-*
4 *ment that would otherwise be made for such services*
5 *under this part, there also shall be paid an amount*
6 *equal to 5 percent of the payment amount for the*
7 *services under this part.*

8 *“(2) IDENTIFICATION OF EFFICIENT AREAS.—*

9 *“(A) IN GENERAL.—Based upon available*
10 *data, the Secretary shall identify those counties*
11 *or equivalent areas in the United States in the*
12 *lowest fifth percentile of utilization based on per*
13 *capita spending for services provided in 2007*
14 *under this part and part A.*

15 *“(B) IDENTIFICATION OF COUNTIES WHERE*
16 *SERVICE IS FURNISHED.—For purposes of pay-*
17 *ing the additional amount specified in para-*
18 *graph (1), if the Secretary uses the 5-digit postal*
19 *ZIP Code where the service is furnished, the*
20 *dominant county of the postal ZIP Code (as de-*
21 *termined by the United States Postal Service, or*
22 *otherwise) shall be used to determine whether the*
23 *postal ZIP Code is in a county described in sub-*
24 *paragraph (A).*

1 “(C) *JUDICIAL REVIEW.*—*There shall be no*
2 *administrative or judicial review under section*
3 *1869, 1878, or otherwise, respecting—*

4 “(i) *the identification of a county or*
5 *other area under subparagraph (A); or*

6 “(ii) *the assignment of a postal ZIP*
7 *Code to a county or other area under sub-*
8 *paragraph (B).*

9 “(D) *PUBLICATION OF LIST OF COUNTIES;*
10 *POSTING ON WEBSITE.*—*With respect to a year*
11 *for which a county or area is identified under*
12 *this paragraph, the Secretary shall identify such*
13 *counties or areas as part of the proposed and*
14 *final rule to implement the physician fee sched-*
15 *ule under section 1848 for the applicable year.*
16 *The Secretary shall post the list of counties iden-*
17 *tified under this paragraph on the Internet*
18 *website of the Centers for Medicare & Medicaid*
19 *Services.”.*

20 **SEC. 305. RECOMMENDATIONS ON REFINING THE PHYSI-**
21 **CIAN FEE SCHEDULE.**

22 (a) *RECOMMENDATIONS ON CONSOLIDATED CODING*
23 *FOR SERVICES COMMONLY PERFORMED TOGETHER.*—*Not*
24 *later than December 31, 2008, the Comptroller General of*
25 *the United States shall—*

1 (1) *complete an analysis of codes paid under the*
2 *Medicare physician fee schedule to determine whether*
3 *the codes for procedures that are commonly furnished*
4 *together should be combined; and*

5 (2) *submit to Congress a report on such analysis*
6 *and include in the report recommendations on wheth-*
7 *er an adjustment should be made to the relative value*
8 *units for such combined code.*

9 (b) *RECOMMENDATIONS ON INCREASED USE OF BUN-*
10 *DLED PAYMENTS.*—*Not later than December 31, 2008, the*
11 *Comptroller General of the United States shall—*

12 (1) *complete an analysis of those procedures*
13 *under the Medicare physician fee schedule for which*
14 *no global payment methodology is applied but for*
15 *which a “bundled” payment methodology would be*
16 *appropriate; and*

17 (2) *submit to Congress a report on such analysis*
18 *and include in the report recommendations on in-*
19 *creasing the use of “bundled” payment methodology*
20 *under such schedule.*

21 (c) *MEDICARE PHYSICIAN FEE SCHEDULE.*—*In this*
22 *section, the term “Medicare physician fee schedule” means*
23 *the fee schedule established under section 1848 of the Social*
24 *Security Act (42 U.S.C. 1395w–4).*

1 **SEC. 306. IMPROVED AND EXPANDED MEDICAL HOME DEM-**
2 **ONSTRATION PROJECT.**

3 (a) *IN GENERAL.*—*The Secretary of Health and*
4 *Human Services (in this section referred to as the “Sec-*
5 *retary”)* shall establish under title XVIII of the Social Secu-
6 *riety Act an expanded medical home demonstration project*
7 *(in this section referred to as the “expanded project”)* under
8 *this section. The expanded project supersedes the project*
9 *that was initiated under section 204 of the Medicare Im-*
10 *provement and Extension Act of 2006 (division B of Public*
11 *Law 109–432). The purpose of the expanded project is—*

12 (1) *to guide the redesign of the health care deliv-*
13 *ery system to provide accessible, continuous, com-*
14 *prehensive, and coordinated, care to Medicare bene-*
15 *ficiaries; and*

16 (2) *to provide care management fees to personal*
17 *physicians delivering continuous and comprehensive*
18 *care in qualified medical homes.*

19 (b) *NATURE AND SCOPE OF PROJECT.*—

20 (1) *DURATION; SCOPE.*—*The expanded project*
21 *shall operate during a period of three years, begin-*
22 *ning not later than October 1, 2009, and shall include*
23 *a nationally representative sample of physicians serv-*
24 *ing urban, rural, and underserved areas throughout*
25 *the United States.*

1 (2) *ENCOURAGING PARTICIPATION OF SMALL*
2 *PHYSICIAN PRACTICES.*—

3 (A) *IN GENERAL.*—*The expanded project*
4 *shall be designed to include the participation of*
5 *physicians in practices with fewer than four full-*
6 *time equivalent physicians, as well as physicians*
7 *in larger practices particularly in rural and un-*
8 *derserved areas.*

9 (B) *TECHNICAL ASSISTANCE.*—*In order to*
10 *facilitate the participation under the expanded*
11 *project of physicians in such practices, the Sec-*
12 *retary shall make available additional technical*
13 *assistance to such practices during the first year*
14 *of the expanded project.*

15 (3) *SELECTION OF HOMES TO PARTICIPATE.*—
16 *The Secretary shall select up to 500 medical homes to*
17 *participate in the expanded project and shall give*
18 *priority to—*

19 (A) *the selection of up to 100 HIT-enhanced*
20 *medical homes; and*

21 (B) *the selection of other medical homes that*
22 *serve communities whose populations are at*
23 *higher risk for health disparities,*

24 (4) *BENEFICIARY PARTICIPATION.*—*The Sec-*
25 *retary shall establish a process for any Medicare bene-*

1 *beneficiary who is served by a medical home participating*
2 *in the expanded project to elect to participate in the*
3 *project. Each beneficiary who elects to so participate*
4 *shall be eligible—*

5 *(A) for enhanced medical home services*
6 *under the project with no cost sharing for the ad-*
7 *ditional services; and*

8 *(B) for a reduction of up to 50 percent in*
9 *the coinsurance for services furnished under the*
10 *physician fee schedule under section 1848 of the*
11 *Social Security Act by the medical home.*

12 *The Secretary shall develop standard recruitment ma-*
13 *terials and election processes for Medicare bene-*
14 *ficiaries who are electing to participate in the ex-*
15 *panded project.*

16 *(c) STANDARDS FOR MEDICAL HOMES, HIT-EN-*
17 *HANCED MEDICAL HOMES.—*

18 *(1) STANDARD SETTING AND CERTIFICATION*
19 *PROCESS.—The Secretary shall establish a process for*
20 *selection of a qualified standard setting and certifi-*
21 *cation organization—*

22 *(A) to establish standards, consistent with*
23 *this section, for medical practices to qualify as*
24 *medical homes or as HIT-enhanced medical*
25 *homes; and*

1 *(B) to provide for the review and certifi-*
2 *cation of medical practices as meeting such*
3 *standards.*

4 *(2) BASIC STANDARDS FOR MEDICAL HOMES.—*
5 *For purposes of this subsection, the term “medical*
6 *home” means a physician-directed practice that has*
7 *been certified, under paragraph (1), as meeting the*
8 *following standards:*

9 *(A) ACCESS AND COMMUNICATION WITH PA-*
10 *TIENTS.—The practice applies standards for ac-*
11 *cess to care and communication with partici-*
12 *parting beneficiaries.*

13 *(B) MANAGING PATIENT INFORMATION AND*
14 *USING INFORMATION IN MANAGEMENT TO SUP-*
15 *PORT PATIENT CARE.—The practice has readily*
16 *accessible, clinically useful information on par-*
17 *ticipating beneficiaries that enables the practice*
18 *to treat such beneficiaries comprehensively and*
19 *systematically.*

20 *(C) MANAGING AND COORDINATING CARE*
21 *ACCORDING TO INDIVIDUAL NEEDS.—The prac-*
22 *tice maintains continuous relationships with*
23 *participating beneficiaries by implementing evi-*
24 *dence-based guidelines and applying them to the*
25 *identified needs of individual beneficiaries over*

1 *time and with the intensity needed by such bene-*
2 *ficiaries.*

3 (D) *PROVIDING ONGOING ASSISTANCE AND*
4 *ENCOURAGEMENT IN PATIENT SELF-MANAGE-*
5 *MENT.—The practice—*

6 (i) *collaborates with participating*
7 *beneficiaries to pursue their goals for opti-*
8 *mal achievable health; and*

9 (ii) *assesses patient-specific barriers to*
10 *communication and conducts activities to*
11 *support patient self-management.*

12 (E) *RESOURCES TO MANAGE CARE.—The*
13 *practice has in place the resources and processes*
14 *necessary to achieve improvements in the man-*
15 *agement and coordination of care for partici-*
16 *pating beneficiaries.*

17 (F) *MONITORING PERFORMANCE.—The*
18 *practice monitors its clinical process and per-*
19 *formance (including outcome measures) in meet-*
20 *ing the applicable standards under this sub-*
21 *section and provides information in a form and*
22 *manner specified by the Secretary with respect to*
23 *such process and performance.*

24 (3) *ADDITIONAL STANDARDS FOR HIT-ENHANCED*
25 *MEDICAL HOME.—For purposes of this subsection, the*

1 *term “HIT-enhanced medical home” means a medical*
2 *home that has been certified, under paragraph (1), as*
3 *using a health information technology system that in-*
4 *cludes at least the following elements:*

5 (A) *ELECTRONIC HEALTH RECORD (EHR).—*

6 *The system uses, for participating beneficiaries,*
7 *an electronic health record that meets the fol-*
8 *lowing standards:*

9 (i) *IN GENERAL.—The record—*

10 (I) *has the capability of interoper-*
11 *ability with secure data acquisition*
12 *from health information technology*
13 *systems of other health care providers*
14 *in the area served by the home; or*

15 (II) *the capability to securely ac-*
16 *quire clinical data delivered by such*
17 *other health care providers to a secure*
18 *common data source.*

19 (ii) *The record protects the privacy*
20 *and security of health information.*

21 (iii) *The record has the capability to*
22 *acquire, manage, and display all the types*
23 *of clinical information commonly relevant*
24 *to services furnished by the medical home,*
25 *such as complete medical records, radio-*

1 *graphic image retrieval, and clinical lab-*
2 *oratory information.*

3 *(iv) The record is integrated with deci-*
4 *sion support capacities that facilitate the*
5 *use of evidence-based medicine and clinical*
6 *decision support tools to guide decision-*
7 *making at the point-of-care based on pa-*
8 *tient-specific factors.*

9 *(B) E-PRESCRIBING.—The system supports*
10 *e-prescribing and computerized physician order*
11 *entry.*

12 *(C) OUTCOME MEASUREMENT.—The system*
13 *supports the secure, confidential provision of*
14 *clinical process and outcome measures approved*
15 *by the National Quality Forum to the Secretary*
16 *for use in confidential manner for provider feed-*
17 *back and peer review and for outcomes and clin-*
18 *ical effectiveness research.*

19 *(D) PATIENT EDUCATION CAPABILITY.—The*
20 *system actively facilitates participating bene-*
21 *ficiaries engaging in the management of their*
22 *own health through education and support sys-*
23 *tems and tools for shared decision-making.*

24 *(E) SUPPORT OF BASIC STANDARDS.—The*
25 *elements of such system, such as the electronic*

1 *health record, email communications, patient*
2 *registries, and clinical-decision support tools, are*
3 *integrated in a manner to better achieve the*
4 *basic standards specified in paragraph (2) for a*
5 *medical home.*

6 (4) *USE OF DATA.*—*The Secretary shall use the*
7 *data submitted under paragraph (1)(F) in a con-*
8 *fidential manner for feedback and peer review for*
9 *medical homes and for outcomes and clinical effective-*
10 *ness research. After the first two years of the expanded*
11 *project, these data may be used for adjustment in the*
12 *monthly medical home care management fee under*
13 *subsection (d)(2)(E).*

14 (d) *MONTHLY MEDICAL HOME CARE MANAGEMENT*
15 *FEE.*—

16 (1) *IN GENERAL.*—*Under the expanded project,*
17 *the Secretary shall provide for payment to the per-*
18 *sonal physician of each participating beneficiary of a*
19 *monthly medical home care management fee.*

20 (2) *AMOUNT OF PAYMENT.*—*In determining the*
21 *amount of such fee, the Secretary shall consider the*
22 *following:*

23 (A) *OPERATING EXPENSES.*—*The additional*
24 *practice expenses for the delivery of services*
25 *through a medical home, taking into account the*

1 *additional expenses for an HIT-enhanced med-*
2 *ical home. Such expenses include costs associated*
3 *with—*

4 *(i) structural expenses, such as equip-*
5 *ment, maintenance, and training costs;*

6 *(ii) enhanced access and communica-*
7 *tion functions;*

8 *(iii) population management and reg-*
9 *istry functions;*

10 *(iv) patient medical data and referral*
11 *tracking functions;*

12 *(v) provision of evidence-based care;*

13 *(vi) implementation and maintenance*
14 *of health information technology;*

15 *(vii) reporting on performance and im-*
16 *provement conditions; and*

17 *(viii) patient education and patient*
18 *decision support, including print and elec-*
19 *tronic patient education materials.*

20 *(B) ADDED VALUE SERVICES.—The value of*
21 *additional physician work, such as augmented*
22 *care plan oversight, expanded e-mail and tele-*
23 *phonic consultations, extended patient medical*
24 *data review (including data stored and trans-*
25 *mitted electronically), and physician supervision*

1 of enhanced self management education, and ex-
2 panded follow-up accomplished by non-physician
3 personnel, in a medical home that is not ade-
4 quately taken into account in the establishment
5 of the physician fee schedule under section 1848
6 of the Social Security Act.

7 (C) *RISK ADJUSTMENT.*—The development
8 of an appropriate risk adjustment mechanism to
9 account for the varying costs of medical homes
10 based upon characteristics of participating bene-
11 ficiaries.

12 (D) *HIT ADJUSTMENT.*—Variation of the
13 fee based on the extensiveness of use of the health
14 information technology in the medical home.

15 (E) *PERFORMANCE-BASED.*—After the first
16 two years of the expanded project, an adjustment
17 of the fee based on performance of the medical
18 home in achieving quality or outcomes stand-
19 ards.

20 (3) *PERSONAL PHYSICIAN DEFINED.*—For pur-
21 poses of this subsection, the term “personal physi-
22 cian” means, with respect to a participating Medi-
23 care beneficiary, a physician (as defined in section
24 1861(r)(1) of the Social Security Act (42 U.S.C.
25 1395x(r)(1)) who provides accessible, continuous, co-

1 *ordinated, and comprehensive care for the beneficiary*
2 *as part of a medical practice that is a qualified med-*
3 *ical home. Such a physician may be a specialist for*
4 *a beneficiary requiring ongoing care for a chronic*
5 *condition or multiple chronic conditions (such as se-*
6 *vere asthma, complex diabetes, cardiovascular disease,*
7 *rheumatologic disorder) or for a beneficiary with a*
8 *prolonged illness.*

9 *(e) FUNDING.—*

10 *(1) USE OF CURRENT PROJECT FUNDING.—*
11 *Funds otherwise applied to the demonstration under*
12 *section 204 of the Medicare Improvement and Exten-*
13 *sion Act of 2006 (division B of Public Law 109–432)*
14 *shall be available to carry out the expanded project*

15 *(2) ADDITIONAL FUNDING FROM SMI TRUST*
16 *FUND.—*

17 *(A) IN GENERAL.—In addition to the funds*
18 *provided under paragraph (1), there shall be*
19 *available, from the Federal Supplementary Med-*
20 *ical Insurance Trust Fund (under section 1841*
21 *of the Social Security Act), the amount of*
22 *\$500,000,000 to carry out the expanded project,*
23 *including payments to of monthly medical home*
24 *care management fees under subsection (d), re-*
25 *ductions in coinsurance for participating bene-*

1 *ficiaries under subsection (b)(4)(B), and funds*
2 *for the design, implementation, and evaluation*
3 *of the expanded project.*

4 *(B) MONITORING EXPENDITURES; EARLY*
5 *TERMINATION.—The Secretary shall monitor the*
6 *expenditures under the expanded project and*
7 *may terminate the project early in order that ex-*
8 *penditures not exceed the amount of funding pro-*
9 *vided for the project under subparagraph (A).*

10 *(f) EVALUATIONS AND REPORTS.—*

11 *(1) ANNUAL INTERIM EVALUATIONS AND RE-*
12 *PORTS.—For each year of the expanded project, the*
13 *Secretary shall provide for an evaluation of the*
14 *project and shall submit to Congress, by a date speci-*
15 *fied by the Secretary, a report on the project and on*
16 *the evaluation of the project for each such year.*

17 *(2) FINAL EVALUATION AND REPORT.—The Sec-*
18 *retary shall provide for an evaluation of the expanded*
19 *project and shall submit to Congress, not later than*
20 *18 months after the date of completion of the project,*
21 *a report on the project and on the evaluation of the*
22 *project.*

1 **SEC. 307. REPEAL OF PHYSICIAN ASSISTANCE AND QUALITY**
2 **INITIATIVE FUND.**

3 *Subsection (l) of section 1848 of the Social Security*
4 *Act (42 U.S.C. 1395w-4) is repealed.*

5 **SEC. 308. ADJUSTMENT TO MEDICARE PAYMENT LOCAL-**
6 **ITIES.**

7 *Section 1848(e) of the Social Security Act (42*
8 *U.S.C.1395w-4(e)) is amended by adding at the end the*
9 *following new paragraph:*

10 *“(6) FEE SCHEDULE GEOGRAPHIC AREAS.—*

11 *“(A) IN GENERAL.—*

12 *“(i) REVISION.—Subject to clause (ii),*
13 *for services furnished on or after January 1,*
14 *2008, the Secretary shall revise the fee*
15 *schedule areas used for payment under this*
16 *section applicable to the State of California*
17 *using the county-based geographic adjust-*
18 *ment factor as specified in option 3 (table*
19 *9) in the proposed rule for the 2008 physi-*
20 *cian fee schedule published at 72 Fed. Reg.*
21 *38,122 (July 12, 2007).*

22 *“(ii) TRANSITION.—For services fur-*
23 *nished during the period beginning Janu-*
24 *ary 1, 2008, and ending December 31, 2010,*
25 *after calculating the work, practice expense,*
26 *and malpractice geographic indices de-*

1 *scribed in clauses (i), (ii), and (iii) of para-*
2 *graph (1)(A) that would otherwise apply,*
3 *the Secretary shall increase any such geo-*
4 *graphic index for any county in California*
5 *that is lower than the geographic index used*
6 *for payment for services under this section*
7 *as of December 31, 2007, in such county to*
8 *such geographic index level.*

9 “(B) *SUBSEQUENT REVISIONS.—*

10 “(i) *TIMING.—Not later than January*
11 *1, 2011, the Secretary shall review and*
12 *make revisions to fee schedule areas in all*
13 *States for which more than one fee schedule*
14 *area is used for payment of services under*
15 *this section. The Secretary may revise fee*
16 *schedule areas in States in which a single*
17 *fee schedule area is used for payment for*
18 *services under this section using the same*
19 *methodology applied in the previous sen-*
20 *tence.*

21 “(ii) *LINK WITH GEOGRAPHIC INDEX*
22 *DATA REVISION.—The revision described in*
23 *clause (i) shall be made effective concur-*
24 *rently with the application of the periodic*
25 *review of geographic adjustment factors re-*

1 *quired under paragraph (1)(C) for 2011*
2 *and subsequent periods.”.*

3 **SEC. 309. PAYMENT FOR IMAGING SERVICES.**

4 *(a) PAYMENT UNDER PART B OF THE MEDICARE PRO-*
5 *GRAM FOR DIAGNOSTIC IMAGING SERVICES FURNISHED IN*
6 *FACILITIES CONDITIONED ON ACCREDITATION OF FACILI-*
7 *TIES.—*

8 *(1) SPECIAL PAYMENT RULE.—*

9 *(A) IN GENERAL.—Section 1848(b)(4) of the*
10 *Social Security Act (42 U.S.C. 1395w-4(b)(4))*
11 *is amended—*

12 *(i) in the heading, by striking “RULE”*
13 *and inserting “RULES”;*

14 *(ii) in subparagraph (A), by striking*
15 *“IN GENERAL” and inserting “LIMITA-*
16 *TION”; and*

17 *(iii) by adding at the end the following*
18 *new subparagraph:*

19 *“(C) PAYMENT ONLY FOR SERVICES PRO-*
20 *VIDED IN ACCREDITED FACILITIES.—*

21 *“(i) IN GENERAL.—In the case of im-*
22 *aging services that are diagnostic imaging*
23 *services described in clause (ii), the pay-*
24 *ment amount for the technical component*
25 *and the professional component of the serv-*

1 *ices established for a year under the fee*
2 *schedule described in paragraph (1) shall*
3 *each be zero, unless the services are fur-*
4 *nished at a diagnostic imaging services fa-*
5 *cility that meets the certificate requirement*
6 *described in section 354(b)(1) of the Public*
7 *Health Service Act, as applied under sub-*
8 *section (m). The previous sentence shall not*
9 *apply with respect to the technical compo-*
10 *nent if the imaging equipment meets certifi-*
11 *cation standards and the professional com-*
12 *ponent of a diagnostic imaging service that*
13 *is furnished by a physician.*

14 *“(ii) DIAGNOSTIC IMAGING SERV-*
15 *ICES.—For purposes of clause (i) and sub-*
16 *section (m), the term ‘diagnostic imaging*
17 *services’ means all imaging modalities, in-*
18 *cluding diagnostic magnetic resonance im-*
19 *aging (‘MRI’), computed tomography*
20 *(‘CT’), positron emission tomography*
21 *(‘PET’), nuclear medicine procedures, x-*
22 *rays, sonograms, ultrasounds, echocardi-*
23 *grams, and such emerging diagnostic imag-*
24 *ing technologies as specified by the Sec-*
25 *retary.”.*

1 (B) *EFFECTIVE DATE.*—

2 (i) *IN GENERAL.*—Subject to clause
3 (ii), the amendments made by subpara-
4 graph (A) shall apply to diagnostic imaging
5 services furnished on or after January 1,
6 2010.

7 (ii) *EXTENSION FOR ULTRASOUND*
8 *SERVICES.*—The amendments made by sub-
9 paragraph (A) shall apply to diagnostic im-
10 aging services that are ultrasound services
11 on or after January 1, 2012.

12 (2) *CERTIFICATION OF FACILITIES THAT FUR-*
13 *NISH DIAGNOSTIC IMAGING SERVICES.*—Section 1848
14 of the Social Security Act (42 U.S.C. 1395w-4) is
15 amended by adding at the end the following new sub-
16 section:

17 “(m) *CERTIFICATION OF FACILITIES THAT FURNISH*
18 *DIAGNOSTIC IMAGING SERVICES.*—

19 “(1) *IN GENERAL.*—For purposes of subsection
20 (b)(4)(C)(i), except as provided under paragraphs (2)
21 through (8), the provisions of section 354 of the Public
22 Health Service Act (as in effect as of June 1, 2007),
23 relating to the certification of mammography facili-
24 ties, shall apply, with respect to the provision of diag-
25 nostic imaging services (as defined in subsection

1 **(b)(4)(C)(ii)** and to a diagnostic imaging services fa-
2 cility defined in paragraph (8) (and to the process of
3 accrediting such facilities) in the same manner that
4 such provisions apply, with respect to the provision
5 of mammograms and to a facility defined in sub-
6 section (a)(3) of such section (and to the process of ac-
7 crediting such mammography facilities).

8 “(2) *TERMINOLOGY AND REFERENCES.*—For
9 purposes of applying section 354 of the Public Health
10 Service Act under paragraph (1)—

11 “(A) any reference to ‘mammography’, or
12 ‘breast imaging’ is deemed a reference to ‘diag-
13 nostic imaging services (as defined in section
14 1848(b)(4)(C)(ii) of the Social Security Act)’;

15 “(B) any reference to a mammogram or
16 film is deemed a reference to an image, as de-
17 fined in paragraph (8);

18 “(C) any reference to ‘mammography facil-
19 ity’ or to a ‘facility’ under such section 354 is
20 deemed a reference to a diagnostic imaging serv-
21 ices facility, as defined in paragraph (8);

22 “(D) any reference to radiological equip-
23 ment used to image the breast is deemed a ref-
24 erence to medical imaging equipment used to
25 provide diagnostic imaging services;

1 “(E) any reference to radiological proce-
2 dures or radiological is deemed a reference to
3 medical imaging services, as defined in para-
4 graph (8) or medical imaging, respectively;

5 “(F) any reference to an inspection (as de-
6 fined in subsection (a)(4) of such section) or in-
7 spector is deemed a reference to an audit (as de-
8 fined in paragraph (8)) or auditor, respectively;

9 “(G) any reference to a medical physicist
10 (as described in subsection (f)(1)(E) of such sec-
11 tion) is deemed to include a reference to a mag-
12 netic resonance scientist or the appropriate
13 qualified expert as determined by the accrediting
14 body;

15 “(H) in applying subsection (d)(1)(A)(i) of
16 such section, the reference to ‘type of each x-ray
17 machine, image receptor, and processor’ is
18 deemed a reference to ‘type of imaging equip-
19 ment’;

20 “(I) in applying subsection (d)(1)(B) of
21 such section, the reference that ‘the person or
22 agent submits to the Secretary’ is deemed a ref-
23 erence that ‘the person or agent submits to the
24 Secretary, through the appropriate accreditation
25 body’;

1 “(J) in applying subsection (d)(1)(B)(i) of
2 such section, the reference to standards estab-
3 lished by the Secretary is deemed a reference to
4 standards established by an accreditation body
5 and approved by the Secretary;

6 “(K) in applying subsection (e) of such sec-
7 tion, relating to an accreditation body—

8 “(i) in paragraph (1)(A), the reference
9 to ‘may’ is deemed a reference to ‘shall’;

10 “(ii) in paragraph (1)(B)(i)(II), the
11 reference to ‘a random sample of clinical
12 images from such facilities’ is deemed a ref-
13 erence to ‘a statistically significant random
14 sample of clinical images from a statis-
15 tically significant random sample of facili-
16 ties’;

17 “(iii) in paragraph (3)(A) of such sec-
18 tion—

19 “(I) the reference to ‘paragraph
20 (1)(B)’ in such subsection is deemed to
21 be a reference to ‘paragraph (1)(B)
22 and subsection (f)’; and

23 “(II) the reference to the ‘Sec-
24 retary’ is deemed a reference to ‘an ac-

1 *creditation body, with the approval of*
2 *the Secretary’; and*

3 “(iv) in paragraph (6)(B), the ref-
4 *erence to the Committee on Labor and*
5 *Human Resources of the Senate is deemed*
6 *to be the Committee on Finance of the Sen-*
7 *ate and the reference to the Committee on*
8 *Energy and Commerce of the House of Rep-*
9 *resentatives is deemed to include a reference*
10 *to the Committee on Ways and Means of the*
11 *House of Representatives;*

12 “(L) in applying subsection (f), relating to
13 *quality standards—*

14 “(i) each reference to standards estab-
15 *lished by the Secretary is deemed a ref-*
16 *erence to standards established by an ac-*
17 *creditation body involved and approved by*
18 *the Secretary under subsection (d)(1)(B)(i)*
19 *of such section;*

20 “(ii) in paragraph (1)(A), the reference
21 *to ‘radiation dose’ is deemed a reference to*
22 *‘radiation dose, as appropriate’;*

23 “(iii) in paragraph (1)(B), the ref-
24 *erence to ‘radiological standards’ is deemed*

1 a reference to ‘medical imaging standards,
2 as appropriate’;

3 “(iv) in paragraphs (1)(D)(ii) and
4 (1)(E)(iii), the reference to ‘the Secretary’ is
5 deemed a reference to ‘an accreditation body
6 with the approval of the Secretary’; and

7 “(v) in each of subclauses (III) and
8 (IV) of paragraph (1)(G)(ii), each reference
9 to ‘patient’ is deemed a reference to ‘pa-
10 tient, if requested by the patient’; and

11 “(M) in applying subsection (g), relating to
12 inspections—

13 “(i) each reference to the ‘Secretary or
14 State or local agency acting on behalf of the
15 Secretary’ is deemed to include a reference
16 to an accreditation body involved;

17 “(ii) in the first sentence of paragraph
18 (1)(F), the reference to ‘annual inspections
19 required under this paragraph’ is deemed a
20 reference to ‘the audits carried out in facili-
21 ties at least every three years from the date
22 of initial accreditation under this para-
23 graph’; and

24 “(iii) in the second sentence of para-
25 graph (1)(F), the reference to ‘inspections

1 *carried out under this paragraph*’ is deemed
2 *a reference to ‘audits conducted under this*
3 *paragraph during the previous year*’.

4 “(3) *DATES AND PERIODS.—For purposes of*
5 *paragraph (1), in applying section 354 of the Public*
6 *Health Service Act, the following applies:*

7 “(A) *IN GENERAL.—Except as provided in*
8 *subparagraph (B)—*

9 “(i) *any reference to ‘October 1, 1994’*
10 *shall be deemed a reference to ‘January 1,*
11 *2010’;*

12 “(ii) *the reference to ‘the date of the en-*
13 *actment of this section’ in each of sub-*
14 *sections (e)(1)(D) and (f)(1)(E)(iii) is*
15 *deemed to be a reference to ‘the date of the*
16 *enactment of the Children’s Health and*
17 *Medicare Protection Act of 2007’;*

18 “(iii) *the reference to ‘annually’ in*
19 *subsection (g)(1)(E) is deemed a reference to*
20 *‘every three years’;*

21 “(iv) *the reference to ‘October 1, 1996’*
22 *in subsection (l) is deemed to be a reference*
23 *to ‘January 1, 2011’;*

1 “(v) the reference to ‘October 1, 1999’
2 in subsection (n)(3)(H) is deemed to be a
3 reference to ‘January 1, 2012’; and

4 “(vi) the reference to ‘October 1, 1993’
5 in the matter following paragraph (3)(J) of
6 subsection (n) is deemed to be a reference
7 ‘January 1, 2010’.

8 “(B) *ULTRASOUND SERVICES*.—With re-
9 spect to diagnostic imaging services that are
10 ultrasounds—

11 “(i) any reference to ‘October 1, 1994’
12 shall be deemed a reference to ‘January 1,
13 2012’;

14 “(ii) the reference to ‘the date of the en-
15 actment of this section’ in subsection
16 (f)(1)(E)(iii) is deemed to be a reference to
17 ‘7 years after the date of the enactment of
18 the Children’s Health and Medicare Protec-
19 tion Act of 2007’; and

20 “(iii) the reference to ‘October 1, 1996’
21 in subsection (l) is deemed to be a reference
22 to ‘January 1, 2013’.

23 “(4) *PROVISIONS NOT APPLICABLE*.—For pur-
24 poses of paragraph (1), in applying section 354 of the

1 *Public Health Service Act, the following provision*
2 *shall not apply:*

3 *“(A) Subsections (e) and (f) of such section,*
4 *in so far as the respective subsection imposes any*
5 *requirement for a physician to be certified, ac-*
6 *credited, or otherwise meet requirements, with re-*
7 *spect to the provision of any diagnostic imaging*
8 *services, as a condition of payment under sub-*
9 *section (b)(4)(C)(i), with respect to the profes-*
10 *sional or technical component, for such service.*

11 *“(B) Subsection (e)(1)(B)(iv) of such sec-*
12 *tion, insofar as it applies to a facility with re-*
13 *spect to the provision of ultrasounds.*

14 *“(C) Subsection (e)(1)(B)(v).*

15 *“(D) Subsection (f)(1)(H) of such section,*
16 *relating to standards for special techniques for*
17 *mammograms of patients with breast implants.*

18 *“(E) Subsection (g)(6) of such section, relat-*
19 *ing to an inspection demonstration program.*

20 *“(F) Subsection (n)(3)(G) of such section,*
21 *relating to the national advisory committee.*

22 *“(G) Subsection (p) of such section, relating*
23 *to breast cancer screening surveillance research*
24 *grants.*

1 “(H) Paragraphs (1)(B) and (2) of sub-
2 section (r) of such section, related to funding.

3 “(5) ACCREDITATION BODIES.—For purposes of
4 paragraph (1), in applying section 354(e)(1) of the
5 Public Health Service, the following shall apply:

6 “(A) APPROVAL OF TWO ACCREDITATION
7 BODIES FOR EACH TREATMENT MODALITY.—In
8 the case that there is more than one accreditation
9 body for a treatment modality that qualifies for
10 approval under this subsection, the Secretary
11 shall approve at least two accreditation bodies
12 for such treatment modality.

13 “(B) ADDITIONAL ACCREDITATION BODY
14 STANDARDS.—In addition to the standards de-
15 scribed in subparagraph (B) of such section for
16 accreditation bodies, the Secretary shall establish
17 standards that require—

18 “(i) the timely integration of new tech-
19 nology by accreditation bodies for purposes
20 of accrediting facilities under this sub-
21 section; and

22 “(ii) the accreditation body involved to
23 evaluate the annual medical physicist sur-
24 vey (or annual medical survey of another
25 appropriate qualified expert chosen by the

1 *accreditation body) of a facility upon onsite*
2 *review of such facility.*

3 “(6) *ADDITIONAL QUALITY STANDARDS.—For*
4 *purposes of paragraph (1), in applying subsection*
5 *(f)(1) of section 354 of the Public Health Service—*

6 “(A) *the quality standards under such sub-*
7 *section shall, with respect to a facility include—*

8 “(i) *standards for qualifications of*
9 *medical personnel who are not physicians*
10 *and who perform diagnostic imaging serv-*
11 *ices at the facility that require such per-*
12 *sonnel to ensure that individuals, prior to*
13 *performing medical imaging, demonstrate*
14 *compliance with the standards established*
15 *under subsection (a) through successful com-*
16 *pletion of certification by a nationally rec-*
17 *ognized professional organization, licensure,*
18 *completion of an examination, pertinent*
19 *coursework or degree program, verified per-*
20 *tinent experience, or through other ways de-*
21 *termined appropriate by an accreditation*
22 *body (with the approval of the Secretary, or*
23 *through some combination thereof);*

24 “(ii) *standards requiring the facility to*
25 *maintain records of the credentials of physi-*

1 *cians and other medical personnel described*
2 *in clause (i);*

3 *“(iii) standards for qualifications and*
4 *responsibilities of medical directors and*
5 *other personnel with supervising roles at the*
6 *facility;*

7 *“(iv) standards that require the facil-*
8 *ity has procedures to ensure the safety of*
9 *patients of the facility; and*

10 *“(v) standards for the establishment of*
11 *a quality control program at the facility to*
12 *be implemented as described in subpara-*
13 *graph (E) of such subsection;*

14 *“(B) the quality standards described in sub-*
15 *paragraph (B) of such subsection shall be deemed*
16 *to include standards that require the establish-*
17 *ment and maintenance of a quality assurance*
18 *and quality control program at each facility that*
19 *is adequate and appropriate to ensure the reli-*
20 *ability, clarity, and accuracy of the technical*
21 *quality of diagnostic images produced at such fa-*
22 *cilities; and*

23 *“(C) the quality standard described in sub-*
24 *paragraph (C) of such subsection, relating to a*
25 *requirement for personnel who perform specified*

1 *services, shall include in such requirement that*
2 *such personnel must meet continuing medical*
3 *education standards as specified by an accredita-*
4 *tion body (with the approval of the Secretary)*
5 *and update such standards at least once every*
6 *three years.*

7 “(7) *ADDITIONAL REQUIREMENTS.—Notwith-*
8 *standing any provision of section 354 of the Public*
9 *Health Service Act, the following shall apply to the*
10 *accreditation process under this subsection for pur-*
11 *poses of subsection (b)(4)(C)(i):*

12 “(A) *Any diagnostic imaging services facil-*
13 *ity accredited before January 1, 2010 (or Janu-*
14 *ary 1, 2012 in the case of ultrasounds), by an*
15 *accrediting body approved by the Secretary shall*
16 *be deemed a facility accredited by an approved*
17 *accreditation body for purposes of such sub-*
18 *section as of such date if the facility submits to*
19 *the Secretary proof of such accreditation by*
20 *transmittal of the certificate of accreditation, in-*
21 *cluding by electronic means.*

22 “(B) *The Secretary may require the accred-*
23 *itation under this subsection of an emerging*
24 *technology used in the provision of a diagnostic*
25 *imaging service as a condition of payment under*

1 *subsection (b)(4)(C)(i) for such service at such*
2 *time as the Secretary determines there is suffi-*
3 *cient empirical and scientific information to*
4 *properly carry out the accreditation process for*
5 *such technology.*

6 “(8) *DEFINITIONS.—For purposes of this sub-*
7 *section:*

8 “(A) *AUDIT.—The term ‘audit’ means an*
9 *onsite evaluation, with respect to a diagnostic*
10 *imaging services facility, by the Secretary, State*
11 *or local agency on behalf of the Secretary, or ac-*
12 *creditation body approved under this subsection*
13 *that includes the following:*

14 “(i) *Equipment verification.*

15 “(ii) *Evaluation of policies and proce-*
16 *dures for compliance with accreditation re-*
17 *quirements.*

18 “(iii) *Evaluation of personnel quali-*
19 *fications and credentialing.*

20 “(iv) *Evaluation of the technical qual-*
21 *ity of images.*

22 “(v) *Evaluation of patient reports.*

23 “(vi) *Evaluation of peer-review mecha-*
24 *nisms and other quality assurance activi-*
25 *ties.*

1 “(vii) *Evaluation of quality control*
2 *procedures, results, and follow-up actions.*

3 “(viii) *Evaluation of medical physi-*
4 *cists (or other appropriate professionals*
5 *chosen by the accreditation body) and mag-*
6 *netic resonance scientist surveys.*

7 “(ix) *Evaluation of consumer com-*
8 *plaint mechanisms.*

9 “(x) *Provision of recommendations for*
10 *improvement based on findings with respect*
11 *to clauses (i) through (ix).*

12 “(B) *DIAGNOSTIC IMAGING SERVICES FACIL-*
13 *ITY.—The term ‘diagnostic imaging services fa-*
14 *ility’ has the meaning given the term ‘facility’*
15 *in section 354(a)(3) of the Public Health Service*
16 *Act (42 U.S.C. 263b(a)(3)) subject to the ref-*
17 *erence changes specified in paragraph (2), but*
18 *does not include any facility that does not fur-*
19 *nish diagnostic imaging services for which pay-*
20 *ment may be made under this section.*

21 “(C) *IMAGE.—The term ‘image’ means the*
22 *portrayal of internal structures of the human*
23 *body for the purpose of detecting and deter-*
24 *mining the presence or extent of disease or in-*
25 *jury and may be produced through various tech-*

1 *niques or modalities, including radiant energy*
2 *or ionizing radiation and ultrasound and mag-*
3 *netic resonance. Such term does not include*
4 *image guided procedures.*

5 *“(D) MEDICAL IMAGING SERVICE.—The*
6 *term ‘medical imaging service’ means a service*
7 *that involves the science of an image.”.*

8 *(b) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT*
9 *HIGHER PRESUMED UTILIZATION.—Section 1848 of the*
10 *Social Security Act (42 U.S.C. 1395w) is amended—*

11 *(1) in subsection (b)(4)—*

12 *(A) in subparagraph (B), by striking “sub-*
13 *paragraph (A)” and inserting “this paragraph”;*
14 *and*

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

17 *“(D) ADJUSTMENT IN PRACTICE EXPENSE*
18 *TO REFLECT HIGHER PRESUMED UTILIZATION.—*
19 *In computing the number of practice expense rel-*
20 *ative value units under subsection (c)(2)(C)(ii)*
21 *with respect to imaging services described in sub-*
22 *paragraph (B), the Secretary shall adjust such*
23 *number of units so it reflects a 75 percent (rath-*
24 *er than 50 percent) presumed rate of utilization*
25 *of imaging equipment.”; and*

1 (2) in subsection (c)(2)(B)(v)(II), by inserting
2 “AND OTHER PROVISIONS” after “OPD PAYMENT CAP”

3 (c) *ADJUSTMENT IN TECHNICAL COMPONENT “DIS-*
4 *COUNT” ON SINGLE-SESSION IMAGING TO CONSECUTIVE*
5 *BODY PARTS.*—Section 1848(b)(4) of such Act is further
6 amended by adding at the end the following new subpara-
7 graph:

8 “(E) *ADJUSTMENT IN TECHNICAL COMPO-*
9 *NENT DISCOUNT ON SINGLE-SESSION IMAGING IN-*
10 *VOLVING CONSECUTIVE BODY PARTS.*—The Sec-
11 *retary shall increase the reduction in expendi-*
12 *tures attributable to the multiple procedure pay-*
13 *ment reduction applicable to the technical com-*
14 *ponent for imaging under the final rule pub-*
15 *lished by the Secretary in the Federal Register*
16 *on November 21, 2005 (42 CFR 405, et al.) from*
17 *25 percent to 50 percent.”.*

18 (d) *ADJUSTMENT IN ASSUMED INTEREST RATE FOR*
19 *CAPITAL PURCHASES.*—Section 1848(b)(4) of such Act is
20 further amended by adding at the end the following new
21 subparagraph:

22 “(F) *ADJUSTMENT IN ASSUMED INTEREST*
23 *RATE FOR CAPITAL PURCHASES.*—In computing
24 *the practice expense component for imaging serv-*
25 *ices under this section, the Secretary shall*

1 *change the interest rate assumption for capital*
2 *purchases of imaging devices to reflect the pre-*
3 *vailing rate in the market, but in no case higher*
4 *than 11 percent.”.*

5 *(e) DISALLOWANCE OF GLOBAL BILLING.—Effective*
6 *for claims filed for imaging services (as defined in sub-*
7 *section (b)(4)(B) of section 1848 of the Social Security Act)*
8 *furnished on or after the first day of the first month that*
9 *begins more than 1 year after the date of the enactment*
10 *of this Act, the Secretary of Health and Human Services*
11 *shall not accept (or pay) a claim under such section unless*
12 *the claim is made separately for each component of such*
13 *services.*

14 *(f) EFFECTIVE DATE.—Except as otherwise provided,*
15 *this section, and the amendments made by this section, shall*
16 *apply to services furnished on or after January 1, 2008.*

17 **SEC. 310. REDUCING FREQUENCY OF MEETINGS OF THE**
18 **PRACTICING PHYSICIANS ADVISORY COUN-**
19 **CIL.**

20 *Section 1868(a)(2) of the Social Security Act (42*
21 *U.S.C. 1395ee(a)(2)) is amended by striking “once during*
22 *each calendar quarter” and inserting “once each year (and*
23 *at such other times as the Secretary may specify)”.*

1 **TITLE IV—MEDICARE**
 2 **ADVANTAGE REFORMS**
 3 **Subtitle A—Payment Reform**

4 **SEC. 401. EQUALIZING PAYMENTS BETWEEN MEDICARE AD-**
 5 **VANTAGE PLANS AND FEE-FOR-SERVICE**
 6 **MEDICARE.**

7 (a) *PHASE IN OF PAYMENT BASED ON FEE-FOR-SERV-*
 8 *ICE COSTS.*—Section 1853 of the Social Security Act (42
 9 *U.S.C. 1395w–23)* is amended—

10 (1) *in subsection (j)(1)(A)—*

11 (A) *by striking “beginning with 2007” and*
 12 *inserting “for 2007 and 2008”; and*

13 (B) *by inserting after “(k)(1)” the fol-*
 14 *lowing: “, or, beginning with 2009, $\frac{1}{12}$ of the*
 15 *blended benchmark amount determined under*
 16 *subsection (l)(1)”;* and

17 (2) *by adding at the end the following new sub-*
 18 *section:*

19 “(l) *DETERMINATION OF BLENDED BENCHMARK*
 20 *AMOUNT.*—

21 “(1) *IN GENERAL.*—*For purposes of subsection*
 22 *(j), subject to paragraphs (2) and (3), the term ‘blend-*
 23 *ed benchmark amount’ means for an area—*

24 “(A) *for 2009 the sum of—*

1 “(i) $\frac{2}{3}$ of the applicable amount (as
2 defined in subsection (k)(1)) for the area
3 and year; and

4 “(ii) $\frac{1}{3}$ of the amount specified in sub-
5 section (c)(1)(D)(i) for the area and year;

6 “(B) for 2010 the sum of—

7 “(i) $\frac{1}{3}$ of the applicable amount for
8 the area and year; and

9 “(ii) $\frac{2}{3}$ of the amount specified in sub-
10 section (c)(1)(D)(i) for the area and year;
11 and

12 “(C) for a subsequent year the amount spec-
13 ified in subsection (c)(1)(D)(i) for the area and
14 year.

