AMENDMENT TO H.R. 3162

OFFERED BY MR. RANGEL OF NEW YORK

Strike all after the enacting clause and insert the following:

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

2 (a) SHORT TITLE.—This Act may be cited as the
3 ''Children's Health and Medicare Protection Act of 2007''.

4 (b) TABLE OF CONTENTS.—The table of contents of
5 this 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 J—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 K—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. Repeal of Physicians Advisory Council.

TITLE L—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 M—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 N—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 O—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 P—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 Q—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.

TITLE R—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.

TITLE I—CHILDREN'S HEALTH INSURANCE PROGRAM

SEC. 100. PURPOSE.

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

Subtitle A—Funding

SEC. 101. ESTABLISHMENT OF NEW BASE CHIP ALLOTMENTS.

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

(1) in subsection (a)—

(A) in paragraph (9), by striking ''and'' at the end;

(B) in paragraph (10), by striking the period at the end and inserting ''; and''; and

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

"(11) for fiscal year 2008 and each succeeding fiscal year, the sum of the State allotments provided under subsection (i) for such fiscal year."; and

(2) in subsections (b)(1) and (c)(1), by striking "subsection (d)" and inserting "subsections (d) and (i)"; and

(3) by adding at the end the following new subsection:

"(i) ALLOTMENTS FOR STATES AND TERRITORIES BEGINNING WITH FISCAL YEAR 2008.—

"(1) GENERAL ALLOTMENT COMPUTATION.—Subject to the succeeding provisions of this subsection, the Secretary shall compute a State allotment for each State for each fiscal year as follows:

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

"(i) the State projection (in its submission on forms CMS—21B and CMS—37 for May 2007) of Federal payments to the State under this title for such fiscal year, except that, in the case of a State that has enacted legislation to modify its

State child health plan during 2007, the State may substitute its projection in its submission on forms CMS—21B and CMS—37 for August 2007, instead of such forms for May 2007; or

"(ii) the allotment of the State under this section for fiscal year 2007 multiplied by the allotment increase factor under paragraph (2) for fiscal year 2008.

"(B) INFLATION UPDATE FOR FISCAL YEAR 2009 AND EACH SECOND SUCCEEDING FISCAL YEAR.—For fiscal year 2009 and each second succeeding fiscal year, the allotment of a State is equal to the amount of the State allotment under this paragraph for the previous fiscal year multiplied by the allotment increase factor under paragraph (2) for the fiscal year involved.

"(C) REBASING IN FISCAL YEAR 2010 AND EACH SECOND SUCCEEDING FISCAL YEAR.—For fiscal year 2010 and each second succeeding fiscal year, the allotment of a State is equal to the Federal payments to the State that are attributable to (and countable towards) the total amount of allotments available under this sec-

tion to the State (including allotments made available under paragraph (3) as well as amounts redistributed to the State) in the previous fiscal year multiplied by the allotment increase factor under paragraph (2) for the fiscal year involved.

"(D) SPECIAL RULES FOR TERRITORIES.—Notwithstanding the previous subparagraphs, the allotment for a State that is not one of the 50 States or the District of Columbia for fiscal year 2008 and for a succeeding fiscal year is equal to the Federal payments provided to the State under this title for the previous fiscal year multiplied by the allotment increase factor under paragraph (2) for the fiscal year involved (but determined by applying under paragraph (2)(B) as if the reference to 'in the State' were a reference to 'in the United States').

"(2) ALLOTMENT INCREASE FACTOR.—The allotment increase factor under this paragraph for a fiscal year is equal to the product of the following:

"(A) PER CAPITA HEALTH CARE GROWTH FACTOR.—1 plus the percentage increase in the projected per capita amount of National Health Expenditures from the calendar year in which

the previous fiscal year ends to the calendar year in which the fiscal year involved ends, as most recently published by the Secretary before the beginning of the fiscal year.