15 “(2) *FEE-FOR-SERVICE PAYMENT FLOOR.*—In no
16 case shall the blended benchmark amount for an area
17 and year be less than the amount specified in sub-
18 section (c)(1)(D)(i) for the area and year.

19 “(3) *EXCEPTION FOR PACE PLANS.*—This sub-
20 section shall not apply to payments to a *PACE* pro-
21 gram under section 1894.”.

22 (b) *PHASE IN OF PAYMENT BASED ON IME COSTS.*—

23 (1) *IN GENERAL.*—Section 1853(c)(1)(D)(i) of
24 such Act (42 U.S.C. 1395w-23(c)(1)(D)(i)) is amend-

1 ed by inserting “and costs attributable to payments
2 under section 1886(d)(5)(B)” after “1886(h)”.

3 (2) *EFFECTIVE DATE.*—The amendment made by
4 paragraph (1) shall apply to the capitation rate for
5 years beginning with 2009.

6 (c) *LIMITATION ON PLAN ENROLLMENT IN CASES OF*
7 *EXCESS BIDS FOR 2009 AND 2010.*—

8 (1) *IN GENERAL.*—In the case of a Medicare
9 Part C organization that offers a Medicare Part C
10 plan in the 50 States or the District of Columbia for
11 which—

12 (A) bid amount described in paragraph (2)
13 for a Medicare Part C plan for 2009 or 2010, ex-
14 ceeds

15 (B) the percent specified in paragraph (4)
16 of the fee-for-service amount described in para-
17 graph (3),

18 the Medicare Part C plan may not enroll any new en-
19 rollees in the plan during the annual, coordinated
20 election period (under section 1851(e)(3)(B) of such
21 Act (42 U.S.C. 1395w–21(e)(3)(B)) for the year or
22 during the year (if the enrollment becomes effective
23 during the year).

24 (2) *BID AMOUNT FOR PART A AND B SERVICES.*—

1 (A) *IN GENERAL.*—*Except as provided in*
2 *subparagraph (B), the bid amount described in*
3 *this paragraph is the unadjusted Medicare Part*
4 *C statutory non-drug monthly bid amount (as*
5 *defined in section 1854(b)(2)(E) of the Social Se-*
6 *curity Act (42 U.S.C. 1395w–24(b)(2)(E)).*

7 (B) *TREATMENT OF MSA PLANS.*—*In the*
8 *case of an MSA plan (as defined in section*
9 *1859(b)(3) of the Social Security Act, 42 U.S.C.*
10 *1935w–28(b)(3)), the bid amount described in*
11 *this paragraph is the amount described in sec-*
12 *tion 1854(a)(3)(A) of such Act (42 U.S.C.*
13 *1395w–24(a)(3)(A)).*

14 (3) *FEE-FOR-SERVICE AMOUNT DESCRIBED.*—

15 (A) *IN GENERAL.*—*Subject to subparagraph*
16 *(B), the fee-for-service amount described in this*
17 *paragraph for an Medicare Part C local area is*
18 *the amount described in section 1853(c)(1)(D)(i)*
19 *of the Social Security Act (42 U.S.C. 1395w–23)*
20 *for such area.*

21 (B) *TREATMENT OF MULTI-COUNTY*
22 *PLANS.*—*In the case of an MA plan the service*
23 *area for which covers more than one Medicare*
24 *Part C local area, the fee-for-service amount de-*
25 *scribed in this paragraph is the amount de-*

1 *scribed in section 1853(c)(1)(D)(i) of the Social*
2 *Security Act for each such area served, weighted*
3 *for each such area by the proportion of the en-*
4 *rollment of the plan that resides in the county*
5 *(as determined based on amounts posted by the*
6 *Administrator of the Centers for Medicare &*
7 *Medicaid Services in the April bid notice for the*
8 *year involved).*

9 (4) *PERCENTAGE PHASE DOWN.*—*For purposes of*
10 *paragraph (1), the percentage specified in this para-*
11 *graph—*

12 (A) *for 2009 is 106 percent; and*

13 (B) *for 2010 is 103 percent.*

14 (5) *EXEMPTION OF AGE-INS.*—*For purposes of*
15 *paragraph (1), the term “new enrollee” with respect*
16 *to a Medicare Part C plan offered by a Medicare Part*
17 *C organization, does not include an individual who*
18 *was enrolled in a plan offered by the organization in*
19 *the month immediately before the month in which the*
20 *individual was eligible to enroll in such a Medicare*
21 *Part C plan offered by the organization.*

22 (d) *ANNUAL REBASING OF FEE-FOR-SERVICE*
23 *RATES.*—*Section 1853(c)(1)(D)(ii) of the Social Security*
24 *Act (42 U.S.C. 1395w–23(c)(1)(D)(ii)) is amended—*

1 (1) by inserting “(before 2009)” after “for subse-
2 quent years”; and

3 (2) by inserting before the period at the end the
4 following: “and for each year beginning with 2009”.

5 (e) *REPEAL OF PPO STABILIZATION FUND*.—Section
6 1858 of the Social Security Act (42 U.S.C. 1395) is amend-
7 ed—

8 (1) by striking subsection (e); and

9 (2) in subsection (f)(1), by striking “subject to
10 subsection (e),”.

11 ***Subtitle B—Beneficiary Protections***

12 ***SEC. 411. NAIC DEVELOPMENT OF MARKETING, ADVER-*** 13 ***TISING, AND RELATED PROTECTIONS.***

14 (a) *IN GENERAL*.—Section 1852 of the Social Security
15 Act (42 U.S.C. 1395w–22) is amended by adding at the
16 end the following new subsection:

17 “(m) *APPLICATION OF MODEL MARKETING AND EN-*
18 *ROLLMENT STANDARDS*.—

19 “(1) *IN GENERAL*.—The National Association of
20 Insurance Commissioners (in this subsection referred
21 to as the ‘NAIC’) is requested to develop, and to sub-
22 mit to the Secretary of Health and Human Services
23 not later than 12 months after the date of the enact-
24 ment of this Act, model regulations (in this section re-
25 ferred to as ‘model regulations’) regarding Medicare

1 *plan marketing, enrollment, broker and agent train-*
2 *ing and certification, agent and broker commissions,*
3 *and market conduct by plans, agents and brokers for*
4 *implementation (under paragraph (7)) under this*
5 *part and part D, including for enforcement by States*
6 *under section 1856(b)(3).*

7 “(2) *MARKETING GUIDELINES.—*

8 “(A) *IN GENERAL.—The model regulations*
9 *shall address the sales and advertising techniques*
10 *used by Medicare private plans, agents and bro-*
11 *kers in selling plans, including defining and*
12 *prohibiting cold calls, unsolicited door-to-door*
13 *sales, cross-selling, and co-branding.*

14 “(B) *SPECIAL CONSIDERATIONS.—The*
15 *model regulations shall specifically address the*
16 *marketing—*

17 “(i) *of plans to full benefit dual-eligible*
18 *individuals and qualified medicare bene-*
19 *ficiaries;*

20 “(ii) *of plans to populations with lim-*
21 *ited English proficiency;*

22 “(iii) *of plans to beneficiaries in senior*
23 *living facilities; and*

24 “(iv) *of plans at educational events.*

25 “(3) *ENROLLMENT GUIDELINES.—*

1 “(A) *IN GENERAL.*—*The model regulations*
2 *shall address the disclosures Medicare private*
3 *plans, agents, and brokers must make when en-*
4 *rolling beneficiaries, and a process—*

5 “(i) *for affirmative beneficiary sign off*
6 *before enrollment in a plan; and*

7 “(ii) *in the case of Medicare Part C*
8 *plans, for plans to conduct a beneficiary*
9 *call-back to confirm beneficiary sign off and*
10 *enrollment.*

11 “(B) *SPECIFIC CONSIDERATIONS.*—*The*
12 *model regulations shall specially address bene-*
13 *ficiary understanding of the Medicare plan*
14 *through required disclosure (or beneficiary*
15 *verification) of each of the following:*

16 “(i) *The type of Medicare private plan*
17 *involved.*

18 “(ii) *Attributes of the plan, including*
19 *premiums, cost sharing, formularies (if ap-*
20 *plicable), benefits, and provider access limi-*
21 *tations in the plan.*

22 “(iii) *Comparative quality of the plan.*

23 “(iv) *The fact that plan attributes may*
24 *change annually.*

1 “(4) *APPOINTMENT, CERTIFICATION AND TRAIN-*
2 *ING OF AGENTS AND BROKERS.—The model regula-*
3 *tions shall establish procedures and requirements for*
4 *appointment, certification (and periodic recertifi-*
5 *cation), and training of agents and brokers that mar-*
6 *ket or sell Medicare private plans consistent with ex-*
7 *isting State appointment and certification procedures*
8 *and with this paragraph.*

9 “(5) *AGENT AND BROKER COMMISSIONS.—*

10 “(A) *IN GENERAL.—The model regulations*
11 *shall establish standards for fair and appro-*
12 *priate commissions for agents and brokers con-*
13 *sistent with this paragraph.*

14 “(B) *LIMITATION ON TYPES OF COMMIS-*
15 *SION.—The model regulations shall specifically*
16 *prohibit the following:*

17 “(i) *Differential commissions—*

18 “(I) *for Medicare Part C plans*
19 *based on the type of Medicare private*
20 *plan; or*

21 “(II) *prescription drug plans*
22 *under part D based on the type of pre-*
23 *scription drug plan.*

1 “(ii) *Commissions in the first year*
2 *that are more than 200 percent of subse-*
3 *quent year commissions.*

4 “(iii) *The payment of extra bonuses or*
5 *incentives (such as trips, gifts, and other*
6 *non-commission cash payments).*

7 “(C) *AGENT DISCLOSURE.—In developing*
8 *the model regulations, the NAIC shall consider*
9 *requiring agents and brokers to disclose commis-*
10 *sions to a beneficiary upon request of the bene-*
11 *ficiary before enrollment.*

12 “(D) *PREVENTION OF FRAUD.—The model*
13 *regulations shall consider the opportunity for*
14 *fraud and abuse and beneficiary steering in set-*
15 *ting standards under this paragraph and shall*
16 *provide for the ability of State commissioners to*
17 *investigate commission structures.*

18 “(6) *MARKET CONDUCT.—*

19 “(A) *IN GENERAL.—The model regulations*
20 *shall establish standards for the market conduct*
21 *of organizations offering Medicare private plans,*
22 *and of agents and brokers selling such plans, and*
23 *for State review of plan market conduct.*

24 “(B) *MATTERS TO BE INCLUDED.—Such*
25 *standards shall include standards for—*

1 “(i) *timely payment of claims;*

2 “(ii) *beneficiary complaint reporting*
3 *and disclosure; and*

4 “(iii) *State reporting of market con-*
5 *duct violations and sanctions.*

6 “(7) *IMPLEMENTATION.—*

7 “(A) *PUBLICATION OF NAIC MODEL REGU-*
8 *LATIONS.—If the model regulations are sub-*
9 *mitted on a timely basis under paragraph (1)—*

10 “(i) *the Secretary shall publish them*
11 *in the Federal Register upon receipt and re-*
12 *quest public comment on the issue of wheth-*
13 *er such regulations are consistent with the*
14 *requirements established in this subsection*
15 *for such regulations;*

16 “(ii) *not later than 6 months after the*
17 *date of such publication, the Secretary shall*
18 *determine whether such regulations are so*
19 *consistent with such requirements and shall*
20 *publish notice of such determination in the*
21 *Federal Register;*

22 “(iii) *if the Secretary makes the deter-*
23 *mination under clause (i) that such regula-*
24 *tions are consistent with such requirements,*
25 *in the notice published under clause (ii) the*

1 *Secretary shall publish notice of adoption of*
2 *such model regulations as constituting the*
3 *marketing and enrollment standards adopt-*
4 *ed under this subsection to be applied under*
5 *this title; and*

6 *“(iv) if the Secretary makes the deter-*
7 *mination under such clause that such regu-*
8 *lations are not consistent with such require-*
9 *ments, the procedures of clauses (ii) and*
10 *(iii) of subparagraph (B) shall apply (in*
11 *relation to the notice published under clause*
12 *(ii)), in the same manner as such clauses*
13 *would apply in the case of publication of a*
14 *notice under subparagraph (B)(i).*

15 *“(B) NO MODEL REGULATIONS.—If the*
16 *model regulations are not submitted on a timely*
17 *basis under paragraph (1)—*

18 *“(i) the Secretary shall publish notice*
19 *of such fact in the Federal Register;*

20 *“(ii) not later than 6 months after the*
21 *date of publication of such notice, the Sec-*
22 *retary shall propose regulations that pro-*
23 *vide for marketing and enrollment stand-*
24 *ards that incorporate the requirements of*
25 *this subsection for the model regulations*

1 and request public comments on such pro-
2 posed regulations; and

3 “(iii) not later than 6 months after the
4 date of publication of such proposed regula-
5 tions, the Secretary shall publish final regu-
6 lations that shall constitute the marketing
7 and enrollment standards adopted under
8 this subsection to be applied under this title.

9 “(C) *REFERENCES TO MARKETING AND EN-*
10 *ROLLMENT STANDARDS.*—*In this title, a ref-*
11 *erence to marketing and enrollment standards*
12 *adopted under this subsection is deemed a ref-*
13 *erence to the regulations constituting such stand-*
14 *ards adopted under subparagraph (A) or (B), as*
15 *the case may be.*

16 “(D) *EFFECTIVE DATE OF STANDARDS.*—*In*
17 *order to provide for the orderly and timely im-*
18 *plementation of marketing and enrollment stand-*
19 *ards adopted under this subsection, the Sec-*
20 *retary, in consultation with the NAIC, shall*
21 *specify (by program instruction or otherwise) ef-*
22 *fective dates with respect to all components of*
23 *such standards consistent with the following:*

24 “(i) *In the case of components that re-*
25 *late predominantly to operations in relation*

1 to Medicare private plans, the effective date
2 shall be for plan years beginning on or after
3 such date (not later than 1 year after the
4 date of promulgation of the standards) as
5 the Secretary specifies.

6 “(ii) In the case of other components,
7 the effective date shall be such date, not
8 later than 1 year after the date of promul-
9 gation of the standards, as the Secretary
10 specifies.

11 “(E) CONSULTATION.—In promulgating
12 marketing and enrollment standards under this
13 paragraph, the NAIC or Secretary shall consult
14 with a working group composed of representa-
15 tives of issuers of Medicare private plans, con-
16 sumer groups, medicare beneficiaries, State
17 Health Insurance Assistance Programs, and
18 other qualified individuals. Such representatives
19 shall be selected in a manner so as to assure bal-
20 anced representation among the interested
21 groups.

22 “(8) ENFORCEMENT.—

23 “(A) IN GENERAL.—Any Medicare private
24 plan that violates marketing and enrollment

1 standards is subject to sanctions under section
2 1857(g).

3 “(B) *STATE RESPONSIBILITIES.*—Nothing
4 in this subsection or section 1857(g) shall pro-
5 hibit States from imposing sanctions against
6 Medicare private plans, agents, or brokers for
7 violations of the marketing and enrollment
8 standards adopted under section 1852(m). States
9 shall have the sole authority to regulate agents
10 and brokers.

11 “(9) *MEDICARE PRIVATE PLAN DEFINED.*—In
12 this subsection, the term ‘Medicare private plan’
13 means a Medicare Part C plan and a prescription
14 drug plan under part D.”.

15 (b) *EXPANSION OF EXCEPTION TO PREEMPTION OF*
16 *STATE ROLE.*—

17 (1) *IN GENERAL.*—Section 1856(b)(3) of the So-
18 cial Security Act (42 U.S.C. 1395w–26(b)(3)) is
19 amended by striking “(other than State licensing laws
20 or State laws relating to plan solvency)” and insert-
21 ing “(other than State laws relating to licensing or
22 plan solvency and State laws or regulations adopting
23 the marketing and enrollment standards adopted
24 under section 1852(m))”.

1 (2) *EFFECTIVE DATE.*—*The amendment made by*
2 *paragraph (1) shall apply to plans offered on or after*
3 *July 1, 2008.*

4 (c) *APPLICATION TO PRESCRIPTION DRUG PLANS.*—

5 (1) *IN GENERAL.*—*Section 1860D–1 of such Act*
6 *is amended by adding at the end the following new*
7 *subsection:*

8 “(d) *APPLICATION OF MARKETING AND ENROLLMENT*
9 *STANDARDS.*—*The marketing and enrollment standards*
10 *adopted under section 1852(m) shall apply to prescription*
11 *drug plans (and sponsors of such plans) in the same man-*
12 *ner as they apply to Medicare Part C plans and organiza-*
13 *tions offering such plans.”*

14 (2) *REFERENCE TO CURRENT LAW PROVI-*
15 *SIONS.*—*The amendment made by subsection (a) and*
16 *(b) apply, pursuant to section 1860D–1(b)(1)(B)(ii)*
17 *of the Social Security Act (42 U.S.C. 1395w–*
18 *101(b)(1)(B)(ii)), to prescription drug plans under*
19 *part D of title XVIII of such Act.*

20 (d) *CONTRACT REQUIREMENT TO MEET MARKETING*
21 *AND ADVERTISING STANDARDS.*—

22 (1) *IN GENERAL.*—*Section 1857(d) of the Social*
23 *Security Act (42 U.S.C. 1395w–27(d)), as amended*
24 *by subsection (b)(1), is further amended by adding at*
25 *the end the following new paragraph:*

1 “(7) *MARKETING AND ADVERTISING STAND-*
2 *ARDS.—The contract shall require the organization to*
3 *meet all standards adopted under section 1852(m)*
4 *(including those enforced by the State involved pursu-*
5 *ant to section 1856(b)(3)) relating to marketing and*
6 *advertising conduct.”.*

7 (2) *EFFECTIVE DATE.—The amendment made by*
8 *paragraph (1) shall apply to contracts for plan years*
9 *beginning on or after January 1, 2011.*

10 (e) *APPLICATION OF SANCTIONS.—*

11 (1) *APPLICATION TO VIOLATION OF MARKETING*
12 *AND ENROLLMENT STANDARDS.—Section 1857(g)(1)*
13 *of such Act (42 U.S.C. 1395w-27(g)(1)), as amended*
14 *by the preceding provisions of this Act, is further*
15 *amended—*

16 (A) *by striking “and” at the end of sub-*
17 *paragraph (G);*

18 (B) *by adding “and” at the end of subpara-*
19 *graph (H); and*

20 (C) *by inserting after subparagraph (H) the*
21 *following new subparagraph:*

22 “(I) *violates marketing and enrollment*
23 *standards adopted under section 1852(m);”.*

24 (2) *ENHANCED CIVIL MONEY SANCTIONS.—Such*
25 *section is further amended—*

1 (A) in paragraph (2)(A), by striking
2 “\$25,000”, “\$100,000”, and “\$15,000” and in-
3 serting “\$50,000”, “\$200,000”, and “\$30,000”,
4 respectively; and

5 (B) in subparagraphs (A), (B), and (D) of
6 paragraph (3), by striking “\$25,000”,
7 “\$10,000”, and “\$100,000”, respectively, and in-
8 serting “\$50,000”, “\$20,000”, and “\$200,000”,
9 respectively.

10 (3) *EFFECTIVE DATE.*—The amendments made
11 by paragraph (2) shall apply to violations occurring
12 on or after the date of the enactment of this Act.

13 (f) *DISCLOSURE OF MARKET AND ADVERTISING CON-*
14 *TRACT VIOLATIONS AND IMPOSED SANCTIONS.*—Section
15 1857 of such Act is amended by adding at the end the fol-
16 lowing new subsection

17 “(j) *DISCLOSURE OF MARKET AND ADVERTISING CON-*
18 *TRACT VIOLATIONS AND IMPOSED SANCTIONS.*—For years
19 beginning with 2009, the Secretary shall post on its public
20 website for the Medicare program an annual report that—

21 “(1) lists each MA organization for which the
22 Secretary made during the year a determination
23 under subsection (c)(2) the basis of which is described
24 in paragraph (1)(E); and

1 “(2) that describes any applicable sanctions
2 under subsection (g) applied to such organization
3 pursuant to such determination.”.

4 (g) *STANDARD DEFINITIONS OF BENEFITS AND FOR-*
5 *MATS FOR USE IN MARKETING MATERIALS.*—Section
6 *1851(h) of such Act (42 U.S.C. 1395w–21(h)) is amended*
7 *by adding at the end the following new paragraph:*

8 “(6) *STANDARD DEFINITIONS OF BENEFITS AND*
9 *FORMATS FOR USE IN MARKETING MATERIALS.*—

10 “(A) *IN GENERAL.*—Not later than January
11 1, 2010, the Secretary, in consultation with the
12 National Association of Insurance Commis-
13 sioners and a working group of the type de-
14 scribed in section 1852(m)(7)(E), shall develop
15 standard descriptions and definitions for benefits
16 under this title for use in marketing material
17 distributed by Medicare Part C organizations
18 and formats for including such descriptions in
19 such marketing material.

20 “(B) *REQUIRED USE OF STANDARD DEFINI-*
21 *TIONS.*—For plan years beginning on or after
22 January 1, 2011, the Secretary shall disapprove
23 the distribution of marketing material under
24 paragraph (1)(B) if such marketing material
25 does not use, without modification, the applica-

1 *ble descriptions and formats specified under sub-*
2 *paragraph (A).”.*

3 *(h) SUPPORT FOR STATE HEALTH INSURANCE ASSIST-*
4 *ANCE PROGRAMS (SHIPS).—Section 1857(e)(2) of the So-*
5 *cial Security Act (42 U.S.C. 1395w–27(e)(2)) is amended—*

6 *(1) in subparagraph (B), by adding at the end*
7 *the following: “Of the amounts so collected, no less*
8 *than \$55,000,000 for fiscal year 2009, \$65,000,000 for*
9 *fiscal year 2010, \$75,000,000 for fiscal year 2011,*
10 *and \$85,000,000 for fiscal year 2012 and each suc-*
11 *ceeding fiscal year shall be used to support Medicare*
12 *Part C and Part D counseling and assistance pro-*
13 *vided by State Health Insurance Assistance Pro-*
14 *grams.”;*

15 *(2) in subparagraph (C)—*

16 *(A) by striking “and” after*
17 *“\$100,000,000,”;*

18 *(B) by striking “an amount equal to*
19 *\$200,000,000” and inserting “and ending with*
20 *fiscal year 2008 an amount equal to*
21 *\$200,000,000, for fiscal year 2009 an amount*
22 *equal to \$255,000,000, for fiscal year 2010 an*
23 *amount equal to \$265,000,000, for fiscal year*
24 *2011 an amount equal to \$275,000,000, and for*

1 *fiscal year 2012 and each succeeding fiscal year*
2 *an amount equal to \$285,000,000”; and*

3 *(C) by adding at the end the following:*

4 *“The amounts in excess of \$200,000,000 in any*
5 *fiscal year shall be used to support State Health*
6 *Insurance Assistance Programs under subpara-*
7 *graph (B) and the remaining amount used to*
8 *support activities related to enrollment and dis-*
9 *semination of information.”; and*

10 *(3) in subparagraph (D)(ii)—*

11 *(A) by striking “and” at the end of sub-*
12 *clause (IV);*

13 *(B) in subclause (V), by striking the period*
14 *at the end and inserting “before fiscal year 2009;*
15 *and”; and*

16 *(C) by adding at the end the following new*
17 *subclause:*

18 *“(VI) for fiscal year 2009 and each*
19 *succeeding fiscal year the applicable portion*
20 *(as so defined) of the amount specified in*
21 *subparagraph (C) for that fiscal year.”.*

22 **SEC. 412. LIMITATION ON OUT-OF-POCKET COSTS FOR INDI-**
23 **VIDUAL HEALTH SERVICES.**

24 *(a) IN GENERAL.—Section 1852(a)(1) of the Social Se-*
25 *curity Act (42 U.S.C. 1395w–22(a)(1)) is amended—*

1 (1) in subparagraph (A), by inserting before the
2 period at the end the following: “with cost-sharing
3 that is no greater (and may be less) than the cost-
4 sharing that would otherwise be imposed under such
5 program option”;

6 (2) in subparagraph (B)(i), by striking “or an
7 actuarially equivalent level of cost-sharing as deter-
8 mined in this part”; and

9 (3) by amending clause (ii) of subparagraph (B)
10 to read as follows:

11 “(ii) *PERMITTING USE OF FLAT COPAY-*
12 *MENT OR PER DIEM RATE.*—Nothing in
13 clause (i) shall be construed as prohibiting
14 a Medicare part C plan from using a flat
15 copayment or per diem rate, in lieu of the
16 cost-sharing that would be imposed under
17 part A or B, so long as the amount of the
18 cost-sharing imposed does not exceed the
19 amount of the cost-sharing that would be
20 imposed under the respective part if the in-
21 dividual were not enrolled in a plan under
22 this part.”.

23 (b) *LIMITATION FOR DUAL ELIGIBLES AND QUALIFIED*
24 *MEDICARE BENEFICIARIES.*—Section 1852(a) of such Act

1 *is amended by adding at the end the following new para-*
2 *graph:*

3 “(7) *LIMITATION ON COST-SHARING FOR DUAL*
4 *ELIGIBLES AND QUALIFIED MEDICARE BENE-*
5 *FICIARIES.*—*In the case of a individual who is a full-*
6 *benefit dual eligible individual (as defined in section*
7 *1935(c)(6)) or a qualified medicare beneficiary (as*
8 *defined in section 1905(p)(1)) who is enrolled in a*
9 *Medicare Part C plan, the plan may not impose cost-*
10 *sharing that exceeds the amount of cost-sharing that*
11 *would be permitted with respect to the individual*
12 *under this title and title XIX if the individual were*
13 *not enrolled with such plan.”.*

14 *(c) EFFECTIVE DATES.*—

15 (1) *The amendments made by subsection (a)*
16 *shall apply to plan years beginning on or after Janu-*
17 *ary 1, 2009.*

18 (2) *The amendments made by subsection (b)*
19 *shall apply to plan years beginning on or after Janu-*
20 *ary 1, 2008.*

21 **SEC. 413. MA PLAN ENROLLMENT MODIFICATIONS.**

22 (a) *IMPROVED PLAN ENROLLMENT, DISENROLLMENT,*
23 *AND CHANGE OF ENROLLMENT.*—

24 (1) *CONTINUOUS OPEN ENROLLMENT FOR FULL-*
25 *BENEFIT DUAL ELIGIBLE INDIVIDUALS AND QUALI-*

1 *FIED MEDICARE BENEFICIARIES (QMB).*—Section
2 *1851(e)(2)(D) of the Social Security Act (42 U.S.C.*
3 *1395w–21(e)(2)(D)) is amended—*

4 (A) *in the heading, by inserting “, FULL-*
5 *BENEFIT DUAL ELIGIBLE INDIVIDUALS, AND*
6 *QUALIFIED MEDICARE BENEFICIARIES” after “IN-*
7 *STITUTIONALIZED INDIVIDUALS”;* and

8 (B) *in the matter before clause (i), by in-*
9 *serting “, a full-benefit dual eligible individual*
10 *(as defined in section 1935(c)(6)), or a qualified*
11 *medicare beneficiary (as defined in section*
12 *1905(p)(1))” after “institutionalized (as defined*
13 *by the Secretary)”;* and

14 (C) *in clause (i), by inserting “or disenroll”*
15 *after “enroll”.*

16 (2) *SPECIAL ELECTION PERIODS FOR ADDI-*
17 *TIONAL CATEGORIES OF INDIVIDUALS.*—Section
18 *1851(e)(4) of such Act (42 U.S.C. 1395w(e)(4)) is*
19 *amended—*

20 (A) *in subparagraph (C), by striking at the*
21 *end “or”;*

22 (B) *in subparagraph (D), by inserting “,*
23 *taking into account the health or well-being of*
24 *the individual” before the period and redesign-*

1 nating such subparagraph as subparagraph (F);
2 and

3 (C) by inserting after subparagraph (C) the
4 following new subparagraphs:

5 “(D) the individual is described in section
6 1902(a)(10)(E)(iii) (relating to specified low-in-
7 come medicare beneficiaries);

8 “(E) the individual is enrolled in an MA
9 plan and enrollment in the plan is suspended
10 under paragraph (2)(B) or (3)(C) of section
11 1857(g) because of a failure of the plan to meet
12 applicable requirements; or”.

13 (3) *EFFECTIVE DATE.*—The amendments made
14 by this subsection shall take effect on the date of the
15 enactment of this Act.

16 (b) *ACCESS TO MEDIGAP COVERAGE FOR INDIVIDUALS*
17 *WHO LEAVE MA PLANS.*—

18 (1) *IN GENERAL.*—Section 1882(s)(3) of the So-
19 cial Security Act (42 U.S.C. 1395ss(s)(3)) is amend-
20 ed—

21 (A) in each of clauses (v)(III) and (vi) of
22 subparagraph (B), by striking “12 months” and
23 inserting “24 months”; and

1 (B) in each of subclauses (I) and (II) of
2 subparagraph (F)(i), by striking “12 months”
3 and inserting “24 months”.

4 (2) *EFFECTIVE DATE.*—The amendments made
5 by paragraph (1) shall apply to terminations of en-
6 rollments in MA plans occurring on or after the date
7 of the enactment of this Act.

8 (c) *IMPROVED ENROLLMENT POLICIES.*—

9 (1) *NO AUTO-ENROLLMENT OF MEDICAID BENE-*
10 *FICIARIES.*—

11 (A) *IN GENERAL.*—Section 1851(e) of such
12 Act (42 U.S.C. 1395w–21(e)) is amended by add-
13 ing at the end the following new paragraph:

14 “(7) *NO AUTO-ENROLLMENT OF MEDICAID BENE-*
15 *FICIARIES.*—In no case may the Secretary provide for
16 the enrollment in a MA plan of a Medicare Advan-
17 tage eligible individual who is eligible to receive med-
18 ical assistance under title XIX as a full-benefit dual
19 eligible individual or a qualified medicare bene-
20 ficiary, without the affirmative application of such
21 individual (or authorized representative of the indi-
22 vidual) to be enrolled in such plan.”.

23 (B) *NO APPLICATION TO PRESCRIPTION*
24 *DRUG PLANS.*—Section 1860D–1(b)(1)(B)(iii) of

1 *such Act (42 U.S.C. 1395w–101(b)(1)(B)(iii)) is*
2 *amended—*

3 *(i) by striking “paragraph (2) and”*
4 *and by inserting “paragraph (2),”; and*
5 *(ii) by inserting “, and paragraph*
6 *(7),” after “paragraph (4)”.*

7 (C) *EFFECTIVE DATE.—The amendments*
8 *made by this paragraph shall apply to enroll-*
9 *ments that are effective on or after the date of the*
10 *enactment of this Act.*

11 **SEC. 414. INFORMATION FOR BENEFICIARIES ON MA PLAN**
12 **ADMINISTRATIVE COSTS.**

13 (a) *DISCLOSURE OF MEDICAL LOSS RATIOS AND*
14 *OTHER EXPENSE DATA.—Section 1851 of the Social Secu-*
15 *rity Act (42 U.S.C. 1395w–21) is amended by adding at*
16 *the end the following new subsection:*

17 “(j) *PUBLICATION OF MEDICAL LOSS RATIOS AND*
18 *OTHER COST-RELATED INFORMATION.—*

19 “(1) *IN GENERAL.—The Secretary shall publish,*
20 *not later than October 1 of each year (beginning with*
21 *2009), for each Medicare Part C plan contract, the*
22 *following:*

23 “(A) *The medical loss ratio of the plan in*
24 *the previous year.*

1 “(B) *The per enrollee payment under this*
2 *part to the plan, as adjusted to reflect a risk*
3 *score (based on factors described in section*
4 *1853(a)(1)(C)(i) of 1.0.*

5 “(C) *The average risk score (as so based).*

6 “(2) *SUBMISSION OF DATA.—*

7 “(A) *IN GENERAL.—Each Medicare Part C*
8 *organization shall submit to the Secretary, in a*
9 *form and manner specified by the Secretary,*
10 *data necessary for the Secretary to publish the*
11 *information described in paragraph (1) on a*
12 *timely basis, including the information described*
13 *in paragraph (3).*

14 “(B) *DATA FOR 2008 AND 2009.—The data*
15 *submitted under subparagraph (A) for 2008 and*
16 *for 2009 shall be consistent in content with the*
17 *data reported as part of the Medicare Part C*
18 *plan bid in June 2007 for 2008.*

19 “(C) *MEDICAL LOSS RATIO DATA.—The*
20 *data to be submitted under subparagraph (A) re-*
21 *lating to medical loss ratio for a year—*

22 “(i) *shall be submitted not later than*
23 *June 1 of the following year; and*

24 “(ii) *beginning with 2010, shall be*
25 *submitted based on the standardized ele-*

1 *ments and definitions developed under*
2 *paragraph (4).*

3 *“(D) AUDITED DATA.—Data submitted*
4 *under this paragraph shall be data that has been*
5 *audited by an independent third party auditor.*

6 *“(3) MLR INFORMATION.—The information de-*
7 *scribed in this paragraph with respect to a Medicare*
8 *Part C plan for a year is as follows:*

9 *“(A) The costs for the plan in the previous*
10 *year for each of the following:*

11 *“(i) Total medical expenses, separately*
12 *indicated for benefits for the original medi-*
13 *care fee-for-service program option and for*
14 *supplemental benefits.*

15 *“(ii) Non-medical expenses, shown sep-*
16 *arately for each of the following categories*
17 *of expenses:*

18 *“(I) Marketing and sales.*

19 *“(II) Direct administration.*

20 *“(III) Indirect administration.*

21 *“(IV) Net cost of private reinsur-*
22 *ance.*

23 *“(B) Gain or loss margin.*

24 *“(C) Total revenue requirement, computed*
25 *as the total of medical and nonmedical expenses*

1 *and gain or loss margin, multiplied by the gain*
2 *or loss margin.*

3 “(D) *Percent of revenue ratio, computed as*
4 *the total revenue requirement expressed as a per-*
5 *centage of revenue.*

6 “(4) *DEVELOPMENT OF DATA REPORTING STAND-*
7 *ARDS.—*

8 “(A) *IN GENERAL.—The Secretary shall de-*
9 *velop and implement standardized data elements*
10 *and definitions for reporting under this sub-*
11 *section, for contract years beginning with 2010,*
12 *of data necessary for the calculation of the med-*
13 *ical loss ratio for Medicare Part C plans. Not*
14 *later than December 31, 2008, the Secretary*
15 *shall publish a report describing the elements*
16 *and definitions so developed.*

17 “(B) *CONSULTATION.—The Secretary shall*
18 *consult with representatives of Medicare Part C*
19 *organizations, experts on health plan accounting*
20 *systems, and representatives of the National As-*
21 *sociation of Insurance Commissioners, in the de-*
22 *velopment of such data elements and definitions*

23 “(5) *MEDICAL LOSS RATIO DEFINED.—For pur-*
24 *poses of this part, the term ‘medical loss ratio’ means,*
25 *with respect to an MA plan for a year, the ratio of—*

1 “(A) the aggregate benefits (excluding non-
2 medical expenses described in paragraph
3 (3)(A)(ii)) paid under the plan for the year, to

4 “(B) the aggregate amount of premiums
5 (including basic and supplemental beneficiary
6 premiums) and payments made under sections
7 1853 and 1860D–15) collected for the plan and
8 year.

9 Such ratio shall be computed without regard to
10 whether the benefits or premiums are for required or
11 supplemental benefits under the plan.”.

12 (b) *AUDIT OF ADMINISTRATIVE COSTS AND COMPLI-*
13 *ANCE WITH THE FEDERAL ACQUISITION REGULATION.—*

14 (1) *IN GENERAL.—*Section 1857(d)(2)(B) of such
15 *Act (42 U.S.C. 1395w–27(d)(2)(B)) is amended—*

16 (A) by striking “or (ii)” and inserting
17 “(ii)”; and

18 (B) by inserting before the period at the end
19 the following: “, or (iii) to compliance with the
20 requirements of subsection (e)(4) and the extent
21 to which administrative costs comply with the
22 applicable requirements for such costs under the
23 Federal Acquisition Regulation”.

1 (2) *EFFECTIVE DATE.*—*The amendments made*
2 *by this subsection shall apply for contract years be-*
3 *ginning after the date of the enactment of this Act.*

4 (c) *MINIMUM MEDICAL LOSS RATIO.*—*Section 1857(e)*
5 *of the Social Security Act (42 U.S.C. 1395w–27(e)) is*
6 *amended by adding at the end the following new paragraph:*

7 “(4) *REQUIREMENT FOR MINIMUM MEDICAL*
8 *LOSS RATIO.*—*If the Secretary determines for a con-*
9 *tract year (beginning with 2010) that an MA plan*
10 *has failed to have a medical loss ratio (as defined in*
11 *section 1851(j)(4)) of at least .85—*

12 “(A) *for that contract year, the Secretary*
13 *shall reduce the blended benchmark amount*
14 *under subsection (l) for the second succeeding*
15 *contract year by the number of percentage points*
16 *by which such loss ratio was less than 85 per-*
17 *cent;*

18 “(B) *for 3 consecutive contract years, the*
19 *Secretary shall not permit the enrollment of new*
20 *enrollees under the plan for coverage during the*
21 *second succeeding contract year; and*

22 “(C) *the Secretary shall terminate the plan*
23 *contract if the plan fails to have such a medical*
24 *loss ratio for 5 consecutive contract years.”.*

1 (d) *INFORMATION ON MEDICARE PART C PLAN EN-*
2 *ROLLMENT AND SERVICES.*—Section 1851 of such Act, as
3 *amended by subsection (a), is further amended by adding*
4 *at the end the following new subsection:*

5 “(k) *PUBLICATION OF ENROLLMENT AND OTHER IN-*
6 *FORMATION.*—

7 “(1) *MONTHLY PUBLICATION OF PLAN-SPECIFIC*
8 *ENROLLMENT DATA.*—The Secretary shall publish (on
9 *the public website of the Centers for Medicare & Med-*
10 *icaid Services or otherwise) not later than 30 days*
11 *after the end of each month (beginning with January*
12 *2008) on the actual enrollment in each Medicare Part*
13 *C plan by contract and by county.*

14 “(2) *AVAILABILITY OF OTHER INFORMATION.*—
15 *The Secretary shall make publicly available data and*
16 *other information in a format that may be readily*
17 *used for analysis of the Medicare Part C program*
18 *under this part and will contribute to the under-*
19 *standing of the organization and operation of such*
20 *program.”.*

21 (e) *MEDPAC REPORT ON VARYING MINIMUM MEDICAL*
22 *LOSS RATIOS.*—

23 “(1) *STUDY.*—The Medicare Payment Advisory
24 *Commission shall conduct a study of the need and*
25 *feasibility of providing for different minimum medical*

1 *loss ratios for different types of Medicare Part C*
2 *plans, including coordinated care plans, group model*
3 *plans, coordinated care independent practice associa-*
4 *tion plans, preferred provider organization plans,*
5 *and private fee-for-services plans.*

6 (2) *REPORT.—Not later than 1 year after the*
7 *date of the enactment of this Act, submit to Congress*
8 *a report on the study conducted under paragraph (1).*

9 ***Subtitle C—Quality and Other***
10 ***Provisions***

11 ***SEC. 421. REQUIRING ALL MA PLANS TO MEET EQUAL***
12 ***STANDARDS.***

13 (a) *COLLECTION AND REPORTING OF INFORMATION.—*

14 (1) *IN GENERAL.—Section 1852(e)(1) of the So-*
15 *cial Security Act (42 U.S.C. 1395w–112(e)(1)) is*
16 *amended by striking “(other than an MA private fee-*
17 *for-service plan or an MSA plan)”.*

18 (2) *REPORTING FOR PRIVATE FEE-FOR-SERVICES*
19 *AND MSA PLANS.—Section 1852(e)(3) of such Act is*
20 *amended by adding at the end the following new sub-*
21 *paragraph:*

22 ***“(C) DATA COLLECTION REQUIREMENTS BY***
23 ***PRIVATE FEE-FOR-SERVICE PLANS AND MSA***
24 ***PLANS.—***

1 “(i) *USING MEASURES FOR PPOS FOR*
2 *CONTRACT YEAR 2009.—For contract year*
3 *2009, the Medicare Part C organization of-*
4 *fering a private fee-for-service plan or an*
5 *MSA plan shall submit to the Secretary for*
6 *such plan the same information on the same*
7 *performance measures for which such infor-*
8 *mation is required to be submitted for*
9 *Medicare Part C plans that are preferred*
10 *provider organization plans for that year.*

11 “(ii) *APPLICATION OF SAME MEASURES*
12 *AS COORDINATED CARE PLANS BEGINNING*
13 *IN CONTRACT YEAR 2010.—For a contract*
14 *year beginning with 2010, a Medicare Part*
15 *C organization offering a private fee-for-*
16 *service plan or an MSA plan shall submit*
17 *to the Secretary for such plan the same in-*
18 *formation on the same performance meas-*
19 *ures for which such information is required*
20 *to be submitted for such contract year Medi-*
21 *care Part C plans described in section*
22 *1851(a)(2)(A)(i) for contract year such con-*
23 *tract year.”.*

1 (3) *EFFECTIVE DATE.*—*The amendment made by*
2 *paragraph (1) shall apply to contract years beginning*
3 *on or after January 1, 2009.*

4 (b) *EMPLOYER PLANS.*—

5 (1) *IN GENERAL.*—*The first sentence of para-*
6 *graph (2) of section 1857(i) of such Act (42 U.S.C.*
7 *1395w–27(i)) is amended by inserting before the pe-*
8 *riod at the end the following: “, but only if 90 percent*
9 *of the Medicare part C eligible individuals enrolled*
10 *under such plan reside in a county in which the*
11 *Medicare Part C organization offers a Medicare Part*
12 *C local plan”.*

13 (2) *LIMITATION ON APPLICATION OF WAIVER AU-*
14 *THORITY.*—*Paragraphs (1) and (2) of such section*
15 *are each amended by inserting “that were in effect be-*
16 *fore the date of the enactment of the Children’s Health*
17 *and Medicare Protection Act of 2007” after “waive or*
18 *modify requirements”.*

19 (3) *EFFECTIVE DATES.*—*The amendment made*
20 *by paragraph (1) shall apply for plan years begin-*
21 *ning on or after January 1, 2009, and the amend-*
22 *ments made by paragraph (2) shall take effect on the*
23 *date of the enactment of this Act.*

1 **SEC. 422. DEVELOPMENT OF NEW QUALITY REPORTING**
2 **MEASURES ON RACIAL DISPARITIES.**

3 *(a) NEW QUALITY REPORTING MEASURES.—*

4 *(1) IN GENERAL.—Section 1852(e)(3) of the So-*
5 *cial Security Act (42 U.S.C. 1395w–22(e)(3)), as*
6 *amended by section 421(a)(2), is amended—*

7 *(A) in subparagraph (B)—*

8 *(i) in clause (i), by striking “The Sec-*
9 *retary” and inserting “Subject to subpara-*
10 *graph (D), the Secretary”; and*

11 *(ii) in clause (ii), by striking “sub-*
12 *clause (iii)” and inserting “clause (iii) and*
13 *subparagraph (C)” ; and*

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

16 *“(D) ADDITIONAL QUALITY REPORTING*
17 *MEASURES.—*

18 *“(i) IN GENERAL.—The Secretary shall*
19 *develop by October 1, 2009, quality meas-*
20 *ures for Medicare Part C plans that meas-*
21 *ure disparities in the amount and quality*
22 *of health services provided to racial and eth-*
23 *nic minorities.*

24 *“(ii) DATA TO MEASURE RACIAL AND*
25 *ETHNIC DISPARITIES IN THE AMOUNT AND*
26 *QUALITY OF CARE PROVIDED TO ENROLL-*

1 *EES.—The Secretary shall provide for Medi-*
2 *care Part C organizations to submit data*
3 *under this paragraph, including data simi-*
4 *lar to those submitted for other quality*
5 *measures, that permits analysis of dispari-*
6 *ties among racial and ethnic minorities in*
7 *health services, quality of care, and health*
8 *status among Medicare Part C plan enroll-*
9 *ees for use in submitting the reports under*
10 *paragraph (5).”.*

11 (2) *EFFECTIVE DATE.—The amendments made*
12 *by this subsection shall apply to reporting of quality*
13 *measures for plan years beginning on or after Janu-*
14 *ary 1, 2010.*

15 (b) *BIENNIAL REPORT ON RACIAL AND ETHNIC MI-*
16 *NORITIES.—Section 1852(e) of such Act (42 U.S.C. 1395w-*
17 *22(e)) is amended by adding at the end the following new*
18 *paragraph:*

19 (5) *REPORT TO CONGRESS.—*

20 (A) *IN GENERAL.—Not later than 2 years*
21 *after the date of the enactment of this paragraph,*
22 *and biennially thereafter, the Secretary shall*
23 *submit to Congress a report regarding how qual-*
24 *ity assurance programs conducted under this*
25 *subsection measure and report on disparities in*

1 *the amount and quality of health care services*
2 *furnished to racial and ethnic minorities.*

3 “(B) *CONTENTS OF REPORT.*—*Each such re-*
4 *port shall include the following:*

5 “(i) *A description of the means by*
6 *which such programs focus on such racial*
7 *and ethnic minorities.*

8 “(ii) *An evaluation of the impact of*
9 *such programs on eliminating health dis-*
10 *parities and on improving health outcomes,*
11 *continuity and coordination of care, man-*
12 *agement of chronic conditions, and con-*
13 *sumer satisfaction.*

14 “(iii) *Recommendations on ways to re-*
15 *duce clinical outcome disparities among ra-*
16 *cial and ethnic minorities.*

17 “(iv) *Data for each MA plan from*
18 *HEDIS and other source reporting the dis-*
19 *parities in the amount and quality of*
20 *health services furnished to racial and eth-*
21 *nic minorities.”.*

22 **SEC. 423. STRENGTHENING AUDIT AUTHORITY.**

23 “(a) *FOR PART C PAYMENTS RISK ADJUSTMENT.*—*Sec-*
24 *tion 1857(d)(1) of the Social Security Act (42 U.S.C.*
25 *1395w–27(d)(1)) is amended by inserting after “section*

1 1858(c))” the following: “, and data submitted with respect
2 to risk adjustment under section 1853(a)(3)”.