"(B) CHILD POPULATION GROWTH FACTOR.—1 plus the percentage increase (if any) in the population of children under 19 years of age in the State from July 1 in the previous fiscal year to July 1 in the fiscal year involved, as determined by the Secretary based on the most recent published estimates of the Bureau of the Census before the beginning of the fiscal year involved, plus 1 percentage point

"(3) PERFORMANCE-BASED SHORTFALL ADJUSTMENT.—

"(A) IN GENERAL.—If a State's expenditures under this title in a fiscal year (beginning with fiscal year 2008) exceed the total amount of allotments available under this section to the State in the fiscal year (determined without regard to any redistribution it receives under subsection (f) that is available for expenditure during such fiscal year, but including any carryover from a previous fiscal year) and if the average monthly unduplicated number of children en-

1 rolled under the State plan under this title (in-
2 cluding children receiving health care coverage
3 through funds under this title pursuant to a
4 waiver under section 1115) during such fiscal
5 year exceeds its target average number of such
6 enrollees (as determined under subparagraph
7 (B)) for that fiscal year, the allotment under
8 this section for the State for the subsequent fis-
9 cal year (or, pursuant to subparagraph (F), for
10 the fiscal year involved) shall be increased by
11 the product of—
12 ''(i) the amount by which such aver-
13 age monthly caseload exceeds such target
14 number of enrollees; and
15 ''(ii) the projected per capita expendi-
16 tures under the State child health plan (as
17 determined under subparagraph (C) for
18 the original fiscal year involved), multiplied
19 by the enhanced FMAP (as defined in sec-
20 tion 2105(b)) for the State and fiscal year
21 involved
22 ''(B) TARGET AVERAGE NUMBER OF CHILD
23 ENROLLEES.—In this subsection, the target av-
24 erage number of child enrollees for a State—

1 "(i) for fiscal year 2008 is equal to
2 the monthly average unduplicated number
3 of children enrolled in the State child
4 health plan under this title (including such
5 children receiving health care coverage
6 through funds under this title pursuant to
7 a waiver under section 1115) during fiscal
8 year 2007 increased by the population
9 growth for children in that State for the
10 year ending on June 30, 2006 (as esti-
11 mated by the Bureau of the Census) plus
12 1 percentage point; or
13 "(ii) for a subsequent fiscal year is
14 equal to the target average number of child
15 enrollees for the State for the previous fis-
16 cal year increased by the population
17 growth for children in that State for the
18 year ending on June 30 before the begin-
19 ning of the fiscal year (as estimated by the
20 Bureau of the Census) plus 1 percentage
21 point.
22 "(C) PROJECTED PER CAPITA EXPENDI-
23 TURES.—For purposes of subparagraph (A)(ii),
24 the projected per capita expenditures under a
25 State child health plan—

1 "(i) for fiscal year 2008 is equal to
2 the average per capita expenditures (in-
3 cluding both State and Federal financial
4 participation) under such plan for the tar-
5 geted low-income children counted in the
6 average monthly caseload for purposes of
7 this paragraph during fiscal year 2007, in-
8 creased by the annual percentage increase
9 in the per capita amount of National
10 Health Expenditures (as estimated by the
11 Secretary) for 2008; or
12 "(ii) for a subsequent fiscal year is
13 equal to the projected per capita expendi-
14 tures under such plan for the previous fis-
15 cal year (as determined under clause (i) or
16 this clause) increased by the annual per-
17 centage increase in the per capita amount
18 of National Health Expenditures (as esti-
19 mated by the Secretary) for the year in
20 which such subsequent fiscal year ends.
21 "(D) AVAILABILITY.—Notwithstanding
22 subsection (e), an increase in allotment under
23 this paragraph shall only be available for ex-
24 penditure during the fiscal year in which it is
25 provided.

1 "(E) NO REDISTRIBUTION OF PERFORM-
2 ANCE-BASED SHORTFALL ADJUSTMENT.—In no
3 case shall any increase in allotment under this
4 paragraph for a State be subject to redistribu-
5 tion to other States.
6 "(F) INTERIM ALLOTMENT ADJUST-
7 MENT.—The Secretary shall develop a process
8 to administer the performance-based shortfall
9 adjustment in a manner so it is applied to (and
10 before the end of) the fiscal year (rather than
11 the subsequent fiscal year) involved for a State
12 that the Secretary estimates will be in shortfall
13 and will exceed its enrollment target for that
14 fiscal year.
15 "(G) PERIODIC AUDITING.—The Comp-
16 troller General of the United States shall peri-
17 odically audit the accuracy of data used in the
18 computation of allotment adjustments under
19 this paragraph. Based on such audits, the
20 Comptroller General shall make such rec-
21 ommendations to the Congress and the Sec-
22 retary as the Comptroller General deems appro-
23 priate.
24 "(4) CONTINUED REPORTING.—For purposes of
25 paragraph (3) and subsection (f), the State shall

1 submit to the Secretary the State's projected Fed-
2 eral expenditures, even if the amount of such ex-
3 penditures exceeds the total amount of allotments
4 available to the State in such fiscal year.''.