3 (b) *ENFORCEMENT OF AUDITS AND DEFICIENCIES.*—

4 (1) *IN GENERAL.*—Section 1857(e) of such Act is
5 amended by adding at the end the following new
6 paragraph:

7 “(5) *ENFORCEMENT OF AUDITS AND DEFICI-*
8 *ENCIES.*—

9 “(A) *INFORMATION IN CONTRACT.*—The Sec-
10 retary shall require that each contract with a
11 Medicare Part C organization under this section
12 shall include terms that inform the organization
13 of the provisions in subsection (d).

14 “(B) *ENFORCEMENT AUTHORITY.*—The Sec-
15 retary is authorized, in connection with con-
16 ducting audits and other activities under sub-
17 section (d), to take such actions, including pur-
18 suit of financial recoveries, necessary to address
19 deficiencies identified in such audits or other ac-
20 tivities.”.

21 (2) *APPLICATION UNDER PART D.*—For provision
22 applying the amendment made by paragraph (1) to
23 prescription drug plans under part D, see section
24 1860D–12(b)(3)(D) of the Social Security Act.

1 (c) *EFFECTIVE DATE.*—*The amendments made by this*
2 *section shall take effect the date of the enactment of this*
3 *Act and shall apply to audits and activities conducted for*
4 *contract years beginning on or after January 1, 2009.*

5 **SEC. 424. IMPROVING RISK ADJUSTMENT FOR MA PAY-**
6 **MENTS.**

7 (a) *IN GENERAL.*—*Not later than 1 year after the date*
8 *of the enactment of this Act, the Secretary of Health and*
9 *Human Services shall submit to Congress a report that*
10 *evaluates the adequacy of the Medicare Advantage risk ad-*
11 *justment system under section 1853(a)(1)(C) of the Social*
12 *Security Act (42 U.S.C. 1395–23(a)(1)(C)).*

13 (b) *PARTICULARS.*—*The report under subsection (a)*
14 *shall include an evaluation of at least the following:*

15 (1) *The need and feasibility of improving the*
16 *adequacy of the risk adjustment system in predicting*
17 *costs for beneficiaries with co-morbid conditions and*
18 *associated cognitive impairments.*

19 (2) *The need and feasibility of including further*
20 *gradations of diseases and conditions (such as the de-*
21 *gree of severity of congestive heart failure).*

22 (3) *The feasibility of measuring difference in*
23 *coding over time between Medicare part C plans and*
24 *the medicare traditional fee-for-service program and,*

1 to the extent this difference exists, the options for ad-
2 dressing it.

3 (4) *The feasibility and value of including part D*
4 *and other drug utilization data in the risk adjust-*
5 *ment model.*

6 **SEC. 425. ELIMINATING SPECIAL TREATMENT OF PRIVATE**
7 **FEE-FOR-SERVICE PLANS.**

8 (a) *ELIMINATION OF EXTRA BILLING PROVISION.—*
9 *Section 1852(k)(2) of the Social Security Act (42 U.S.C.*
10 *1395w–22(k)(2)) is amended—*

11 (1) *in subparagraph (A)(i), by striking “115*
12 *percent” and inserting “100 percent”; and*

13 (2) *in subparagraph (C)(i), by striking “includ-*
14 *ing any liability for balance billing consistent with*
15 *this subsection)”.*

16 (b) *REVIEW OF BID INFORMATION.—Section*
17 *1854(a)(6)(B) of such Act (42 U.S.C. 1395w–24(a)(6)(B))*
18 *is amended—*

19 (1) *in clause (i), by striking “clauses (iii) and*
20 *(iv)” and inserting “clause (iii)”;* and

21 (2) *by striking clause (iv).*

22 (c) *EFFECTIVE DATE.—The amendments made by this*
23 *section shall apply to contract years beginning with 2009.*

1 **SEC. 426. RENAMING OF MEDICARE ADVANTAGE PROGRAM.**

2 (a) *IN GENERAL.*—*The program under part C of title*
 3 *XVIII of the Social Security Act is henceforth to be known*
 4 *as the “Medicare Part C program”.*

5 (b) *CHANGE IN REFERENCES.*—

6 (1) *AMENDING SOCIAL SECURITY ACT.*—*The So-*
 7 *cial Security Act is amended by striking “Medicare*
 8 *Advantage”, “MA”, and “Medicare+Choice” and in-*
 9 *serting “Medicare Part C” each place it appears, with*
 10 *the appropriate, respective typographic formatting,*
 11 *including typeface and capitalization.*

12 (2) *ADDITIONAL REFERENCES.*—*Notwithstanding*
 13 *section 201(b) of the Medicare Prescription Drug, Im-*
 14 *provement, and Modernization Act of 2003 (Public*
 15 *Law 108–173), any reference to the program under*
 16 *part C of title XVIII of the Social Security Act shall*
 17 *be deemed a reference to the “Medicare Part C” pro-*
 18 *gram and, with respect to such part, any reference to*
 19 *“Medicare+Choice”, “Medicare Advantage”, or “MA”*
 20 *is deemed a reference to the program under such part.*

21 ***Subtitle D—Extension of***
 22 ***Authorities***

23 **SEC. 431. EXTENSION AND REVISION OF AUTHORITY FOR**
 24 ***SPECIAL NEEDS PLANS (SNPS).***

25 (a) *EXTENDING RESTRICTION ON ENROLLMENT AU-*
 26 *THORITY FOR SNPS FOR 3 YEARS.*—*Subsection (f) of sec-*

1 *tion 1859 of the Social Security Act (42 U.S.C. 1395w-*
2 *28) is amended by striking “2009” and inserting “2012”.*

3 *(b) STRUCTURE OF AUTHORITY FOR SNPs.—*

4 *(1) IN GENERAL.—Such section is further*
5 *amended—*

6 *(A) in subsection (b)(6)(A), by striking all*
7 *that follows “means” and inserting the following:*

8 *“an MA plan—*

9 *“(i) that serves special needs individ-*
10 *uals (as defined in subparagraph (B));*

11 *“(ii) as of January 1, 2009, either—*

12 *“(I) at least 90 percent of the en-*
13 *rollees in which are described in sub-*
14 *paragraph (B)(i), as determined under*
15 *regulations in effect as of July 1, 2007;*
16 *or*

17 *“(II) at least 90 percent of the en-*
18 *rollees in which are described in sub-*
19 *paragraph (B)(ii) and are full-benefit*
20 *dual eligible individuals (as defined in*
21 *section 1935(c)(6)) or qualified medi-*
22 *care beneficiaries (as defined in section*
23 *1905(p)(1)); and*

1 “(iii) as of January 1, 2009, meets the
2 applicable requirements of paragraph (2) or
3 (3) of subsection (f), as the case may be.”;
4 (B) in subsection (b)(6)(B)(iii), by inserting
5 “only for contract years beginning before Janu-
6 ary 1, 2009,” after “(iii)”; and

7 (C) in subsection (f)—

8 (i) by amending the heading to read as
9 follows: “REQUIREMENTS FOR ENROLLMENT
10 IN PART C PLANS FOR SPECIAL NEEDS
11 BENEFICIARIES”;

12 (ii) by designating the sentence begin-
13 ning “In the case of” as paragraph (1) with
14 the heading “REQUIREMENTS FOR ENROLL-
15 MENT.—” and with appropriate indenta-
16 tion; and

17 (iii) by adding at the end the following
18 new paragraphs:

19 “(2) ADDITIONAL REQUIREMENTS FOR INSTITU-
20 TIONAL SNPS.—In the case of a specialized MA plan
21 for special needs individuals described in subsection
22 (b)(6)(A)(ii)(I), the applicable requirements of this
23 subsection are as follows:

24 “(A) The plan has an agreement with the
25 State that includes provisions regarding coopera-

1 *tion on the coordination of care for such individ-*
2 *uals. Such agreement shall include a description*
3 *of the manner that the State Medicaid program*
4 *under title XIX will pay for the costs of services*
5 *for individuals eligible under such title for med-*
6 *ical assistance for acute care and long-term care*
7 *services.*

8 *“(B) The plan has a contract with long-*
9 *term care facilities and other providers in the*
10 *area sufficient to provide care for enrollees de-*
11 *scribed in subsection (b)(6)(B)(i).*

12 *“(C) The plan reports to the Secretary in-*
13 *formation on additional quality measures speci-*
14 *fied by the Secretary under section*
15 *1852(e)(3)(D)(iv)(I) for such plans.*

16 *“(3) ADDITIONAL REQUIREMENTS FOR DUAL*
17 *SNPS.—In the case of a specialized MA plan for spe-*
18 *cial needs individuals described in subsection*
19 *(b)(6)(A)(ii)(II), the applicable requirements of this*
20 *subsection are as follows:*

21 *“(A) The plan has an agreement with the*
22 *State Medicaid agency that—*

23 *“(i) includes provisions regarding co-*
24 *operation on the coordination of the financ-*
25 *ing of care for such individuals;*

1 “(ii) includes a description of the man-
2 ner that the State Medicaid program under
3 title XIX will pay for the costs of cost-shar-
4 ing and supplemental services for individ-
5 uals enrolled in the plan eligible under such
6 title for medical assistance for acute and
7 long-term care services; and

8 “(iii) effective January 1, 2011, pro-
9 vides for capitation payments to cover costs
10 of supplemental benefits for individuals de-
11 scribed in subsection (b)(6)(A)(ii)(II).

12 “(B) The out-of-pocket costs for services
13 under parts A and B that are charged to enroll-
14 ees may not exceed the out-of-pocket costs for
15 same services permitted for such individuals
16 under title XIX.

17 “(C) The plan reports to the Secretary in-
18 formation on additional quality measures speci-
19 fied by the Secretary under section
20 1852(e)(3)(D)(iv)(II) for such plans.”.

21 (2) *QUALITY STANDARDS AND QUALITY REPORT-*
22 *ING.—Section 1852(e)(3) of such Act (42 U.S.C.*
23 *1395w–22(e)(3) is amended—*

24 (A) in subparagraph (A)(i), by adding at
25 the end the following: “In the case of a special-

1 *ized Medicare Part C plan for special needs in-*
2 *dividuals described in paragraph (2) or (3) of*
3 *section 1859(f), the organization shall provide*
4 *for the reporting on quality measures developed*
5 *for the plan under subparagraph (D)(iii).”;* and

6 *(B) in subparagraph (D), as added by sec-*
7 *tion 422(a)(1), by adding at the end the fol-*
8 *lowing new clause:*

9 *“(iii) SPECIFICATION OF ADDITIONAL*
10 *QUALITY MEASUREMENTS FOR SPECIALIZED*
11 *PART C PLANS.—For implementation for*
12 *plan years beginning not later than Janu-*
13 *ary 1, 2010, the Secretary shall develop new*
14 *quality measures appropriate to meeting the*
15 *needs of—*

16 *“(I) beneficiaries enrolled in spe-*
17 *cialized Medicare Part C plans for spe-*
18 *cial needs individuals (described in*
19 *section 1859(b)(6)(A)(ii)(I)) that serve*
20 *predominantly individuals who are*
21 *dual-eligible individuals eligible for*
22 *medical assistance under title XIX by*
23 *measuring the special needs for care of*
24 *individuals who are both Medicare and*
25 *Medicaid beneficiaries; and*

1 “(II) beneficiaries enrolled in spe-
2 cialized Medicare Part C plans for spe-
3 cial needs individuals (described in
4 section 1859(b)(6)(A)(ii)(II)) that serve
5 predominantly institutionalized indi-
6 viduals by measuring the special needs
7 for care of individuals who are a resi-
8 dent in long-term care institution.”.

9 (3) *EFFECTIVE DATE; GRANDFATHER.*—The
10 amendments made by paragraph (1) shall take effect
11 for enrollments occurring on or after January 1,
12 2009, and shall not apply—

13 (A) to plans with a contract with a State
14 Medicaid agency to operate an integrated Med-
15 icaid-Medicare program, that had been approved
16 by Centers for Medicare & Medicaid Services on
17 January 1, 2004; and

18 (B) to plans that are operational as of the
19 date of the enactment of this Act as approved
20 Medicare demonstration projects and that pro-
21 vide services predominantly to individuals with
22 end-stage renal disease.

23 (4) *TRANSITION FOR NON-QUALIFYING SNPS.*—

24 (A) *RESTRICTIONS IN 2008 FOR CHRONIC*
25 *CARE SNPS.*—In the case of a specialized MA

1 *plan for special needs individuals (as defined in*
2 *section 1859(b)(6)(A) of the Social Security Act*
3 *(42 U.S.C. 1395w–28(b)(6)(A)) that, as of De-*
4 *cember 31, 2007, is not described in either sub-*
5 *clause (I) or subclause (II) of clause (ii) of such*
6 *section, as amended by paragraph (1), then as of*
7 *January 1, 2008—*

8 *(i) the plan may not be offered unless*
9 *it was offered before such date;*

10 *(ii) no new members may be enrolled*
11 *with the plan; and*

12 *(iii) there may be no expansion of the*
13 *service area of such plan.*

14 *(B) TRANSITION OF ENROLLEES.—The Sec-*
15 *retary of Health and Human Services shall pro-*
16 *vide for an orderly transition of those specialized*
17 *MA plans for special needs individuals (as de-*
18 *finied in section 1859(b)(6)(A) of the Social Secu-*
19 *rity Act (42 U.S.C. 1395w–28(b)(6)(A)), as of*
20 *the date of the enactment of this Act), and their*
21 *enrollees, that no longer qualify as such plans*
22 *under such section, as amended by this sub-*
23 *section.*

1 **SEC. 432. EXTENSION AND REVISION OF AUTHORITY FOR**
2 **MEDICARE REASONABLE COST CONTRACTS.**

3 (a) *EXTENSION FOR 3 YEARS OF PERIOD REASONABLE*
4 *COST PLANS CAN REMAIN IN THE MARKET.*—Section
5 *1876(h)(5)(C)(ii) of the Social Security Act (42 U.S.C.*
6 *1395mm(h)(5)(C)(ii)) is amended, in the matter preceding*
7 *subclause (I), by striking “January 1, 2008” and inserting*
8 *“January 1, 2011”.*

9 (b) *APPLICATION OF CERTAIN MEDICARE ADVANTAGE*
10 *REQUIREMENTS TO COST CONTRACTS EXTENDED OR RE-*
11 *NEWED AFTER ENACTMENT.*—Section *1876(h) of such Act*
12 *(42 U.S.C. 1395mm(h)), as amended by subsection (a), is*
13 *amended—*

14 (1) *by redesignating paragraph (5) as para-*
15 *graph (6); and*

16 (2) *by inserting after paragraph (4) the fol-*
17 *lowing new paragraph:*

18 “(5)(A) *Any reasonable cost reimbursement con-*
19 *tract with an eligible organization under this sub-*
20 *section that is extended or renewed on or after the*
21 *date of enactment of the Children’s Health and Medi-*
22 *care Protection Act of 2007 shall provide that the pro-*
23 *visions of the Medicare Part C program described in*
24 *subparagraph (B) shall apply to such organization*
25 *and such contract in a substantially similar manner*

1 *as such provisions apply to Medicare Part C organi-*
2 *zations and Medicare Part C plans under part C.*

3 “(B) *The provisions described in this subpara-*
4 *graph are as follows:*

5 “(i) *Section 1851(h) (relating to the ap-*
6 *proval of marketing material and application*
7 *forms).*

8 “(ii) *Section 1852(e) (relating to the re-*
9 *quirement of having an ongoing quality im-*
10 *provement program and treatment of accredita-*
11 *tion in the same manner as such provisions*
12 *apply to Medicare Part C local plans that are*
13 *preferred provider organization plans).*

14 “(iii) *Section 1852(f) (relating to grievance*
15 *mechanisms).*

16 “(iv) *Section 1852(g) (relating to coverage*
17 *determinations, reconsiderations, and appeals).*

18 “(v) *Section 1852(j)(4) (relating to limita-*
19 *tions on physician incentive plans).*

20 “(vi) *Section 1854(c) (relating to the re-*
21 *quirement of uniform premiums among individ-*
22 *uals enrolled in the plan).*

23 “(vii) *Section 1854(g) (relating to restric-*
24 *tions on imposition of premium taxes with re-*
25 *spect to payments to organizations).*

1 “(viii) Section 1856(b)(3) (relating to rela-
2 tion to State laws).

3 “(ix) The provisions of part C relating to
4 timelines for contract renewal and beneficiary
5 notification.”.

6 **TITLE V—PROVISIONS RELATING**
7 **TO MEDICARE PART A**

8 **SEC. 501. INPATIENT HOSPITAL PAYMENT UPDATES.**

9 (a) *FOR ACUTE HOSPITALS.*—Clause (i) of section
10 1886(b)(3)(B) of the Social Security Act (42 U.S.C.
11 1395ww(b)(3)(B)) is amended—

12 (1) in subclause (XIX), by striking “and”;

13 (2) by redesignating subclause (XX) as subclause
14 (XXII); and

15 (3) by inserting after subclause (XIX) the fol-
16 lowing new subclauses:

17 “(XX) for fiscal year 2007, subject to clause
18 (viii), the market basket percentage increase for hos-
19 pitals in all areas,

20 “(XXI) for fiscal year 2008, subject to clause
21 (viii), the market basket percentage increase minus
22 0.25 percentage point for hospitals in all areas, and”.

23 (b) *FOR OTHER HOSPITALS.*—Clause (i) of such sec-
24 tion is amended—

25 (1) in subclause (VII) by striking “and”;

1 (2) by redesignating subclause (VIII) as sub-
2 clause (X); and

3 (3) by inserting after subclause (VII) the fol-
4 lowing new subclauses:

5 “(VIII) fiscal years 2003 through 2007, is the
6 market basket percentage increase,

7 “(IX) fiscal year 2008, is the market basket per-
8 centage increase minus 0.25 percentage point, and”.

9 (c) *DELAYED EFFECTIVE DATE.*—

10 (1) *ACUTE CARE HOSPITALS.*—The amendments
11 made by subsection (a) shall not apply to discharges
12 occurring before January 1, 2008.

13 (2) *OTHER HOSPITALS.*—The amendments made
14 by subsection (b) shall be applied, only with respect
15 to cost reporting periods beginning during fiscal year
16 2008 and not with respect to the computation for any
17 succeeding cost reporting period, by substituting
18 “0.1875 percentage point” for “0.25 percentage
19 point”.

20 **SEC. 502. PAYMENT FOR INPATIENT REHABILITATION FA-**
21 **CILITY (IRF) SERVICES.**

22 (a) *PAYMENT UPDATE.*—

23 (1) *IN GENERAL.*—Section 1886(j)(3)(C) of the
24 Social Security Act (42 U.S.C. 1395ww(j)(3)(C)) is
25 amended by adding at the end the following: “The in-

1 crease factor to be applied under this subparagraph
2 for fiscal year 2008 shall be 1 percent.”

3 (2) *DELAYED EFFECTIVE DATE.*—The amend-
4 ment made by paragraph (1) shall not apply to pay-
5 ment units occurring before January 1, 2008.

6 (b) *INPATIENT REHABILITATION FACILITY CLASSI-*
7 *FICATION CRITERIA.*—

8 (1) *IN GENERAL.*—Section 5005 of the Deficit
9 Reduction Act of 2005 (Public Law 109–171) is
10 amended—

11 (A) in subsection (a), by striking “apply the
12 applicable percent specified in subsection (b)”
13 and inserting “require a compliance rate that is
14 no greater than the 60 percent compliance rate
15 that became effective for cost reporting periods
16 beginning on or after July 1, 2006,”; and

17 (B) by amending subsection (b) to read as
18 follows:

19 “(b) *CONTINUED USE OF COMORBIDITIES.*—For por-
20 tions of cost reporting periods occurring on or after the date
21 of the enactment of the Children’s Health and Medicare Pro-
22 tection Act of 2007, the Secretary shall include patients
23 with comorbidities as described in section 412.23(b)(2)(i)
24 of title 42, Code of Federal Regulations (as in effect as of

1 *January 1, 2007), in the inpatient population that counts*
2 *towards the percent specified in subsection (a).”.*

3 (2) *EFFECTIVE DATE.*—*The amendment made by*
4 *paragraph (1)(A) shall apply to portions of cost re-*
5 *porting periods beginning on or after the date of the*
6 *enactment of this Act.*

7 (c) *PAYMENT FOR CERTAIN MEDICAL CONDITIONS*
8 *TREATED IN INPATIENT REHABILITATION FACILITIES.*—

9 (1) *IN GENERAL.*—*Section 1886(j) of the Social*
10 *Security Act (42 U.S.C. 1395ww(j)) is amended—*

11 (A) *by redesignating paragraph (7) as*
12 *paragraph (8);*

13 (B) *by inserting after paragraph (6) the fol-*
14 *lowing new paragraph:*

15 “(7) *SPECIAL PAYMENT RULE FOR CERTAIN MED-*
16 *ICAL CONDITIONS.*—

17 “(A) *IN GENERAL.*—*Subject to subpara-*
18 *graph (H), in the case of discharges occurring on*
19 *or after October 1, 2008, in lieu of the standard-*
20 *ized payment amount (as determined pursuant*
21 *to the preceding provisions of this subsection)*
22 *that would otherwise be applicable under this*
23 *subsection, the Secretary shall substitute, for*
24 *payment units with respect to an applicable*
25 *medical condition (as defined in subparagraph*

1 *(G)(i)) that is treated in an inpatient rehabilita-*
2 *tion facility, the modified standardized payment*
3 *amount determined under subparagraph (B).*

4 “(B) *MODIFIED STANDARDIZED PAYMENT*
5 *AMOUNT.—The modified standardized payment*
6 *amount for an applicable medical condition*
7 *shall be based on the amount determined under*
8 *subparagraph (C) for such condition, as adjusted*
9 *under subparagraphs (D), (E), and (F).*

10 “(C) *AMOUNT DETERMINED.—*

11 “(i) *IN GENERAL.—The amount deter-*
12 *mined under this subparagraph for an ap-*
13 *plicable medical condition shall be based on*
14 *the sum of the following:*

15 “(I) *An amount equal to the aver-*
16 *age per stay skilled nursing facility*
17 *payment rate for the applicable med-*
18 *ical condition (as determined under*
19 *clause (ii)).*

20 “(II) *An amount equal to 25 per-*
21 *cent of the difference between the over-*
22 *head costs (as defined in subparagraph*
23 *(G)(ii)) component of the average in-*
24 *patient rehabilitation facility per stay*
25 *payment amount for the applicable*

1 *medical condition (as determined*
2 *under the preceding paragraphs of this*
3 *subsection) and the overhead costs com-*
4 *ponent of the average per stay skilled*
5 *nursing facility payment rate for such*
6 *condition (as determined under clause*
7 *(ii)).*

8 *“(III) An amount equal to 33 per-*
9 *cent of the difference between the pa-*
10 *tient care costs (as defined in subpara-*
11 *graph (G)(iii)) component of the aver-*
12 *age inpatient rehabilitation facility*
13 *per stay payment amount for the ap-*
14 *plicable medical condition (as deter-*
15 *mined under the preceding paragraphs*
16 *of this subsection) and the patient care*
17 *costs component of the average per stay*
18 *skilled nursing facility payment rate*
19 *for such condition (as determined*
20 *under clause (i)).*

21 *“(ii) DETERMINATION OF AVERAGE*
22 *PER STAY SKILLED NURSING FACILITY PAY-*
23 *MENT RATE.—For purposes of clause (i), the*
24 *Secretary shall convert skilled nursing facil-*
25 *ity payment rates for applicable medical*

1 *conditions, as determined under section*
2 *1888(e), to average per stay skilled nursing*
3 *facility payment rates for each such condi-*
4 *tion.*

5 “(D) *ADJUSTMENTS.*—*The Secretary shall*
6 *adjust the amount determined under subpara-*
7 *graph (C) for an applicable medical condition*
8 *using the adjustments to the prospective payment*
9 *rates for inpatient rehabilitation facilities de-*
10 *scribed in paragraphs (2), (3), (4), and (6).*

11 “(E) *UPDATE FOR INFLATION.*—*Except in*
12 *the case of a fiscal year for which the Secretary*
13 *rebases the amounts determined under subpara-*
14 *graph (C) for applicable medical conditions pur-*
15 *suant to subparagraph (F), the Secretary shall*
16 *annually update the amounts determined under*
17 *subparagraph (C) for each applicable medical*
18 *condition by the increase factor for inpatient re-*
19 *habilitation facilities (as described in paragraph*
20 *(3)(C)).*

21 “(F) *REBASING.*—*The Secretary shall peri-*
22 *odically (but in no case less than once every 5*
23 *years) rebase the amounts determined under sub-*
24 *paragraph (C) for applicable medical conditions*
25 *using the methodology described in such subpara-*

1 *graph and the most recent and complete cost re-*
2 *port and claims data available.*

3 “(G) *DEFINITIONS.—In this paragraph:*

4 “(i) *APPLICABLE MEDICAL CONDI-*
5 *TION.—The term ‘applicable medical condi-*
6 *tion’ means—*

7 “(I) *unilateral knee replacement;*

8 “(II) *unilateral hip replacement;*

9 *and*

10 “(III) *unilateral hip fracture.*

11 “(ii) *OVERHEAD COSTS.—The term*
12 *‘overhead costs’ means those Medicare-allow-*
13 *able costs that are contained in the General*
14 *Service cost centers of the Medicare cost re-*
15 *ports for inpatient rehabilitation facilities*
16 *and for skilled nursing facilities, respec-*
17 *tively, as determined by the Secretary.*

18 “(iii) *PATIENT CARE COSTS.—The*
19 *term ‘patient care costs’ means total Medi-*
20 *care-allowable costs minus overhead costs.*

21 “(H) *SUNSET.—The provisions of this*
22 *paragraph shall cease to apply as of the date the*
23 *Secretary implements an integrated, site-neutral*
24 *payment methodology under this title for post-*
25 *acute care.”; and*

1 (C) in paragraph (8), as redesignated by
2 paragraph (1)—

3 (i) in subparagraph (C), by striking
4 “and” at the end;

5 (ii) in subparagraph (D), by striking
6 the period at the end and inserting “, and”;
7 and

8 (iii) by adding at the end the following
9 new subparagraph:

10 “(E) modified standardized payment
11 amounts under paragraph (7).”.

12 (2) SPECIAL RULE FOR DISCHARGES OCCURRING
13 IN THE SECOND HALF OF FISCAL YEAR 2008.—

14 (A) IN GENERAL.—In the case of discharges
15 from an inpatient rehabilitation facility occur-
16 ring during the period beginning on April 1,
17 2008, and ending on September 30, 2008, for ap-
18 plicable medical conditions (as defined in para-
19 graph (7)(G)(i) of section 1886(j) of the Social
20 Security Act (42 U.S.C. 1395ww(j)), as inserted
21 by paragraph (1)(B), in lieu of the standardized
22 payment amount determined pursuant to such
23 section, the standardized payment amount shall
24 be \$9,507 for unilateral knee replacement,
25 \$10,398 for unilateral hip replacement, and

1 \$10,958 for unilateral hip fracture. Such
2 amounts are the amounts that are estimated
3 would be determined under paragraph (7)(C) of
4 such section 1886(j) for such conditions if such
5 paragraph applied for such period. Such stand-
6 ardized payment amounts shall be multiplied by
7 the relative weights for each case-mix group and
8 tier, as published in the final rule of the Sec-
9 retary of Health and Human Services for inpa-
10 tient rehabilitation facility services prospective
11 payment for fiscal year 2008, to obtain the ap-
12 plicable payment amounts for each such condi-
13 tion for each case-mix group and tier.

14 (B) *IMPLEMENTATION.*—Notwithstanding
15 any other provision of law, the Secretary of
16 Health and Human Services may implement
17 this subsection by program instruction or other-
18 wise. Paragraph (8)(E) of such section 1886(j) of
19 the Social Security Act, as added by paragraph
20 (1)(C), shall apply for purposes of this subsection
21 in the same manner as such paragraph applies
22 for purposes of paragraph (7) of such section
23 1886(j).

24 (d) *RECOMMENDATIONS FOR CLASSIFYING INPATIENT*
25 *REHABILITATION HOSPITALS AND UNITS.*—

1 (1) *REPORT TO CONGRESS.*—Not later than 12
2 months after the date of the enactment of this Act, the
3 Secretary of Health and Human Services, in con-
4 sultation with physicians (including geriatricians
5 and physiatrists), administrators of inpatient reha-
6 bilitation, acute care hospitals, skilled nursing facili-
7 ties, and other settings providing rehabilitation serv-
8 ices, Medicare beneficiaries, trade organizations rep-
9 resenting inpatient rehabilitation hospitals and units
10 and skilled nursing facilities, and the Medicare Pay-
11 ment Advisory Commission, shall submit to the Com-
12 mittee on Ways and Means of the House of Represent-
13 atives and the Committee on Finance of the Senate a
14 report that includes—

15 (A) an examination of Medicare bene-
16 ficiaries' access to medically necessary rehabili-
17 tation services;

18 (B) alternatives or refinements to the 75
19 percent rule policy for determining exclusion cri-
20 teria for inpatient rehabilitation hospital and
21 unit designation under the Medicare program,
22 including determining clinical appropriateness
23 of inpatient rehabilitation hospital and unit ad-
24 missions and alternative criteria which would

1 *consider a patient’s functional status, diagnosis,*
2 *co-morbidities, and other relevant factors; and*

3 *(C) an examination that identifies any con-*
4 *dition for which individuals are commonly ad-*
5 *mitted to inpatient rehabilitation hospitals that*
6 *is not included as a condition described in sec-*
7 *tion 412.23(b)(2)(iii) of title 42, Code of Federal*
8 *Regulations, to determine the appropriate setting*
9 *of care, and any variation in patient outcomes*
10 *and costs, across settings of care, for treatment*
11 *of such conditions.*

12 *For the purposes of this subsection, the term “75 per-*
13 *cent rule” means the requirement of section*
14 *412.23(b)(2) of title 42, Code of Federal Regulations,*
15 *that 75 percent of the patients of a rehabilitation hos-*
16 *pital or converted rehabilitation unit are in 1 or*
17 *more of 13 listed treatment categories.*

18 *(2) CONSIDERATIONS.—In developing the report*
19 *described in paragraph (1), the Secretary shall in-*
20 *clude the following:*

21 *(A) The potential effect of the 75 percent*
22 *rule on access to rehabilitation care by Medicare*
23 *beneficiaries for the treatment of a condition,*
24 *whether or not such condition is described in sec-*

1 *tion 412.23(b)(2)(iii) of title 42, Code of Federal*
2 *Regulations.*

3 *(B) An analysis of the effectiveness of reha-*
4 *ilitation care for the treatment of conditions,*
5 *whether or not such conditions are described in*
6 *section 412.23(b)(2)(iii) of title 42, Code of Fed-*
7 *eral Regulations, available to Medicare bene-*
8 *ficiaries in various health care settings, taking*
9 *into account variation in patient outcomes and*
10 *costs across different settings of care, and which*
11 *may include whether the Medicare program and*
12 *Medicare beneficiaries may incur higher costs of*
13 *care for the entire episode of illness due to re-*
14 *admissions, extended lengths of stay, and other*
15 *factors.*

16 **SEC. 503. LONG-TERM CARE HOSPITALS.**

17 *(a) LONG-TERM CARE HOSPITAL PAYMENT UP-*
18 *DATE.—*

19 *(1) IN GENERAL.—Section 1886 of the Social Se-*
20 *curity Act (42 U.S.C. 1395ww) is amended by adding*
21 *at the end the following new subsection:*

22 *“(m) PROSPECTIVE PAYMENT FOR LONG-TERM CARE*
23 *HOSPITALS.—*

24 *“(1) REFERENCE TO ESTABLISHMENT AND IM-*
25 *PLEMENTATION OF SYSTEM.—For provisions related*

1 *to the establishment and implementation of a prospec-*
2 *tive payment system for payments under this title for*
3 *inpatient hospital services furnished by a long-term*
4 *care hospital described in subsection (d)(1)(B)(iv), see*
5 *section 123 of the Medicare, Medicaid, and SCHIP*
6 *Balanced Budget Refinement Act of 1999 and section*
7 *307(b) of Medicare, Medicaid, and SCHIP Benefits*
8 *Improvement and Protection Act of 2000.*

9 “(2) *UPDATE FOR RATE YEAR 2008.*—*In imple-*
10 *menting the system described in paragraph (1) for*
11 *discharges occurring during the rate year ending in*
12 *2008 for a hospital, the base rate for such discharges*
13 *for the hospital shall be the same as the base rate for*
14 *discharges for the hospital occurring during the pre-*
15 *vious rate year.”.*

16 (2) *DELAYED EFFECTIVE DATE.*—*Subsection*
17 *(m)(2) of section 1886 of the Social Security Act, as*
18 *added by paragraph (1), shall not apply to discharges*
19 *occurring on or after July 1, 2007, and before Janu-*
20 *ary 1, 2008.*

21 (b) *PAYMENT FOR LONG-TERM CARE HOSPITAL SERV-*
22 *ICES; PATIENT AND FACILITY CRITERIA.*—

23 (1) *DEFINITION OF LONG-TERM CARE HOS-*
24 *PITAL.*—

1 (A) *DEFINITION.*—Section 1861 of the So-
2 cial Security Act (42 U.S.C. 1395x), as amended
3 by section 201(a)(2), is amended by adding at
4 the end the following new subsection:

5 “Long-Term Care Hospital

6 “(ddd) The term ‘long-term care hospital’ means an
7 institution which—

8 “(1) is primarily engaged in providing inpatient
9 services, by or under the supervision of a physician,
10 to Medicare beneficiaries whose medically complex
11 conditions require a long hospital stay and programs
12 of care provided by a long-term care hospital;

13 “(2) has an average inpatient length of stay (as
14 determined by the Secretary) for Medicare bene-
15 ficiaries of greater than 25 days, or as otherwise de-
16 fined in section 1886(d)(1)(B)(iv);

17 “(3) satisfies the requirements of subsection (e);

18 “(4) meets the following facility criteria:

19 “(A) the institution has a patient review
20 process, documented in the patient medical
21 record, that screens patients prior to admission
22 for appropriateness of admission to a long-term
23 care hospital, validates within 48 hours of ad-
24 mission that patients meet admission criteria for
25 long-term care hospitals, regularly evaluates pa-

1 *tients throughout their stay for continuation of*
2 *care in a long-term care hospital, and assesses*
3 *the available discharge options when patients no*
4 *longer meet such continued stay criteria;*

5 *“(B) the institution has active physician*
6 *involvement with patients during their treatment*
7 *through an organized medical staff, physician-*
8 *directed treatment with physician on-site avail-*
9 *ability on a daily basis to review patient*
10 *progress, and consulting physicians on call and*
11 *capable of being at the patient’s side within a*
12 *moderate period of time, as determined by the*
13 *Secretary;*

14 *“(C) the institution has interdisciplinary*
15 *team treatment for patients, requiring inter-*
16 *disciplinary teams of health care professionals,*
17 *including physicians, to prepare and carry out*
18 *an individualized treatment plan for each pa-*
19 *tient; and*

20 *“(5) meets patient criteria relating to patient*
21 *mix and severity appropriate to the medically com-*
22 *plex cases that long-term care hospitals are designed*
23 *to treat, as measured under section 1886(n).”.*

24 *(B) NEW PATIENT CRITERIA FOR LONG-*
25 *TERM CARE HOSPITAL PROSPECTIVE PAYMENT.—*

1 Section 1886 of such Act (42 U.S.C. 1395ww), as
2 amended by subsection (a), is further amended
3 by adding at the end the following new sub-
4 section:

5 “(n) *PATIENT CRITERIA FOR PROSPECTIVE PAYMENT*
6 *TO LONG-TERM CARE HOSPITALS.*—

7 “(1) *IN GENERAL.*—*To be eligible for prospective*
8 *payment under this section as a long-term care hos-*
9 *pital, a long-term care hospital must admit not less*
10 *than a majority of patients who have a high level of*
11 *severity, as defined by the Secretary, and who are as-*
12 *signed to one or more of the following major diag-*
13 *nostic categories:*

14 “(A) *Circulatory diagnoses.*

15 “(B) *Digestive, endocrine, and metabolic di-*
16 *agnoses.*

17 “(C) *Infection disease diagnoses.*

18 “(D) *Neurological diagnoses.*

19 “(E) *Renal diagnoses.*

20 “(F) *Respiratory diagnoses.*

21 “(G) *Skin diagnoses.*

22 “(H) *Other major diagnostic categories as*
23 *selected by the Secretary.*

24 “(2) *MAJOR DIAGNOSTIC CATEGORY DEFINED.*—

25 *In paragraph (1), the term ‘major diagnostic cat-*

1 *egory’ means the medical categories formed by divid-*
2 *ing all possible principle diagnosis into mutually ex-*
3 *clusive diagnosis areas which are referred to in 67*
4 *Federal Register 49985 (August 1, 2002).”.*

5 (C) *ESTABLISHMENT OF REHABILITATION*
6 *UNITS WITHIN CERTAIN LONG-TERM CARE HOS-*
7 *PITALS.—If the Secretary of Health and Human*
8 *Services does not include rehabilitation services*
9 *within a major diagnostic category under section*
10 *1886(n)(2) of the Social Security Act, as added*
11 *by subparagraph (B), the Secretary shall ap-*
12 *prove for purposes of title XVIII of such Act dis-*
13 *tinct part inpatient rehabilitation hospital units*
14 *in long-term care hospitals consistent with the*
15 *following:*

16 (i) *A hospital that, on or before Octo-*
17 *ber 1, 2004, was classified by the Secretary*
18 *as a long-term care hospital, as described in*
19 *section 1886(d)(1)(B)(iv)(I) of such Act (42*
20 *U.S.C. 1395ww(d)(1)(V)(iv)(I)), and was*
21 *accredited by the Commission on Accredita-*
22 *tion of Rehabilitation Facilities, may estab-*
23 *lish a hospital rehabilitation unit that is a*
24 *distinct part of the long-term care hospital,*
25 *if the distinct part meets the requirements*

1 *(including conditions of participation) that*
2 *would otherwise apply to a distinct-part re-*
3 *habilitation unit if the distinct part were*
4 *established by a subsection (d) hospital in*
5 *accordance with the matter following clause*
6 *(v) of section 1886(d)(1)(B) of such Act, in-*
7 *cluding any regulations adopted by the Sec-*
8 *retary in accordance with this section, ex-*
9 *cept that the one-year waiting period de-*
10 *scribed in section 412.30(c) of title 42, Code*
11 *of Federal Regulations, applicable to the*
12 *conversion of hospital beds into a distinct-*
13 *part rehabilitation unit shall not apply to*
14 *such units.*

15 *(ii) Services provided in inpatient re-*
16 *habilitation units established under clause*
17 *(i) shall not be reimbursed as long-term*
18 *care hospital services under section 1886 of*
19 *such Act and shall be subject to payment*
20 *policies established by the Secretary to re-*
21 *imburse services provided by inpatient hos-*
22 *pital rehabilitation units.*

23 *(D) EFFECTIVE DATE.—The amendments*
24 *made by subparagraphs (A) and (B), and the*
25 *provisions of subparagraph (C), shall apply to*

1 *discharges occurring on or after January 1,*
2 *2008.*

3 (2) *IMPLEMENTATION OF FACILITY AND PATIENT*
4 *CRITERIA.—*

5 (A) *REPORT.—No later than 1 year after*
6 *the date of the enactment of this Act, the Sec-*
7 *retary of Health and Human Services (in this*
8 *section referred to as the “Secretary”) shall sub-*
9 *mit to the appropriate committees of Congress a*
10 *report containing recommendations regarding*
11 *the promulgation of the national long-term care*
12 *hospital facility and patient criteria for applica-*
13 *tion under paragraphs (4) and (5) of section*
14 *1861(ccc) and section 1886(n) of the Social Secu-*
15 *rity Act, as added by subparagraphs (A) and*
16 *(B), respectively, of paragraph (1). In the report,*
17 *the Secretary shall consider recommendations*
18 *contained in a report to Congress by the Medi-*
19 *care Payment Advisory Commission in June*
20 *2004 for long-term care hospital-specific facility*
21 *and patient criteria to ensure that patients ad-*
22 *mitted to long-term care hospitals are medically*
23 *complex and appropriate to receive long-term*
24 *care hospital services.*

1 (B) *IMPLEMENTATION.*—No later than 1
2 year after the date of submittal of the report
3 under subparagraph (A), the Secretary shall,
4 after rulemaking, implement the national long-
5 term care hospital facility and patient criteria
6 referred to in such subparagraph. Such long-term
7 care hospital facility and patient criteria shall
8 be used to screen patients in determining the
9 medical necessity and appropriateness of a Medi-
10 care beneficiary’s admission to, continued stay
11 at, and discharge from, long-term care hospitals
12 under the Medicare program and shall take into
13 account the medical judgment of the patient’s
14 physician, as provided for under sections
15 1814(a)(3) and 1835(a)(2)(B) of the Social Secu-
16 rity Act (42 U.S.C. 1395f(a)(3),
17 1395n(a)(2)(B)).

18 (3) *EXPANDED REVIEW OF MEDICAL NECES-*
19 *SITY.*—

20 (A) *IN GENERAL.*—The Secretary of Health
21 and Human Services shall provide, under con-
22 tracts with one or more appropriate fiscal inter-
23 mediaries or medicare administrative contrac-
24 tors under section 1874A(a)(4)(G) of the Social
25 Security Act (42 U.S.C. 1395kk(a)(4)(G)), for re-

1 *views of the medical necessity of admissions to*
2 *long-term care hospitals (described in section*
3 *1886(d)(1)(B)(iv) of such Act) and continued*
4 *stay at such hospitals, of individuals entitled to,*
5 *or enrolled for, benefits under part A of title*
6 *XVIII of such Act on a hospital-specific basis*
7 *consistent with this paragraph. Such reviews*
8 *shall be made for discharges occurring on or*
9 *after October 1, 2007.*

10 *(B) REVIEW METHODOLOGY.—The medical*
11 *necessity reviews under paragraph (A) shall be*
12 *conducted for each such long-term care hospital*
13 *on an annual basis in accordance with rules (in-*
14 *cluding a sample methodology) specified by the*
15 *Secretary. Such sample methodology shall—*

16 *(i) provide for a statistically valid and*
17 *representative sample of admissions of such*
18 *individuals sufficient to provide results at a*
19 *95 percent confidence interval; and*

20 *(ii) guarantee that at least 75 percent*
21 *of overpayments received by long-term care*
22 *hospitals for medically unnecessary admis-*
23 *sions and continued stays of individuals in*
24 *long-term care hospitals will be identified*
25 *and recovered and that related days of care*

1 *will not be counted toward the length of*
2 *stay requirement contained in section*
3 *1886(d)(1)(B)(iv) of the Social Security Act*
4 *(42 U.S.C. 1395ww(d)(1)(B)(iv)).*

5 (C) *CONTINUATION OF REVIEWS.*—*Under*
6 *contracts under this paragraph, the Secretary*
7 *shall establish a denial rate with respect to such*
8 *reviews that, if exceeded, could require further re-*
9 *view of the medical necessity of admissions and*
10 *continued stay in the hospital involved.*

11 (D) *TERMINATION OF REQUIRED RE-*
12 *VIEWS.*—

13 (i) *IN GENERAL.*—*Subject to clause*
14 *(iii), the previous provisions of this sub-*
15 *section shall cease to apply as of the date*
16 *specified in clause (ii).*

17 (ii) *DATE SPECIFIED.*—*The date speci-*
18 *fied in this clause is the later of January*
19 *1, 2013, or the date of implementation of*
20 *national long-term care hospital facility*
21 *and patient criteria under section para-*
22 *graph (2)(B).*

23 (iii) *CONTINUATION.*—*As of the date*
24 *specified in clause (ii), the Secretary shall*
25 *determine whether to continue to guarantee,*

1 *through continued medical review and sam-*
2 *pling under this paragraph, recovery of at*
3 *least 75 percent of overpayments received by*
4 *long-term care hospitals due to medically*
5 *unnecessary admissions and continued*
6 *stays.*

7 *(E) FUNDING.—The costs to fiscal inter-*
8 *mediaries or medicare administrative contrac-*
9 *tors conducting the medical necessity reviews*
10 *under subparagraph (A) shall be funded from the*
11 *aggregate overpayments recouped by the Sec-*
12 *retary of Health and Human Services from long-*
13 *term care hospitals due to medically unnecessary*
14 *admissions and continued stays. The Secretary*
15 *may use an amount not in excess of 40 percent*
16 *of the overpayments recouped under this para-*
17 *graph to compensate the fiscal intermediaries or*
18 *Medicare administrative contractors for the costs*
19 *of services performed.*

20 *(4) LIMITED, QUALIFIED MORATORIUM OF LONG-*
21 *TERM CARE HOSPITALS.—*

22 *(A) IN GENERAL.—Subject to subparagraph*
23 *(B), the Secretary shall impose a temporary*
24 *moratorium on the certification of new long-term*
25 *care hospitals (and satellite facilities), and new*

1 *long-term care hospital and satellite facility*
2 *beds, for purposes of the Medicare program*
3 *under title XVIII of the Social Security Act. The*
4 *moratorium shall terminate at the end of the 4-*
5 *year period beginning on the date of the enact-*
6 *ment of this Act.*

7 *(B) EXCEPTIONS.—*

8 *(i) IN GENERAL.—The moratorium*
9 *under subparagraph (A) shall not apply as*
10 *follows:*

11 *(I) To a long-term care hospital,*
12 *satellite facility, or additional beds*
13 *under development as of the date of the*
14 *enactment of this Act.*

15 *(II) To an existing long-term care*
16 *hospital that requests to increase its*
17 *number of long-term care hospital beds,*
18 *if the Secretary determines there is a*
19 *need at the long-term care hospital for*
20 *additional beds to accommodate—*

21 *(aa) infectious disease issues*
22 *for isolation of patients;*

23 *(bb) bedside dialysis services;*

24 *(cc) single-sex accommoda-*
25 *tion issues;*

1 *(dd) behavioral issues; or*

2 *(ee) any requirements of*
3 *State or local law.*

4 *(III) To an existing long-term*
5 *care hospital that requests an increase*
6 *in beds because of the closure of a long-*
7 *term care hospital or significant de-*
8 *crease in the number of long-term care*
9 *hospital beds, in a State where there is*
10 *only one other long-term care hospital.*

11 *There shall be no administrative or judicial*
12 *review from a decision of the Secretary*
13 *under this subparagraph.*

14 *(ii) “UNDER DEVELOPMENT” DE-*
15 *FINED.—For purposes of clause (i)(I), a*
16 *long-term care hospital or satellite facility*
17 *is considered to be “under development” as*
18 *of a date if any of the following have oc-*
19 *curred on or before such date :*

20 *(I) The hospital or a related party*
21 *has a binding written agreement with*
22 *an outside, unrelated party for the con-*
23 *struction, reconstruction, lease, rental,*
24 *or financing of the long-term care hos-*
25 *pital and the hospital has expended,*

1 *before the date of the enactment of this*
2 *Act, at least 10 percent of the esti-*
3 *mated cost of the project (or, if less,*
4 *\$2,500,000).*

5 *(II) Actual construction, renova-*
6 *tion or demolition for the long-term*
7 *care hospital has begun and the hos-*
8 *pital has expended, before the date of*
9 *the enactment of this Act, at least 10*
10 *percent of the estimated cost of the*
11 *project (or, if less, \$2,500,000).*

12 *(III) A certificate of need has been*
13 *approved in a State where one is re-*
14 *quired or other necessary approvals*
15 *from appropriate State agencies have*
16 *been received for the operation of the*
17 *hospital.*

18 *(IV) The hospital documents that,*
19 *within 3 months after the date of the*
20 *enactment of this Act, it is within a 6-*
21 *month long-term care hospital dem-*
22 *onstration period required by section*
23 *412.23(e)(1)–(3) of title 42, Code of*
24 *Federal Regulations, to demonstrate*

1 that it has a greater than 25 day aver-
2 age length of stay.

3 (5) *NO APPLICATION OF 25 PERCENT PATIENT*
4 *THRESHOLD PAYMENT ADJUSTMENT TO FREE-*
5 *STANDING AND GRANDFATHERED LTCHS.—The Sec-*
6 *retary shall not apply, during the 5-year period be-*
7 *ginning on the date of the enactment of this Act, sec-*
8 *tion 412.536 of title 42, Code of Federal Regulations,*
9 *or any similar provision, to freestanding long-term*
10 *care hospitals and the Secretary shall not apply such*
11 *section or section 412.534 of title 42, Code of Federal*
12 *Regulations, or any similar provisions, to a long-term*
13 *care hospital identified by section 4417(a) of the Bal-*
14 *anced Budget Act of 1997 (Public Law 105–33). A*
15 *long-term care hospital identified by such section*
16 *4417(a) shall be deemed to be a freestanding long-*
17 *term care hospital for the purpose of this section. Sec-*
18 *tion 412.536 of title 42, Code of Federal Regulations,*
19 *shall be void and of no effect.*

20 (6) *PAYMENT FOR HOSPITALS-WITHIN-HOS-*
21 *PITALS.—*

22 (A) *IN GENERAL.—Payments to an applica-*
23 *ble long-term care hospital or satellite facility*
24 *which is located in a rural area or which is co-*
25 *located with an urban single or MSA dominant*

1 hospital under paragraphs (d)(1), (e)(1), and
2 (e)(4) of section 412.534 of title 42, Code of Fed-
3 eral Regulations, shall not be subject to any pay-
4 ment adjustment under such section if no more
5 than 75 percent of the hospital's Medicare dis-
6 charges (other than discharges described in para-
7 graphs (d)(2) or (e)(3) of such section) are ad-
8 mitted from a co-located hospital.

9 (B) CO-LOCATED LONG-TERM CARE HOS-
10 PITALS AND SATELLITE FACILITIES.—

11 (i) IN GENERAL.—Payment to an ap-
12 plicable long-term care hospital or satellite
13 facility which is co-located with another
14 hospital shall not be subject to any payment
15 adjustment under section 412.534 of title
16 42, Code of Federal Regulations, if no more
17 than 50 percent of the hospital's Medicare
18 discharges (other than discharges described
19 in section 412.534(c)(3) of such title) are
20 admitted from a co-located hospital.

21 (ii) APPLICABLE LONG-TERM CARE
22 HOSPITAL OR SATELLITE FACILITY DE-
23 FINED.—In this paragraph, the term “ap-
24 plicable long-term care hospital or satellite
25 facility” means a hospital or satellite facil-

1 *ity that is subject to the transition rules*
2 *under section 412.534(g) of title 42, Code of*
3 *Federal Regulations.*

4 (C) *EFFECTIVE DATE.*—Subparagraphs (A)
5 *and (B) shall apply to discharges occurring on*
6 *or after October 1, 2007, and before October 1,*
7 *2012.*

8 (7) *NO APPLICATION OF VERY SHORT-STAY*
9 *OUTLIER POLICY.*—*The Secretary shall not apply,*
10 *during the 5-year period beginning on the date of the*
11 *enactment of this Act, the amendments finalized on*
12 *May 11, 2007 (72 Federal Register 26904) made to*
13 *the short-stay outlier payment provision for long-term*
14 *care hospitals contained in section 412.529(c)(3)(i) of*
15 *title 42, Code of Federal Regulations, or any similar*
16 *provision.*

17 (8) *NO APPLICATION OF ONE TIME ADJUSTMENT*
18 *TO STANDARD AMOUNT.*—*The Secretary shall not,*
19 *during the 5-year period beginning on the date of the*
20 *enactment of this Act, make the one-time prospective*
21 *adjustment to long-term care hospital prospective*
22 *payment rates provided for in section 412.523(d)(3)*
23 *of title 42, Code of Federal Regulations, or any simi-*
24 *lar provision.*

1 (c) *SEPARATE CLASSIFICATION FOR CERTAIN LONG-*
2 *STAY CANCER HOSPITALS.*—

3 (1) *IN GENERAL.*—*Subsection (d)(1)(B) of sec-*
4 *tion 1886 of the Social Security Act (42 U.S.C.*
5 *1395ww) is amended—*

6 (A) *in clause (iv)—*

7 (i) *in subclause (I), by striking*
8 *“(iv)(I)” and inserting “(iv)” and by strik-*
9 *ing “or” at the end; and*

10 (ii) *in subclause (II)—*

11 (I) *by striking “, or” at the end*
12 *and inserting a semicolon; and*

13 (II) *by redesignating such sub-*
14 *clause as clause (vi) and by moving it*
15 *to immediately follow clause (v); and*

16 (B) *in clause (v), by striking the semicolon*
17 *at the end and inserting “, or”.*

18 (2) *CONFORMING PAYMENT REFERENCES.*—*Sub-*
19 *section (b) of such section is amended—*

20 (A) *in paragraph (2)(E)(ii), by adding at*
21 *the end the following new subclause:*

22 “(III) *Hospitals described in clause (vi) of such*
23 *subsection.*”;

24 (B) *in paragraph (3)(F)(iii), by adding at*
25 *the end the following new subclause:*

1 “(VI) Hospitals described in clause (vi) of such
2 subsection.”;

3 (C) in paragraphs (3)(G)(vi), (3)(H)(i), and
4 (3)(H)(ii)(I), by inserting “or (vi)” after “clause
5 (iv)” each place it appears;

6 (D) in paragraph (3)(H)(iv), by adding at
7 the end the following new subclause:

8 “(IV) Hospitals described in clause (vi) of such
9 subsection.”;

10 (E) in paragraph (3)(J), by striking “sub-
11 section (d)(1)(B)(iv)” and inserting “clause (iv)
12 or (vi) of subsection (d)(1)(B)”;

13 (F) in paragraph (7)(B), by adding at the
14 end the following new clause:

15 “(iv) Hospitals described in clause (vi) of such
16 subsection.”.

17 (3) *ADDITIONAL CONFORMING AMENDMENTS.—*

18 *The second sentence of subsection (d)(1)(B) of such*
19 *section is amended—*

20 (A) by inserting “(as in effect as of such
21 date)” after “clause (iv)”;

22 (B) by inserting “(or, in the case of a hos-
23 pital classified under clause (iv)(II), as so in ef-
24 fect, shall be classified under clause (vi) on and

1 *after the effective date of such clause)” after “so*
2 *classified”.*

3 (4) *TRANSITION RULE.—In the case of a hospital*
4 *that is classified under clause (iv)(II) of section*
5 *1886(d)(1)(B) of the Social Security Act immediately*
6 *before the date of the enactment of this Act and which*
7 *is classified under clause (vi) of such section after*
8 *such date of enactment, payments under section 1886*
9 *of such Act for cost reporting periods beginning after*
10 *the date of the enactment of this Act shall be based*
11 *upon payment rates in effect for the cost reporting pe-*
12 *riod for such hospital beginning during fiscal year*
13 *2001, increased for each succeeding cost reporting pe-*
14 *riod (beginning before the date of the enactment of*
15 *this Act) by the applicable percentage increase under*
16 *section 1886(b)(3)(B)(ii) of such Act.*

17 (5) *CLARIFICATION OF TREATMENT OF SAT-*
18 *ELLITE FACILITIES AND REMOTE LOCATIONS.—A*
19 *long-stay cancer hospital described in section*
20 *1886(d)(1)(B)(vi) of the Social Security Act, as des-*
21 *ignated under paragraph (1), shall include satellites*
22 *or remote site locations for such hospital established*
23 *before or after the date of the enactment of this Act*
24 *if the provider-based requirements under section*
25 *413.65 of title 42, Code of Federal Regulations, appli-*

1 *cable certification requirements under title XVIII of*
2 *the Social Security, and such other applicable State*
3 *licensure and certificate of need requirements are met*
4 *with respect to such satellites or remote site locations.*

5 **SEC. 504. INCREASING THE DSH ADJUSTMENT CAP.**

6 *Section 1886(d)(5)(F)(xiv) of the Social Security Act*
7 *(42 U.S.C. 1395ww(d)(5)(F)(xiv)) is amended—*

8 *(1) in subclause (II), by striking “12 percent”*
9 *and inserting “the percent specified in subclause*
10 *(III)”;* and

11 *(2) by adding at the end the following new sub-*
12 *clause:*

13 *“(III) The percent specified in this subclause is, in the*
14 *case of discharges occurring—*

15 *“(a) before October 1, 2007, 12 percent;*

16 *“(b) during fiscal year 2008, 16 percent;*

17 *“(c) during fiscal year 2009, 18 percent; and*

18 *“(d) on or after October 1, 2009, 12 percent.”.*

19 **SEC. 505. PPS-EXEMPT CANCER HOSPITALS.**

20 *(a) AUTHORIZING REBASING FOR PPS-EXEMPT CAN-*
21 *CER HOSPITALS.—Section 1886(b)(3)(F) of the Social Se-*
22 *curity Act (42 U.S.C. 1395ww(b)(3)(F)) is amended by*
23 *adding at the end the following new clause:*

24 *“(iv) In the case of a hospital (or unit*
25 *described in the matter following clause (v)*

1 of subsection (d)(1)(B)) that received pay-
2 ment under this subsection for inpatient
3 hospital services furnished during cost re-
4 porting periods beginning before October 1,
5 1999, that is within a class of hospital de-
6 scribed in clause (iii) (other than subclause
7 (IV), relating to long-term care hospitals,
8 and that requests the Secretary (in a form
9 and manner specified by the Secretary) to
10 effect a rebasing under this clause for the
11 hospital, the Secretary may compute the
12 target amount for the hospital's 12-month
13 cost reporting period beginning during fis-
14 cal year 2008 as an amount equal to the
15 average described in clause (ii) but deter-
16 mined as if any reference in such clause to
17 'the date of the enactment of this subpara-
18 graph' were a reference to 'the date of the
19 enactment of this clause'."

20 (b) *ADDITIONAL CANCER HOSPITAL PROVISIONS.*—

21 (1) *IN GENERAL.*—Section 1886(d)(1) of the So-
22 cial Security Act (42 U.S.C. 1395ww(d)(1)) is
23 amended—

24 (A) in subparagraph (B)(v)—

1 (i) by striking “or” at the end of sub-
2 clause (II); and

3 (ii) by adding at the end the following:

4 “(IV) a hospital that is a nonprofit corporation,
5 the sole member of which is affiliated with a univer-
6 sity that has been the recipient of a cancer center sup-
7 port grant from the National Cancer Institute of the
8 National Institutes of Health, and which sole member
9 (or its predecessors or such university) was recognized
10 as a comprehensive cancer center by the National
11 Cancer Institute of the National Institutes of Health
12 as of April 20, 1983, if the hospital’s articles of incor-
13 poration specify that at least 50 percent of its total
14 discharges have a principal finding of neoplastic dis-
15 ease (as defined in subparagraph (E)) and if, of De-
16 cember 31, 2005, the hospital was licensed for less
17 than 150 acute care beds, or

18 “(V) a hospital (aa) that the Secretary has deter-
19 mined to be, at any time on or before December 31,
20 2011, a hospital involved extensively in treatment for,
21 or research on, cancer, (bb) that is (as of the date of
22 such determination) a free-standing facility, (cc) for
23 which the hospital’s predecessor provider entity was
24 University Hospitals of Cleveland with medicare pro-
25 vider number 36-0137;”;

1 *(B) in subparagraph (B), by inserting after*
2 *clause (vi), as redesignated by section*
3 *503(c)(1)(A)(ii)(II), the following new clause:*

4 *“(vii) a hospital that—*

5 *“(I) is located in a State which ranks (ac-*
6 *ording to the National Cancer Institute’s statis-*
7 *tics published in May of 2005) among the top*
8 *ten States in the incidence of non-Hodgkins*
9 *lymphoma, ovarian cancer, thyroid cancer, and*
10 *cervical cancer and among the top ten States*
11 *with the highest death rate for breast cancer and*
12 *uterine cancer;*

13 *“(II) is located in a State that as of Decem-*
14 *ber 31, 2006, had only one center under section*
15 *414 of the Public Health Service Act that has*
16 *been designated by the National Cancer Institute*
17 *as a comprehensive center currently serving all*
18 *21 counties in the most densely populated State*
19 *in the nation (U.S. Census estimate for 2005:*
20 *8,717,925 persons; 1,134.5 persons per square*
21 *mile), serving more than 70,000 patient visits*
22 *annually;*

23 *“(III) as of December 31, 2006, served as*
24 *the teaching and clinical care, research and*
25 *training hospital for the Center described in sub-*

1 *clause (II), providing significant financial and*
2 *operational support to such Center;*

3 *“(IV) as of December 31, 2006, served as a*
4 *core and essential element in such Center which*
5 *conducts more than 130 clinical trial activities,*
6 *national cooperative group studies, investigator-*
7 *initiated and peer review studies and has re-*
8 *ceived as of 2005 at least \$93,000,000 in re-*
9 *search grant awards;*

10 *“(V) as of December 31, 2006, can dem-*
11 *onstrate that it has been a unique and an inte-*
12 *gral component of such Center since such Cen-*
13 *ter’s inception;*

14 *“(VI) as of December 31, 2006, includes*
15 *dedicated patient care units organized primarily*
16 *for the treatment of and research on cancer with*
17 *approximately 125 beds, 75 percent of which are*
18 *dedicated to cancer patients, and contains a ra-*
19 *diation oncology department as well as special-*
20 *ized emergency services for oncology patients;*

21 *“(VII) as of December 31, 2004, is identi-*
22 *fied as the focus of the Center’s inpatient activi-*
23 *ties in the Center’s application as a NCI-des-*
24 *ignated comprehensive cancer center and shares*

1 *the NCI comprehensive cancer designation with*
2 *the Center; and*

3 *“(VIII) as of December 31, 2006, has been*
4 *recognized with a certificate of approval with*
5 *commendation by the American College of Sur-*
6 *geons Commission on Cancer;”;* and

7 *(D) in subparagraph (E)—*

8 *(i) by striking “subclauses (II) and*
9 *(III)” and inserting “subclauses (II), (III),*
10 *and (IV)”;* and

11 *(ii) by inserting “and subparagraph*
12 *(B)(vi)” after “subparagraph (B)(v)”.*

13 (2) *EFFECTIVE DATES; PAYMENTS.—*

14 (A) *APPLICATION TO COST REPORTING PE-*
15 *RIODS.—*

16 *(i) Any classification by reason of sec-*
17 *tion 1886(d)(1)(B)(vi) of the Social Secu-*
18 *rity Act (42 U.S.C. 1395ww(d)(1)(B)(vi)),*
19 *as inserted by paragraph (1), shall apply to*
20 *cost reporting periods beginning on or after*
21 *January 1, 2006.*

22 *(ii) The provisions of section*
23 *1886(d)(1)(B)(v)(IV) of the Social Security*
24 *Act, as added by paragraph (1), shall take*
25 *effect on January 1, 2008.*

1 (B) *BASE TARGET AMOUNT.*—*Notwith-*
2 *standing subsection (b)(3)(E) of section 1886 of*
3 *the Social Security Act (42 U.S.C. 1395ww), in*
4 *the case of a hospital described in subsection*
5 *(d)(1)(B)(vi) of such section, as inserted by*
6 *paragraph (1)—*

7 (i) *the hospital shall be permitted to*
8 *resubmit the 2006 Medicare 2552 cost re-*
9 *port incorporating a cancer hospital sub-*
10 *provider number and to apply the Medicare*
11 *ratio-of-cost-to-charge settlement method-*
12 *ology for outpatient cancer services; and*

13 (ii) *the hospital's target amount under*
14 *subsection (b)(3)(E)(i) of such section for*
15 *the first cost reporting period beginning on*
16 *or after January 1, 2006, shall be the allow-*
17 *able operating costs of inpatient hospital*
18 *services (referred to in subclause (I) of such*
19 *subsection) for such first cost reporting pe-*
20 *riod.*

21 (C) *DEADLINE FOR PAYMENTS.*—*Any pay-*
22 *ments owed to a hospital as a result of this sub-*
23 *section for periods occurring before the date of*
24 *the enactment of this Act shall be made expedi-*

1 *tiously, but in no event later than 1 year after*
2 *such date of enactment.*

3 (3) *APPLICATION TO CERTAIN HOSPITALS.—*

4 (A) *INAPPLICABILITY OF CERTAIN REQUIRE-*
5 *MENTS.—The provisions of section 412.22(e) of*
6 *title 42, Code of Federal Regulations, shall not*
7 *apply to a hospital described in section*
8 *1886(d)(1)(B)(v)(V) of the Social Security Act,*
9 *as added by paragraph (1).*

10 (B) *APPLICATION TO COST REPORTING PE-*
11 *RIODS.—If the Secretary makes a determination*
12 *that a hospital is described in section*
13 *1886(d)(1)(B)(v)(V) of the Social Security Act,*
14 *as added by paragraph (1), such determination*
15 *shall apply as of the first cost reporting period*
16 *beginning on or after the date of such determina-*
17 *tion.*

18 (C) *BASE PERIOD.—Notwithstanding the*
19 *provisions of section 1886(b)(3)(E) of the Social*
20 *Security Act (42 U.S.C. 1395ww(b)(3)(E)) or*
21 *any other provision of law, the base cost report-*
22 *ing period for purposes of determining the target*
23 *amount for any hospital for which a determina-*
24 *tion described in subparagraph (B) has been*
25 *made shall be the first full 12-month cost report-*

1 *ing period beginning on or after the date of such*
2 *determination.*

3 *(D) RULE.—A hospital described in sub-*
4 *clause (V) of section 1886(b)(1)(B)(v) of the So-*
5 *cial Security Act, as added by paragraph (1),*
6 *shall not qualify as a hospital described in such*
7 *subclause for any cost reporting period in which*
8 *less than 50 percent of its total discharges have*
9 *a principal finding of neoplastic disease. With*
10 *respect to the first cost reporting period for*
11 *which a determination described in subpara-*
12 *graph (B) has been made, the Secretary shall ac-*
13 *cept a self-certification by the hospital, which*
14 *shall be applicable to such first cost reporting pe-*
15 *riod, that the hospital intends to have total dis-*
16 *charges during such first cost reporting period of*
17 *which 50 percent or more have a principal find-*
18 *ing of neoplastic disease.*

19 *(c) MEDPAC REPORT ON PPS-EXEMPT CANCER HOS-*
20 *PITALS.—Not later than March 1, 2009, the Medicare Pay-*
21 *ment Advisory Commission (established under section 1805*
22 *of the Social Security Act (42 U.S.C. 1395b–6)) shall sub-*
23 *mit to the Secretary and Congress a report evaluating the*
24 *following:*

1 (1) *Measures of payment adequacy and Medicare*
 2 *margins for PPS-exempt cancer hospitals, as estab-*
 3 *lished under section 1886(d)(1)(B)(v) of the Social*
 4 *Security Act (42 U.S.C. 1395ww(d)(1)(B)(v)).*

5 (2) *To the extent a PPS-exempt cancer hospital*
 6 *was previously affiliated with another hospital, the*
 7 *margins of the PPS-exempt hospital and the other*
 8 *hospital as separate entities and the margins of such*
 9 *hospitals that existed when the hospitals were pre-*
 10 *viously affiliated.*

11 (3) *Payment adequacy for cancer discharges*
 12 *under the Medicare inpatient hospital prospective*
 13 *payment system.*

14 **SEC. 506. SKILLED NURSING FACILITY PAYMENT UPDATE.**

15 (a) *IN GENERAL.*—*Section 1888(e)(4)(E)(ii) of the So-*
 16 *cial Security Act (42 U.S.C. 1395yy(e)(4)(E)(ii)) is amend-*
 17 *ed—*

18 (1) *in subclause (III), by striking “and” at the*
 19 *end;*

20 (2) *by redesignating subclause (IV) as subclause*
 21 *(VI); and*

22 (3) *by inserting after subclause (III) the fol-*
 23 *lowing new subclauses:*

24 *“(IV) for each of fiscal years*
 25 *2004, 2005, 2006, and 2007, the rate*

1 *computed for the previous fiscal year*
 2 *increased by the skilled nursing facility*
 3 *market basket percentage change for*
 4 *the fiscal year involved;*

5 “*(V) for fiscal year 2008, the rate*
 6 *computed for the previous fiscal year;*
 7 *and”.*

8 **(b) DELAYED EFFECTIVE DATE.**—*Section*
 9 *1888(e)(4)(E)(ii)(V) of the Social Security Act, as inserted*
 10 *by subsection (a)(3), shall not apply to payment for days*
 11 *before January 1, 2008.*

12 **SEC. 507. REVOCATION OF UNIQUE DEEMING AUTHORITY**
 13 **OF THE JOINT COMMISSION FOR THE AC-**
 14 **CREDITATION OF HEALTHCARE ORGANIZA-**
 15 **TIONS.**

16 **(a) REVOCATION.**—*Section 1865 of the Social Security*
 17 *Act (42 U.S.C. 1395bb) is amended—*

18 **(1)** *by striking subsection (a); and*

19 **(2)** *by redesignating subsections (b), (c), (d), and*
 20 *(e) as subsections (a), (b), (c), and (d), respectively.*

21 **(b) CONFORMING AMENDMENTS.**—*(1) Such section is*
 22 *further amended—*

23 **(A)** *in subsection (a)(1), as so redesignated,*
 24 *by striking “In addition, if” and inserting “If”;*

25 **(B)** *in subsection (b), as so redesignated—*

1 (i) by striking “released to him by the
2 Joint Commission on Accreditation of Hos-
3 pitals,” and inserting “released to the Sec-
4 retary by”; and

5 (ii) by striking the comma after “Asso-
6 ciation”;

7 (C) in subsection (c), as so redesignated, by
8 striking “pursuant to subsection (a) or (b)(1)”
9 and inserting “pursuant to subsection (a)(1)”;
10 and

11 (D) in subsection (d), as so redesignated, by
12 striking “pursuant to subsection (a) or (b)(1)”
13 and inserting “pursuant to subsection (a)(1)”.

14 (2) Section 1861(e) of such Act (42 U.S.C.
15 1395x(e)) is amended in the fourth sentence by strik-
16 ing “and (ii) is accredited by the Joint Commission
17 on Accreditation of Hospitals, or is accredited by or
18 approved by a program of the country in which such
19 institution is located if the Secretary finds the accred-
20 itation or comparable approval standards of such
21 program to be essentially equivalent to those of the
22 Joint Commission on Accreditation of Hospitals.”
23 and inserting “and (ii) is accredited by a national
24 accreditation body recognized by the Secretary under
25 section 1865(a), or is accredited by or approved by a

1 *program of the country in which such institution is*
2 *located if the Secretary finds the accreditation or*
3 *comparable approval standards of such program to be*
4 *essentially equivalent to those of such a national ac-*
5 *creditation body.”.*

6 (3) *Section 1864(c) of such Act (42 U.S.C.*
7 *1395aa(c)) is amended by striking “pursuant to sub-*
8 *section (a) or (b)(1) of section 1865” and inserting*
9 *“pursuant to section 1865(a)(1)”.*

10 (4) *Section 1875(b) of such Act (42 U.S.C.*
11 *1395ll(b)) is amended by striking “the Joint Commis-*
12 *sion on Accreditation of Hospitals,” and inserting*
13 *“national accreditation bodies under section*
14 *1865(a)”.*

15 (5) *Section 1834(a)(20)(B) of such Act (42*
16 *U.S.C. 1395m(a)(20)(B)) is amended by striking*
17 *“section 1865(b)” and inserting “section 1865(a)”.*

18 (6) *Section 1852(e)(4)(C) of such Act (42 U.S.C.*
19 *1395w-22(e)(4)(C)) is amended by striking “section*
20 *1865(b)(2)” and inserting “section 1865(a)(2)”.*

21 (c) *AUTHORITY TO RECOGNIZE JCAHO AS A NA-*
22 *TIONAL ACCREDITATION BODY.—The Secretary of Health*
23 *and Human Services may recognize the Joint Commission*
24 *on Accreditation of Healthcare Organizations as a national*
25 *accreditation body under section 1865 of the Social Secu-*

1 rity Act (42 U.S.C. 1395bb), as amended by this section,
 2 upon such terms and conditions, and upon submission of
 3 such information, as the Secretary may require.

4 (d) *EFFECTIVE DATE; TRANSITION RULE.*—(1) Sub-
 5 ject to paragraph (2), the amendments made by this section
 6 shall apply with respect to accreditations of hospitals grant-
 7 ed on or after the date that is 18 months after the date
 8 of the enactment of this Act.

9 (2) For purposes of title XVIII of the Social Security
 10 Act (42 U.S.C. 1395 et seq.), the amendments made by this
 11 section shall not effect the accreditation of a hospital by
 12 the Joint Commission on Accreditation of Healthcare Orga-
 13 nizations, or under accreditation or comparable approval
 14 standards found to be essentially equivalent to accreditation
 15 or approval standards of the Joint Commission on Accredi-
 16 tation of Healthcare Organizations, for the period of time
 17 applicable under such accreditation.

18 **SEC. 508. TREATMENT OF MEDICARE HOSPITAL RECLASSI-**
 19 **FICATIONS.**

20 (a) *EXTENDING CERTAIN MEDICARE HOSPITAL WAGE*
 21 *INDEX RECLASSIFICATIONS THROUGH FISCAL YEAR*
 22 *2009.*—

23 (1) *IN GENERAL.*—Section 106(a) of the Medi-
 24 care Improvements and Extension Act of 2006 (divi-
 25 sion B of Public Law 109–432) is amended by strik-

1 *ing “September 30, 2007” and inserting “September*
2 *30, 2009”.*

3 (2) *SPECIAL EXCEPTION RECLASSIFICATIONS.—*
4 *The Secretary of Health and Human Services shall*
5 *extend for discharges occurring through September 30,*
6 *2009, the special exception reclassification made*
7 *under the authority of section 1886(d)(5)(I)(i) of the*
8 *Social Security Act (42 U.S.C. 1395ww(d)(5)(I)(i))*
9 *and contained in the final rule promulgated by the*
10 *Secretary in the Federal Register on August 11, 2004*
11 *(69 Fed. Reg. 49105, 49107).*

12 (b) *DISREGARDING SECTION 508 HOSPITAL RECLASSI-*
13 *FICATIONS FOR PURPOSES OF GROUP RECLASSIFICA-*
14 *TIONS.—Section 508 of the Medicare Prescription Drug,*
15 *Improvement, and Modernization Act of 2003 (Public Law*
16 *108–173, 42 U.S.C. 1395ww note) is amended by adding*
17 *at the end the following new subsection:*

18 “(g) *DISREGARDING HOSPITAL RECLASSIFICATIONS*
19 *FOR PURPOSES OF GROUP RECLASSIFICATIONS.—For pur-*
20 *poses of the reclassification of a group of hospitals in a geo-*
21 *graphic area under section 1886(d), a hospital reclassified*
22 *under this section (including any such reclassification*
23 *which is extended under section 106(a) of the Medicare Im-*
24 *provements and Extension Act of 2006) shall not be taken*

1 *into account and shall not prevent the other hospitals in*
2 *such area from establishing such a group for such purpose.”.*

3 *(c) APPLICATION OF MEDICARE RURAL MINIMUM*
4 *HOSPITAL WAGE INDEX OF NON-LOCATION STATES TO*
5 *HOSPITALS RECLASSIFIED TO URBAN AREAS IN SUCH*
6 *STATES.—Section 1886(d)(8)(C) of the Social Security Act*
7 *(42 U.S.C. 1395ww(d)(8)(C)) is amended—*

8 *(1) by redesignating clause (v) as clause (vi);*
9 *and*

10 *(2) by inserting after clause (iv) the following*
11 *new clause:*

12 *“(v) Notwithstanding the previous provisions of this*
13 *subparagraph, in the case that the application of subpara-*
14 *graph (B) or a decision of the Medicare Geographic Classi-*
15 *fication Review Board or the Secretary under paragraph*
16 *(10) results in the redesignation of a rural hospital that*
17 *is classified as a rural referral center under paragraph*
18 *(5)(C) and sole community hospital under paragraph*
19 *(5)(D)(iii) and that has at least 250 beds to an urban area*
20 *that is in a non-location State, for which the combined av-*
21 *erage hourly wage of all hospitals located in such area is*
22 *less than the combined average hourly wage of all hospitals*
23 *located in the rural area of such State, and which was not*
24 *reclassified under section 508 of the Medicare Prescription*
25 *Drug, Improvement, and Modernization Act of 2003, the*

1 *wage index applicable to such hospital may not be less than*
2 *the area wage index otherwise applicable to a hospital lo-*
3 *cated in the rural area in the non-location State (or, if the*
4 *non-location State has no rural area, the minimum wage*
5 *index that the Secretary establishes for such State). For*
6 *purposes of this clause, the term ‘non-location State’ means,*
7 *with respect to a hospital, a State other than the State in*
8 *which the hospital is located.”.*

9 *(d) APPLICATION OF FLOOR ON AREA WAGE INDEX IN*
10 *CASE OF RECLASSIFIED HOSPITALS.—*

11 *(1) IN GENERAL.—Section 4410 of the Balanced*
12 *Budget Act of 1997 (Public Law 105-33) is amended*
13 *by adding at the end the following new subsection:*

14 *“(d) APPLICATION TO RECLASSIFIED HOSPITALS.—In*
15 *the case of a hospital that is reclassified based on wages*
16 *under paragraph (8) or (10) of section 1886(d) of the Social*
17 *Security Act into an area the area wage index for which*
18 *is increased under subsection (a), such increased area wage*
19 *index shall also apply to such hospital.”.*

20 *(2) EFFECTIVE DATE.—The amendment made by*
21 *paragraph (1) shall apply to payments for discharges*
22 *occurring on or after October 1, 2008.*

23 *(e) OTHER HOSPITAL RECLASSIFICATION PROVI-*
24 *SIONS.—Notwithstanding any other provision of law—*

1 (1) *In the case of a subsection (d) hospital (as*
2 *defined for purposes of section 1886 of the Social Se-*
3 *curity Act (42 U.S.C. 1395ww)) located in Putnam*
4 *County, Tennessee with respect to which a reclassi-*
5 *fication of its wage index for purposes of such section*
6 *would (but for this subsection) expire on September*
7 *30, 2007, such reclassification of such hospital shall*
8 *be extended through September 30, 2008.*

9 (2) *For purposes of making payments under sec-*
10 *tion 1886(d) of the Social Security Act (42 U.S.C.*
11 *1395ww(d)), the Secretary of Health and Human*
12 *Services shall classify any hospital located in Orange*
13 *County, New York that was reclassified under the au-*
14 *thority of section 508 of the the Medicare Prescription*
15 *Drug, Improvement and Modernization Act of 2003*
16 *(Public Law 108-173) as being located in the New*
17 *York-White Plains-Wayne, NY-NJ Core Based Statis-*
18 *tical Area. Any reclassification under this subsection*
19 *shall be treated as a reclassification under section*
20 *1886(d)(8) of such Act.*

21 (3) *For purposes of making payments under sec-*
22 *tion 1886(d) of the Social Security Act (42 U.S.C.*
23 *1395ww(d)), the large urban area of New York, New*
24 *York is deemed to include hospitals, required by State*

1 *law enacted prior to June 30, 2007, to join under a*
2 *single unified governance structure if—*

3 *(A) such hospitals are located in a city with*
4 *a population of no less than 20,000 and no than*
5 *30,000; and*

6 *(B) such hospitals are less than 3/4 miles*
7 *apart.*

8 *(4) For purposes of making payments under sec-*
9 *tion 1886(d) of the Social Security Act (42 U.S.C.*
10 *1395ww(d)) the large urban area of Buffalo-Niagara*
11 *Falls, New York is deemed to include Chautauqua*
12 *County, New York. Notwithstanding paragraph (6),*
13 *in no case shall there be a reduction in the hospital*
14 *wage index for Erie County, New York, or any ad-*
15 *joining county, as a result of the application of this*
16 *section (other than as a result of a general reduction*
17 *required to carry out paragraph (8)(D) of that sec-*
18 *tion).*

19 *(5) For purposes of making payments under sec-*
20 *tion 1886(d) of the Social Security Act (42 U.S.C.*
21 *1395ww(d)) a hospital shall be reclassified into the*
22 *New York-White Plains-Wayne, New York-New Jersey*
23 *core based statistical area (CBSA code 35644) if the*
24 *hospital is a subsection (d) hospital (as defined in*

1 *section 1886(d)(1)(B) of the Social Security Act (42*
2 *U.S.C. 1395ww(d)(1)(B)) that—*

3 *(A) is licensed by the State in which it is*
4 *located as a specialty hospital;*

5 *(B) specializes in the treatment of cardiac,*
6 *vascular, and pulmonary diseases;*

7 *(C) provides at least 100 beds; and*

8 *(D) is located in Burlington County, New*
9 *Jersey.*

10 *(6)(A) Any hospital described in subparagraph*
11 *(B) shall be treated as located in the core based statis-*
12 *tical area described in subparagraph (C) for purposes*
13 *of making payments under section 1886(d) of the So-*
14 *cial Security Act (42 U.S.C. 1395ww(d)).*

15 *(B) A hospital described in this subparagraph is*
16 *any hospital that—*

17 *(i) is located in a core based statistical area*
18 *(CBSA) that—*

19 *(I) had a population (as reported in*
20 *the decennial census for the year 2000) of at*
21 *least 500,000, but not more than 750,000;*

22 *(II) had a population (as reported in*
23 *such census) that was at least 10,000 below*
24 *the population for the area as reported in*
25 *the previous decennial census; and*

1 (III) has as of January 1, 2006, at
2 least 5, and no more than 7, subsection (d)
3 hospitals; and

4 (ii) demonstrates that its average hourly
5 wage amount (as determined consistent with sec-
6 tion 1886(d)(10)(D)(vi) of the Social Security
7 Act is not less than 96 percent of such average
8 hourly wage amount rate for all subsection (d)
9 hospitals located in same core base statistical
10 area of the hospital.

11 (C) The area described in this subparagraph,
12 with respect to a hospital described in subparagraph
13 (B), is the core based statistical area that—

14 (i) is within the same State as, and is adja-
15 cent to, the core based statistical area in which
16 the hospital is located; and

17 (ii) has an average hourly wage amount
18 (described in subparagraph (B)(ii)) that is clos-
19 est to (but does not exceed) such average hourly
20 wage amount of the hospital.

21 (7) For purposes of making payments under sec-
22 tion 1886(d) of the Social Security Act (42 U.S.C.
23 1395ww(d)), the large urban area of Hartford, Con-
24 necticut is deemed to include Albany, Schenectady,
25 and Rensselaer Counties, New York.

1 (8) *For purposes of the previous provisions of*
 2 *this subsection (other than paragraph (1))—*

3 (A) *any reclassification effected under such*
 4 *provisions shall be treated as a decision of the*
 5 *Medicare Geographic Classification Review*
 6 *Board under section 1886(d) of the Social Secu-*
 7 *rity Act and subject to budget neutrality under*
 8 *paragraph (8)(D) of such section.; and*

9 (B) *such provisions shall only apply to dis-*
 10 *charges occurring on or after October 1, 2008,*
 11 *during the 3-year reclassification period begin-*
 12 *ning on such date.*

13 **SEC. 509. MEDICARE CRITICAL ACCESS HOSPITAL DESIGNA-**
 14 **TIONS.**

15 (a) *IN GENERAL.—*

16 (1) *Section 405(h) of the Medicare Prescription*
 17 *Drug, Improvement, and Modernization Act of 2003*
 18 *(Public Law 108–173; 117 Stat. 2269) is amended by*
 19 *adding at the end the following new paragraph:*

20 “(3) *EXCEPTION.—*

21 “(A) *IN GENERAL.—The amendment made*
 22 *by paragraph (1) shall not apply to the certifi-*
 23 *cation by the State of Minnesota on or after Jan-*
 24 *uary 1, 2006, under section 1820(c)(2)(B)(i)(II)*
 25 *of the Social Security Act (42 U.S.C. 1395i–*

1 4(c)(2)(B)(i)(II)) of one hospital that meets the
2 criteria described in subparagraph (B) and is lo-
3 cated in Cass County, Minnesota, as a necessary
4 provider of health care services to residents in
5 the area of the hospital.

6 “(B) CRITERIA DESCRIBED.—A hospital
7 meets the criteria described in this subparagraph
8 if the hospital

9 “(i) has been granted an exception by
10 the State to an otherwise applicable statu-
11 tory restriction on hospital construction or
12 licensing prior to the date of enactment of
13 this subparagraph; and

14 “(ii) is located on property which the
15 State has approved for conveyance to a
16 county within the State prior to such date
17 of enactment.”.

18 (2) Section 1820(c)(2)(B)(i)(I) of the Social Se-
19 curity Act (42 U.S.C. 1395i-4(c)(2)(B)(i)(I)) is
20 amended by striking “or,” and inserting “or, in the
21 case of a hospital that is located in the county seat
22 of Butler, Alabama, a 32-mile drive, or,”.

23 (b) EFFECTIVE DATE.—The amendment made by sub-
24 section (a)(2) shall apply to cost reporting periods begin-
25 ning on or after the date of the enactment of this Act.