5 **SEC. 102. 2-YEAR INITIAL AVAILABILITY OF CHIP ALLOT-**
6 **MENTS.**

7 Section 2104(e) of the Social Security Act (42 U.S.C.
8 1397dd(e)) is amended to read as follows:

9 ''(e) AVAILABILITY OF AMOUNTS ALLOTTED.—

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

13 ''(A) for each of fiscal years 1998 through
14 2007, shall remain available for expenditure by
15 the State through the end of the second suc-
16 ceeding fiscal year; and

17 ''(B) for fiscal year 2008 and each fiscal
18 year thereafter, shall remain available for ex-
19 penditure by the State through the end of the
20 succeeding fiscal year.

21 ''(2) AVAILABILITY OF AMOUNTS REDISTRIB-
22 UTED.—Amounts redistributed to a State under sub-
23 section (f) shall be available for expenditure by the
24 State through the end of the fiscal year in which
25 they are redistributed, except that funds so redis-

tributed to a State that are not expended by the end of such fiscal year shall remain available after the end of such fiscal year and shall be available in the following fiscal year for subsequent redistribution under such subsection.''.

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

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

(1) by striking ''The Secretary'' and inserting the following:

''(1) IN GENERAL.—The Secretary'';

(2) by striking ''States that have fully expended the amount of their allotments under this section.'' and inserting ''States that the Secretary determines with respect to the fiscal year for which unused allotments are available for redistribution under this subsection, are shortfall States described in paragraph (2) for such fiscal year, but not to exceed the amount of the shortfall described in paragraph (2)(A) for each such State (as may be adjusted under paragraph (2)(C)). The amount of allotments not expended or redistributed under the previous sentence shall remain available for redistribution in the succeeding fiscal year.''; and

(3) by adding at the end the following new paragraph:

"(2) SHORTFALL STATES DESCRIBED.—

"(A) IN GENERAL.—For purposes of paragraph (1), with respect to a fiscal year, a shortfall State described in this subparagraph is a State with a State child health plan approved under this title for which the Secretary estimates on the basis of the most recent data available to the Secretary, that the projected expenditures under such plan for the State for the fiscal year will exceed the sum of—

"(i) the amount of the State's allotments for any preceding fiscal years that remains available for expenditure and that will not be expended by the end of the immediately preceding fiscal year;

"(ii) the amount (if any) of the performance based adjustment under subsection (i)(3)(A); and

"(iii) the amount of the State's allotment for the fiscal year.

"(B) PRORATION RULE.—If the amounts available for redistribution under paragraph (1) for a fiscal year are less than the total amounts

of the estimated shortfalls determined for the year under subparagraph (A), the amount to be redistributed under such paragraph for each shortfall State shall be reduced proportionally.

"(C) RETROSPECTIVE ADJUSTMENT.—The Secretary may adjust the estimates and determinations made under paragraph (1) and this paragraph with respect to a fiscal year as necessary on the basis of the amounts reported by States not later than November 30 of the succeeding fiscal year, as approved by the Secretary.".

SEC. 104. EXTENSION OF OPTION FOR QUALIFYING STATES.

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

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.

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

"(3) PERFORMANCE BONUS PAYMENT TO OFFSET ADDITIONAL MEDICAID AND CHIP CHILD ENROLLMENT COSTS RESULTING FROM ENROLLMENT AND RETENTION EFFORTS.—

"(A) IN GENERAL.—In addition to the payments made under paragraph (1), for each fiscal year (beginning with fiscal year 2008) the Secretary shall pay to each State that meets the condition under paragraph (4) for the fiscal year, an amount equal to the amount described in subparagraph (B) for the State and fiscal year. The payment under this paragraph shall be made, to a State for a fiscal year, as a single payment not later than the last day of the first calendar quarter of the following fiscal year.