1 **TITLE VI—OTHER PROVISIONS**
2 **RELATING TO MEDICARE PART B**
3 **Subtitle A—Payment and Coverage**
4 **Improvements**

5 **SEC. 601. PAYMENT FOR THERAPY SERVICES.**

6 (a) *EXTENSION OF EXCEPTIONS PROCESS FOR MEDI-*
7 *CARE THERAPY CAPS.*—Section 1833(g)(5) of the Social Se-
8 *curity Act (42 U.S.C. 1395l(g)(5)), as amended by section*
9 *201 of the Medicare Improvements and Extension Act of*
10 *2006 (division B of Public Law 109–432), is amended by*
11 *striking “2007” and inserting “2009”.*

12 (b) *STUDY AND REPORT.*—

13 (1) *STUDY.*—*The Secretary of Health and*
14 *Human Services, in consultation with appropriate*
15 *stakeholders, shall conduct a study on refined and al-*
16 *ternative payment systems to the Medicare payment*
17 *cap under section 1833(g) of the Social Security Act*
18 *(42 U.S.C. 1395l(g)) for physical therapy services and*
19 *speech-language pathology services, described in para-*
20 *graph (1) of such section and occupational therapy*
21 *services described in paragraph (3) of such section.*
22 *Such study shall consider, with respect to payment*
23 *amounts under Medicare, the following:*

1 (A) *The creation of multiple payment caps*
2 *for such services to better reflect costs associated*
3 *with specific health conditions.*

4 (B) *The development of a prospective pay-*
5 *ment system, including an episode-based system*
6 *of payments, for such services.*

7 (C) *The data needed for the development of*
8 *a system of multiple payment caps (or an alter-*
9 *native payment methodology) for such services*
10 *and the availability of such data.*

11 (2) *REPORT.—Not later than January 1, 2009,*
12 *the Secretary shall submit to Congress a report on the*
13 *study conducted under paragraph (1).*

14 **SEC. 602. MEDICARE SEPARATE DEFINITION OF OUT-**
15 **PATIENT SPEECH-LANGUAGE PATHOLOGY**
16 **SERVICES.**

17 (a) *IN GENERAL.—Section 1861(ll) of the Social Secu-*
18 *rity Act (42 U.S.C. 1395x(ll)) is amended—*

19 (1) *by redesignating paragraphs (2) and (3) as*
20 *paragraphs (3) and (4), respectively; and*

21 (2) *by inserting after paragraph (1) the fol-*
22 *lowing new paragraph:*

23 “(2) *The term ‘outpatient speech-language pathology*
24 *services’ has the meaning given the term ‘outpatient phys-*

1 ical therapy services’ in subsection (p), except that in ap-
2 plying such subsection—

3 “(A) ‘speech-language pathology’ shall be sub-
4 stituted for ‘physical therapy’ each place it appears;
5 and

6 “(B) ‘speech-language pathologist’ shall be sub-
7 stituted for ‘physical therapist’ each place it ap-
8 pears.”.

9 (b) CONFORMING AMENDMENTS.—

10 (1) Section 1832(a)(2)(C) of the Social Security
11 Act (42 U.S.C. 1395k(a)(2)(C)) is amended—

12 (A) by striking “and outpatient” and in-
13 serting “, outpatient”; and

14 (B) by inserting before the semicolon at the
15 end the following: “, and outpatient speech-lan-
16 guage pathology services (other than services to
17 which the second sentence of section 1861(p) ap-
18 plies through the application of section
19 1861(l)(2))”.

20 (2) Subparagraphs (A) and (B) of section
21 1833(a)(8) of such Act (42 U.S.C. 1395l(a)(8)) are
22 each amended by striking “(which includes outpatient
23 speech-language pathology services)” and inserting “,
24 outpatient speech-language pathology services,”.

1 (3) *Section 1833(g)(1) of such Act (42 U.S.C.*
2 *1395l(g)(1)) is amended—*

3 (A) *by inserting “and speech-language pa-*
4 *thology services of the type described in such sec-*
5 *tion through the application of section*
6 *1861(l)(2)” after “1861(p)”;* and

7 (B) *by inserting “and speech-language pa-*
8 *thology services” after “and physical therapy*
9 *services”.*

10 (4) *The second sentence of section 1835(a) of*
11 *such Act (42 U.S.C. 1395n(a)) is amended—*

12 (A) *by striking “section 1861(g)” and in-*
13 *serting “subsection (g) or (l)(2) of section 1861”*
14 *each place it appears;* and

15 (B) *by inserting “or outpatient speech-lan-*
16 *guage pathology services, respectively” after “oc-*
17 *cupational therapy services”.*

18 (5) *Section 1861(p) of such Act (42 U.S.C.*
19 *1395x(p)) is amended by striking the fourth sentence.*

20 (6) *Section 1861(s)(2)(D) of such Act (42 U.S.C.*
21 *1395x(s)(2)(D)) is amended by inserting “, outpatient*
22 *speech-language pathology services,” after “physical*
23 *therapy services”.*

24 (7) *Section 1862(a)(20) of such Act (42 U.S.C.*
25 *1395y(a)(20)) is amended—*

1 (A) by striking “outpatient occupational
2 therapy services or outpatient physical therapy
3 services” and inserting “outpatient physical
4 therapy services, outpatient speech-language pa-
5 thology services, or outpatient occupational ther-
6 apy services”; and

7 (B) by striking “section 1861(g)” and in-
8 serting “subsection (g) or (ll)(2) of section 1861”.

9 (8) Section 1866(e)(1) of such Act (42 U.S.C.
10 1395cc(e)(1)) is amended—

11 (A) by striking “section 1861(g)” and in-
12 serting “subsection (g) or (ll)(2) of section 1861”
13 the first two places it appears;

14 (B) by striking “defined) or” and inserting
15 “defined),”; and

16 (C) by inserting before the semicolon at the
17 end the following: “, or (through the operation of
18 section 1861(ll)(2)) with respect to the furnishing
19 of outpatient speech-language pathology”.

20 (c) *EFFECTIVE DATE.*—The amendments made by this
21 section shall apply to services furnished on or after January
22 1, 2008.

23 (d) *CONSTRUCTION.*—Nothing in this section shall be
24 construed to affect existing regulations and policies of the
25 Centers for Medicare & Medicaid Services that require phy-

1 sician oversight of care as a condition of payment for
2 speech-language pathology services under part B of the
3 medicare program.

4 **SEC. 603. INCREASED REIMBURSEMENT RATE FOR CER-**
5 **TIFIED NURSE-MIDWIVES.**

6 (a) *IN GENERAL.*—Section 1833(a)(1)(K) of the Social
7 Security Act (42 U.S.C.1395l(a)(1)(K)) is amended by
8 striking “(but in no event” and all that follows through
9 “performed by a physician)”.

10 (b) *EFFECTIVE DATE.*—The amendment made by sub-
11 section (a) shall apply to services furnished on or after
12 April 1, 2008.

13 **SEC. 604. ADJUSTMENT IN OUTPATIENT HOSPITAL FEE**
14 **SCHEDULE INCREASE FACTOR.**

15 The first sentence of section 1833(t)(3)(C)(iv) of the
16 Social Security Act (42 U.S.C. 1395l(t)(3)(C)(iv)) is
17 amended by inserting before the period at the end the fol-
18 lowing: “and reduced by 0.25 percentage point for such fac-
19 tor for such services furnished in 2008”.

20 **SEC. 605. EXCEPTION TO 60-DAY LIMIT ON MEDICARE SUB-**
21 **STITUTE BILLING ARRANGEMENTS IN CASE**
22 **OF PHYSICIANS ORDERED TO ACTIVE DUTY**
23 **IN THE ARMED FORCES.**

24 (a) *IN GENERAL.*—Section 1842(b)(6)(D)(iii) of the
25 Social Security Act (42 U.S.C. 1395u(b)(6)(D)(iii)) is

1 amended by inserting after “of more than 60 days” the fol-
2 lowing: “or are provided over a longer continuous period
3 during all of which the first physician has been called or
4 ordered to active duty as a member of a reserve component
5 of the Armed Forces”.

6 (b) *EFFECTIVE DATE.*—The amendment made by sub-
7 section (a) shall apply to services furnished on or after the
8 date of the enactment of this section.

9 **SEC. 606. EXCLUDING CLINICAL SOCIAL WORKER SERVICES**
10 **FROM COVERAGE UNDER THE MEDICARE**
11 **SKILLED NURSING FACILITY PROSPECTIVE**
12 **PAYMENT SYSTEM AND CONSOLIDATED PAY-**
13 **MENT.**

14 (a) *IN GENERAL.*—Section 1888(e)(2)(A)(ii) of the So-
15 cial Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amend-
16 ed by inserting “clinical social worker services,” after
17 “qualified psychologist services,”.

18 (b) *CONFORMING AMENDMENT.*—Section 1861(hh)(2)
19 of the Social Security Act (42 U.S.C. 1395x(hh)(2)) is
20 amended by striking “and other than services furnished to
21 an inpatient of a skilled nursing facility which the facility
22 is required to provide as a requirement for participation”.

23 (c) *EFFECTIVE DATE.*—The amendments made by this
24 section shall apply to items and services furnished on or
25 after January 1, 2008.

1 **SEC. 607. COVERAGE OF MARRIAGE AND FAMILY THERA-**
2 **PIST SERVICES AND MENTAL HEALTH COUN-**
3 **SELOR SERVICES.**

4 (a) *COVERAGE OF MARRIAGE AND FAMILY THERAPIST*
5 *SERVICES.*—

6 (1) *COVERAGE OF SERVICES.*—Section 1861(s)(2)
7 of the Social Security Act (42 U.S.C. 1395x(s)(2)), as
8 amended by section 201(a)(1), is amended—

9 (A) in subparagraph (AA), by striking
10 “and” at the end;

11 (B) in subparagraph (BB), by adding
12 “and” at the end; and

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

15 “(CC) marriage and family therapist services (as
16 defined in subsection (eee));”.

17 (2) *DEFINITION.*—Section 1861 of the Social Se-
18 curity Act (42 U.S.C. 1395x), as amended by sections
19 201(a)(2) and 503(b)(1), is amended by adding at the
20 end the following new subsection:

21 “*Marriage and Family Therapist Services*

22 “(eee)(1) The term ‘marriage and family therapist
23 services’ means services performed by a marriage and fam-
24 ily therapist (as defined in paragraph (2)) for the diagnosis
25 and treatment of mental illnesses, which the marriage and
26 family therapist is legally authorized to perform under

1 *State law (or the State regulatory mechanism provided by*
2 *State law) of the State in which such services are performed,*
3 *provided such services are covered under this title, as would*
4 *otherwise be covered if furnished by a physician or as inci-*
5 *dent to a physician’s professional service, but only if no*
6 *facility or other provider charges or is paid any amounts*
7 *with respect to the furnishing of such services.*

8 “(2) *The term ‘marriage and family therapist’ means*
9 *an individual who—*

10 “(A) *possesses a master’s or doctoral degree*
11 *which qualifies for licensure or certification as a mar-*
12 *riage and family therapist pursuant to State law;*

13 “(B) *after obtaining such degree has performed*
14 *at least 2 years of clinical supervised experience in*
15 *marriage and family therapy; and*

16 “(C) *is licensed or certified as a marriage and*
17 *family therapist in the State in which marriage and*
18 *family therapist services are performed.”.*

19 (3) *PROVISION FOR PAYMENT UNDER PART b.—*
20 *Section 1832(a)(2)(B) of the Social Security Act (42*
21 *U.S.C. 1395k(a)(2)(B)) is amended by adding at the*
22 *end the following new clause:*

23 “(v) *marriage and family therapist*
24 *services;”.*

25 (4) *AMOUNT OF PAYMENT.—*

1 (A) *IN GENERAL.*—Section 1833(a)(1) of the
2 *Social Security Act (42 U.S.C. 1395l(a)(1))*, as
3 amended by section 201(b)(1), is amended—

4 (i) by striking “and” before “(W)”;

5 and

6 (ii) by inserting before the semicolon at
7 the end the following: “, and (X) with re-
8 spect to marriage and family therapist serv-
9 ices under section 1861(s)(2)(CC), the
10 amounts paid shall be 80 percent of the less-
11 er of (i) the actual charge for the services or
12 (ii) 75 percent of the amount determined for
13 payment of a psychologist under subpara-
14 graph (L)”.

15 (B) *DEVELOPMENT OF CRITERIA WITH RE-*
16 *SPECT TO CONSULTATION WITH A PHYSICIAN.*—
17 *The Secretary of Health and Human Services*
18 *shall, taking into consideration concerns for pa-*
19 *tient confidentiality, develop criteria with re-*
20 *spect to payment for marriage and family thera-*
21 *pist services for which payment may be made di-*
22 *rectly to the marriage and family therapist*
23 *under part B of title XVIII of the Social Secu-*
24 *rity Act (42 U.S.C. 1395j et seq.) under which*
25 *such a therapist must agree to consult with a pa-*

1 *tient’s attending or primary care physician in*
2 *accordance with such criteria.*

3 (5) *EXCLUSION OF MARRIAGE AND FAMILY THER-*
4 *APIST SERVICES FROM SKILLED NURSING FACILITY*
5 *PROSPECTIVE PAYMENT SYSTEM.—Section*
6 *1888(e)(2)(A)(ii) of the Social Security Act (42*
7 *U.S.C. 1395yy(e)(2)(A)(ii)), is amended by inserting*
8 *“marriage and family therapist services (as defined*
9 *in subsection (eee)(1)),” after “qualified psychologist*
10 *services,”.*

11 (6) *COVERAGE OF MARRIAGE AND FAMILY THER-*
12 *APIST SERVICES PROVIDED IN RURAL HEALTH CLIN-*
13 *ICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—*
14 *Section 1861(aa)(1)(B) of the Social Security Act (42*
15 *U.S.C. 1395x(aa)(1)(B)) is amended by striking “or*
16 *by a clinical social worker (as defined in subsection*
17 *(hh)(1)),” and inserting “, by a clinical social worker*
18 *(as defined in subsection (hh)(1)), or by a marriage*
19 *and family therapist (as defined in subsection*
20 *(eee)(2)),”.*

21 (7) *INCLUSION OF MARRIAGE AND FAMILY*
22 *THERAPISTS AS PRACTITIONERS FOR ASSIGNMENT OF*
23 *CLAIMS.—Section 1842(b)(18)(C) of the Social Secu-*
24 *urity Act (42 U.S.C. 1395u(b)(18)(C)) is amended by*
25 *adding at the end the following new clause:*

1 “(A) possesses a master’s or doctor’s degree which
2 qualifies the individual for licensure or certification
3 for the practice of mental health counseling in the
4 State in which the services are performed;

5 “(B) after obtaining such a degree has performed
6 at least 2 years of supervised mental health counselor
7 practice; and

8 “(C) is licensed or certified as a mental health
9 counselor or professional counselor by the State in
10 which the services are performed.

11 “(2) The term ‘mental health counselor services’ means
12 services performed by a mental health counselor (as defined
13 in paragraph (1)) for the diagnosis and treatment of mental
14 illnesses which the mental health counselor is legally author-
15 ized to perform under State law (or the State regulatory
16 mechanism provided by the State law) of the State in which
17 such services are performed, provided such services are cov-
18 ered under this title, as would otherwise be covered if fur-
19 nished by a physician or as incident to a physician’s profes-
20 sional service, but only if no facility or other provider
21 charges or is paid any amounts with respect to the fur-
22 nishing of such services.”.

23 (3) PROVISION FOR PAYMENT UNDER PART b.—
24 Section 1832(a)(2)(B) of the Social Security Act (42
25 U.S.C. 1395k(a)(2)(B)), as amended by subsection

1 (a)(3), is further amended by adding at the end the
2 following new clause:

3 “(vi) mental health counselor serv-
4 ices;”.

5 (4) AMOUNT OF PAYMENT.—

6 (A) IN GENERAL.—Section 1833(a)(1) of the
7 Social Security Act (42 U.S.C. 1395l(a)(1)), as
8 amended by subsection (a)(4), is further amend-
9 ed—

10 (i) by striking “and” before “(X)”; and

11 (ii) by inserting before the semicolon at
12 the end the following: “, and (Y) with re-
13 spect to mental health counselor services
14 under section 1861(s)(2)(DD), the amounts
15 paid shall be 80 percent of the lesser of (i)
16 the actual charge for the services or (ii) 75
17 percent of the amount determined for pay-
18 ment of a psychologist under subparagraph
19 (L)”.

20 (B) DEVELOPMENT OF CRITERIA WITH RE-
21 SPECT TO CONSULTATION WITH A PHYSICIAN.—

22 The Secretary of Health and Human Services
23 shall, taking into consideration concerns for pa-
24 tient confidentiality, develop criteria with re-
25 spect to payment for mental health counselor

1 *services for which payment may be made directly*
2 *to the mental health counselor under part B of*
3 *title XVIII of the Social Security Act (42 U.S.C.*
4 *1395j et seq.) under which such a counselor must*
5 *agree to consult with a patient’s attending or*
6 *primary care physician in accordance with such*
7 *criteria.*

8 (5) *EXCLUSION OF MENTAL HEALTH COUNSELOR*
9 *SERVICES FROM SKILLED NURSING FACILITY PRO-*
10 *SPECTIVE PAYMENT SYSTEM.—Section*
11 *1888(e)(2)(A)(ii) of the Social Security Act (42*
12 *U.S.C. 1395yy(e)(2)(A)(ii)), as amended by sub-*
13 *section (a)(5), is amended by inserting “mental*
14 *health counselor services (as defined in section*
15 *1861(ddd)(2)),” after “marriage and family therapist*
16 *services (as defined in subsection (eee)(1)),”.*

17 (6) *COVERAGE OF MENTAL HEALTH COUNSELOR*
18 *SERVICES PROVIDED IN RURAL HEALTH CLINICS AND*
19 *FEDERALLY QUALIFIED HEALTH CENTERS.—Section*
20 *1861(aa)(1)(B) of the Social Security Act (42 U.S.C.*
21 *1395x(aa)(1)(B)), as amended by subsection (a)(6), is*
22 *amended by striking “or by a marriage and family*
23 *therapist (as defined in subsection (eee)(2)),” and in-*
24 *serting “by a marriage and family therapist (as de-*

1 *defined in subsection (eee)(2)), or a mental health coun-*
 2 *selor (as defined in subsection (fff)(1)),”.*

3 (7) *INCLUSION OF MENTAL HEALTH COUNSELORS*
 4 *AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—*
 5 *Section 1842(b)(18)(C) of the Social Security Act (42*
 6 *U.S.C. 1395u(b)(18)(C)), as amended by subsection*
 7 *(a)(7), is amended by adding at the end the following*
 8 *new clause:*

9 *“(viii) A mental health counselor (as defined in*
 10 *section 1861(fff)(1)).”.*

11 (c) *EFFECTIVE DATE.—The amendments made by this*
 12 *section shall apply to items and services furnished on or*
 13 *after January 1, 2008.*

14 **SEC. 608. RENTAL AND PURCHASE OF POWER-DRIVEN**
 15 **WHEELCHAIRS.**

16 (a) *IN GENERAL.—Section 1834(a)(7) of the Social Se-*
 17 *curity Act (42 U.S.C. 1395m(a)(7)) is amended—*

18 (1) *in subparagraph (A)—*

19 (A) *in clause (i)(I), by striking “Except as*
 20 *provided in clause (iii), payment” and inserting*
 21 *“Payment”;*

22 (B) *by striking clause (iii); and*

23 (C) *in clause (iv)—*

24 (i) *by redesignating such clause as*
 25 *clause (iii); and*

1 (ii) by striking “or in the case of a
2 power-driven wheelchair for which a pur-
3 chase agreement has been entered into under
4 clause (iii)”; and

5 (2) in subparagraph (C)(i)(II), by striking “or
6 (A)(iii)”.

7 (b) *EFFECTIVE DATE.*—

8 (1) *IN GENERAL.*—Subject to paragraph (1), the
9 amendments made by subsection (a) shall take effect
10 on January 1, 2008, and shall apply to power-driven
11 wheelchairs furnished on or after such date.

12 (2) *APPLICATION TO COMPETITIVE ACQUISI-*
13 *TION.*—The amendments made by subsection (a) shall
14 not apply to contracts entered into under section 1847
15 of the Social Security Act (42 U.S.C. 1395w–3) pur-
16 suant to a bid submitted under such section before
17 July 21, 2007.

18 **SEC. 609. RENTAL AND PURCHASE OF OXYGEN EQUIPMENT.**

19 (a) *IN GENERAL.*—Section 1834(a)(5)(F) of the Social
20 Security Act (42 U.S.C. 1395m(a)(5)(F)) is amended—

21 (1) in clause (i)—

22 (A) by striking “Payment” and inserting
23 “Subject to clause (iii), payment”; and

24 (B) by striking “36 months” and inserting
25 “18 months”;

1 (2) *in clause (ii)(I), by striking “36th contin-*
2 *uous month” and inserting “18th continuous month”;*
3 *and*

4 (3) *by adding at the end the following new*
5 *clause:*

6 “(iii) *SPECIAL RULE FOR OXYGEN*
7 *GENERATING PORTABLE EQUIPMENT.—In*
8 *the case of oxygen generating portable*
9 *equipment referred to in the final rule pub-*
10 *lished in the Federal Register on November*
11 *9, 2006 (71 Fed. Reg. 65897–65899), in ap-*
12 *plying clauses (i) and (ii)(I) each reference*
13 *to ‘18 months’ is deemed a reference to ‘36*
14 *months’.*”.

15 (b) *EFFECTIVE DATE.—*

16 (1) *IN GENERAL.—Subject to paragraph (3), the*
17 *amendments made by subsection (a) shall apply to*
18 *oxygen equipment furnished on or after January 1,*
19 *2008.*

20 (2) *TRANSITION.—In the case of an individual*
21 *receiving oxygen equipment on December 31, 2007,*
22 *for which payment is made under section 1834(a) of*
23 *the Social Security Act (42 U.S.C. 1395m(a)), the 18-*
24 *month period described in paragraph (5)(F)(i) of*
25 *such section, as amended by subsection (a), shall*

1 *begin on January 1, 2008, but in no case shall the*
2 *rental period for such equipment exceed 36 months.*

3 (3) *APPLICATION TO COMPETITIVE ACQUISITION.—The amendments made by subsection (a) shall*
4 *not apply to contracts entered into under section 1847*
5 *of the Social Security Act (42 U.S.C. 1395w–3) pur-*
6 *suant to a bid submitted under such section before*
7 *July 21, 2007.*

8 (c) *STUDY AND REPORT.—*

9 (1) *STUDY.—The Secretary of Health and*
10 *Human Services shall conduct a study to examine the*
11 *service component and the equipment component of*
12 *the provision of oxygen to Medicare beneficiaries. The*
13 *study shall assess—*

14 (A) *the type of services provided and vari-*
15 *ation across suppliers in providing such services;*

16 (B) *whether the services are medically nec-*
17 *essary or affect patient outcomes;*

18 (C) *whether the Medicare program pays ap-*
19 *propriately for equipment in connection with the*
20 *provision of oxygen;*

21 (D) *whether such program pays appro-*
22 *priately for necessary services;*

23 (E) *whether such payment in connection*
24 *with the provision of oxygen should be divided*
25

1 *between equipment and services, and if so, how;*
2 *and*

3 *(F) how such payment rate compares to a*
4 *competitively bid rate.*

5 *(2) REPORT.—Not later than 18 months after the*
6 *date of the enactment of this Act, the Secretary of*
7 *Health and Human Services shall submit to Congress*
8 *a report on the study conducted under paragraph (1).*

9 **SEC. 610. ADJUSTMENT FOR MEDICARE MENTAL HEALTH**
10 **SERVICES.**

11 *(a) IN GENERAL.—For purposes of payment for serv-*
12 *ices furnished under the physician fee schedule under sec-*
13 *tion 1848 of the Social Security Act (42 U.S.C. 1395w-*
14 *4) during the applicable period, the Secretary of Health and*
15 *Human Services shall increase the amount otherwise pay-*
16 *able for applicable services by 5 percent.*

17 *(b) DEFINITIONS.—For purposes of subsection (a):*

18 *(1) APPLICABLE PERIOD.—The term “applicable*
19 *period” means the period beginning on January 1,*
20 *2008, and ending on December 31 of the year before*
21 *the effective date of the first review after January 1,*
22 *2008, of work relative value units conducted under*
23 *section 1848(c)(2)(B)(i) of the Social Security Act.*

24 *(2) APPLICABLE SERVICES.—The term “applica-*
25 *ble services” means procedure codes for services—*

1 (A) *in the categories of psychiatric thera-*
2 *peutic procedures furnished in office or other*
3 *outpatient facility settings, or inpatient hospital,*
4 *partial hospital or residential care facility set-*
5 *tings; and*

6 (B) *which cover insight oriented, behavior*
7 *modifying, or supportive psychotherapy and*
8 *interactive psychotherapy services in the*
9 *Healthcare Common Procedure Coding System*
10 *established by the Secretary of Health and*
11 *Human Services under section 1848(c)(5) of such*
12 *Act.*

13 (c) *IMPLEMENTATION.—Notwithstanding any other*
14 *provision of law, the Secretary of Health and Human Serv-*
15 *ices may implement this section by program instruction or*
16 *otherwise.*

17 **SEC. 611. EXTENSION OF BRACHYTHERAPY SPECIAL RULE.**

18 *Section 1833(t)(16)(C) of the Social Security Act (42*
19 *U.S.C. 1395l(t)(16)(C)) is amended by striking “2008” and*
20 *inserting “2009”.*

21 **SEC. 612. PAYMENT FOR PART B DRUGS.**

22 (a) *APPLICATION OF CONSISTENT VOLUME*
23 *WEIGHTING IN COMPUTATION OF ASP.—In order to assure*
24 *that payments for drugs and biologicals under section*
25 *1847A of the Social Security Act (42 U.S.C. 1395w–3a) are*

1 *correct and consistent with law, the Secretary of Health and*
2 *Human Services shall, for payment for drugs and*
3 *biologicals furnished on or after July 1, 2008, compute the*
4 *volume-weighted average sales price using equation #2*
5 *(specified in appendix A of the report of the Inspector Gen-*
6 *eral of the Department of Health and Human Services on*
7 *“Calculation of Volume-Weighted Average Sales Price for*
8 *Medicare Part B Prescription Drugs” (February 2006;*
9 *OEI–03–05–00310)) used by the Office of Inspector General*
10 *to calculate a volume-weighted ASP.*

11 *(b) IMPROVEMENTS IN THE COMPETITIVE ACQUISITION*
12 *PROGRAM (CAP).—*

13 *(1) CONTINUOUS OPEN ENROLLMENT; AUTOMATIC*
14 *REENROLLMENT WITHOUT NEED FOR REAPPLICA-*
15 *TION.—Subsection (a)(1)(A) of section 1847B of the*
16 *Social Security Act (42 U.S.C. 1395w–3b) is amend-*
17 *ed—*

18 *(A) in clause (ii), by striking “annually”*
19 *and inserting “on an ongoing basis”;*

20 *(B) in clause (iii), by striking “an annual*
21 *selection” and inserting “a selection (which may*
22 *be changed on an annual basis)” ; and*

23 *(C) by adding at the end the following: “An*
24 *election and selection described in clauses (ii)*
25 *and (iii) shall continue to be effective without*

1 *the need for any periodic reelection or reapplica-*
2 *tion or selection.”.*

3 (2) *PERMITTING VENDER TO DELIVER DRUGS TO*
4 *SITE OF ADMINISTRATION.—Subsection (b)(4)(E) of*
5 *such section is amended—*

6 (A) *by striking “or” at the end of clause (i);*

7 (B) *by striking the period at the end of*
8 *clause (ii) and inserting “; or”; and*

9 (C) *by adding at the end the following new*
10 *clause:*

11 *“(iii) prevent a contractor from deliv-*
12 *ering drugs and biologicals to the site in*
13 *which the drugs or biologicals will be ad-*
14 *ministered.”.*

15 (3) *PHYSICIAN OUTREACH AND EDUCATION.—*
16 *Subsection (a)(1) of such section is amended by add-*
17 *ing at the end the following new subparagraph:*

18 *“(E) PHYSICIAN OUTREACH AND EDU-*
19 *CATION.—The Secretary shall conduct a program*
20 *of outreach to education physicians concerning*
21 *the program and the ongoing opportunity of*
22 *physicians to elect to obtain drugs and*
23 *biologicals under the program.”.*

24 (4) *REBIDDING OF CONTRACTS.—The Secretary*
25 *of Health and Human Services shall provide for the*

1 *rebidding of contracts under section 1847B(c) of the*
2 *Social Security Act (42 U.S.C. 1395w-3b(c)) only for*
3 *periods on or after the expiration of the contract in*
4 *effect under such section as of the date of the enact-*
5 *ment of this Act.*

6 (c) *TREATMENT OF CERTAIN DRUGS.—Section*
7 *1847A(b) of the Social Security Act (42 U.S.C. 1395w-*
8 *3a(b)) is amended—*

9 (1) *in paragraph (1), by inserting “paragraph*
10 *(6) and” after “Subject to”; and*

11 (2) *by adding at the end the following new para-*
12 *graph:*

13 “(6) *SPECIAL RULE.—In applying subsection*
14 *(c)(6)(C)(ii), beginning with January 1, 2008, the av-*
15 *erage sales price for drugs or biologicals described in*
16 *section 1842(o)(1)(G) is the lower of the average sales*
17 *price calculated including drugs or biologicals to*
18 *which such subsection applies and the average sales*
19 *price that would have been calculated if such sub-*
20 *section were not applied.”.*

21 (d) *EFFECTIVE DATE.—Except as otherwise provided,*
22 *the amendments made by this section shall apply to drugs*
23 *furnished on or after January 1, 2008.*

1 ***Subtitle B—Extension of Medicare***
2 ***Rural Access Protections***

3 **SEC. 621. 2-YEAR EXTENSION OF FLOOR ON MEDICARE**
4 **WORK GEOGRAPHIC ADJUSTMENT.**

5 *Section 1848(e)(1)(E) of such Act (42 U.S.C. 1395w–*
6 *4(e)(1)(E)) is amended by striking “2008” and inserting*
7 *“2010”.*

8 **SEC. 622. 2-YEAR EXTENSION OF SPECIAL TREATMENT OF**
9 **CERTAIN PHYSICIAN PATHOLOGY SERVICES**
10 **UNDER MEDICARE.**

11 *Section 542(c) of the Medicare, Medicaid, and SCHIP*
12 *Benefits Improvement and Protection Act of 2000, as*
13 *amended by section 732 of the Medicare Prescription Drug,*
14 *Improvement, and Modernization Act of 2003, and section*
15 *104 of the Medicare Improvements and Extension Act of*
16 *2006 (division B of Public Law 109–432), is amended by*
17 *striking “and 2007” and inserting “2007, 2008, and 2009”.*

18 **SEC. 623. 2-YEAR EXTENSION OF MEDICARE REASONABLE**
19 **COSTS PAYMENTS FOR CERTAIN CLINICAL DI-**
20 **AGNOSTIC LABORATORY TESTS FURNISHED**
21 **TO HOSPITAL PATIENTS IN CERTAIN RURAL**
22 **AREAS.**

23 *Section 416(b) of the Medicare Prescription Drug, Im-*
24 *provement, and Modernization Act of 2003 (Public Law*
25 *108–173; 117 Stat. 2282; 42 U.S.C. 1395l–4(b)), as amend-*

1 *ed by section 105 of the Medicare Improvement and Exten-*
2 *sion Act of 2006 (division B of Public Law 109–432), is*
3 *amended by striking “3-year” and inserting “5-year”.*

4 **SEC. 624. 2-YEAR EXTENSION OF MEDICARE INCENTIVE**
5 **PAYMENT PROGRAM FOR PHYSICIAN SCAR-**
6 **CITY AREAS .**

7 *(a) IN GENERAL.—Section 1833(u)(1) of the Social Se-*
8 *curity Act (42 U.S.C. 1395l(u)(1)) is amended by striking*
9 *“2008” and inserting “2010”.*

10 *(b) TRANSITION.—With respect to physicians’ services*
11 *furnished during 2008 and 2009, for purposes of subsection*
12 *(a), the Secretary of Health and Human Services shall use*
13 *the primary care scarcity areas and the specialty care scar-*
14 *city areas (as identified in section 1833(u)(4)) that the Sec-*
15 *retary was using under such subsection with respect to phy-*
16 *sicians’ services furnished on December 31, 2007.*

17 **SEC. 625. 2-YEAR EXTENSION OF MEDICARE INCREASE PAY-**
18 **MENTS FOR GROUND AMBULANCE SERVICES**
19 **IN RURAL AREAS.**

20 *Section 1834(l)(13) of the Social Security Act (42*
21 *U.S.C. 1395m(l)(13)) is amended—*

22 *(1) in subparagraph (A)—*

23 *(A) in the matter before clause (i), by strik-*
24 *ing “furnished on or after July 1, 2004, and be-*
25 *fore January 1, 2007,”;*

1 (B) in clause (i), by inserting “for services
2 furnished on or after July 1, 2004, and before
3 January 1, 2007, and on or after January 1,
4 2008, and before January 1, 2010,” after “in
5 such paragraph,”; and

6 (C) in clause (ii), by inserting “for services
7 furnished on or after July 1, 2004, and before
8 January 1, 2007,” after “in clause (i),”; and
9 (2) in subparagraph (B)—

10 (A) in the heading, by striking “AFTER
11 2006” and inserting “FOR SUBSEQUENT PERI-
12 ODS”;

13 (B) by inserting “clauses (i) and (ii) of” be-
14 fore “subparagraph (A)”; and

15 (C) by striking “in such subparagraph”
16 and inserting “in the respective clause”.

17 **SEC. 626. EXTENDING HOLD HARMLESS FOR SMALL RURAL**
18 **HOSPITALS UNDER THE HOPD PROSPECTIVE**
19 **PAYMENT SYSTEM.**

20 Section 1833(t)(7)(D)(i)(II) of the Social Security Act
21 (42 U.S.C. 1395l(t)(7)(D)(I)(II)) is amended—

22 (1) by striking “January 1, 2009” and inserting
23 “January 1, 2010”;

24 (2) by striking “2007, or 2008,”; and

1 (3) by striking “90 percent, and 85 percent, re-
2 spectively.” and inserting “and with respect to such
3 services furnished after 2006 the applicable percentage
4 shall be 90 percent.”.

5 ***Subtitle C—End Stage Renal***
6 ***Disease Program***

7 ***SEC. 631. CHRONIC KIDNEY DISEASE DEMONSTRATION***
8 ***PROJECTS.***

9 (a) *IN GENERAL.*—The Secretary of Health and
10 Human Services (in this section referred to as the “Sec-
11 retary”), acting through the Director of the National Insti-
12 tutes of Health, shall establish demonstration projects to—

13 (1) *increase public and medical community*
14 *awareness (particularly of those who treat patients*
15 *with diabetes and hypertension) about the factors that*
16 *lead to chronic kidney disease, how to prevent it, how*
17 *to diagnose it, and how to treat it;*

18 (2) *increase screening and use of prevention tech-*
19 *niques for chronic kidney disease for Medicare bene-*
20 *ficiaries and the general public (particularly among*
21 *patients with diabetes and hypertension, where pre-*
22 *vention techniques are well established and early de-*
23 *tection makes prevention possible); and*

24 (3) *enhance surveillance systems and expand re-*
25 *search to better assess the prevalence and incidence of*

1 *chronic kidney disease, (building on work done by*
2 *Centers for Disease Control and Prevention).*

3 *(b) SCOPE AND DURATION.—*

4 *(1) SCOPE.—The Secretary shall select at least 3*
5 *States in which to conduct demonstration projects*
6 *under this section. In selecting the States under this*
7 *paragraph, the Secretary shall take into account the*
8 *size of the population of individuals with end-stage*
9 *renal disease who are enrolled in part B of title*
10 *XVIII of the Social Security Act and ensure the par-*
11 *ticipation of individuals who reside in rural and*
12 *urban areas.*

13 *(2) DURATION.—The demonstration projects*
14 *under this section shall be conducted for a period that*
15 *is not longer than 5 years and shall begin on Janu-*
16 *ary 1, 2009.*

17 *(c) EVALUATION AND REPORT.—*

18 *(1) EVALUATION.—The Secretary shall conduct*
19 *an evaluation of the demonstration projects conducted*
20 *under this section.*

21 *(2) REPORT.—Not later than 12 months after the*
22 *date on which the demonstration projects under this*
23 *section are completed, the Secretary shall submit to*
24 *Congress a report on the evaluation conducted under*
25 *paragraph (1) together with recommendations for*

1 *such legislation and administrative action as the Sec-*
2 *retary determines appropriate.*

3 **SEC. 632. MEDICARE COVERAGE OF KIDNEY DISEASE PA-**
4 **TIENT EDUCATION SERVICES.**

5 *(a) COVERAGE OF KIDNEY DISEASE EDUCATION*
6 *SERVICES.—*

7 *(1) COVERAGE.—Section 1861(s)(2) of the Social*
8 *Security Act (42 U.S.C. 1395x(s)(2)), as amended by*
9 *sections 201(a)(1), 607(a)(1), and 607(b)(1), is*
10 *amended—*

11 *(A) in subparagraph (CC), by striking*
12 *“and” after the semicolon at the end;*

13 *(B) in subparagraph (DD), by adding*
14 *“and” after the semicolon at the end; and*

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

17 *“(EE) kidney disease education services (as de-*
18 *finied in subsection (ggg));”.*

19 *(2) SERVICES DESCRIBED.—Section 1861 of the*
20 *Social Security Act (42 U.S.C. 1395x), as amended*
21 *by sections 201(a)(2), 503(b)(1), 607(a)(2), and*
22 *607(b)(2), is amended by adding at the end the fol-*
23 *lowing new subsection:*

1 *“Kidney Disease Education Services*

2 *“(ggg)(1) The term ‘kidney disease education services’*

3 *means educational services that are—*

4 *“(A) furnished to an individual with stage IV*
5 *chronic kidney disease who, according to accepted*
6 *clinical guidelines identified by the Secretary, will re-*
7 *quire dialysis or a kidney transplant;*

8 *“(B) furnished, upon the referral of the physi-*
9 *cian managing the individual’s kidney condition, by*
10 *a qualified person (as defined in paragraph (2)); and*

11 *“(C) designed—*

12 *“(i) to provide comprehensive information*
13 *(consistent with the standards developed under*
14 *paragraph (3)) regarding—*

15 *“(I) the management of comorbidities,*
16 *including for purposes of delaying the need*
17 *for dialysis;*

18 *“(II) the prevention of uremic com-*
19 *plications; and*

20 *“(III) each option for renal replace-*
21 *ment therapy (including hemodialysis and*
22 *peritoneal dialysis at home and in-center as*
23 *well as vascular access options and trans-*
24 *plantation);*

1 “(ii) to ensure that the individual has the
2 opportunity to actively participate in the choice
3 of therapy; and

4 “(iii) to be tailored to meet the needs of the
5 individual involved.

6 “(2) The term ‘qualified person’ means a physician,
7 physician assistant, nurse practitioner, or clinical nurse
8 specialist who furnishes services for which payment may
9 be made under the fee schedule established under section
10 1848. Such term does not include a renal dialysis facility.

11 “(3) The Secretary shall set standards for the content
12 of such information to be provided under paragraph
13 (1)(C)(i) after consulting with physicians, other health pro-
14 fessionals, health educators, professional organizations, ac-
15 crediting organizations, kidney patient organizations, di-
16 alysis facilities, transplant centers, network organizations
17 described in section 1881(c)(2), and other knowledgeable
18 persons. To the extent possible the Secretary shall consult
19 with a person or entity described in the previous sentence,
20 other than a dialysis facility, that has not received industry
21 funding from a drug or biological manufacturer or dialysis
22 facility.

23 “(4) In promulgating regulations to carry out this sub-
24 section, the Secretary shall ensure that each individual who
25 is eligible for benefits for kidney disease education services

1 *under this title receives such services in a timely manner*
2 *to maximize the benefit of those services.*

3 “(5) *The Secretary shall monitor the implementation*
4 *of this subsection to ensure that individuals who are eligible*
5 *for benefits for kidney disease education services receive*
6 *such services in the manner described in paragraph (4).*

7 “(6) *No individual shall be eligible to be provided more*
8 *than 6 sessions of kidney disease education services under*
9 *this title.*”.

10 (3) *PAYMENT UNDER THE PHYSICIAN FEE*
11 *SCHEDULE.—Section 1848(j)(3) of the Social Security*
12 *Act (42 U.S.C. 1395w-4(j)(3)) is amended by insert-*
13 *ing “(2)(DD),” after “(2)(AA),”.*

14 (4) *LIMITATION ON NUMBER OF SESSIONS.—Sec-*
15 *tion 1862(a)(1) of the Social Security Act (42 U.S.C.*
16 *1395y(a)(1)) is amended—*

17 (A) *in subparagraph (M), by striking*
18 *“and” at the end;*

19 (B) *in subparagraph (N), by striking the*
20 *semicolon at the end and inserting “, and”; and*

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

23 “(O) *in the case of kidney disease education serv-*
24 *ices (as defined in section 1861(ggg)), which are fur-*

1 *nished in excess of the number of sessions covered*
2 *under such section;”.*

3 (5) *GAO REPORT.*—*Not later than September 1,*
4 *2010, the Comptroller General of the United States*
5 *shall submit to Congress a report on the following:*

6 (A) *The number of Medicare beneficiaries*
7 *who are eligible to receive benefits for kidney dis-*
8 *ease education services (as defined in section*
9 *1861(ggg) of the Social Security Act, as added*
10 *by paragraph (2)) under title XVIII of such Act*
11 *and who receive such services.*

12 (B) *The extent to which there is a sufficient*
13 *amount of physicians, physician assistants,*
14 *nurse practitioners, and clinical nurse specialists*
15 *to furnish kidney disease education services (as*
16 *so defined) under such title and whether or not*
17 *renal dialysis facilities (and appropriate em-*
18 *ployees of such facilities) should be included as*
19 *an entity eligible under such section to furnish*
20 *such services.*

21 (C) *Recommendations, if appropriate, for*
22 *renal dialysis facilities (and appropriate em-*
23 *ployees of such facilities) to structure kidney dis-*
24 *ease education services (as so defined) in a man-*
25 *ner that is objective and unbiased and that pro-*

1 *vides a range of options and alternative loca-*
2 *tions for renal replacement therapy and manage-*
3 *ment of co-morbidities that may delay the need*
4 *for dialysis.*

5 *(b) EFFECTIVE DATE.—The amendments made by this*
6 *section shall apply to services furnished on or after January*
7 *1, 2009.*

8 **SEC. 633. REQUIRED TRAINING FOR PATIENT CARE DIALY-**
9 **SIS TECHNICIANS.**

10 *Section 1881 of the Social Security Act (42 U.S.C.*
11 *1395rr) is amended by adding the following new subsection:*

12 *“(h)(1) Except as provided in paragraph (2), a pro-*
13 *vider of services or a renal dialysis facility may not use,*
14 *for more than 12 months during 2009, or for any period*
15 *beginning on January 1, 2010, any individual as a patient*
16 *care dialysis technician unless the individual—*

17 *“(A) has completed a training program in the*
18 *care and treatment of an individual with chronic kid-*
19 *ney failure who is undergoing dialysis treatment; and*

20 *“(B) has been certified by a nationally recog-*
21 *nized certification entity for dialysis technicians.*

22 *“(2)(A) A provider of services or a renal dialysis facil-*
23 *ity may permit an individual enrolled in a training pro-*
24 *gram described in paragraph (1)(A) to serve as a patient*
25 *care dialysis technician while they are so enrolled.*

1 “(B) *The requirements described in subparagraphs*
2 *(A), (B), and (C) of paragraph (1) do not apply to an indi-*
3 *vidual who has performed dialysis-related services for at*
4 *least 5 years.*

5 “(3) *For purposes of paragraph (1), if, since the most*
6 *recent completion by an individual of a training program*
7 *described in paragraph (1)(A), there has been a period of*
8 *24 consecutive months during which the individual has not*
9 *furnished dialysis-related services for monetary compensa-*
10 *tion, such individual shall be required to complete a new*
11 *training program or become recertified as described in*
12 *paragraph (1)(B).*

13 “(4) *A provider of services or a renal dialysis facility*
14 *shall provide such regular performance review and regular*
15 *in-service education as assures that individuals serving as*
16 *patient care dialysis technicians for the provider or facility*
17 *are competent to perform dialysis-related services.”.*

18 **SEC. 634. MEDPAC REPORT ON TREATMENT MODALITIES**

19 **FOR PATIENTS WITH KIDNEY FAILURE.**

20 (a) *EVALUATION.—*

21 (1) *IN GENERAL.—Not later than March 1, 2009,*
22 *the Medicare Payment Advisory Commission (estab-*
23 *lished under section 1805 of the Social Security Act)*
24 *shall submit to the Secretary and Congress a report*
25 *evaluating the barriers that exist to increasing the*

1 *number of individuals with end-stage renal disease*
2 *who elect to receive home dialysis services under the*
3 *Medicare program under title XVIII of the Social Se-*
4 *curity Act (42 U.S.C. 1395 et seq.).*

5 (2) *REPORT DETAILS.—The report shall include*
6 *the following:*

7 (A) *A review of Medicare home dialysis*
8 *demonstration projects initiated before the date*
9 *of the enactment of this Act, and the results of*
10 *such demonstration projects and recommenda-*
11 *tions for future Medicare home dialysis dem-*
12 *onstration projects or Medicare program changes*
13 *that will test models that can improve Medicare*
14 *beneficiary access to home dialysis.*

15 (B) *A comparison of current Medicare home*
16 *dialysis costs and payments with current in-cen-*
17 *ter and hospital dialysis costs and payments.*

18 (C) *An analysis of the adequacy of Medicare*
19 *reimbursement for patient training for home di-*
20 *alysis (including hemodialysis and peritoneal di-*
21 *alysis) and recommendations for ensuring ap-*
22 *propriate payment for such home dialysis train-*
23 *ing.*

24 (D) *A catalogue and evaluation of the in-*
25 *centives and disincentives in the current reim-*

1 “(C)(i) *The payment amounts under this title for*
2 *erythropoietin furnished during 2008 or 2009 to an indi-*
3 *vidual with end stage renal disease by a large dialysis facil-*
4 *ity (as defined in subparagraph (D)) (whether to individ-*
5 *uals in the facility or at home), in an amount equal to*
6 *\$8.75 per thousand units (rounded to the nearest 100 units)*
7 *or, if less, 102 percent of the average sales price (as deter-*
8 *mined under section 1847A) for such drug or biological.*

9 “(ii) *The payment amounts under this title for*
10 *darbepoetin alfa furnished during 2008 or 2009 to an indi-*
11 *vidual with end stage renal disease by a large dialysis facil-*
12 *ity (as defined in clause (iii)) (whether to individuals in*
13 *the facility or at home), in an amount equal to \$2.92 per*
14 *microgram or, if less, 102 percent of the average sales price*
15 *(as determined under section 1847A) for such drug or bio-*
16 *logical.*

17 “(iii) *For purposes of this subparagraph, the term*
18 *‘large dialysis facility’ means a provider of services or renal*
19 *dialysis facility that is owned or managed by a corporate*
20 *entity that, as of July 24, 2007, owns or manages 300 or*
21 *more such providers or facilities, and includes a successor*
22 *to such a corporate entity.”.*

23 **(b) NO IMPACT ON DRUG ADD-ON PAYMENT.**—*Nothing*
24 *in the amendments made by subsection (a) shall be con-*
25 *strued to affect the amount of any payment adjustment*

1 *made under section 1881(b)(12)(B)(ii) of the Social Secu-*
2 *rity Act (42 U.S.C. 1395rr(b)(12)(B)(ii)).*

3 **SEC. 636. SITE NEUTRAL COMPOSITE RATE.**

4 *Subsection (b)(12)(A) of section 1881 of the Social Se-*
5 *curity Act (42 U.S.C. 1395rr) is amended by adding at the*
6 *end the following new sentence: “Under such system the*
7 *payment rate for dialysis services furnished on or after*
8 *January 1, 2008, by providers of such services for hospital-*
9 *based facilities shall be the same as the payment rate (com-*
10 *puted without regard to this sentence) for such services fur-*
11 *nished by renal dialysis facilities that are not hospital-*
12 *based, except that in applying the geographic index under*
13 *subparagraph (D) to hospital-based facilities, the labor*
14 *share shall be based on the labor share otherwise applied*
15 *for such facilities.”.*

16 **SEC. 637. DEVELOPMENT OF ESRD BUNDLING SYSTEM AND**
17 **QUALITY INCENTIVE PAYMENTS.**

18 *(a) DEVELOPMENT OF ESRD BUNDLING SYSTEM.—*
19 *Subsection (b) of section 1881 of the Social Security Act*
20 *(42 U.S.C. 1395rr) is further amended—*

21 *(1) in paragraph (12)(A), by striking “In lieu of*
22 *payment” and inserting “Subject to paragraph (14),*
23 *in lieu of payment”;*

24 *(2) in the second sentence of paragraph*
25 *(12)(F)—*

1 (A) by inserting “or paragraph (14)” after
2 “this paragraph”; and

3 (B) by inserting “or under the system under
4 paragraph (14)” after “subparagraph (B)”;

5 (3) in paragraph (12)(H)—

6 (A) by inserting “or paragraph (14)” after
7 “under this paragraph” the first place it ap-
8 pears; and

9 (B) by inserting before the period at the end
10 the following: “or, under paragraph (14), the
11 identification of renal dialysis services included
12 in the bundled payment, the adjustment for
13 outliers, the identification of facilities to which
14 the phase-in may apply, and the determination
15 of payment amounts under subparagraph (A)
16 under such paragraph, and the application of
17 paragraph (13)(C)(iii)”;

18 (4) in paragraph (13)—

19 (A) in subparagraph (A), by striking “The
20 payment amounts” and inserting “subject to
21 paragraph (14), the payment amounts”; and

22 (B) in subparagraph (B)—

23 (i) in clause (i), by striking “(i)” after
24 “(B)” and by inserting “, subject to para-

1 graph (14)” before the period at the end;

2 and

3 (ii) by striking clause (ii); and

4 (5) by adding at the end the following new para-
5 graph:

6 “(14)(A) Subject to subparagraph (E), for services fur-
7 nished on or after January 1, 2010, the Secretary shall im-
8 plement a payment system under which a single payment
9 is made under this title for renal dialysis services (as de-
10 fined in subparagraph (B)) in lieu of any other payment
11 (including a payment adjustment under paragraph
12 (12)(B)(ii)) for such services and items furnished pursuant
13 to paragraph (4). In implementing the system the Secretary
14 shall ensure that the estimated total amount of payments
15 under this title for 2010 for renal dialysis services shall
16 equal 96 percent of the estimated amount of payments for
17 such services, including payments under paragraph
18 (12)(B)(ii), that would have been made if such system had
19 not been implemented.

20 “(B) For purposes of this paragraph, the term ‘renal
21 dialysis services’ includes—

22 “(i) items and services included in the com-
23 posite rate for renal dialysis services as of De-
24 cember 31, 2009;

1 “(ii) erythropoietin stimulating agents fur-
2 nished to individuals with end stage renal dis-
3 ease;

4 “(iii) other drugs and biologicals and diag-
5 nostic laboratory tests, that the Secretary identi-
6 fies as commonly used in the treatment of such
7 patients and for which payment was (before the
8 application of this paragraph) made separately
9 under this title, and any oral equivalent form of
10 such drugs and biologicals or of drugs and
11 biologicals described in clause (i); and

12 “(iv) home dialysis training for which pay-
13 ment was (before the application of this para-
14 graph) made separately under this section.

15 Such term does not include vaccines.

16 “(C) The system under this paragraph may provide
17 for payment on the basis of services furnished during a week
18 or month or such other appropriate unit of payment as the
19 Secretary specifies.

20 “(D) Such system—

21 “(i) shall include a payment adjustment based
22 on case mix that may take into account patient
23 weight, body mass index, comorbidities, length of time
24 on dialysis, age, race, ethnicity, and other appro-
25 priate factors;

1 “(ii) shall include a payment adjustment for
2 high cost outliers due to unusual variations in the
3 type or amount of medically necessary care, including
4 variations in the amount of erythropoietin stimu-
5 lating agents necessary for anemia management; and

6 “(iii) may include such other payment adjust-
7 ments as the Secretary determines appropriate, such
8 as a payment adjustment—

9 “(I) by a geographic index, such as the
10 index referred to in paragraph (12)(D), as the
11 Secretary determines to be appropriate;

12 “(II) for pediatric providers of services and
13 renal dialysis facilities;

14 “(III) for low volume providers of services
15 and renal dialysis facilities;

16 “(IV) for providers of services or renal di-
17 alysis facilities located in rural areas; and

18 “(V) for providers of services or renal dialy-
19 sis facilities that are not large dialysis facilities.

20 “(E) The Secretary may provide for a phase-in of the
21 payment system described in subparagraph (A) for services
22 furnished by a provider of services or renal dialysis facility
23 described in any of subclauses (II) through (V) of subpara-
24 graph (D)(iii), but such payment system shall be fully im-

1 *plemented for services furnished in the case of any such pro-*
2 *vider or facility on or after January 1, 2013.*

3 “(F) *The Secretary shall apply the annual increase*
4 *that would otherwise apply under subparagraph (F) of*
5 *paragraph (12) to payment amounts established under such*
6 *paragraph (if this paragraph did not apply) in an appro-*
7 *priate manner under this paragraph.”.*

8 (b) *PROHIBITION OF UNBUNDLING.—Section 1862(a)*
9 *of such Act (42 U.S.C. 1395y(a)) is amended—*

10 (1) *by striking “or” at the end of paragraph*
11 *(21);*

12 (2) *by striking the period at the end of para-*
13 *graph (22) and inserting “; or”; and*

14 (3) *by inserting after paragraph (22) the fol-*
15 *lowing new paragraph:*

16 “(23) *where such expenses are for renal dialysis*
17 *services (as defined in subparagraph (B) of section*
18 *1881(b)(14)) for which payment is made under such*
19 *section (other than under subparagraph (E) of such*
20 *section) unless such payment is made under such sec-*
21 *tion to a provider of services or a renal dialysis facil-*
22 *ity for such services.”.*

23 (c) *QUALITY INCENTIVE PAYMENTS.—Section 1881 of*
24 *such Act is amended by adding at the end the following*
25 *new subsection:*

1 “(i) *QUALITY INCENTIVE PAYMENTS IN THE END-*
2 *STAGE RENAL DISEASE PROGRAM.*—

3 “(1) *QUALITY INCENTIVE PAYMENTS FOR SERV-*
4 *ICES FURNISHED IN 2008, 2009, AND 2010.*—

5 “(A) *IN GENERAL.*—*With respect to renal*
6 *dialysis services furnished during a performance*
7 *period (as defined in subparagraph (B)) by a*
8 *provider of services or renal dialysis facility that*
9 *the Secretary determines meets the applicable*
10 *performance standard for the period under sub-*
11 *paragraph (C) and reports on measures for 2009*
12 *and 2010 under subparagraph (D) for such serv-*
13 *ices, in addition to the amount otherwise paid*
14 *under this section, subject to subparagraph (G),*
15 *there also shall be paid to the provider or facility*
16 *an amount equal to the applicable percentage*
17 *(specified in subparagraph (E) for the period) of*
18 *the Secretary’s estimate (based on claims sub-*
19 *mitted not later than two months after the end*
20 *of the performance period) of the amount speci-*
21 *fied in subparagraph (F) for such period.*

22 “(B) *PERFORMANCE PERIOD.*—*In this*
23 *paragraph, the term ‘performance period’ means*
24 *each of the following:*

1 “(i) *The period beginning on July 1,*
2 *2008, and ending on December 31, 2008.*

3 “(ii) *2009.*

4 “(iii) *2010.*

5 “(C) *PERFORMANCE STANDARD.—*

6 “(i) *2008.—For the performance pe-*
7 *riod occurring in 2008, the applicable per-*
8 *formance standards for a provider or facil-*
9 *ity under this subparagraph are—*

10 “(I) *92 percent or more of indi-*
11 *viduals with end stage renal disease re-*
12 *ceiving erythropoetin stimulating agents*
13 *who have an average hematocrit of*
14 *33.0 percent or more; and*

15 “(II) *less than a percentage, speci-*
16 *fied by the Secretary, of individuals*
17 *with end stage renal disease receiving*
18 *erythropoetin stimulating agents who*
19 *have an average hematocrit of 39.0*
20 *percent or more.*

21 “(ii) *2009 AND 2010.—For the 2009*
22 *and 2010 performance periods, the applica-*
23 *ble performance standard for a provider or*
24 *facility under this subparagraph is success-*

1 *ful performance (relative to national aver-*
2 *age) on—*

3 *“(I) such measures of anemia*
4 *management as the Secretary shall*
5 *specify, including measures of hemo-*
6 *globin levels or hematocrit levels for*
7 *erythropoietin stimulating agents that*
8 *are consistent with the labeling for dos-*
9 *age of erythropoietin stimulating*
10 *agents approved by the Food and Drug*
11 *Administration for treatment of ane-*
12 *mia in patients with end stage renal*
13 *disease, taking into account variations*
14 *in hemoglobin ranges or hematocrit*
15 *levels of patients; and*

16 *“(II) such other measures, relat-*
17 *ing to subjects described in subpara-*
18 *graph (D)(i), as the Secretary may*
19 *specify.*

20 *“(D) REPORTING PERFORMANCE MEAS-*
21 *URES.—The performance measures under this*
22 *subparagraph to be reported shall include—*

23 *“(i) such measures as the Secretary*
24 *specifies, before the beginning of the per-*
25 *formance period involved and taking into*

1 *account measures endorsed by the National*
2 *Quality Forum, including, to the extent fea-*
3 *sible measures on—*

4 “(I) *iron management;*

5 “(II) *dialysis adequacy; and*

6 “(III) *vascular access, including*
7 *for maximizing the placement of arte-*
8 *rial venous fistula; and*

9 “(ii) *to the extent feasible, such meas-*
10 *ure (or measures) of patient satisfaction as*
11 *the Secretary shall specify.*

12 *The provider or facility submitting information*
13 *on such measures shall attest to the completeness*
14 *and accuracy of such information.*

15 “(E) *APPLICABLE PERCENTAGE.—The ap-*
16 *plicable percentage specified in this subpara-*
17 *graph for—*

18 “(i) *the performance period occurring*
19 *in 2008, is 1.0 percent;*

20 “(ii) *the 2009 performance period, is*
21 *2.0 percent; and*

22 “(iii) *the 2010 performance period, is*
23 *3.0 percent.*

24 *In the case of any performance period which is*
25 *less than an entire year, the applicable percent-*

1 age specified in this subparagraph shall be mul-
2 tiplied by the ratio of the number of months in
3 the year to the number of months in such per-
4 formance period. In the case of 2010, the appli-
5 cable percentage specified in this subparagraph
6 shall be multiplied by the Secretary's estimate of
7 the ratio of the aggregate payment amount de-
8 scribed in subparagraph (F)(i) that would apply
9 in 2010 if paragraph (14) did not apply, to the
10 aggregate payment base under subparagraph
11 (F)(ii) for 2010.

12 “(F) PAYMENT BASE.—The payment base
13 described in this subparagraph for a provider or
14 facility is—

15 “(i) for performance periods before
16 2010, the payment amount determined
17 under paragraph (12) for services furnished
18 by the provider or facility during the per-
19 formance period, including the drug pay-
20 ment adjustment described in subparagraph
21 (B)(ii) of such paragraph; and

22 “(ii) for the 2010 performance period
23 is the amount determined under paragraph
24 (14) for services furnished by the provider
25 or facility during the period.

1 “(G) *LIMITATION ON FUNDING.*—

2 “(i) *IN GENERAL.*—*If the Secretary de-*
3 *termines that the total payments under this*
4 *paragraph for a performance period is pro-*
5 *jected to exceed the dollar amount specified*
6 *in clause (ii) for such period, the Secretary*
7 *shall reduce, in a pro rata manner, the*
8 *amount of such payments for each provider*
9 *or facility for such period to eliminate any*
10 *such projected excess for the period.*

11 “(ii) *DOLLAR AMOUNT.*—*The dollar*
12 *amount specified in this clause—*

13 “(I) *for the performance period*
14 *occurring in 2008, is \$50,000,000;*

15 “(II) *for the 2009 performance pe-*
16 *riod is \$100,000,000; and*

17 “(III) *for the 2010 performance*
18 *period is \$150,000,000.*

19 “(H) *FORM OF PAYMENT.*—*The payment*
20 *under this paragraph shall be in the form of a*
21 *single consolidated payment.*

22 “(2) *QUALITY INCENTIVE PAYMENTS FOR FACILI-*
23 *TIES AND PROVIDERS FOR 2011.*—

24 “(A) *INCREASED PAYMENT.*—*For 2011, in*
25 *the case of a provider or facility that, for the*

1 *performance period (as defined in subparagraph*
2 *(B))—*

3 *“(i) meets (or exceeds) the performance*
4 *standard for anemia management specified*
5 *in paragraph (1)(C)(i)(I);*

6 *“(ii) has substantially improved per-*
7 *formance or exceeds a performance standard*
8 *(as determined under subparagraph (E));*
9 *and*

10 *“(iii) reports measures specified in*
11 *paragraph (1)(D),*

12 *with respect to renal dialysis services furnished*
13 *by the provider or facility during the quality*
14 *bonus payment period (as specified in subpara-*
15 *graph (C)) the payment amount otherwise made*
16 *to such provider or facility under subsection*
17 *(b)(14) shall be increased, subject to subpara-*
18 *graph (F), by the applicable percentage specified*
19 *in subparagraph (D). Payment amounts under*
20 *paragraph (1) shall not be counted for purposes*
21 *of applying the previous sentence.*

22 *“(B) PERFORMANCE PERIOD.—In this*
23 *paragraph, the term ‘performance period’ means*
24 *a multi-month period specified by the Secretary*

25 .

1 “(C) *QUALITY BONUS PAYMENT PERIOD.*—
2 *In this paragraph, the term ‘quality bonus pay-*
3 *ment period’ means, with respect to a perform-*
4 *ance period, a multi-month period beginning on*
5 *January 1, 2011, specified by the Secretary that*
6 *begins at least 3 months (but not more than 9*
7 *months) after the end of the performance period.*

8 “(D) *APPLICABLE PERCENTAGE.*—*The ap-*
9 *plicable percentage specified in this subpara-*
10 *graph is a percentage, not to exceed the 4.0 per-*
11 *cent, specified by the Secretary consistent with*
12 *subparagraph (F). Such percentage may vary*
13 *based on the level of performance and improve-*
14 *ment. The applicable percentage specified in this*
15 *subparagraph shall be multiplied by the ratio*
16 *applied under the third sentence of paragraph*
17 *(1)(E) for 2010.*

18 “(E) *PERFORMANCE STANDARD.*—*Based on*
19 *performance of a provider of services or a renal*
20 *dialysis facility on performance measures de-*
21 *scribed in paragraph (1)(D) for a performance*
22 *period, the Secretary shall determine a composite*
23 *score for such period.*

24 “(F) *LIMITATION ON FUNDING.*—*If the Sec-*
25 *retary determines that the total amount to be*

1 *paid under this paragraph for a quality bonus*
2 *payment period is projected to exceed*
3 *\$200,000,000, the Secretary shall reduce, in a*
4 *uniform manner, the applicable percentage oth-*
5 *erwise applied under subparagraph (D) for serv-*
6 *ices furnished during the period to eliminate any*
7 *such projected excess.*

8 “(3) *APPLICATION.—*

9 “(A) *IMPLEMENTATION.—Notwithstanding*
10 *any other provision of law, the Secretary may*
11 *implement by program instruction or otherwise*
12 *this subsection.*

13 “(B) *LIMITATIONS ON REVIEW.—*

14 “(i) *IN GENERAL.—There shall be no*
15 *administrative or judicial review under sec-*
16 *tion 1869 or 1878 or otherwise of—*

17 “(I) *the determination of perform-*
18 *ance measures and standards under*
19 *this subsection;*

20 “(II) *the determination of success-*
21 *ful reporting, including a determina-*
22 *tion of composite scores; and*

23 “(III) *the determination of the*
24 *quality incentive payments made*
25 *under this subsection.*

1 “(i) *TREATMENT OF DETERMINA-*
2 *TIONS.—A determination under this sub-*
3 *paragraph shall not be treated as a deter-*
4 *mination for purposes of section 1869.*

5 “(4) *TECHNICAL ASSISTANCE.—The Secretary*
6 *shall identify or establish an appropriately skilled*
7 *group or organization, such as the ESRD Networks,*
8 *to provide technical assistance to consistently low-per-*
9 *forming facilities or providers that are in the bottom*
10 *quintile.*

11 “(5) *PUBLIC REPORTING.—*

12 “(A) *ANNUAL NOTICE.—The Secretary shall*
13 *provide an annual written notification to each*
14 *individual who is receiving renal dialysis serv-*
15 *ices from a provider of services or renal dialysis*
16 *facility that—*

17 “(i) *informs such individual of the*
18 *composite scores described in subparagraph*
19 *(A) and other relevant quality measures*
20 *with respect to providers of services or renal*
21 *dialysis facilities in the local area;*

22 “(ii) *compares such scores and meas-*
23 *ures to the average local and national scores*
24 *and measures; and*

1 “(iii) provides information on how to
2 access additional information on quality of
3 such services furnished and options for al-
4 ternative providers and facilities.

5 “(B) CERTIFICATES.—The Secretary shall
6 provide certificates to facilities and providers
7 who provide services to individuals with end-
8 stage renal disease under this title to display in
9 patient areas. The certificate shall indicate the
10 composite score obtained by the facility or pro-
11 vider under the quality initiative.

12 “(C) WEB-BASED QUALITY LIST.—The Sec-
13 retary shall establish a web-based list of facilities
14 and providers who furnish renal dialysis services
15 under this section that indicates their composite
16 score of each provider and facility.

17 “(6) RECOMMENDATIONS FOR REPORTING AND
18 QUALITY INCENTIVE INITIATIVE FOR PHYSICIANS.—
19 The Secretary shall develop recommendations for ap-
20 plying quality incentive payments under this sub-
21 section to physicians who receive the monthly
22 capitated payment under this title. Such rec-
23 ommendations shall include the following:

24 “(A) Recommendations to include pediatric
25 specific measures for physicians with at least 50

1 *percent of their patients with end stage renal*
2 *disease being individuals under 18 years of age.*

3 “(B) *Recommendations on how to structure*
4 *quality incentive payments for physicians who*
5 *demonstrate improvements in quality or who at-*
6 *tain quality standards, as specified by the Sec-*
7 *retary.*

8 “(7) *REPORTS.—*

9 “(A) *INITIAL REPORT.—Not later than Jan-*
10 *uary 1, 2013, the Secretary shall submit to Con-*
11 *gress a report on the implementation of the bun-*
12 *dled payment system under subsection (b)(14)*
13 *and the quality initiative under this subsection.*
14 *Such report shall include the following informa-*
15 *tion:*

16 “(i) *A comparison of the aggregate*
17 *payments under subsection (b)(14) for items*
18 *and services to the cost of such items and*
19 *services.*

20 “(ii) *The changes in utilization rates*
21 *for erythropoietin stimulating agents.*

22 “(iii) *The mode of administering such*
23 *agents, including information on the pro-*
24 *portion of such individuals receiving such*

1 *agents intravenously as compared to*
2 *subcutaneously.*

3 “(iv) *The frequency of dialysis.*

4 “(v) *Other differences in practice pat-*
5 *terns, such as the adoption of new tech-*
6 *nology, different modes of practice, and*
7 *variations in use of drugs other than drugs*
8 *described in clause (iii).*

9 “(vi) *The performance of facilities and*
10 *providers under paragraph (2).*

11 “(vii) *Other recommendations for legis-*
12 *lative and administrative actions deter-*
13 *mined appropriate by the Secretary.*

14 “(B) *SUBSEQUENT REPORT.—Not later*
15 *than January 1, 2015, the Secretary shall sub-*
16 *mit to Congress a report that contains the infor-*
17 *mation described in each of clauses (ii) through*
18 *(vii) of subparagraph (A) and a comparison of*
19 *the results of the payment system under sub-*
20 *section (b)(14) for renal dialysis services fur-*
21 *nished during the 2-year period beginning on*
22 *January 1, 2013, and the results of such pay-*
23 *ment system for such services furnished during*
24 *the previous two-year period.”.*

1 **SEC. 638. MEDPAC REPORT ON ESRD BUNDLING SYSTEM.**

2 *Not later than March 1, 2012, the Medicare Payment*
3 *Advisory Commission (established under section 1805 of the*
4 *Social Security Act) shall submit to Congress a report on*
5 *the implementation of the payment system under section*
6 *1881(b)(14) of the Social Security Act (as added by section*
7 *7) for renal dialysis services and related services (defined*
8 *in subparagraph (B) of such section). Such report shall in-*
9 *clude, with respect to such payment system for such services,*
10 *an analysis of each of the following:*

11 *(1) An analysis of the overall adequacy of pay-*
12 *ment under such system for all such services.*

13 *(2) An analysis that compares the adequacy of*
14 *payment under such system for services furnished*
15 *by—*

16 *(A) a provider of services or renal dialysis*
17 *facility that is described in section*
18 *1881(b)(13)(C)(iv) of the Social Security Act;*

19 *(B) a provider of services or renal dialysis*
20 *facility not described in such section;*

21 *(C) a hospital-based facility;*

22 *(D) a freestanding renal dialysis facility;*

23 *(E) a renal dialysis facility located in an*
24 *urban area; and*

25 *(F) a renal dialysis facility located in a*
26 *rural area.*

1 (3) *An analysis of the financial status of pro-*
2 *viders of such services and renal dialysis facilities, in-*
3 *cluding access to capital, return on equity, and re-*
4 *turn on capital.*

5 (4) *An analysis of the adequacy of payment*
6 *under such method and the adequacy of the quality*
7 *improvement payments under section 1881(i) of the*
8 *Social Security Act in ensuring that payments for*
9 *such services under the Medicare program are con-*
10 *sistent with costs for such services.*

11 (5) *Recommendations, if appropriate, for modi-*
12 *fications to such payment system.*

13 **SEC. 639. OIG STUDY AND REPORT ON ERYTHROPOIETIN.**

14 (a) *STUDY.*—*The Inspector General of the Department*
15 *of Health and Human Services shall conduct a study on*
16 *the following:*

17 (1) *The dosing guidelines, standards, protocols,*
18 *and algorithms for erythropoietin stimulating agents*
19 *recommended or used by providers of services and*
20 *renal dialysis facilities that are described in section*
21 *1881(b)(13)(C)(iv) of the Social Security Act and*
22 *providers and facilities that are not described in such*
23 *section.*

24 (2) *The extent to which such guidelines, stand-*
25 *ards, protocols, and algorithms are consistent with the*

1 *labeling of the Food and Drug Administration for*
2 *such agents.*

3 (3) *The extent to which physicians sign standing*
4 *orders for such agents that are consistent with such*
5 *guidelines, standards, protocols, and algorithms rec-*
6 *ommended or used by the provider or facility in-*
7 *volved.*

8 (4) *The extent to which the prescribing decisions*
9 *of physicians, with respect to such agents, are inde-*
10 *pendent of—*

11 (A) *such relevant guidelines, standards, pro-*
12 *ocols, and algorithms; or*

13 (B) *recommendations of an anemia man-*
14 *agement nurse or other appropriate employee of*
15 *the provider or facility involved.*

16 (5) *The role of medical directors of providers of*
17 *services and renal dialysis facilities and the financial*
18 *relationships between such providers and facilities*
19 *and the physicians hired as medical directors of such*
20 *providers and facilities, respectively.*

21 (b) *REPORT.—Not later than January 1, 2009, the In-*
22 *spector General of the Department of Health and Human*
23 *Services shall submit to Congress a report on the study con-*
24 *ducted under subsection (a), together with such rec-*

1 *ommendations as the Inspector General determines appro-*
2 *priate.*

3 ***Subtitle D—Miscellaneous***

4 ***SEC. 651. LIMITATION ON EXCEPTION TO THE PROHIBITION***
5 ***ON CERTAIN PHYSICIAN REFERRALS FOR***
6 ***HOSPITALS.***

7 *(a) IN GENERAL.—Section 1877 of the Social Security*
8 *Act (42 U.S.C. 1395) is amended—*

9 *(1) in subsection (d)(2)—*

10 *(A) in subparagraph (A), by striking “and”*
11 *at the end;*

12 *(B) in subparagraph (B), by striking the*
13 *period at the end and inserting “; and”; and*

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

16 *“(C) if the entity is a hospital, the hospital*
17 *meets the requirements of paragraph (3)(D).”;*

18 *(2) in subsection (d)(3)—*

19 *(A) in subparagraph (B), by striking “and”*
20 *at the end;*

21 *(B) in subparagraph (C), by striking the*
22 *period at the end and inserting “; and”; and*

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

1 “(D) the hospital meets the requirements de-
2 scribed in subsection (i)(1) not later than 18
3 months after the date of the enactment of this
4 subparagraph.”; and

5 (3) by adding at the end the following new sub-
6 section:

7 “(i) *REQUIREMENTS FOR HOSPITALS TO QUALIFY FOR*
8 *HOSPITAL EXCEPTION TO OWNERSHIP OR INVESTMENT*
9 *PROHIBITION.*—

10 “(1) *REQUIREMENTS DESCRIBED.*—For purposes
11 of paragraphs subsection (d)(3)(D), the requirements
12 described in this paragraph for a hospital are as fol-
13 lows:

14 “(A) *PROVIDER AGREEMENT.*—The hospital
15 had a provider agreement under section 1866 in
16 effect on July 24, 2007.

17 “(B) *PROHIBITION OF EXPANSION OF FA-*
18 *CILITY CAPACITY.*—The number of operating
19 rooms and beds of the hospital at any time on
20 or after the date of the enactment of this sub-
21 section are no greater than the number of oper-
22 ating rooms and beds as of such date.

23 “(C) *PREVENTING CONFLICTS OF INTER-*
24 *EST.*—

1 “(i) *The hospital submits to the Sec-*
2 *retary an annual report containing a de-*
3 *tailed description of—*

4 “(I) *the identity of each physician*
5 *owner and any other owners of the hos-*
6 *pital; and*

7 “(II) *the nature and extent of all*
8 *ownership interests in the hospital.*

9 “(ii) *The hospital has procedures in*
10 *place to require that any referring physi-*
11 *cian owner discloses to the patient being re-*
12 *ferred, by a time that permits the patient to*
13 *make a meaningful decision regarding the*
14 *receipt of care, as determined by the Sec-*
15 *retary—*

16 “(I) *the ownership interest of such*
17 *referring physician in the hospital;*
18 *and*

19 “(II) *if applicable, any such own-*
20 *ership interest of the treating physi-*
21 *cian.*

22 “(iii) *The hospital does not condition*
23 *any physician ownership interests either di-*
24 *rectly or indirectly on the physician owner*
25 *making or influencing referrals to the hos-*

1 *pital or otherwise generating business for*
2 *the hospital.*

3 “(D) *ENSURING BONA FIDE INVESTMENT.*—

4 “(i) *Physician owners in the aggregate*
5 *do not own more than 40 percent of the*
6 *total value of the investment interests held*
7 *in the hospital or in an entity whose assets*
8 *include the hospital.*

9 “(ii) *The investment interest of any in-*
10 *dividual physician owner does not exceed 2*
11 *percent of the total value of the investment*
12 *interests held in the hospital or in an entity*
13 *whose assets include the hospital.*

14 “(iii) *Any ownership or investment in-*
15 *terests that the hospital offers to a physician*
16 *owner are not offered on more favorable*
17 *terms than the terms offered to a person*
18 *who is not a physician owner.*

19 “(iv) *The hospital does not directly or*
20 *indirectly provide loans or financing for*
21 *any physician owner investments in the*
22 *hospital.*

23 “(v) *The hospital does not directly or*
24 *indirectly guarantee a loan, make a pay-*
25 *ment toward a loan, or otherwise subsidize*

1 *a loan, for any individual physician owner*
2 *or group of physician owners that is related*
3 *to acquiring any ownership interest in the*
4 *hospital.*

5 “(vi) *Investment returns are distrib-*
6 *uted to investors in the hospital in an*
7 *amount that is directly proportional to the*
8 *investment of capital by the physician*
9 *owner in the hospital.*

10 “(vii) *Physician owners do not receive,*
11 *directly or indirectly, any guaranteed re-*
12 *ceipt of or right to purchase other business*
13 *interests related to the hospital, including*
14 *the purchase or lease of any property under*
15 *the control of other investors in the hospital*
16 *or located near the premises of the hospital.*

17 “(viii) *The hospital does not offer a*
18 *physician owner the opportunity to pur-*
19 *chase or lease any property under the con-*
20 *trol of the hospital or any other investor in*
21 *the hospital on more favorable terms than*
22 *the terms offered to an individual who is*
23 *not a physician owner.*

24 “(E) *PATIENT SAFETY.—*

1 “(i) Insofar as the hospital admits a
2 patient and does not have any physician
3 available on the premises to provide services
4 during all hours in which the hospital is
5 providing services to such patient, before
6 admitting the patient—

7 “(I) the hospital discloses such
8 fact to a patient; and

9 “(II) following such disclosure, the
10 hospital receives from the patient a
11 signed acknowledgment that the pa-
12 tient understands such fact.

13 “(ii) The hospital has the capacity
14 to—

15 “(I) provide assessment and ini-
16 tial treatment for patients; and

17 “(II) refer and transfer patients
18 to hospitals with the capability to treat
19 the needs of the patient involved.

20 “(2) PUBLICATION OF INFORMATION RE-
21 PORTED.—The Secretary shall publish, and update on
22 an annual basis, the information submitted by hos-
23 pitals under paragraph (1)(C)(i) on the public Inter-
24 net website of the Centers for Medicare & Medicaid
25 Services.

1 “(3) *COLLECTION OF OWNERSHIP AND INVEST-*
2 *MENT INFORMATION.*—For purposes of clauses (i) and
3 (ii) of paragraph (1)(D), the Secretary shall collect
4 physician ownership and investment information for
5 each hospital as it existed on the date of the enact-
6 ment of this subsection.

7 “(4) *PHYSICIAN OWNER DEFINED.*—For purposes
8 of this subsection, the term ‘physician owner’ means
9 a physician (or an immediate family member of such
10 physician) with a direct or an indirect ownership in-
11 terest in the hospital.”

12 (b) *ENFORCEMENT.*—

13 (1) *ENSURING COMPLIANCE.*—The Secretary of
14 Health and Human Services shall establish policies
15 and procedures to ensure compliance with the require-
16 ments described in such section 1877(i)(1) of the So-
17 cial Security Act, as added by subsection (a)(3), be-
18 ginning on the date such requirements first apply.
19 Such policies and procedures may include unan-
20 nounced site reviews of hospitals.

21 (2) *AUDITS.*—Beginning not later than 18
22 months after the date of the enactment of this Act, the
23 Secretary of Health and Human Services shall con-
24 duct audits to determine if hospitals violate the re-
25 quirements referred to in paragraph (1).

1 **TITLE VII—PROVISIONS RELAT-**
2 **ING TO MEDICARE PARTS A**
3 **AND B**

4 **SEC. 701. HOME HEALTH PAYMENT UPDATE FOR 2008.**

5 *Section 1895(b)(3)(B)(ii) of the Social Security Act*
6 *(42 U.S.C. 1395fff(b)(3)(B)(ii)) is amended—*

7 *(1) in subclause (IV) at the end, by striking*
8 *“and”;*

9 *(2) by redesignating subclause (V) as subclause*
10 *(VII); and*

11 *(3) by inserting after subclause (IV) the fol-*
12 *lowing new subclauses:*

13 *“(V) 2007, subject to clause (v),*
14 *the home health market basket percent-*
15 *age increase;*

16 *“(VI) 2008, subject to clause (v), 0*
17 *percent; and”.*

18 **SEC. 702. 2-YEAR EXTENSION OF TEMPORARY MEDICARE**
19 **PAYMENT INCREASE FOR HOME HEALTH**
20 **SERVICES FURNISHED IN A RURAL AREA.**

21 *Section 421 of the Medicare Prescription Drug, Im-*
22 *provement, and Modernization Act of 2003 (Public Law*
23 *108–173; 117 Stat. 2283; 42 U.S.C. 1395fff note), as*
24 *amended by section 5201(b) of the Deficit Reduction Act*
25 *of 2005, is amended—*

1 (1) *in the heading, by striking “**ONE-YEAR**”*
2 *and inserting “**TEMPORARY**”; and*

3 (2) *in subsection (a), by striking “and episodes*
4 *and visits beginning on or after January 1, 2006,*
5 *and before January 1, 2007” and inserting “episodes*
6 *and visits beginning on or after January 1, 2006,*
7 *and before January 1, 2007, and episodes and visits*
8 *beginning on or after January 1, 2008, and before*
9 *January 1, 2010”.*

10 **SEC. 703. EXTENSION OF MEDICARE SECONDARY PAYER**

11 **FOR BENEFICIARIES WITH END STAGE RENAL**

12 **DISEASE FOR LARGE GROUP PLANS.**

13 (a) *IN GENERAL.*—*Section 1862(b)(1)(C) of the Social*
14 *Security Act (42 U.S.C. 1395y(b)(1)(C)) is amended—*

15 (1) *by redesignating clauses (i) and (ii) as sub-*
16 *clauses (I) and (II), respectively, and indenting ac-*
17 *cordingly;*

18 (2) *by amending the text preceding subclause (I),*
19 *as so redesignated, to read as follows:*

20 “(C) *INDIVIDUALS WITH END STAGE RENAL*
21 *DISEASE.—*

22 “(i) *IN GENERAL.*—*A group health*
23 *plan (as defined in subparagraph*
24 *(A)(v))—”;*

1 (3) *in the matter following subclause (II), as so*
2 *redesignated—*

3 (A) *by striking “clause (i)” and inserting*
4 *“subclause (I)”;*

5 (B) *by striking “clause (ii)” and inserting*
6 *“subclause (II)”;*

7 (C) *by striking “clauses (i) and (ii)” and*
8 *inserting “subclauses (I) and (II)”;* and

9 (D) *in the last sentence, by striking “Effec-*
10 *tive for items” and inserting “Subject to clause*
11 *(ii), effective for items”;* and

12 (4) *by adding at the end the following new*
13 *clause:*

14 “(ii) *SPECIAL RULE FOR LARGE*
15 *GROUP PLANS.—In applying clause (i) to a*
16 *large group health plan (as defined in sub-*
17 *paragraph (B)(iii)). effective for items and*
18 *services furnished on or after January 1,*
19 *2008, (with respect to periods beginning on*
20 *or after the date that is 30 months prior to*
21 *January 1, 2008), subclauses (I) and (II) of*
22 *such clause shall be applied by substituting*
23 *‘42-month’ for ‘12-month’ each place it ap-*
24 *pears.’.*”

1 **SEC. 704. PLAN FOR MEDICARE PAYMENT ADJUSTMENTS**
2 **FOR NEVER EVENTS.**

3 (a) *IN GENERAL.*—The Secretary of Health and
4 Human Services (in this section referred to as the “Sec-
5 retary”) shall develop a plan (in this section referred to
6 as the “never events plan”) to implement, beginning in fis-
7 cal year 2010, a policy to reduce or eliminate payments
8 under title XVIII of the Social Security Act for never events.

9 (b) *NEVER EVENT DEFINED.*—For purposes of this sec-
10 tion, the term “never event” means an event involving the
11 delivery of (or failure to deliver) physicians’ services, inpa-
12 tient or outpatient hospital services, or facility services fur-
13 nished in an ambulatory surgical facility in which there
14 is an error in medical care that is clearly identifiable, usu-
15 ally preventable, and serious in consequences to patients,
16 and that indicates a deficiency in the safety and process
17 controls of the services furnished with respect to the physi-
18 cian, hospital, or ambulatory surgical center involved.

19 (c) *PLAN DETAILS.*—

20 (1) *DEFINING NEVER EVENTS.*—With respect to
21 criteria for identifying never events under the never
22 events plan, the Secretary should consider whether the
23 event meets the following characteristics:

24 (A) *CLEARLY IDENTIFIABLE.*—The event is
25 clearly identifiable and measurable and feasible
26 to include in a reporting system for never events.

1 (B) *USUALLY PREVENTABLE.*—*The event is*
2 *usually preventable taking into consideration*
3 *that, because of the complexity of medical care,*
4 *certain medical events are not always avoidable.*

5 (C) *SERIOUS.*—*The event is serious and*
6 *could result in death or loss of a body part, dis-*
7 *ability, or more than transient loss of a body*
8 *function.*

9 (D) *DEFICIENCY IN SAFETY AND PROCESS*
10 *CONTROLS.*—*The event is indicative of a problem*
11 *in safety systems and process controls used by*
12 *the physician, hospital, or ambulatory surgical*
13 *center involved and is indicative of the reli-*
14 *ability of the quality of services provided by the*
15 *physician, hospital, or ambulatory surgical cen-*
16 *ter, respectively.*

17 (2) *IDENTIFICATION AND PAYMENT ISSUES.*—
18 *With respect to policies under the never events plan*
19 *for identifying and reducing (or eliminating) pay-*
20 *ment for never events, the Secretary shall consider—*

21 (A) *mechanisms used by hospitals and phy-*
22 *sicians in reporting and coding of services that*
23 *would reliably identify never events; and*

24 (B) *modifications in billing and payment*
25 *mechanisms that would enable the Secretary to*

1 *efficiently and accurately reduce or eliminate*
2 *payments for never events.*

3 (3) *PRIORITIES.*—*Under the never events plan*
4 *the Secretary shall identify priorities regarding the*
5 *services to focus on and, among those, the never events*
6 *for which payments should be reduced or eliminated.*

7 (4) *CONSULTATION.*—*In developing the never*
8 *events plan, the Secretary shall consult with affected*
9 *parties that are relevant to payment reductions in re-*
10 *sponse to never events.*

11 (d) *CONGRESSIONAL REPORT.*—*By not later than*
12 *June 1, 2008, the Secretary shall submit a report to Con-*
13 *gress on the never events plan developed under this sub-*
14 *section and shall include in the report recommendations on*
15 *specific methods for implementation of the plan on a timely*
16 *basis.*

17 **SEC. 705. REINSTATEMENT OF RESIDENCY SLOTS.**

18 (a) *IN GENERAL.*—*Section 1886(h) of the Social Secu-*
19 *rity Act (42 U.S.C. 1395ww(h)) is amended—*

20 (1) *in paragraph (4)(H), by adding at the end*
21 *the following new clause:*

22 “(v) *INCREASE IN RESIDENT LIMIT*
23 *DUE TO CLOSURE OF OTHER HOSPITALS.—*
24 *If one or more hospitals with approved*
25 *medical residency training programs, which*

1 are located within the same metropolitan
2 division of the core based statistical area as
3 of January 1, 2001, closed, the Secretary
4 shall increase by not more than 10 (sub-
5 ject to the limitation set forth in the last
6 sentence of this clause) the otherwise appli-
7 cable resident limit under subparagraph (F)
8 for each hospital within the same metropoli-
9 tan division of the core based statistical
10 area that meets all the following criteria:

11 “(I) The hospital is described in
12 subsection (d)(5)(F)(i).

13 “(II) The hospital instituted a
14 medical residency training program in
15 internal medicine that was accredited
16 by the American Osteopathic Associa-
17 tion on or after January 1, 2004.

18 “(III) The hospital had a provider
19 number and a resident limit as of Jan-
20 uary 1, 2000, and remained open as of
21 October 1, 2007.

22 “(IV) The hospital did not receive
23 an increase in its resident limit under
24 paragraph (7)(B).