1 "(B) AMOUNT.—The amount described in
2 this subparagraph for a State for a fiscal year
3 is equal to the sum of the following amounts:
4 "(i) FOR ABOVE BASELINE MEDICAID
5 CHILD ENROLLMENT COSTS.—
6 "(I) FIRST TIER ABOVE BASE-
7 LINE MEDICAID ENROLLEES.—An
8 amount equal to the number of first
9 tier above baseline child enrollees (as
10 determined under subparagraph
11 (C)(i)) under title XIX for the State
12 and fiscal year multiplied by 35 per-
13 cent of the projected per capita State
14 Medicaid expenditures (as determined
15 under subparagraph (D)(i)) for the
16 State and fiscal year under title XIX.
17 "(II) SECOND TIER ABOVE BASE-
18 LINE MEDICAID ENROLLEES .—An
19 amount equal to the number of second
20 tier above baseline child enrollees (as
21 determined under subparagraph
22 (C)(ii)) under title XIX for the State
23 and fiscal year multiplied by 90 per-
24 cent of the projected per capita State
25 Medicaid expenditures (as determined

1 under subparagraph (D)(i)) for the
2 State and fiscal year under title XIX.
3 "(ii) FOR ABOVE BASELINE CHIP EN-
4 ROLLMENT COSTS.—
5 "(I) FIRST TIER ABOVE BASE-
6 LINE CHIP ENROLLEES.—An amount
7 equal to the number of first tier above
8 baseline child enrollees under this title
9 (as determined under subparagraph
10 (C)(i)) for the State and fiscal year
11 multiplied by 5 percent of the pro-
12 jected per capita State CHIP expendi-
13 tures (as determined under subpara-
14 graph (D)(ii)) for the State and fiscal
15 year under this title.
16 "(II) SECOND TIER ABOVE BASE-
17 LINE CHIP ENROLLEES.—An amount
18 equal to the number of second tier
19 above baseline child enrollees under
20 this title (as determined under sub-
21 paragraph (C)(ii)) for the State and
22 fiscal year multiplied by 75 percent of
23 the projected per capita State CHIP
24 expenditures (as determined under

1 subparagraph (D)(ii)) for the State
2 and fiscal year under this title.
3 "(C) NUMBER OF FIRST AND SECOND TIER
4 ABOVE BASELINE CHILD ENROLLEES; BASELINE
5 NUMBER OF CHILD ENROLLEES.—For purposes
6 of this paragraph:
7 "(i) FIRST TIER ABOVE BASELINE
8 CHILD ENROLLEES.—The number of first
9 tier above baseline child enrollees for a
10 State for a fiscal year under this title or
11 title XIX is equal to the number (if any,
12 as determined by the Secretary) by
13 which—
14 "(I) the monthly average
15 unduplicated number of qualifying
16 children (as defined in subparagraph
17 (E)) enrolled during the fiscal year
18 under the State child health plan
19 under this title or under the State
20 plan under title XIX, respectively; ex-
21 ceeds
22 "(II) the baseline number of en-
23 rollees described in clause (iii) for the
24 State and fiscal year under this title
25 or title XIX, respectively;

1 but not to exceed 3 percent (in the case of
2 title XIX) or 7.5 percent (in the case of
3 this title) of the baseline number of enroll-
4 ees described in subclause (II).
5 ''(ii) SECOND TIER ABOVE BASELINE
6 CHILD ENROLLEES.—The number of sec-
7 ond tier above baseline child enrollees for
8 a State for a fiscal year under this title or
9 title XIX is equal to the number (if any,
10 as determined by the Secretary) by
11 which—
12 ''(I) the monthly average
13 unduplicated number of qualifying
14 children (as defined in subparagraph
15 (E)) enrolled during the fiscal year
16 under this title or under title XIX, re-
17 spectively, as described in clause
18 (i)(I); exceeds
19 ''(II) the sum of the baseline
20 number of child enrollees described in
21 clause (iii) for the State and fiscal
22 year under this title or title XIX, re-
23 spectively, as described in clause
24 (i)(II), and the maximum number of
25 first tier above baseline child enrollees

for the State and fiscal year under this title or title XIX, respectively, as determined under clause (i).

"(iii) BASELINE NUMBER OF CHILD ENROLLEES.—The baseline number of child enrollees for a State under this title or title XIX—

"(I) for fiscal year 2008 is equal to the monthly average unduplicated number of qualifying children enrolled in the State child health plan under this title or in the State plan under title XIX, respectively, during fiscal year 2007 increased by the population growth for children in that State for the year ending on June 30, 2006 (as estimated by the Bureau of the Census) plus 1 percentage point; or

"(II) for a subsequent fiscal year is equal to the baseline number of child enrollees for the State for the previous fiscal year under this title or title XIX, respectively, increased by the population growth for children in that State for the year ending on

1 June 30 before the beginning of the
2 fiscal year (as estimated by the Bu-
3 reau of the Census) plus 1 percentage
4 point.
5 "(D) PROJECTED PER CAPITA STATE EX-
6 PENDITURES.—For purposes of subparagraph
7 (B)—
8 "(i) PROJECTED PER CAPITA STATE
9 MEDICAID EXPENDITURES.—The projected
10 per capita State Medicaid expenditures for
11 a State and fiscal year under title XIX is
12 equal to the average per capita expendi-
13 tures (including both State and Federal fi-
14 nancial participation) for children under
15 the State plan under such title, including
16 under waivers but not including such chil-
17 dren eligible for assistance by virtue of the
18 receipt of benefits under title XVI, for the
19 most recent fiscal year for which actual
20 data are available (as determined by the
21 Secretary), increased (for each subsequent
22 fiscal year up to and including the fiscal
23 year involved) by the annual percentage in-
24 crease in per capita amount of National
25 Health Expenditures (as estimated by the

1 Secretary) for the calendar year in which
2 the respective subsequent fiscal year ends
3 and multiplied by a State matching per-
4 centage equal to 100 percent minus the
5 Federal medical assistance percentage (as
6 defined in section 1905(b)) for the fiscal
7 year involved.
8 ''(ii) PROJECTED PER CAPITA STATE
9 CHIP EXPENDITURES.—The projected per
10 capita State CHIP expenditures for a
11 State and fiscal year under this title is
12 equal to the average per capita expendi-
13 tures (including both State and Federal fi-
14 nancial participation) for children under
15 the State child health plan under this title,
16 including under waivers, for the most re-
17 cent fiscal year for which actual data are
18 available (as determined by the Secretary),
19 increased (for each subsequent fiscal year
20 up to and including the fiscal year in-
21 volved) by the annual percentage increase
22 in per capita amount of National Health
23 Expenditures (as estimated by the Sec-
24 retary) for the calendar year in which the
25 respective subsequent fiscal year ends and

multiplied by a State matching percentage equal to 100 percent minus the enhanced FMAP (as defined in section 2105(b)) for the fiscal year involved.

"(E) QUALIFYING CHILDREN DEFINED.—For purposes of this subsection, the term 'qualifying children' means, with respect to this title or title XIX, children who meet the eligibility criteria (including income, categorical eligibility, age, and immigration status criteria) in effect as of July 1, 2007, for enrollment under this title or title XIX, respectively, taking into account crtieria applied as of such date under this title or title XIX, respectively, pursuant to a waiver under section 1115.

"(4) ENROLLMENT AND RETENTION PROVISIONS FOR CHILDREN.— For purposes of paragraph (3)(A), a State meets the condition of this paragraph for a fiscal year if it is implementing at least 4 of the following enrollment and retention provisions (treating each subparagraph as a separate enrollment and retention provision) throughout the entire fiscal year:

"(A) CONTINUOUS ELIGIBILITY.—The State has elected the option of continuous eligi-

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

6 ''(B) LIBERALIZATION OF ASSET REQUIRE-
7 MENTS.—The State meets the requirement
8 specified in either of the following clauses:

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

13 ''(ii) ADMINISTRATIVE VERIFICATION
14 OF ASSETS.—The State—

15 ''(I) permits a parent or care-
16 taker relative who is applying on be-
17 half of a child for medical assistance
18 under title XIX or child health assist-
19 ance under this title to declare and
20 certify by signature under penalty of
21 perjury information relating to family
22 assets for purposes of determining
23 and redetermining financial eligibility;
24 and