1 *In no event may the resident limit for any*
2 *hospital be increased above 50 through ap-*
3 *plication of this clause and in no event may*
4 *the total of the residency positions added by*
5 *this clause for all hospitals exceed 10.”; and*

6 *(2) in paragraph (7)—*

7 *(A) by redesignating subparagraph (D) as*
8 *subparagraph (E); and*

9 *(B) by inserting after subparagraph (C) the*
10 *following new subparagraph:*

11 *“(D) ADJUSTMENT BASED ON SETTLED*
12 *COST REPORT.—In the case of a hospital with a*
13 *dual accredited osteopathic and allopathic fam-*
14 *ily practice program for which—*

15 *“(i) the otherwise applicable resident*
16 *limit was reduced under subparagraph*
17 *(A)(i)(I); and*

18 *“(ii) such reduction was based on a*
19 *reference resident level that was determined*
20 *using a cost report and where a revised or*
21 *corrected notice of program reimbursement*
22 *was issued between September 1, 2006 and*
23 *September 15, 2006, whether as a result of*
24 *an appeal or otherwise, and the reference*
25 *resident level under such settled cost report*

1 is higher than the level used for the reduc-
2 tion under subparagraph (A)(i)(I);
3 the Secretary shall apply subparagraph (A)(i)(I)
4 using the higher resident reference level and
5 make any necessary adjustments to such reduc-
6 tion. Any such necessary adjustments shall be ef-
7 fective for portions of cost reporting periods oc-
8 curring on or after July 1, 2005.”.

9 (b) *EFFECTIVE DATES.*—The amendment made by
10 paragraph (1) shall be effective for cost reporting periods
11 beginning on or after October 1, 2007, and the amendments
12 made by paragraph (2) shall take effect as if included in
13 the enactment of section 422 of the Medicare Prescription
14 Drug, Improvement, and Modernization Act of 2003 (Public
15 Law 108–173).

16 **TITLE VIII—MEDICAID**

17 **Subtitle A—Protecting Existing** 18 **Coverage**

19 **SEC. 801. MODERNIZING TRANSITIONAL MEDICAID.**

20 (a) *TWO-YEAR EXTENSION.*—

21 (1) *IN GENERAL.*—Sections 1902(e)(1)(B) and
22 1925(f) of the Social Security Act (42 U.S.C.
23 1396a(e)(1)(B), 1396r–6(f)) are each amended by
24 striking “September 30, 2003” and inserting “Sep-
25 tember 30, 2009”.

1 (2) *EFFECTIVE DATE.*—*The amendments made*
2 *by this subsection shall take effect on October 1, 2007.*

3 (b) *STATE OPTION OF INITIAL 12-MONTH ELIGI-*
4 *BILITY.*—*Section 1925 of the Social Security Act (42 U.S.C.*
5 *1396r–6) is amended—*

6 (1) *in subsection (a)(1), by inserting “but subject*
7 *to paragraph (5)” after “Notwithstanding any other*
8 *provision of this title”;*

9 (2) *by adding at the end of subsection (a) the fol-*
10 *lowing:*

11 “(5) *OPTION OF 12-MONTH INITIAL ELIGIBILITY*
12 *PERIOD.*—*A State may elect to treat any reference in*
13 *this subsection to a 6-month period (or 6 months) as*
14 *a reference to a 12-month period (or 12 months). In*
15 *the case of such an election, subsection (b) shall not*
16 *apply.”; and*

17 (3) *in subsection (b)(1), by inserting “but subject*
18 *to subsection (a)(5)” after “Notwithstanding any*
19 *other provision of this title”.*

20 (c) *REMOVAL OF REQUIREMENT FOR PREVIOUS RE-*
21 *CEIPT OF MEDICAL ASSISTANCE.*—*Section 1925(a)(1) of*
22 *such Act (42 U.S.C. 1396r–6(a)(1)), as amended by sub-*
23 *section (b)(1), is further amended—*

24 (1) *by inserting “subparagraph (B) and” before*
25 *“paragraph (5)”;*

1 (2) by redesignating the matter after “REQUIRE-
2 MENT.—” as a subparagraph (A) with the heading
3 “IN GENERAL.—” and with the same indentation as
4 subparagraph (B) (as added by paragraph (3)); and
5 (3) by adding at the end the following:

6 “(B) STATE OPTION TO WAIVE REQUIRE-
7 MENT FOR 3 MONTHS BEFORE RECEIPT OF MED-
8 ICAL ASSISTANCE.—A State may, at its option,
9 elect also to apply subparagraph (A) in the case
10 of a family that was receiving such aid for fewer
11 than three months or that had applied for and
12 was eligible for such aid for fewer than 3 months
13 during the 6 immediately preceding months de-
14 scribed in such subparagraph.”.

15 (d) CMS REPORT ON ENROLLMENT AND PARTICIPA-
16 TION RATES UNDER TMA.—Section 1925 of such Act (42
17 U.S.C. 1396r-6), as amended by this section, is further
18 amended by adding at the end the following new subsection:

19 “(g) COLLECTION AND REPORTING OF PARTICIPATION
20 INFORMATION.—

21 “(1) COLLECTION OF INFORMATION FROM
22 STATES.—Each State shall collect and submit to the
23 Secretary (and make publicly available), in a format
24 specified by the Secretary, information on average
25 monthly enrollment and average monthly participa-

1 *tion rates for adults and children under this section*
2 *and of the number and percentage of children who be-*
3 *come ineligible for medical assistance under this sec-*
4 *tion whose medical assistance is continued under an-*
5 *other eligibility category or who are enrolled under*
6 *the State's child health plan under title XXI. Such*
7 *information shall be submitted at the same time and*
8 *frequency in which other enrollment information*
9 *under this title is submitted to the Secretary.*

10 *“(2) ANNUAL REPORTS TO CONGRESS.—Using*
11 *the information submitted under paragraph (1), the*
12 *Secretary shall submit to Congress annual reports*
13 *concerning enrollment and participation rates de-*
14 *scribed in such paragraph.”.*

15 *(e) EFFECTIVE DATE.—The amendments made by sub-*
16 *sections (b) through (d) shall take effect on the date of the*
17 *enactment of this Act.*

18 **SEC. 802. FAMILY PLANNING SERVICES.**

19 *(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY*
20 *GROUP.—*

21 *(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of*
22 *the Social Security Act (42 U.S.C.*
23 *1396a(a)(10)(A)(ii)) is amended—*

24 *(A) in subclause (XVIII), by striking “or”*
25 *at the end;*

1 (B) in subclause (XIX), by adding “or” at
2 the end; and

3 (C) by adding at the end the following new
4 subclause:

5 “(XX) who are described in subsection (ee) (re-
6 lating to individuals who meet certain income stand-
7 ards);”.

8 (2) GROUP DESCRIBED.—Section 1902 of the So-
9 cial Security Act (42 U.S.C. 1396a), as amended by
10 section 112(c), is amended by adding at the end the
11 following new subsection:

12 “(ee)(1) Individuals described in this subsection are
13 individuals—

14 “(A) whose income does not exceed an in-
15 come eligibility level established by the State that
16 does not exceed the highest income eligibility
17 level established under the State plan under this
18 title (or under its State child health plan under
19 title XXI) for pregnant women; and

20 “(B) who are not pregnant.

21 “(2) At the option of a State, individuals de-
22 scribed in this subsection may include individuals
23 who are determined to meet the eligibility require-
24 ments referred to in paragraph (1) under the terms,
25 conditions, and procedures applicable to making eligi-

1 *bility determinations for medical assistance under*
2 *this title under a waiver to provide the benefits de-*
3 *scribed in clause (XV) of the matter following sub-*
4 *paragraph (G) of section 1902(a)(10) granted to the*
5 *State under section 1115 as of January 1, 2007.”.*

6 (3) *LIMITATION ON BENEFITS.*—Section
7 *1902(a)(10) of the Social Security Act (42 U.S.C.*
8 *1396a(a)(10)) is amended in the matter following*
9 *subparagraph (G)—*

10 (A) *by striking “and (XIV)” and inserting*
11 *“(XIV)”;* and

12 (B) *by inserting “, and (XV) the medical*
13 *assistance made available to an individual de-*
14 *scribed in subsection (ee) shall be limited to fam-*
15 *ily planning services and supplies described in*
16 *section 1905(a)(4)(C) including medical diag-*
17 *nosis or treatment services that are provided*
18 *pursuant to a family planning service in a fam-*
19 *ily planning setting provided during the period*
20 *in which such an individual is eligible” after*
21 *“cervical cancer”.*

22 (4) *CONFORMING AMENDMENTS.*—Section
23 *1905(a) of the Social Security Act (42 U.S.C.*
24 *1396d(a)) is amended in the matter preceding para-*
25 *graph (1)—*

1 (A) in clause (xii), by striking “or” at the
2 end;

3 (B) in clause (xiii), by adding “or” at the
4 end; and

5 (C) by inserting after clause (xiii) the fol-
6 lowing:

7 “(xiv) individuals described in section
8 1902(ee),”.

9 (b) *PRESUMPTIVE ELIGIBILITY.*—

10 (1) *IN GENERAL.*—*Title XIX of the Social Secu-*
11 *urity Act (42 U.S.C. 1396 et seq.) is amended by in-*
12 *serting after section 1920B the following:*

13 “*PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING*
14 *SERVICES*

15 “*SEC. 1920C. (a) STATE OPTION.*—*State plan ap-*
16 *proved under section 1902 may provide for making medical*
17 *assistance available to an individual described in section*
18 *1902(ee) (relating to individuals who meet certain income*
19 *eligibility standard) during a presumptive eligibility pe-*
20 *riod. In the case of an individual described in section*
21 *1902(ee), such medical assistance shall be limited to family*
22 *planning services and supplies described in 1905(a)(4)(C)*
23 *and, at the State’s option, medical diagnosis or treatment*
24 *services that are provided in conjunction with a family*
25 *planning service in a family planning setting provided*
26 *during the period in which such an individual is eligible.*

1 “(b) *DEFINITIONS.—For purposes of this section:*

2 “(1) *PRESUMPTIVE ELIGIBILITY PERIOD.—The*
3 *term ‘presumptive eligibility period’ means, with re-*
4 *spect to an individual described in subsection (a), the*
5 *period that—*

6 “(A) *begins with the date on which a quali-*
7 *fied entity determines, on the basis of prelimi-*
8 *nary information, that the individual is de-*
9 *scribed in section 1902(ee); and*

10 “(B) *ends with (and includes) the earlier*
11 *of—*

12 “(i) *the day on which a determination*
13 *is made with respect to the eligibility of*
14 *such individual for services under the State*
15 *plan; or*

16 “(ii) *in the case of such an individual*
17 *who does not file an application by the last*
18 *day of the month following the month dur-*
19 *ing which the entity makes the determina-*
20 *tion referred to in subparagraph (A), such*
21 *last day.*

22 “(2) *QUALIFIED ENTITY.—*

23 “(A) *IN GENERAL.—Subject to subpara-*
24 *graph (B), the term ‘qualified entity’ means any*
25 *entity that—*

1 “(i) is eligible for payments under a
2 State plan approved under this title; and

3 “(ii) is determined by the State agency
4 to be capable of making determinations of
5 the type described in paragraph (1)(A).

6 “(B) *RULE OF CONSTRUCTION.*—Nothing in
7 this paragraph shall be construed as preventing
8 a State from limiting the classes of entities that
9 may become qualified entities in order to prevent
10 fraud and abuse.

11 “(c) *ADMINISTRATION.*—

12 “(1) *IN GENERAL.*—The State agency shall pro-
13 vide qualified entities with—

14 “(A) such forms as are necessary for an ap-
15 plication to be made by an individual described
16 in subsection (a) for medical assistance under
17 the State plan; and

18 “(B) information on how to assist such in-
19 dividuals in completing and filing such forms.

20 “(2) *NOTIFICATION REQUIREMENTS.*—A quali-
21 fied entity that determines under subsection (b)(1)(A)
22 that an individual described in subsection (a) is pre-
23 sumptively eligible for medical assistance under a
24 State plan shall—

1 “(A) notify the State agency of the deter-
2 mination within 5 working days after the date
3 on which determination is made; and

4 “(B) inform such individual at the time the
5 determination is made that an application for
6 medical assistance is required to be made by not
7 later than the last day of the month following the
8 month during which the determination is made.

9 “(3) APPLICATION FOR MEDICAL ASSISTANCE.—
10 In the case of an individual described in subsection
11 (a) who is determined by a qualified entity to be pre-
12 sumptively eligible for medical assistance under a
13 State plan, the individual shall apply for medical as-
14 sistance by not later than the last day of the month
15 following the month during which the determination
16 is made.

17 “(d) PAYMENT.—Notwithstanding any other provision
18 of this title, medical assistance that—

19 “(1) is furnished to an individual described in
20 subsection (a)—

21 “(A) during a presumptive eligibility pe-
22 riod;

23 “(B) by a entity that is eligible for pay-
24 ments under the State plan; and

1 “(2) is included in the care and services covered
2 by the State plan, shall be treated as medical assist-
3 ance provided by such plan for purposes of clause (4)
4 of the first sentence of section 1905(b).”.

5 (2) CONFORMING AMENDMENTS.—

6 (A) Section 1902(a)(47) of the Social Secu-
7 rity Act (42 U.S.C. 1396a(a)(47)) is amended by
8 inserting before the semicolon at the end the fol-
9 lowing: “and provide for making medical assist-
10 ance available to individuals described in sub-
11 section (a) of section 1920C during a presump-
12 tive eligibility period in accordance with such
13 section”.

14 (B) Section 1903(u)(1)(D)(v) of such Act
15 (42 U.S.C. 1396b(u)(1)(D)(v)) is amended—

16 (i) by striking “or for” and inserting
17 “for”; and

18 (ii) by inserting before the period the
19 following: “, or for medical assistance pro-
20 vided to an individual described in sub-
21 section (a) of section 1920C during a pre-
22 sumptive eligibility period under such sec-
23 tion”.

24 (e) CLARIFICATION OF COVERAGE OF FAMILY PLAN-
25 NING SERVICES AND SUPPLIES.—Section 1937(b) of the So-

1 *cial Security Act (42 U.S.C. 1396u-7(b)) is amended by*
2 *adding at the end the following:*

3 “(5) *COVERAGE OF FAMILY PLANNING SERVICES*
4 *AND SUPPLIES.—Notwithstanding the previous provi-*
5 *sions of this section, a State may not provide for*
6 *medical assistance through enrollment of an indi-*
7 *vidual with benchmark coverage or benchmark-equiva-*
8 *lent coverage under this section unless such coverage*
9 *includes for any individual described in section*
10 *1905(a)(4)(C), medical assistance for family planning*
11 *services and supplies in accordance with such sec-*
12 *tion.”.*

13 (f) *EFFECTIVE DATE.—The amendments made by this*
14 *section take effect on October 1, 2007.*

15 **SEC. 803. AUTHORITY TO CONTINUE PROVIDING ADULT**
16 **DAY HEALTH SERVICES APPROVED UNDER A**
17 **STATE MEDICAID PLAN.**

18 (a) *IN GENERAL.—During the period described in sub-*
19 *section (b), the Secretary of Health and Human Services*
20 *shall not—*

21 (1) *withhold, suspend, disallow, or otherwise*
22 *deny Federal financial participation under section*
23 *1903(a) of the Social Security Act (42 U.S.C.*
24 *1396b(a)) for the provision of adult day health care*
25 *services, day activity and health services, or adult*

1 *medical day care services, as defined under a State*
 2 *Medicaid plan approved during or before 1994, dur-*
 3 *ing such period if such services are provided con-*
 4 *sistent with such definition and the requirements of*
 5 *such plan; or*

6 *(2) withdraw Federal approval of any such State*
 7 *plan or part thereof regarding the provision of such*
 8 *services (by regulation or otherwise).*

9 *(b) PERIOD DESCRIBED.—The period described in this*
 10 *subsection is the period that begins on November 3, 2005,*
 11 *and ends on March 1, 2009.*

12 **SEC. 804. STATE OPTION TO PROTECT COMMUNITY**
 13 **SPOUSES OF INDIVIDUALS WITH DISABIL-**
 14 **ITIES.**

15 *Section 1924(h)(1)(A) of the Social Security Act (42*
 16 *U.S.C. 1396r-5(h)(1)(A)) is amended by striking “is de-*
 17 *scribed in section 1902(a)(10)(A)(i)(VI)” and inserting “is*
 18 *being provided medical assistance for home and commu-*
 19 *nity-based services under subsection (c), (d), (e), (i), or (j)*
 20 *of section 1915 or pursuant to section 1115”.*

21 **SEC. 805. COUNTY MEDICAID HEALTH INSURING ORGANIZA-**
 22 **TIONS .**

23 *(a) IN GENERAL.—Section 9517(c)(3) of the Consoli-*
 24 *dated Omnibus Budget Reconciliation Act of 1985 (42*
 25 *U.S.C. 1396b note), as added by section 4734 of the Omni-*

1 “(4) *FISCAL YEARS 2009 THROUGH 2012 FOR CER-*
2 *TAIN INSULAR AREAS.—The amounts otherwise deter-*
3 *mined under this subsection for Puerto Rico, the Vir-*
4 *gin Islands, Guam, the Northern Mariana Islands,*
5 *and American Samoa for fiscal years 2009 through*
6 *2012 shall be increased by the following amounts:*

7 “(A) *PUERTO RICO.—For Puerto Rico,*
8 *\$250,000,000 for fiscal year 2009, \$350,000,000*
9 *for fiscal year 2010, \$500,000,000 for fiscal year*
10 *2011, and \$600,000,000 for fiscal year 2012.*

11 “(B) *VIRGIN ISLANDS.—For the Virgin Is-*
12 *lands, \$5,000,000 for each of fiscal years 2009*
13 *through 2012.*

14 “(C) *GUAM.—For Guam, \$5,000,000 for*
15 *each of fiscal years 2009 through 2012.*

16 “(D) *NORTHERN MARIANA ISLANDS.—For*
17 *the Northern Mariana Islands, \$4,000,000 for*
18 *each of fiscal years 2009 through 2012.*

19 “(E) *AMERICAN SAMOA.—For American*
20 *Samoa, \$4,000,000 for each of fiscal years 2009*
21 *through 2012.*

22 *Such amounts shall not be taken into account in ap-*
23 *plying paragraph (2) for fiscal years 2009 through*
24 *2012 but shall be taken into account in applying such*

1 *paragraph for fiscal year 2013 and subsequent fiscal*
2 *years.”.*

3 ***(b) REMOVAL OF FEDERAL MATCHING PAYMENTS FOR***
4 ***IMPROVING DATA REPORTING SYSTEMS FROM THE OVER-***
5 ***ALL LIMIT ON PAYMENTS TO TERRITORIES UNDER TITLE***
6 ***XIX.—Such section is further amended by adding at the***
7 ***end the following new paragraph:***

8 ***“(5) EXCLUSION OF CERTAIN EXPENDITURES***
9 ***FROM PAYMENT LIMITS.—With respect to fiscal year***
10 ***2008 and each fiscal year thereafter, if Puerto Rico,***
11 ***the Virgin Islands, Guam, the Northern Mariana Is-***
12 ***lands, or American Samoa qualify for a payment***
13 ***under subparagraph (A)(i) or (B) of section***
14 ***1903(a)(3) for a calendar quarter of such fiscal year***
15 ***with respect to expenditures for improvements in data***
16 ***reporting systems described in such subparagraph, the***
17 ***limitation on expenditures under title XIX for such***
18 ***commonwealth or territory otherwise determined***
19 ***under subsection (f) and this subsection for such fiscal***
20 ***year shall be determined without regard to payment***
21 ***for such expenditures.”.***

22 ***SEC. 812. MEDICAID DRUG REBATE.***

23 ***(a) BRAND.—Paragraph (1)(B)(i) of section 1927(c)***
24 ***of the Social Security Act (42 U.S.C. 1396r–8(c)) is amend-***
25 ***ed—***

1 (1) *by striking “and” at the end of subclause*
2 *(IV);*

3 (2) *in subclause (V)—*

4 (A) *by inserting “and before January 1,*
5 *2008,” after “December 31, 1995,”; and*

6 (B) *by striking the period at the end and*
7 *inserting “; and”; and*

8 (3) *by adding at the end the following new sub-*
9 *clause:*

10 *“(VI) after December 31, 2007, is*
11 *20.1 percent.”.*

12 ***(b) PBMS TO BEST PRICE DEFINITION.—***

13 (1) *IN GENERAL.—Section 1927(c)(1)(C)(ii)(I) of*
14 *the Social Security Act (42 U.S.C. 1396r–*
15 *8(c)(1)(C)(ii)(I)) is amended—*

16 (A) *by striking “and” before “rebates”; and*

17 (B) *by inserting before the semicolon at the*
18 *end the following: “, and rebates, discounts, and*
19 *other price concessions to pharmaceutical benefit*
20 *managers (PBMs)”.*

21 (2) *EFFECTIVE DATE.—The amendments made*
22 *by paragraph (1) shall apply to calendar quarters be-*
23 *ginning on or after January 1, 2008.*

1 **SEC. 813. ADJUSTMENT IN COMPUTATION OF MEDICAID**
2 **FMAP TO DISREGARD AN EXTRAORDINARY**
3 **EMPLOYER PENSION CONTRIBUTION.**

4 (a) *IN GENERAL.*—Only for purposes of computing the
5 Federal medical assistance percentage under section
6 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) for
7 a State for a fiscal year (beginning with fiscal year 2006),
8 any significantly disproportionate employer pension con-
9 tribution described in subsection (b) shall be disregarded in
10 computing the per capita income of such State, but shall
11 not be disregarded in computing the per capita income for
12 the continental United States (and Alaska) and Hawaii.

13 (b) *SIGNIFICANTLY DISPROPORTIONATE EMPLOYER*
14 *PENSION CONTRIBUTION.*—For purposes of subsection (a),
15 a significantly disproportionate employer pension contribu-
16 tion described in this subsection with respect to a State for
17 a fiscal year is an employer contribution towards pensions
18 that is allocated to such State for a period if the aggregate
19 amount so allocated exceeds 25 percent of the total increase
20 in personal income in that State for the period involved.

21 **SEC. 814. MORATORIUM ON CERTAIN PAYMENT RESTRIC-**
22 **TIONS.**

23 Notwithstanding any other provision of law, the Sec-
24 retary of Health and Human Services shall not, prior to
25 the date that is 1 year after the date of enactment of this
26 Act, take any action (through promulgation of regulation,

1 *issuance of regulatory guidance, use of federal payment*
2 *audit procedures, or other administrative action, policy, or*
3 *practice, including a Medical Assistance Manual trans-*
4 *mittal or letter to State Medicaid directors) to restrict cov-*
5 *erage or payment under title XIX of the Social Security*
6 *Act for rehabilitation services, or school-based administra-*
7 *tion, transportation, or medical services if such restrictions*
8 *are more restrictive in any aspect than those applied to*
9 *such coverage or payment as of July 1, 2007.*

10 **SEC. 815. TENNESSEE DSH.**

11 *The DSH allotments for Tennessee for each fiscal year*
12 *beginning with fiscal year 2008 under subsection (f)(3) of*
13 *section 1923 of the Social Security Act (42 U.S.C.*
14 *13961396r-4) are deemed to be \$30,000,000. The Secretary*
15 *of Health and Human Services may impose a limitation*
16 *on the total amount of payments made to hospitals under*
17 *the TennCare Section 1115 waiver only to the extent that*
18 *such limitation is necessary to ensure that a hospital does*
19 *not receive payment in excess of the amounts described in*
20 *subsection (f) of such section or as necessary to ensure that*
21 *the waiver remains budget neutral.*

22 **SEC. 816. CLARIFICATION TREATMENT OF REGIONAL MED-**
23 **ICAL CENTER.**

24 *(a) IN GENERAL.—Nothing in section 1903(w) of the*
25 *Social Security Act (42 U.S.C. 1396b(w)) shall be construed*

1 *by the Secretary of Health and Human Services as prohib-*
2 *iting a State's use of funds as the non-Federal share of ex-*
3 *penditures under title XIX of such Act where such funds*
4 *are transferred from or certified by a publicly-owned re-*
5 *gional medical center located in another State and de-*
6 *scribed in subsection (b), so long as the Secretary deter-*
7 *mines that such use of funds is proper and in the interest*
8 *of the program under title XIX.*

9 **(b) CENTER DESCRIBED.**—*A center described in this*
10 *subsection is a publicly-owned regional medical center*
11 *that—*

12 (1) *provides level 1 trauma and burn care serv-*
13 *ices;*

14 (2) *provides level 3 neonatal care services;*

15 (3) *is obligated to serve all patients, regardless of*
16 *ability to pay;*

17 (4) *is located within a Standard Metropolitan*
18 *Statistical Area (SMSA) that includes at least 3*
19 *States;*

20 (5) *provides services as a tertiary care provider*
21 *for patients residing within a 125-mile radius; and*

22 (6) *meets the criteria for a disproportionate*
23 *share hospital under section 1923 of such Act (42*
24 *U.S.C. 1396r-4) in at least one State other than the*
25 *State in which the center is located.*

1 ***Subtitle C—Miscellaneous***

2 ***SEC. 821. DEMONSTRATION PROJECT FOR EMPLOYER BUY-***

3 ***IN.***

4 *Title XXI of the Social Security Act, as amended by*
 5 *section 133(a)(1), is further amended by adding at the end*
 6 *the following new section:*

7 ***“SEC. 2112. DEMONSTRATION PROJECT FOR EMPLOYER***

8 ***BUY-IN.***

9 *“(a) AUTHORITY.—*

10 *“(1) IN GENERAL.—The Secretary shall establish*
 11 *a demonstration project under which up to 10 States*
 12 *(each referred to in this section as a ‘participating*
 13 *State’) that meets the conditions of paragraph (2)*
 14 *may provide, under its State child health plan (not-*
 15 *withstanding section 2102(b)(3)(C)) for a period of 5*
 16 *years, for child health assistance in relation to family*
 17 *coverage described in subsection (d) for children who*
 18 *would be targeted low-income children but for cov-*
 19 *erage as beneficiaries under a group health plan as*
 20 *the children of participants by virtue of a qualifying*
 21 *employer’s contribution under subsection (b)(2).*

22 *“(2) CONDITIONS.—The conditions described in*
 23 *this paragraph for a State are as follows:*

24 *“(A) NO WAITING LISTS.—The State does*
 25 *not impose any waiting list, enrollment cap, or*

1 *similar limitation on enrollment of targeted low-*
2 *income children under the State child health*
3 *plan.*

4 “(B) *ELIGIBILITY OF ALL CHILDREN UNDER*
5 *200 PERCENT OF POVERTY LINE.—The State is*
6 *applying an income eligibility level under sec-*
7 *tion 2110(b)(1)(B)(ii)(I) that is at least 200 per-*
8 *cent of the poverty line.*

9 “(3) *QUALIFYING EMPLOYER DEFINED.—In this*
10 *section, the term ‘qualifying employer’ means an em-*
11 *ployer that has a majority of its workforce composed*
12 *of full-time workers with family incomes reasonably*
13 *estimated by the employer (based on wage informa-*
14 *tion available to the employer) at or below 200 per-*
15 *cent of the poverty line. In applying the previous sen-*
16 *tence, two part-time workers shall be treated as a sin-*
17 *gle full-time worker.*

18 “(b) *FUNDING.—A demonstration project under this*
19 *section in a participating State shall be funded, with re-*
20 *spect to assistance provided to children described in sub-*
21 *section (a)(1), consistent with the following:*

22 “(1) *LIMITED FAMILY CONTRIBUTION.—The fam-*
23 *ily involved shall be responsible for providing pay-*
24 *ment towards the premium for such assistance of such*
25 *amount as the State may specify, except that the lim-*

1 *itations on cost-sharing (including premiums) under*
2 *paragraphs (2) and (3) of section 2103(e) shall apply*
3 *to all cost-sharing of such family under this section.*

4 “(2) *MINIMUM EMPLOYER CONTRIBUTION.—The*
5 *qualifying employer involved shall be responsible for*
6 *providing payment to the State child health plan in*
7 *the State of at least 50 percent of the portion of the*
8 *cost (as determined by the State) of the family cov-*
9 *erage in which the employer is enrolling the family*
10 *that exceeds the amount of the family contribution*
11 *under paragraph (1) applied towards such coverage.*

12 “(3) *LIMITATION ON FEDERAL FINANCIAL PAR-*
13 *TICIPATION.—In no case shall the Federal financial*
14 *participation under section 2105 with respect to a*
15 *demonstration project under this section be made for*
16 *any portion of the costs of family coverage described*
17 *in subsection (d) (including the costs of administra-*
18 *tion of such coverage) that are not attributable to*
19 *children described in subsection (a)(1).*

20 “(c) *UNIFORM ELIGIBILITY RULES.—In providing as-*
21 *sistance under a demonstration project under this section—*

22 “(1) *a State shall establish uniform rules of eli-*
23 *gibility for families to participate; and*

1 “(2) a State shall not permit a qualifying em-
2 ployer to select, within those families that meet such
3 eligibility rules, which families may participate.

4 “(d) *TERMS AND CONDITIONS.*—*The family coverage*
5 *offered to families of qualifying employers under a dem-*
6 *onstrations project under this section in a State shall be the*
7 *same as the coverage and benefits provided under the State*
8 *child health plan in the State for targeted low-income chil-*
9 *ren with the highest family income level permitted.”.*

10 **SEC. 822. DIABETES GRANTS.**

11 *Section 2104 of the Social Security Act (42 U.C.C*
12 *1397dd), as amended by section 101, is further amended—*

13 (1) *in subsection (a)(11), by inserting before the*
14 *period at the end the following: “plus for fiscal year*
15 *2009 the total of the amount specified in subsection*
16 *(j)”;* and

17 (2) *by adding at the end the following new sub-*
18 *section:*

19 “(j) *FUNDING FOR DIABETES GRANTS.*—*From the*
20 *amounts appropriated under subsection (a)(11), for fiscal*
21 *year 2009 from the amounts—*

22 (1) *\$150,000,000 is hereby transferred and*
23 *made available in such fiscal year for grants under*
24 *section 330B of the Public Health Service Act; and*

1 *Law 108–173) is repealed and the provisions of law amend-*
2 *ed by such subtitle are restored as if such subtitle had never*
3 *been enacted.*

4 **SEC. 903. REPEAL OF COMPARATIVE COST ADJUSTMENT**
5 **(CCA) PROGRAM.**

6 *Section 1860C–1 of the Social Security Act (42 U.S.C.*
7 *1395w–29), as added by section 241(a) of the Medicare Pre-*
8 *scription Drug, Improvement, and Modernization Act of*
9 *2003 (Public Law 108–173), is repealed.*

10 **SEC. 904. COMPARATIVE EFFECTIVENESS RESEARCH.**

11 *(a) IN GENERAL.—Part A of title XVIII of the Social*
12 *Security Act is amended by adding at the end the following*
13 *new section:*

14 *“COMPARATIVE EFFECTIVENESS RESEARCH*

15 *“SEC. 1822. (a) CENTER FOR COMPARATIVE EFFEC-*
16 *TIVENESS RESEARCH ESTABLISHED.—*

17 *“(1) IN GENERAL.—The Secretary shall establish*
18 *within the Agency of Healthcare Research and Qual-*
19 *ity a Center for Comparative Effectiveness Research*
20 *(in this section referred to as the ‘Center’) to conduct,*
21 *support, and synthesize research (including research*
22 *conducted or supported under section 1013 of the*
23 *Medicare Prescription Drug, Improvement, and Mod-*
24 *ernization Act of 2003) with respect to the outcomes,*
25 *effectiveness, and appropriateness of health care serv-*
26 *ices and procedures in order to identify the manner*

1 *in which diseases, disorders, and other health condi-*
2 *tions can most effectively and appropriately be pre-*
3 *vented, diagnosed, treated, and managed clinically.*

4 “(2) *DUTIES.—The Center shall—*

5 “(A) *conduct, support, and synthesize re-*
6 *search relevant to the comparative clinical effec-*
7 *tiveness of the full spectrum of health care treat-*
8 *ments, including pharmaceuticals, medical de-*
9 *VICES, medical and surgical procedures, and other*
10 *medical interventions;*

11 “(B) *conduct and support systematic re-*
12 *views of clinical research, including original re-*
13 *search conducted subsequent to the date of the en-*
14 *actment of this section;*

15 “(C) *use methodologies such as randomized*
16 *controlled clinical trials as well as other various*
17 *types of clinical research, such as observational*
18 *studies;*

19 “(D) *submit to the Comparative Effective-*
20 *ness Research Commission, the Secretary, and*
21 *Congress appropriate relevant reports described*
22 *in subsection (d)(2);*

23 “(E) *encourage, as appropriate, the develop-*
24 *ment and use of clinical registries and the devel-*
25 *opment of clinical effectiveness research data net-*

1 works from electronic health records, post mar-
2 keting drug and medical device surveillance ef-
3 forts, and other forms of electronic health data;
4 and

5 “(F) not later than 180 days after the date
6 of the enactment of this section, develop methodo-
7 logical standards to be used when conducting
8 studies of comparative clinical effectiveness and
9 value (and procedures for use of such standards)
10 in order to help ensure accurate and effective
11 comparisons and update such standards at least
12 biennially.

13 “(b) *OVERSIGHT BY COMPARATIVE EFFECTIVENESS*
14 *RESEARCH COMMISSION.*—

15 “(1) *IN GENERAL.*—The Secretary shall establish
16 an independent Comparative Effectiveness Research
17 Commission (in this section referred to as the ‘Com-
18 mission’) to oversee and evaluate the activities carried
19 out by the Center under subsection (a) to ensure such
20 activities result in highly credible research and infor-
21 mation resulting from such research.

22 “(2) *DUTIES.*—The Commission shall—

23 “(A) determine national priorities for re-
24 search described in subsection (a) and in making

1 *such determinations consult with patients and*
2 *health care providers and payers;*

3 “(B) *monitor the appropriateness of use of*
4 *the CERTF described in subsection (f) with re-*
5 *spect to the timely production of comparative ef-*
6 *fectiveness research determined to be a national*
7 *priority under subparagraph (A);*

8 “(C) *identify highly credible research meth-*
9 *ods and standards of evidence for such research*
10 *to be considered by the Center;*

11 “(D) *review and approve the methodological*
12 *standards (and updates to such standards) devel-*
13 *oped by the Center under subsection (a)(2)(F);*

14 “(E) *enter into an arrangement under*
15 *which the Institute of Medicine of the National*
16 *Academy of Sciences shall conduct an evaluation*
17 *and report on standards of evidence for such re-*
18 *search;*

19 “(F) *support forums to increase stakeholder*
20 *awareness and permit stakeholder feedback on*
21 *the efforts of the Agency of Healthcare Research*
22 *and Quality to advance methods and standards*
23 *that promote highly credible research;*

24 “(G) *make recommendations for public data*
25 *access policies of the Center that would allow for*

1 *access of such data by the public while ensuring*
2 *the information produced from research involved*
3 *is timely and credible;*

4 “(H) appoint a clinical perspective advi-
5 sory panel for each research priority determined
6 under subparagraph (A), which shall frame the
7 specific research inquiry to be examined with re-
8 spect to such priority to ensure that the informa-
9 tion produced from such research is clinically
10 relevant to decisions made by clinicians and pa-
11 tients at the point of care;

12 “(I) make recommendations for the priority
13 for periodic reviews of previous comparative ef-
14 fectiveness research and studies conducted by the
15 Center under subsection (a);

16 “(J) routinely review processes of the Center
17 with respect to such research to confirm that the
18 information produced by such research is objec-
19 tive, credible, consistent with standards of evi-
20 dence established under this section, and devel-
21 oped through a transparent process that includes
22 consultations with appropriate stakeholders;

23 “(K) at least annually, provide guidance or
24 recommendations to health care providers and
25 consumers for the use of information on the com-

1 *parative effectiveness of health care services by*
2 *consumers, providers (as defined for purposes of*
3 *regulations promulgated under section 264(c) of*
4 *the Health Insurance Portability and Account-*
5 *ability Act of 1996) and public and private pur-*
6 *chasers;*

7 *“(L) make recommendations for a strategy*
8 *to disseminate the findings of research conducted*
9 *and supported under this section that enables cli-*
10 *nicians to improve performance, consumers to*
11 *make more informed health care decisions, and*
12 *payers to set medical policies that improve qual-*
13 *ity and value;*

14 *“(M) provide for the public disclosure of rel-*
15 *evant reports described in subsection (d)(2); and*

16 *“(N) submit to Congress an annual report*
17 *on the progress of the Center in achieving na-*
18 *tional priorities determined under subparagraph*
19 *(A) for the provision of credible comparative ef-*
20 *fectiveness information produced from such re-*
21 *search to all interested parties.*

22 *“(3) COMPOSITION OF COMMISSION.—*

23 *“(A) IN GENERAL.—The members of the*
24 *Commission shall consist of—*

1 “(i) *the Director of the Agency for*
2 *Healthcare Research and Quality;*

3 “(ii) *the Chief Medical Officer of the*
4 *Centers for Medicare & Medicaid Services;*
5 *and*

6 “(iii) *up to 15 additional members*
7 *who shall represent broad constituencies of*
8 *stakeholders including clinicians, patients,*
9 *researchers, third-party payers, consumers*
10 *of Federal and State beneficiary programs.*

11 “(B) *QUALIFICATIONS.—*

12 “(i) *DIVERSE REPRESENTATION OF*
13 *PERSPECTIVES.—The members of the Com-*
14 *mission shall represent a broad range of*
15 *perspectives and shall collectively have expe-*
16 *rience in the following areas:*

17 “(I) *Epidemiology.*

18 “(II) *Health services research.*

19 “(III) *Bioethics.*

20 “(IV) *Decision sciences.*

21 “(V) *Economics.*

22 “(ii) *DIVERSE REPRESENTATION OF*
23 *HEALTH CARE COMMUNITY.—At least one*
24 *member shall represent each of the following*
25 *health care communities:*

1 “(I) *Consumers.*

2 “(II) *Practicing physicians, in-*
3 *cluding surgeons.*

4 “(III) *Employers.*

5 “(IV) *Public payers.*

6 “(V) *Insurance plans.*

7 “(VI) *Clinical researchers who*
8 *conduct research on behalf of pharma-*
9 *ceutical or device manufacturers.*

10 “(4) *APPOINTMENT.—The Comptroller General of*
11 *the United States, in consultation with the chairs of*
12 *the committees of jurisdiction of the House of Rep-*
13 *resentatives and the Senate, shall appoint the mem-*
14 *bers of the Commission.*

15 “(5) *CHAIRMAN; VICE CHAIRMAN.—The Comp-*
16 *troller General of the United States shall designate a*
17 *member of the Commission, at the time of appoint-*
18 *ment of the member, as Chairman and a member as*
19 *Vice Chairman for that term of appointment, except*
20 *that in the case of vacancy of the Chairmanship or*
21 *Vice Chairmanship, the Comptroller General may*
22 *designate another member for the remainder of that*
23 *member’s term.*

24 “(6) *TERMS.—*

1 “(A) *IN GENERAL.*—*Except as provided in*
2 *subparagraph (B), each member of the Commis-*
3 *sion shall be appointed for a term of 4 years.*

4 “(B) *TERMS OF INITIAL APPOINTEES.*—*Of*
5 *the members first appointed—*

6 “(i) *10 shall be appointed for a term*
7 *of 4 years; and*

8 “(ii) *9 shall be appointed for a term of*
9 *3 years.*

10 “(7) *COORDINATION.*—*To enhance effectiveness*
11 *and coordination, the Comptroller General is encour-*
12 *aged, to the greatest extent possible, to seek coordina-*
13 *tion between the Commission and the National Advi-*
14 *sory Council of the Agency for Healthcare Research*
15 *and Quality.*

16 “(8) *CONFLICTS OF INTEREST.*—*In appointing*
17 *the members of the Commission or a clinical perspec-*
18 *tive advisory panel described in paragraph (2)(H),*
19 *the Comptroller General of the United States or the*
20 *Commission, respectively, shall take into consider-*
21 *ation any financial conflicts of interest.*

22 “(9) *COMPENSATION.*—*While serving on the busi-*
23 *ness of the Commission (including traveltime), a*
24 *member of the Commission shall be entitled to com-*
25 *penensation at the per diem equivalent of the rate pro-*

1 *vided for level IV of the Executive Schedule under sec-*
2 *tion 5315 of title 5, United States Code; and while so*
3 *servng away from home and the member's regular*
4 *place of business, a member may be allowed travel ex-*
5 *penses, as authorized by the Director of the Commis-*
6 *sion.*

7 *“(10) AVAILABILITY OF REPORTS.—The Commis-*
8 *sion shall transmit to the Secretary a copy of each re-*
9 *port submitted under this subsection and shall make*
10 *such reports available to the public.*

11 *“(11) DIRECTOR AND STAFF; EXPERTS AND CON-*
12 *SULTANTS.—Subject to such review as the Secretary,*
13 *in consultation with the Comptroller General deems*
14 *necessary to assure the efficient administration of the*
15 *Commission, the Commission may—*

16 *“(A) employ and fix the compensation of an*
17 *Executive Director (subject to the approval of the*
18 *Secretary, in consultation with the Comptroller*
19 *General) and such other personnel as may be*
20 *necessary to carry out its duties (without regard*
21 *to the provisions of title 5, United States Code,*
22 *governing appointments in the competitive serv-*
23 *ice);*

24 *“(B) seek such assistance and support as*
25 *may be required in the performance of its duties*

1 *from appropriate Federal departments and agen-*
2 *cies;*

3 “(C) *enter into contracts or make other ar-*
4 *rangements, as may be necessary for the conduct*
5 *of the work of the Commission (without regard*
6 *to section 3709 of the Revised Statutes (41*
7 *U.S.C. 5));*

8 “(D) *make advance, progress, and other*
9 *payments which relate to the work of the Com-*
10 *mission;*

11 “(E) *provide transportation and subsistence*
12 *for persons serving without compensation; and*

13 “(F) *prescribe such rules and regulations as*
14 *it deems necessary with respect to the internal*
15 *organization and operation of the Commission.*

16 “(12) *POWERS.—*

17 “(A) *OBTAINING OFFICIAL DATA.—The*
18 *Commission may secure directly from any de-*
19 *partment or agency of the United States infor-*
20 *mation necessary to enable it to carry out this*
21 *section. Upon request of the Executive Director,*
22 *the head of that department or agency shall fur-*
23 *nish that information to the Commission on an*
24 *agreed upon schedule.*

1 “(B) *DATA COLLECTION.*—*In order to carry*
2 *out its functions, the Commission shall—*

3 “(i) *utilize existing information, both*
4 *published and unpublished, where possible,*
5 *collected and assessed either by its own staff*
6 *or under other arrangements made in ac-*
7 *cordance with this section,*

8 “(ii) *carry out, or award grants or*
9 *contracts for, original research and experi-*
10 *mentation, where existing information is*
11 *inadequate, and*

12 “(iii) *adopt procedures allowing any*
13 *interested party to submit information for*
14 *the Commission’s use in making reports*
15 *and recommendations.*

16 “(C) *ACCESS OF GAO TO INFORMATION.*—
17 *The Comptroller General shall have unrestricted*
18 *access to all deliberations, records, and non-*
19 *proprietary data of the Commission, imme-*
20 *diately upon request.*

21 “(D) *PERIODIC AUDIT.*—*The Commission*
22 *shall be subject to periodic audit by the Comp-*
23 *troller General.*

1 “(c) *RESEARCH REQUIREMENTS.*—Any research con-
2 ducted, supported, or synthesized under this section shall
3 meet the following requirements:

4 “(1) *ENSURING TRANSPARENCY, CREDIBILITY,*
5 *AND ACCESS.*—

6 “(A) *The establishment of the agenda and*
7 *conduct of the research shall be insulated from*
8 *inappropriate political or stakeholder influence.*

9 “(B) *Methods of conducting such research*
10 *shall be scientifically based.*

11 “(C) *All aspects of the prioritization of re-*
12 *search, conduct of the research, and development*
13 *of conclusions based on the research shall be*
14 *transparent to all stakeholders.*

15 “(D) *The process and methods for con-*
16 *ducting such research shall be publicly docu-*
17 *mented and available to all stakeholders.*

18 “(E) *Throughout the process of such re-*
19 *search, the Center shall provide opportunities for*
20 *all stakeholders involved to review and provide*
21 *comment on the methods and findings of such re-*
22 *search.*

23 “(2) *USE OF CLINICAL PERSPECTIVE ADVISORY*
24 *PANELS.*—*The research shall meet a national research*
25 *priority determined under subsection (b)(2)(A) and*

1 *shall examine the specific research inquiry framed by*
2 *the clinical perspective advisory panel for the na-*
3 *tional research priority.*

4 “(3) *STAKEHOLDER INPUT.—The priorities of*
5 *the research, the research, and the dissemination of*
6 *the research shall involve the consultation of patients,*
7 *health care providers, and health care consumer rep-*
8 *resentatives through transparent mechanisms rec-*
9 *ommended by the Commission.*

10 “(d) *PUBLIC ACCESS TO COMPARATIVE EFFECTIVE-*
11 *NESS INFORMATION.—*

12 “(1) *IN GENERAL.—Not later than 90 days after*
13 *receipt by the Center or Commission, as applicable, of*
14 *a relevant report described in paragraph (2) made by*
15 *the Center, Commission, or clinical perspective advi-*
16 *sory panel under this section, appropriate informa-*
17 *tion contained in such report shall be posted on the*
18 *official public Internet site of the Center and of the*
19 *Commission, as applicable.*

20 “(2) *RELEVANT REPORTS DESCRIBED.—For pur-*
21 *poses of this section, a relevant report is each of the*
22 *following submitted by a grantee or contractor of the*
23 *Center:*

24 “(A) *An interim progress report.*

1 “(B) *A draft final comparative effectiveness*
2 *review.*

3 “(C) *A final progress report on new re-*
4 *search submitted for publication by a peer re-*
5 *view journal.*

6 “(D) *Stakeholder comments.*

7 “(E) *A final report.*

8 “(3) *ACCESS BY CONGRESS AND THE COMMIS-*
9 *SION TO THE CENTER’S INFORMATION.—Congress and*
10 *the Commission shall each have unrestricted access to*
11 *all deliberations, records, and nonproprietary data of*
12 *the Center, immediately upon request.*

13 “(e) *DISSEMINATION AND INCORPORATION OF COM-*
14 *PARATIVE EFFECTIVENESS INFORMATION.—*

15 “(1) *DISSEMINATION.—The Center shall provide*
16 *for the dissemination of appropriate findings pro-*
17 *duced by research supported, conducted, or syn-*
18 *thesized under this section to health care providers,*
19 *patients, vendors of health information technology fo-*
20 *ocused on clinical decision support, appropriate profes-*
21 *sional associations, and Federal and private health*
22 *plans.*

23 “(2) *INCORPORATION.—The Center shall assist*
24 *users of health information technology focused on clin-*
25 *ical decision support to promote the timely incorpora-*

1 *tion of the findings described in paragraph (1) into*
2 *clinical practices and to promote the ease of use of*
3 *such incorporation.*

4 *“(f) REPORTS TO CONGRESS.—*

5 *“(1) ANNUAL REPORTS.—Beginning not later*
6 *than one year after the date of the enactment of this*
7 *section, the Director of the Agency of Healthcare Re-*
8 *search and Quality and the Commission shall submit*
9 *to Congress an annual report on the activities of the*
10 *Center and the Commission, as well as the research,*
11 *conducted under this section.*

12 *“(2) RECOMMENDATION FOR FAIR SHARE PER*
13 *CAPITA AMOUNT FOR ALL-PAYER FINANCING.—Begin-*
14 *ning not later than December 31, 2009, the Secretary*
15 *shall submit to Congress an annual recommendation*
16 *for a fair share per capita amount described in sub-*
17 *section (c)(1) of section 9511 of the Internal Revenue*
18 *Code of 1986 for purposes of funding the CERTF*
19 *under such section.*

20 *“(3) ANALYSIS AND REVIEW.—Not later than De-*
21 *cember 31, 2011, the Secretary, in consultation with*
22 *the Commission, shall submit to Congress a report on*
23 *all activities conducted or supported under this sec-*
24 *tion as of such date. Such report shall include an*
25 *evaluation of the return on investment resulting from*

1 *such activities, the overall costs of such activities, and*
2 *an analysis of the backlog of any research proposals*
3 *approved by the Commission but not funded. Such re-*
4 *port shall also address whether Congress should ex-*
5 *pand the responsibilities of the Center and of the*
6 *Commission to include studies of the effectiveness of*
7 *various aspects of the health care delivery system, in-*
8 *cluding health plans and delivery models, such as*
9 *health plan features, benefit designs and performance,*
10 *and the ways in which health services are organized,*
11 *managed, and delivered.*

12 “(g) *COORDINATING COUNCIL FOR HEALTH SERVICES*
13 *RESEARCH.*—

14 “(1) *ESTABLISHMENT.*—*The Secretary shall es-*
15 *tablish a permanent council (in this section referred*
16 *to as the ‘Council’) for the purpose of—*

17 “(A) *assisting the offices and agencies of the*
18 *Department of Health and Human Services, the*
19 *Department of Veterans Affairs, the Department*
20 *of Defense, and any other Federal department or*
21 *agency to coordinate the conduct or support of*
22 *health services research; and*

23 “(B) *advising the President and Congress*
24 *on—*

1 “(i) *the national health services re-*
2 *search agenda;*

3 “(ii) *strategies with respect to infra-*
4 *structure needs of health services research;*
5 *and*

6 “(iii) *appropriate organizational ex-*
7 *penditures in health services research by rel-*
8 *evant Federal departments and agencies.*

9 “(2) *MEMBERSHIP.—*

10 “(A) *NUMBER AND APPOINTMENT.—The*
11 *Council shall be composed of 20 members. One*
12 *member shall be the Director of the Agency for*
13 *Healthcare Research and Quality. The Director*
14 *shall appoint the other members not later than*
15 *30 days after the enactment of this Act.*

16 “(B) *TERMS.—*

17 “(i) *IN GENERAL.—Except as provided*
18 *in clause (ii), each member of the Council*
19 *shall be appointed for a term of 4 years.*

20 “(ii) *TERMS OF INITIAL AP-*
21 *POINTEES.—Of the members first ap-*
22 *pointed—*

23 “(I) *8 shall be appointed for a*
24 *term of 4 years; and*

1 “(II) 7 shall be appointed for a
2 term of 3 years.