1 "(II) takes steps to verify assets
2 through means other than by requir-
3 ing documentation from parents and
4 applicants except in individual cases
5 of discrepancies or where otherwise
6 justified.
7 "(C) ELIMINATION OF IN-PERSON INTER-
8 VIEW REQUIREMENT.—The State does not re-
9 quire an application of a child for medical as-
10 sistance under title XIX (or for child health as-
11 sistance under this title), including an applica-
12 tion for renewal of such assistance, to be made
13 in person nor does the State require a face-to-
14 face interview, unless there are discrepancies or
15 individual circumstances justifying an in-person
16 application or face-to-face interview.
17 "(D) USE OF JOINT APPLICATION FOR
18 MEDICAID AND CHIP.—The application form
19 and supplemental forms (if any) and informa-
20 tion verification process is the same for pur-
21 poses of establishing and renewing eligibility for
22 children for medical assistance under title XIX
23 and child health assistance under this title.
24 "(E) AUTOMATIC RENEWAL (USE OF AD-
25 MINISTRATIVE RENEWAL).—

1 "(i) IN GENERAL.—The State pro-
2 vides, in the case of renewal of a child's
3 eligibility for medical assistance under title
4 XIX or child health assistance under this
5 title, a pre-printed form completed by the
6 State based on the information available to
7 the State and notice to the parent or care-
8 taker relative of the child that eligibility of
9 the child will be renewed and continued
10 based on such information unless the State
11 is provided other information. Nothing in
12 this clause shall be construed as preventing
13 a State from verifying, through electronic
14 and other means, the information so pro-
15 vided.
16 "(ii) SATISFACTION THROUGH DEM-
17 ONSTRATED USE OF EX PARTE PROCESS.—
18 A State shall be treated as satisfying the
19 requirement of clause (i) if renewal of eli-
20 gibility of children under title XIX or this
21 title is determined without any require-
22 ment for an in-person interview, unless
23 sufficient information is not in the State's
24 possession and cannot be acquired from
25 other sources (including other State agen-

1 cies) without the participation of the appli-
2 cant or the applicant's parent or caretaker
3 relative.
4 "(F) PRESUMPTIVE ELIGIBILITY FOR
5 CHILDREN.—The State is implementing section
6 1920A under title XIX as well as, pursuant to
7 section 2107(e)(1), under this title .
8 "(G) EXPRESS LANE.—The State is imple-
9 menting the option described in section
10 1902(e)(13) under title XIX as well as, pursu-
11 ant to section 2107(e)(1), under this title.".
12 **SEC. 112. STATE OPTION TO RELY ON FINDINGS FROM AN**
13 **EXPRESS LANE AGENCY TO CONDUCT SIM-**
14 **PLIFIED ELIGIBILITY DETERMINATIONS.**
15 (a) MEDICAID.—Section 1902(e) of the Social Secu-
16 rity Act (42 U.S.C. 1396a(e)) is amended by adding at
17 the end the following:
18 "(13) EXPRESS LANE OPTION.—
19 "(A) IN GENERAL.—
20 "(i) OPTION TO USE A FINDING FROM AN
21 EXPRESS LANE AGENCY.—At the option of the
22 State, the State plan may provide that in deter-
23 mining eligibility under this title for a child (as
24 defined in subparagraph (F)), the State may
25 rely on a finding made within a reasonable pe-

1 riod (as determined by the State) from an Ex-
2 press Lane agency (as defined in subparagraph
3 (E)) when it determines whether a child satis-
4 fies one or more components of eligibility for
5 medical assistance under this title. The State
6 may rely on a finding from an Express Lane
7 agency notwithstanding sections
8 1902(a)(46)(B), 1903(x), and 1137(d) and any
9 differences in budget unit, disregard, deeming
10 or other methodology, if the following require-
11 ments are met:
12 ''(I) PROHIBITION ON DETERMINING
13 CHILDREN INELIGIBLE FOR COVERAGE.—
14 If a finding from an Express Lane agency
15 would result in a determination that a
16 child does not satisfy an eligibility require-
17 ment for medical assistance under this title
18 and for child health assistance under title
19 XXI, the State shall determine eligibility
20 for assistance using its regular procedures.
21 ''(II) NOTICE REQUIREMENT.—For
22 any child who is found eligible for medical
23 assistance under the State plan under this
24 title or child health assistance under title
25 XXI and who is subject to premiums based

on an Express Lane agency's finding of such child's income level, the State shall provide notice that the child may qualify for lower premium payments if evaluated by the State using its regular policies and of the procedures for requesting such an evaluation.

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

"(ii) OPTION TO APPLY TO RENEWALS AND REDETERMINATIONS.— The State may apply the provisions of this paragraph when conducting initial determinations of eligibility, redeterminations of eligibility, or both, as described in the State plan.

"(B) RULES OF CONSTRUCTION.—Nothing in this paragraph shall be construed—

1 "(i) to limit or prohibit a State from tak-
2 ing any actions otherwise permitted under this
3 title or title XXI in determining eligibility for
4 or enrolling children into medical assistance
5 under this title or child health assistance under
6 title XXI; or
7 "(ii) to modify the limitations in section
8 1902(a)(5) concerning the agencies that may
9 make a determination of eligibility for medical
10 assistance under this title.
11 "(C) OPTIONS FOR SATISFYING THE SCREEN
12 AND ENROLL REQUIREMENT.—
13 "(i) IN GENERAL.—With respect to a child
14 whose eligibility for medical assistance under
15 this title or for child health assistance under
16 title XXI has been evaluated by a State agency
17 using an income finding from an Express Lane
18 agency, a State may carry out its duties under
19 subparagraphs (A) and (B) of section
20 2102(b)(3) (relating to screen and enroll) in ac-
21 cordance with either clause (ii) or clause (iii).
22 "(ii) ESTABLISHING A SCREENING
23 THRESHOLD.—
24 "(I) IN GENERAL.—Under this clause,
25 the State establishes a screening threshold

1 set as a percentage of the Federal poverty
2 level that exceeds the highest income
3 threshold applicable under this title to the
4 child by a minimum of 30 percentage
5 points or, at State option, a higher number
6 of percentage points that reflects the value
7 (as determined by the State and described
8 in the State plan) of any differences be-
9 tween income methodologies used by the
10 program administered by the Express Lane
11 agency and the methodologies used by the
12 State in determining eligibility for medical
13 assistance under this title.

14 ''(II) CHILDREN WITH INCOME NOT
15 ABOVE THRESHOLD.—If the income of a
16 child does not exceed the screening thresh-
17 old, the child is deemed to satisfy the in-
18 come eligibility criteria for medical assist-
19 ance under this title regardless of whether
20 such child would otherwise satisfy such cri-
21 teria.

22 ''(III) CHILDREN WITH INCOME
23 ABOVE THRESHOLD.—If the income of a
24 child exceeds the screening threshold, the
25 child shall be considered to have an income

above the Medicaid applicable income level described in section 2110(b)(4) and to satisfy the requirement under section 2110(b)(1)(C) (relating to the requirement that CHIP matching funds be used only for children not eligible for Medicaid). If such a child is enrolled in child health assistance under title XXI, the State shall provide the parent, guardian, or custodial relative with the following:

"(aa) Notice that the child may be eligible to receive medical assistance under the State plan under this title if evaluated for such assistance under the State's regular procedures and notice of the process through which a parent, guardian, or custodial relative can request that the State evaluate the child's eligibility for medical assistance under this title using such regular procedures.

"(bb) A description of differences between the medical assistance provided under this title and child health assistance under title XXI, including

1 differences in cost-sharing require-
2 ments and covered benefits.
3 ''(iii) TEMPORARY ENROLLMENT IN CHIP
4 PENDING SCREEN AND ENROLL.—
5 ''(I) IN GENERAL.—Under this clause,
6 a State enrolls a child in child health as-
7 sistance under title XXI for a temporary
8 period if the child appears eligible for such
9 assistance based on an income finding by
10 an Express Lane agency.
11 ''(II) DETERMINATION OF ELIGI-
12 BILITY.—During such temporary enroll-
13 ment period, the State shall determine the
14 child's eligibility for child health assistance
15 under title XXI or for medical assistance
16 under this title in accordance with this
17 clause.
18 ''(III) PROMPT FOLLOW UP.—In mak-
19 ing such a determination, the State shall
20 take prompt action to determine whether
21 the child should be enrolled in medical as-
22 sistance under this title or child health as-
23 sistance under title XXI pursuant to sub-
24 paragraphs (A) and (B) of section
25 2102(b)(3) (relating to screen and enroll).