3 “(iii) VACANCIES.—Any vacancies
4 shall not affect the power and duties of the
5 Council and shall be filled in the same
6 manner as the original appointment.

7 “(C) QUALIFICATIONS.—

8 “(i) IN GENERAL.—The members of the
9 Council shall include one senior official
10 from each of the following agencies:

11 “(I) The Veterans Health Admin-
12 istration.

13 “(II) The Department of Defense
14 Military Health Care System.

15 “(III) The Centers for Disease
16 Control and Prevention.

17 “(IV) The National Center for
18 Health Statistics.

19 “(V) The National Institutes of
20 Health.

21 “(VI) The Center for Medicare &
22 Medicaid Services.

23 “(VII) The Federal Employees
24 Health Benefits Program.

1 “(ii) NATIONAL, PHILANTHROPIC
2 FOUNDATIONS.—The members of the Council
3 shall include 4 senior leaders from major
4 national, philanthropic foundations that
5 fund and use health services research.

6 “(iii) STAKEHOLDERS.—The remain-
7 ing members of the Council shall be rep-
8 resentatives of other stakeholders in health
9 services research, including private pur-
10 chasers, health plans, hospitals and other
11 health facilities, and health consumer
12 groups.

13 “(3) ANNUAL REPORT.—The Council shall sub-
14 mit to Congress an annual report on the progress of
15 the implementation of the national health services re-
16 search agenda.

17 “(h) FUNDING OF COMPARATIVE EFFECTIVENESS RE-
18 SEARCH.—For fiscal year 2008 and each subsequent fiscal
19 year, amounts in the Comparative Effectiveness Research
20 Trust Fund (referred to in this section as the ‘CERTF’)
21 under section 9511 of the Internal Revenue Code of 1986
22 shall be available to the Secretary to carry out this sec-
23 tion.”.

24 (b) COMPARATIVE EFFECTIVENESS RESEARCH TRUST
25 FUND; FINANCING FOR TRUST FUND.—

1 (1) *ESTABLISHMENT OF TRUST FUND.*—

2 (A) *IN GENERAL.*—Subchapter A of chapter
3 98 of the Internal Revenue Code of 1986 (relat-
4 ing to trust fund code) is amended by adding at
5 the end the following new section:

6 **“SEC. 9511. HEALTH CARE COMPARATIVE EFFECTIVENESS**
7 **RESEARCH TRUST FUND.**

8 “(a) *CREATION OF TRUST FUND.*—There is established
9 in the Treasury of the United States a trust fund to be
10 known as the ‘Health Care Comparative Effectiveness Re-
11 search Trust Fund’ (hereinafter in this section referred to
12 as the ‘CERTF’), consisting of such amounts as may be ap-
13 propriated or credited to such Trust Fund as provided in
14 this section and section 9602(b).

15 “(b) *TRANSFERS TO FUND.*—There are hereby appro-
16 priated to the Trust Fund the following:

17 “(1) For fiscal year 2008, \$90,000,000.

18 “(2) For fiscal year 2009, \$100,000,000.

19 “(3) For fiscal year 2010, \$110,000,000.

20 “(4) For each fiscal year beginning with fiscal
21 year 2011—

22 “(A) an amount equivalent to the net reve-
23 nues received in the Treasury from the fees im-
24 posed under subchapter B of chapter 34 (relating

1 to fees on health insurance and self-insured
2 plans) for such fiscal year; and

3 “(B) subject to subsection (c)(2), amounts
4 determined by the Secretary of Health and
5 Human Services to be equivalent to the fair
6 share per capita amount computed under sub-
7 section (c)(1) for the fiscal year multiplied by
8 the average number of individuals entitled to
9 benefits under part A, or enrolled under part B,
10 of title XVIII of the Social Security Act during
11 such fiscal year.

12 The amounts appropriated under paragraphs (1), (2), (3),
13 and (4)(B) shall be transferred from the Federal Hospital
14 Insurance Trust Fund and from the Federal Supple-
15 mentary Medical Insurance Trust Fund (established under
16 section 1841 of such Act), and from the Medicare Prescrip-
17 tion Drug Account within such Trust Fund, in proportion
18 (as estimated by the Secretary) to the total expenditures
19 during such fiscal year that are made under title XVIII
20 of such Act from the respective trust fund or account.

21 “(c) FAIR SHARE PER CAPITA AMOUNT.—

22 “(1) COMPUTATION.—

23 “(A) IN GENERAL.—Subject to subpara-
24 graph (B), the fair share per capita amount
25 under this paragraph for a fiscal year (begin-

1 ning with fiscal year 2011) is an amount com-
2 puted by the Secretary of Health and Human
3 Services for such fiscal year that, when applied
4 under this section and subchapter B of chapter
5 34 of the Internal Revenue Code of 1986, will re-
6 sult in revenues to the CERTF of \$375,000,000
7 for the fiscal year.

8 “(B) ALTERNATIVE COMPUTATION.—

9 “(i) IN GENERAL.—If the Secretary is
10 unable to compute the fair share per capita
11 amount under subparagraph (A) for a fiscal
12 year, the fair share per capita amount
13 under this paragraph for the fiscal year
14 shall be the default amount determined
15 under clause (ii) for the fiscal year.

16 “(ii) DEFAULT AMOUNT.—The default
17 amount under this clause for—

18 “(I) fiscal year 2011 is equal to
19 \$2; or

20 “(II) a subsequent year is equal to
21 the default amount under this clause
22 for the preceeding fiscal year increased
23 by the annual percentage increase in
24 the medical care component of the con-
25 sumer price index (United States city

1 *average) for the 12-month period end-*
2 *ing with April of the preceding fiscal*
3 *year.*

4 *Any amount determined under subclause*
5 *(II) shall be rounded to the nearest penny.*

6 “(2) *LIMITATION ON MEDICARE FUNDING.—In no*
7 *case shall the amount transferred under subsection*
8 *(b)(4)(B) for any fiscal year exceed \$90,000,000.*

9 “(d) *EXPENDITURES FROM FUND.—*

10 “(1) *IN GENERAL.—Subject to paragraph (2),*
11 *amounts in the CERTF are available to the Secretary*
12 *of Health and Human Services for carrying out sec-*
13 *tion 1822 of the Social Security Act.*

14 “(2) *ALLOCATION FOR COMMISSION.—Not less*
15 *than the following amounts in the CERTF for a fiscal*
16 *year shall be available to carry out the activities of*
17 *the Comparative Effectiveness Research Commission*
18 *established under section 1822(b) of the Social Secu-*
19 *rity Act for such fiscal year:*

20 “(A) *For fiscal year 2008, \$7,000,000.*

21 “(B) *For fiscal year 2009, \$9,000,000.*

22 “(C) *For each fiscal year beginning with*
23 *2010, \$10,000,000.*

24 *Nothing in this paragraph shall be construed as pre-*
25 *venting additional amounts in the CERTF from*

1 *being made available to the Comparative Effectiveness*
 2 *Research Commission for such activities.*

3 “(e) *NET REVENUES.*—*For purposes of this section, the*
 4 *term ‘net revenues’ means the amount estimated by the Sec-*
 5 *retary based on the excess of—*

6 “(1) *the fees received in the Treasury under sub-*
 7 *chapter B of chapter 34, over*

8 “(2) *the decrease in the tax imposed by chapter*
 9 *1 resulting from the fees imposed by such sub-*
 10 *chapter.”.*

11 (B) *CLERICAL AMENDMENT.*—*The table of*
 12 *sections for such subchapter A is amended by*
 13 *adding at the end thereof the following new item:*

“*Sec. 9511. Health Care Comparative Effectiveness Research Trust Fund.*”.

14 (2) *FINANCING FOR FUND FROM FEES ON IN-*
 15 *SURED AND SELF-INSURED HEALTH PLANS.*—

16 (A) *GENERAL RULE.*—*Chapter 34 of the In-*
 17 *ternal Revenue Code of 1986 is amended by add-*
 18 *ing at the end the following new subchapter:*

19 **“Subchapter B—Insured and Self-Insured**
 20 **Health Plans**

“*Sec. 4375. Health insurance.*

“*Sec. 4376. Self-insured health plans*

“*Sec. 4377. Definitions and special rules*

21 **“SEC. 4375. HEALTH INSURANCE.**

22 “(a) *IMPOSITION OF FEE.*—*There is hereby imposed*
 23 *on each specified health insurance policy for each policy*

1 *year a fee equal to the fair share per capita amount deter-*
2 *mined under section 9511(c)(1) multiplied by the average*
3 *number of lives covered under the policy.*

4 “(b) *LIABILITY FOR FEE.*—*The fee imposed by sub-*
5 *section (a) shall be paid by the issuer of the policy.*

6 “(c) *SPECIFIED HEALTH INSURANCE POLICY.*—*For*
7 *purposes of this section—*

8 “(1) *IN GENERAL.*—*Except as otherwise provided*
9 *in this section, the term ‘specified health insurance*
10 *policy’ means any accident or health insurance policy*
11 *issued with respect to individuals residing in the*
12 *United States.*

13 “(2) *EXEMPTION OF CERTAIN POLICIES.*—*The*
14 *term ‘specified health insurance policy’ does not in-*
15 *clude any insurance policy if substantially all of the*
16 *coverage provided under such policy relates to—*

17 “(A) *liabilities incurred under workers’*
18 *compensation laws,*

19 “(B) *tort liabilities,*

20 “(C) *liabilities relating to ownership or use*
21 *of property,*

22 “(D) *credit insurance,*

23 “(E) *medicare supplemental coverage, or*

24 “(F) *such other similar liabilities as the*
25 *Secretary may specify by regulations.*

1 “(3) *TREATMENT OF PREPAID HEALTH COV-*
2 *ERAGE ARRANGEMENTS.—*

3 “(A) *IN GENERAL.—In the case of any ar-*
4 *rangement described in subparagraph (B)—*

5 “(i) *such arrangement shall be treated*
6 *as a specified health insurance policy, and*

7 “(ii) *the person referred to in such sub-*
8 *paragraph shall be treated as the issuer.*

9 “(B) *DESCRIPTION OF ARRANGEMENTS.—*

10 *An arrangement is described in this subpara-*
11 *graph if under such arrangement fixed payments*
12 *or premiums are received as consideration for*
13 *any person’s agreement to provide or arrange for*
14 *the provision of accident or health coverage to*
15 *residents of the United States, regardless of how*
16 *such coverage is provided or arranged to be pro-*
17 *vided.*

18 **“SEC. 4376. SELF-INSURED HEALTH PLANS.**

19 “(a) *IMPOSITION OF FEE.—In the case of any applica-*
20 *ble self-insured health plan for each plan year, there is here-*
21 *by imposed a fee equal to the fair share per capita amount*
22 *determined under section 9511(c)(1) multiplied by the aver-*
23 *age number of lives covered under the plan.*

24 “(b) *LIABILITY FOR FEE.—*

1 “(1) *IN GENERAL.*—*The fee imposed by sub-*
2 *section (a) shall be paid by the plan sponsor.*

3 “(2) *PLAN SPONSOR.*—*For purposes of para-*
4 *graph (1) the term ‘plan sponsor’ means—*

5 “(A) *the employer in the case of a plan es-*
6 *tablished or maintained by a single employer,*

7 “(B) *the employee organization in the case*
8 *of a plan established or maintained by an em-*
9 *ployee organization,*

10 “(C) *in the case of—*

11 “(i) *a plan established or maintained*
12 *by 2 or more employers or jointly by 1 or*
13 *more employers and 1 or more employee or-*
14 *ganizations,*

15 “(ii) *a multiple employer welfare ar-*
16 *rangement, or*

17 “(iii) *a voluntary employees’ bene-*
18 *ficiary association described in section*
19 *501(c)(9),*

20 *the association, committee, joint board of trust-*
21 *ees, or other similar group of representatives of*
22 *the parties who establish or maintain the plan,*
23 *or*

24 “(D) *the cooperative or association de-*
25 *scribed in subsection (c)(2)(F) in the case of a*

1 *plan established or maintained by such a cooper-*
2 *ative or association.*

3 “(c) *APPLICABLE SELF-INSURED HEALTH PLAN.*—

4 *For purposes of this section, the term ‘applicable self-in-*
5 *sured health plan’ means any plan for providing accident*
6 *or health coverage if—*

7 “(1) *any portion of such coverage is provided*
8 *other than through an insurance policy, and*

9 “(2) *such plan is established or maintained—*

10 “(A) *by one or more employers for the ben-*
11 *efit of their employees or former employees,*

12 “(B) *by one or more employee organizations*
13 *for the benefit of their members or former mem-*
14 *bers,*

15 “(C) *jointly by 1 or more employers and 1*
16 *or more employee organizations for the benefit of*
17 *employees or former employees,*

18 “(D) *by a voluntary employees’ beneficiary*
19 *association described in section 501(c)(9),*

20 “(E) *by any organization described in sec-*
21 *tion 501(c)(6), or*

22 “(F) *in the case of a plan not described in*
23 *the preceding subparagraphs, by a multiple em-*
24 *ployer welfare arrangement (as defined in sec-*
25 *tion 3(40) of Employee Retirement Income Secu-*

1 *rity Act of 1974), a rural electric cooperative (as*
2 *defined in section 3(40)(B)(iv) of such Act), or*
3 *a rural telephone cooperative association (as de-*
4 *defined in section 3(40)(B)(v) of such Act).*

5 **“SEC. 4377. DEFINITIONS AND SPECIAL RULES.**

6 *“(a) DEFINITIONS.—For purposes of this subchapter—*

7 *“(1) ACCIDENT AND HEALTH COVERAGE.—The*
8 *term ‘accident and health coverage’ means any cov-*
9 *erage which, if provided by an insurance policy,*
10 *would cause such policy to be a specified health insur-*
11 *ance policy (as defined in section 4375(c)).*

12 *“(2) INSURANCE POLICY.—The term ‘insurance*
13 *policy’ means any policy or other instrument whereby*
14 *a contract of insurance is issued, renewed, or ex-*
15 *tended.*

16 *“(3) UNITED STATES.—The term ‘United States’*
17 *includes any possession of the United States.*

18 *“(b) TREATMENT OF GOVERNMENTAL ENTITIES.—*

19 *“(1) IN GENERAL.—For purposes of this sub-*
20 *chapter—*

21 *“(A) the term ‘person’ includes any govern-*
22 *mental entity, and*

23 *“(B) notwithstanding any other law or rule*
24 *of law, governmental entities shall not be exempt*

1 *from the fees imposed by this subchapter except*
2 *as provided in paragraph (2).*

3 “(2) *TREATMENT OF EXEMPT GOVERNMENTAL*
4 *PROGRAMS.—In the case of an exempt governmental*
5 *program, no fee shall be imposed under section 4375*
6 *or section 4376 on any covered life under such pro-*
7 *gram.*

8 “(3) *EXEMPT GOVERNMENTAL PROGRAM DE-*
9 *FINED.—For purposes of this subchapter, the term ‘ex-*
10 *empt governmental program’ means—*

11 “(A) *any insurance program established*
12 *under title XVIII of the Social Security Act,*

13 “(B) *the medical assistance program estab-*
14 *lished by title XIX or XXI of the Social Security*
15 *Act,*

16 “(C) *any program established by Federal*
17 *law for providing medical care (other than*
18 *through insurance policies) to individuals (or the*
19 *spouses and dependents thereof) by reason of*
20 *such individuals being—*

21 “(i) *members of the Armed Forces of*
22 *the United States, or*

23 “(ii) *veterans, and*

24 “(D) *any program established by Federal*
25 *law for providing medical care (other than*

1 *through insurance policies) to members of Indian*
 2 *tribes (as defined in section 4(d) of the Indian*
 3 *Health Care Improvement Act).*

4 “(c) *TREATMENT AS TAX.—For purposes of subtitle F,*
 5 *the fees imposed by this subchapter shall be treated as if*
 6 *they were taxes.*

7 “(d) *NO COVER OVER TO POSSESSIONS.—Notwith-*
 8 *standing any other provision of law, no amount collected*
 9 *under this subchapter shall be covered over to any posses-*
 10 *sion of the United States.”*

11 *(B) CLERICAL AMENDMENTS.—*

12 *(i) Chapter 34 of such Code is amend-*
 13 *ed by striking the chapter heading and in-*
 14 *serting the following:*

15 **“CHAPTER 34—TAXES ON CERTAIN**
 16 **INSURANCE POLICIES**

“SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

“SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

17 **“Subchapter A—Policies Issued By Foreign**
 18 **Insurers”.**

19 *(ii) The table of chapters for subtitle D*
 20 *of such Code is amended by striking the*
 21 *item relating to chapter 34 and inserting*
 22 *the following new item:*

“CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES”.

1 (C) *EFFECTIVE DATE.*—*The amendments*
2 *made by this subsection shall apply with respect*
3 *to policies and plans for portions of policy or*
4 *plan years beginning on or after October 1,*
5 *2010.*

6 **SEC. 905. IMPLEMENTATION OF HEALTH INFORMATION**
7 **TECHNOLOGY (IT) UNDER MEDICARE.**

8 (a) *IN GENERAL.*—*Not later than January 1, 2010,*
9 *the Secretary of Health and Human Services shall submit*
10 *to Congress a report that includes—*

11 (1) *a plan to develop and implement a health in-*
12 *formation technology (health IT) system for all health*
13 *care providers under the Medicare program that*
14 *meets the specifications described in subsection (b);*
15 *and*

16 (2) *an analysis of the impact, feasibility, and*
17 *costs associated with the use of health information*
18 *technology in medically underserved communities.*

19 (b) *PLAN SPECIFICATION.*—*The specifications de-*
20 *scribed in this subsection, with respect to a health informa-*
21 *tion technology system described in subsection (a), are the*
22 *following:*

23 (1) *The system protects the privacy and security*
24 *of individually identifiable health information.*

1 (2) *The system maintains and provides per-*
2 *mitted access to health information in an electronic*
3 *format (such as through computerized patient records*
4 *or a clinical data repository).*

5 (3) *The system utilizes interface software that al-*
6 *lows for interoperability.*

7 (4) *The system includes clinical decision sup-*
8 *port.*

9 (5) *The system incorporates e-prescribing and*
10 *computerized physician order entry.*

11 (6) *The system incorporates patient tracking and*
12 *reminders.*

13 (7) *The system utilizes technology that is open*
14 *source (if available) or technology that has been devel-*
15 *oped by the government.*

16 *The report shall include an analysis of the financial and*
17 *administrative resources necessary to develop such system*
18 *and recommendations regarding the level of subsidies need-*
19 *ed for all such health care providers to adopt the system.*

20 **SEC. 906. DEVELOPMENT, REPORTING, AND USE OF HEALTH**
21 **CARE MEASURES.**

22 (a) *IN GENERAL.*—*Part E of title XVIII of the Social*
23 *Security Act (42 U.S.C. 1395x et seq.) is amended by insert-*
24 *ing after section 1889 the following:*

1 “(4) endorsing national consensus health care
2 measures; and

3 “(5) advancing the use of electronic health
4 records for automating the collection, aggregation,
5 and transmission of measurement information.

6 “(c) *REQUIREMENTS DESCRIBED.*—For purposes of
7 subsection (a), the requirements described in this subsection,
8 with respect to an organization, are the following:

9 “(1) *PRIVATE NONPROFIT.*—The organization is
10 a private nonprofit entity governed by a board and
11 an individual designated as president and chief execu-
12 tive officer.

13 “(2) *BOARD MEMBERSHIP.*—The members of the
14 board of the organization include representatives of—

15 “(A) health care providers or groups rep-
16 resenting such providers;

17 “(B) health plans or groups representing
18 health plans;

19 “(C) groups representing health care con-
20 sumers;

21 “(D) health care purchasers and employers
22 or groups representing such purchasers or em-
23 ployers; and

24 “(E) health care practitioners or groups
25 representing practitioners.

1 “(3) *OTHER MEMBERSHIP REQUIREMENTS.*—*The*
2 *membership of the organization is representative of*
3 *individuals with experience with—*

4 “(A) *urban health care issues;*

5 “(B) *safety net health care issues;*

6 “(C) *rural and frontier health care issues;*

7 *and*

8 “(D) *health care quality and safety issues.*

9 “(4) *OPEN AND TRANSPARENT.*—*With respect to*
10 *matters related to the arrangement described in sub-*
11 *section (a), the organization conducts its business in*
12 *an open and transparent manner and provides the*
13 *opportunity for public comment.*

14 “(5) *VOLUNTARY CONSENSUS STANDARDS SET-*
15 *TING ORGANIZATION.*—*The organization operates as a*
16 *voluntary consensus standards setting organization as*
17 *defined for purposes of section 12(d) of the National*
18 *Technology Transfer and Advancement Act of 1995*
19 *(Public Law 104–113) and Office of Management and*
20 *Budget Revised Circular A–119 (published in the*
21 *Federal Register on February 10, 1998).*

22 “(6) *EXPERIENCE.*—*The organization has at*
23 *least 7 years experience in establishing national con-*
24 *sensus standards.*

1 “(d) *REQUIREMENTS FOR HEALTH CARE MEAS-*
2 *URES.—In carrying out its duties under subsection (b), the*
3 *designated organization shall ensure the following:*

4 “(1) *MEASURES.—The designated organization*
5 *shall ensure that the measures established or endorsed*
6 *under subsection (b) are evidence-based, reliable, and*
7 *valid; and include—*

8 “(A) *measures of clinical processes and out-*
9 *comes, patient experience, efficiency, and equity;*

10 “(B) *measures to assess effectiveness, timeli-*
11 *ness, patient self-management, patient*
12 *centeredness, and safety; and*

13 “(C) *measures of under use and over use.*

14 “(2) *PRIORITIES.—*

15 “(A) *IN GENERAL.—The designated organi-*
16 *zation shall ensure that priority is given to es-*
17 *tablishing and endorsing—*

18 “(i) *measures with the greatest poten-*
19 *tial impact for improving the effectiveness*
20 *and efficiency of health care;*

21 “(ii) *measures that may be rapidly*
22 *implemented by group health plans, health*
23 *insurance issuers, physicians, hospitals,*
24 *nursing homes, long-term care providers,*
25 *and other providers;*

1 “(iii) measures which may inform
2 health care decisions made by consumers
3 and patients; and

4 “(iv) measures that apply to multiple
5 services furnished by different providers
6 during an episode of care.

7 “(B) ANNUAL REPORT ON PRIORITIES; SEC-
8 RETARIAL PUBLICATION AND COMMENT.—

9 “(i) ANNUAL REPORT.—The designated
10 organization shall issue and submit to the
11 Secretary a report by March 31 of each
12 year (beginning with 2009) on the organi-
13 zation’s recommendations for priorities and
14 goals in establishing and endorsing health
15 care measures under this section over the
16 next five years.

17 “(ii) SECRETARIAL REVIEW AND COM-
18 MENT.—After receipt of the report under
19 clause (i) for a year, the Secretary shall
20 publish the report in the Federal Register,
21 including any comments of the Secretary on
22 the priorities and goals set forth in the re-
23 port.

24 “(3) RISK ADJUSTMENT.—The designated orga-
25 nization, in consultation with health care measure de-

1 *velopers and other stakeholders, shall establish proce-*
2 *dures to assure that health care measures established*
3 *and endorsed under this section account for dif-*
4 *ferences in patient health status, patient characteris-*
5 *tics, and geographic location, as appropriate.*

6 “(4) *MAINTENANCE.*—*The designated organiza-*
7 *tion, in consultation with owners and developers of*
8 *health care measures, shall require the owners or de-*
9 *velopers of such measures to update and enhance such*
10 *measures, including the development of more accurate*
11 *and precise specifications, and retire existing out-*
12 *dated measures. Such updating shall occur not more*
13 *often than once during each 12-month period, except*
14 *in the case of emergent circumstances requiring a*
15 *more immediate update to a measure.*

16 “(e) *USE OF HEALTH CARE MEASURES; REPORT-*
17 *ING.*—

18 “(1) *USE OF MEASURES.*—*For purposes of ac-*
19 *tivities authorized or required under this title, the*
20 *Secretary shall select from health care measures—*

21 “(A) *recommended by multi-stakeholder*
22 *groups; and*

23 “(B) *endorsed by the designated organiza-*
24 *tion under subsection (b)(4).*

1 “(2) *REPORTING.*—*The Secretary shall imple-*
2 *ment procedures, consistent with generally accepted*
3 *standards, to enable the Department of Health and*
4 *Human Services to accept the electronic submission of*
5 *data for purposes of—*

6 “(A) *effectiveness measurement using the*
7 *health care measures developed pursuant to this*
8 *section; and*

9 “(B) *reporting to the Secretary measures*
10 *used to make value-based payments under this*
11 *title.*

12 “(f) *CONTRACTS.*—*The Secretary, acting through the*
13 *Agency for Healthcare Research and Quality, may contract*
14 *with organizations to support the development and testing*
15 *of health care measures meeting the standards established*
16 *by the designated organization.*

17 “(g) *DISSEMINATION OF INFORMATION.*—*In order to*
18 *make information on health care measures available to*
19 *health care consumers, health professionals, public health of-*
20 *ficials, oversight organizations, researchers, and other ap-*
21 *propriate individuals and entities, the Secretary shall work*
22 *with multi-stakeholder groups to provide for the dissemina-*
23 *tion of information developed pursuant to this title.*

24 “(h) *FUNDING.*—*For purposes of carrying out sub-*
25 *sections (a), (b), (c), and (d), including for expenses in-*

1 *curred for the arrangement under subsection (a) with the*
 2 *designated organization, there is payable from the Federal*
 3 *Hospital Insurance Trust Fund (established under section*
 4 *1817) and the Federal Supplementary Medical Insurance*
 5 *Trust Fund (established under section 1841)—*

6 “(1) for fiscal year 2008, \$15,000,000, multiplied
 7 by the ratio of the total number of months in the year
 8 to the number of months (and portions of months) of
 9 such year during which the arrangement under sub-
 10 section (a) is effective; and

11 “(2) for each of the fiscal years, 2009 through
 12 2012, \$15,000,000.”.

13 **SEC. 907. IMPROVEMENTS TO THE MEDIGAP PROGRAM.**

14 (a) *IMPLEMENTATION OF NAIC RECOMMENDA-*
 15 *TIONS.—The Secretary of Health and Human Services shall*
 16 *provide, under subsections (p)(1)(E) of section 1882 of the*
 17 *Social Security Act (42 U.S.C. 1395s), for implementation*
 18 *of the changes in the NAIC model law and regulations rec-*
 19 *ommended by the National Association of Insurance Com-*
 20 *missioners in its Model #651 (“Model Regulation to Imple-*
 21 *ment the NAIC Medicare Supplement Insurance Minimum*
 22 *Standards Model Act”) on March 11, 2007, as modified to*
 23 *reflect the changes made under this Act. In carrying out*
 24 *the previous sentence, the benefit packages classified as “K”*
 25 *and “L” shall be eliminated and such NAIC recommenda-*

1 *tions shall be treated as having been adopted by such Asso-*
 2 *ciation as of January 1, 2008.*

3 *(b) REQUIRED OFFERING OF A RANGE OF POLICIES.—*

4 *(1) IN GENERAL.—Subsection (o) of such section*
 5 *is amended by adding at the end the following new*
 6 *paragraph:*

7 *“(4) In addition to the requirement of paragraph*
 8 *(2), the issuer of the policy must make available to*
 9 *the individual at least medicare supplemental policies*
 10 *with benefit packages classified as ‘C’ or ‘F’.”.*

11 *(2) EFFECTIVE DATE.—The amendment made by*
 12 *paragraph (1) shall apply to medicare supplemental*
 13 *policies issued on or after January 1, 2008.*

14 *(c) REMOVAL OF NEW BENEFIT PACKAGES.—Such sec-*
 15 *tion is further amended—*

16 *(1) in subsection (o)(1), by striking “(p), (v),*
 17 *and (w)” and inserting “(p) and (v)”;*

18 *(2) in subsection (v)(3)(A)(i), by striking “or a*
 19 *benefit package described in subparagraph (A) or (B)*
 20 *of subsection (w)(2)”;* and

21 *(3) in subsection (w)—*

22 *(A) by striking “POLICIES” and all that fol-*
 23 *lows through “The Secretary” and inserting*
 24 *“POLICIES.—The Secretary”;*

25 *(B) by striking the second sentence; and*

1 (C) by striking paragraph (2).

2 **SEC. 908. IMPLEMENTATION FUNDING.**

3 For purposes of implementing the provisions of this
4 Act (other than title X), the Secretary of Health and
5 Human Services shall provide for the transfer, from the
6 Federal Supplementary Medical Insurance Trust Fund es-
7 tablished under section 1841 of the Social Security Act (42
8 U.S.C. 1395t), of \$40,000,000 to the Centers for Medicare
9 & Medicaid Services Program Management Account for fis-
10 cal year 2008.

11 **TITLE X—REVENUES**

12 **SEC. 1001. INCREASE IN RATE OF EXCISE TAXES ON TO-**
13 **BACCO PRODUCTS AND CIGARETTE PAPERS**
14 **AND TUBES.**

15 (a) *SMALL CIGARETTES.*—Paragraph (1) of section
16 5701(b) of the Internal Revenue Code of 1986 is amended
17 by striking “\$19.50 per thousand (\$17 per thousand on
18 cigarettes removed during 2000 or 2001)” and inserting
19 “\$42 per thousand”.

20 (b) *LARGE CIGARETTES.*—Paragraph (2) of section
21 5701(b) of such Code is amended by striking “\$40.95 per
22 thousand (\$35.70 per thousand on cigarettes removed dur-
23 ing 2000 or 2001)” and inserting “\$88.20 per thousand”.

24 (c) *SMALL CIGARS.*—Paragraph (1) of section 5701(a)
25 of such Code is amended by striking “\$1.828 cents per thou-

1 *sand (\$1.594 cents per thousand on cigars removed during*
2 *2000 or 2001)” and inserting “\$42 per thousand”.*

3 (d) *LARGE CIGARS.*—Paragraph (2) of section 5701(a)
4 *of such Code is amended—*

5 (1) *by striking “20.719 percent (18.063 percent*
6 *on cigars removed during 2000 or 2001)” and insert-*
7 *ing “44.63 percent”, and*

8 (2) *by striking “\$48.75 per thousand (\$42.50 per*
9 *thousand on cigars removed during 2000 or 2001)”*
10 *and inserting “\$1 per cigar”.*

11 (e) *CIGARETTE PAPERS.*—Subsection (c) of section
12 *5701 of such Code is amended by striking “1.22 cents (1.06*
13 *cents on cigarette papers removed during 2000 or 2001)”*
14 *and inserting “2.63 cents”.*

15 (f) *CIGARETTE TUBES.*—Subsection (d) of section 5701
16 *of such Code is amended by striking “2.44 cents (2.13 cents*
17 *on cigarette tubes removed during 2000 or 2001)” and in-*
18 *serting “5.26 cents”.*

19 (g) *SNUFF.*—Paragraph (1) of section 5701(e) of such
20 *Code is amended by striking “58.5 cents (51 cents on snuff*
21 *removed during 2000 or 2001)” and inserting “\$1.26”.*

22 (h) *CHEWING TOBACCO.*—Paragraph (2) of section
23 *5701(e) of such Code is amended by striking “19.5 cents*
24 *(17 cents on chewing tobacco removed during 2000 or*
25 *2001)” and inserting “42 cents”.*

1 (i) *PIPE TOBACCO.*—Subsection (f) of section 5701 of
2 such Code is amended by striking “\$1.0969 cents (95.67
3 cents on pipe tobacco removed during 2000 or 2001)” and
4 inserting “\$2.36”.

5 (j) *ROLL-YOUR-OWN TOBACCO.*—

6 (1) *IN GENERAL.*—Subsection (g) of section 5701
7 of such Code is amended by striking “\$1.0969 cents
8 (95.67 cents on roll-your-own tobacco removed during
9 2000 or 2001)” and inserting “\$7.4667”.

10 (2) *INCLUSION OF CIGAR TOBACCO.*—Subsection
11 (o) of section 5702 of such Code is amended by insert-
12 ing “or cigars, or for use as wrappers for making ci-
13 gars” before the period at the end.

14 (k) *EFFECTIVE DATE.*—The amendments made by this
15 section shall apply to articles removed after December 31,
16 2007.

17 (l) *FLOOR STOCKS TAXES.*—

18 (1) *IMPOSITION OF TAX.*—On cigarettes manu-
19 factured in or imported into the United States which
20 are removed before January 1, 2008, and held on such
21 date for sale by any person, there is hereby imposed
22 a tax in an amount equal to the excess of—

23 (A) the tax which would be imposed under
24 section 5701 of the Internal Revenue Code of

1 1986 on the article if the article had been re-
2 moved on such date, over

3 (B) the prior tax (if any) imposed under
4 section 5701 of such Code on such article.

5 (2) *AUTHORITY TO EXEMPT CIGARETTES HELD*
6 *IN VENDING MACHINES.*—To the extent provided in
7 regulations prescribed by the Secretary, no tax shall
8 be imposed by paragraph (1) on cigarettes held for re-
9 tail sale on January 1, 2008, by any person in any
10 vending machine. If the Secretary provides such a
11 benefit with respect to any person, the Secretary may
12 reduce the \$500 amount in paragraph (3) with re-
13 spect to such person.

14 (3) *CREDIT AGAINST TAX.*—Each person shall be
15 allowed as a credit against the taxes imposed by
16 paragraph (1) an amount equal to \$500. Such credit
17 shall not exceed the amount of taxes imposed by para-
18 graph (1) for which such person is liable.

19 (4) *LIABILITY FOR TAX AND METHOD OF PAY-*
20 *MENT.*—

21 (A) *LIABILITY FOR TAX.*—A person holding
22 cigarettes on January 1, 2008, to which any tax
23 imposed by paragraph (1) applies shall be liable
24 for such tax.

1 (B) *METHOD OF PAYMENT.*—*The tax im-*
2 *posed by paragraph (1) shall be paid in such*
3 *manner as the Secretary shall prescribe by regu-*
4 *lations.*

5 (C) *TIME FOR PAYMENT.*—*The tax imposed*
6 *by paragraph (1) shall be paid on or before*
7 *April 14, 2008.*

8 (5) *ARTICLES IN FOREIGN TRADE ZONES.*—
9 *Notwithstanding the Act of June 18, 1934 (48 Stat.*
10 *998, 19 U.S.C. 81a) and any other provision of law,*
11 *any article which is located in a foreign trade zone*
12 *on January 1, 2008, shall be subject to the tax im-*
13 *posed by paragraph (1) if—*

14 (A) *internal revenue taxes have been deter-*
15 *mined, or customs duties liquidated, with respect*
16 *to such article before such date pursuant to a re-*
17 *quest made under the 1st proviso of section 3(a)*
18 *of such Act, or*

19 (B) *such article is held on such date under*
20 *the supervision of a customs officer pursuant to*
21 *the 2d proviso of such section 3(a).*

22 (6) *DEFINITIONS.*—*For purposes of this sub-*
23 *section—*

24 (A) *IN GENERAL.*—*Terms used in this sub-*
25 *section which are also used in section 5702 of the*

1 *Internal Revenue Code of 1986 shall have the re-*
2 *spective meanings such terms have in such sec-*
3 *tion.*

4 (B) *SECRETARY.*—*The term “Secretary”*
5 *means the Secretary of the Treasury or the Sec-*
6 *retary’s delegate.*

7 (7) *CONTROLLED GROUPS.*—*Rules similar to the*
8 *rules of section 5061(e)(3) of such Code shall apply*
9 *for purposes of this subsection.*

10 (8) *OTHER LAWS APPLICABLE.*—*All provisions of*
11 *law, including penalties, applicable with respect to*
12 *the taxes imposed by section 5701 of such Code shall,*
13 *insofar as applicable and not inconsistent with the*
14 *provisions of this subsection, apply to the floor stocks*
15 *taxes imposed by paragraph (1), to the same extent*
16 *as if such taxes were imposed by such section 5701.*
17 *The Secretary may treat any person who bore the ul-*
18 *timite burden of the tax imposed by paragraph (1)*
19 *as the person to whom a credit or refund under such*
20 *provisions may be allowed or made.*

21 **SEC. 1002. EXEMPTION FOR EMERGENCY MEDICAL SERV-**
22 **ICES TRANSPORTATION.**

23 (a) *IN GENERAL.*—*Subsection (l) of section 4041 of the*
24 *Internal Revenue Code of 1986 is amended to read as fol-*
25 *lows:*

1 “(l) *EXEMPTION FOR CERTAIN USES.*—

2 “(1) *CERTAIN AIRCRAFT.*—No tax shall be im-
3 posed under this section on any liquid sold for use in,
4 or used in, a helicopter or a fixed-wing aircraft for
5 purposes of providing transportation with respect to
6 which the requirements of subsection (f) or (g) of sec-
7 tion 4261 are met.

8 “(2) *EMERGENCY MEDICAL SERVICES.*—No tax
9 shall be imposed under this section on any liquid sold
10 for use in, or used in, any ambulance for purposes of
11 providing transportation for emergency medical serv-
12 ices. The preceding sentence shall not apply to any
13 liquid used after December 31, 2012.”.

14 (b) *FUELS NOT USED FOR TAXABLE PURPOSES.*—Sec-
15 tion 6427 of such Code is amended by inserting after sub-
16 section (e) the following new subsection:

17 “(f) *USE TO PROVIDE EMERGENCY MEDICAL SERV-*
18 *ICES.*—Except as provided in subsection (k), if any fuel on
19 which tax was imposed by section 4081 or 4041 is used
20 in an ambulance for a purpose described in section
21 4041(l)(2), the Secretary shall pay (without interest) to the
22 ultimate purchaser of such fuel an amount equal to the ag-
23 gregate amount of the tax imposed on such fuel. The pre-
24 ceding sentence shall not apply to any liquid used after De-
25 cember 31, 2012.”.

1 (c) *TIME FOR FILING CLAIMS; PERIOD COVERED.*—
2 *Paragraphs (1) and (2)(A) of section 6427(i) of such Code*
3 *are each amended by inserting “(f),” after “(d),”.*

4 (d) *CONFORMING AMENDMENT.*—*Section 6427(d) of*
5 *such Code is amended by striking “4041(l)” and inserting*
6 *“4041(l)(1)”.*

7 (e) *EFFECTIVE DATE.*—*The amendments made by this*
8 *section shall apply to fuel used in transportation provided*
9 *in quarters beginning after the date of the enactment of this*
10 *Act.*

○