1 "(IV) REQUIREMENT FOR SIMPLIFIED
2 DETERMINATION.—In making such a de-
3 termination, the State shall use procedures
4 that, to the maximum feasible extent, re-
5 duce the burden imposed on the individual
6 of such determination. Such procedures
7 may not require the child's parent, guard-
8 ian, or custodial relative to provide or
9 verify information that already has been
10 provided to the State agency by an Ex-
11 press Lane agency or another source of in-
12 formation unless the State agency has rea-
13 son to believe the information is erroneous.
14 "(V) AVAILABILITY OF CHIP MATCH-
15 ING FUNDS DURING TEMPORARY ENROLL-
16 MENT PERIOD.—Medical assistance for
17 items and services that are provided to a
18 child enrolled in title XXI during a tem-
19 porary enrollment period under this clause
20 shall be treated as child health assistance
21 under such title.
22 "(D) OPTION FOR AUTOMATIC ENROLLMENT.—
23 "(i) IN GENERAL.— At its option, a State
24 may initiate an evaluation of an individual's eli-
25 gibility for medical assistance under this title

without an application and determine the individual's eligibility for such assistance using findings from one or more Express Lane agencies and information from sources other than a child, if the requirements of clauses (ii) and (iii) are met.

"(ii) INDIVIDUAL CHOICE REQUIREMENT.—The requirement of this clause is that the child is enrolled in medical assistance under this title or child health assistance under title XXI only if the child (or a parent, caretaker relative, or guardian on the behalf of the child) has affirmatively assented to such enrollment.

"(iii) INFORMATION REQUIREMENT.—The requirement of this clause is that the State informs the parent, guardian, or custodial relative of the child of the services that will be covered, appropriate methods for using such services, premium or other cost sharing charges (if any) that apply, medical support obligations (under section 1912(a)) created by enrollment (if applicable), and the actions the parent, guardian, or relative must take to maintain enrollment and renew coverage.

1 "(E) EXPRESS LANE AGENCY DEFINED.—In
2 this paragraph, the term 'express lane agency'
3 means an agency that meets the following require-
4 ments:
5 "(i) The agency determines eligibility for
6 assistance under the Food Stamp Act of 1977,
7 the Richard B. Russell National School Lunch
8 Act, the Child Nutrition Act of 1966, or the
9 Child Care and Development Block Grant Act
10 of 1990.
11 "(ii) The agency notifies the child (or a
12 parent, caretaker relative, or guardian on the
13 behalf of the child)—
14 "(I) of the information which shall be
15 disclosed;
16 "(II) that the information will be used
17 by the State solely for purposes of deter-
18 mining eligibility for and for providing
19 medical assistance under this title or child
20 health assistance under title XXI; and
21 "(III) that the child, or parent, care-
22 taker relative, or guardian, may elect to
23 not have the information disclosed for such
24 purposes.

1 "(iii) The agency and the State agency are
2 subject to an interagency agreement limiting
3 the disclosure and use of such information to
4 such purposes.
5 "(iv) The agency is determined by the
6 State agency to be capable of making the deter-
7 minations described in this paragraph and is
8 identified in the State plan under this title or
9 title XXI.
10 For purposes of this subparagraph, the term 'State
11 agency' refers to the agency determining eligibility
12 for medical assistance under this title or child health
13 assistance under title XXI.
14 "(F) CHILD DEFINED.—For purposes of this
15 paragraph, the term 'child' means an individual
16 under 19 years of age, or, at the option of a State,
17 such higher age, not to exceed 21 years of age, as
18 the State may elect.".
19 (b) CHIP.—Section 2107(e)(1) of such Act (42
20 U.S.C. 1397gg(e)(1)) is amended by redesignating sub-
21 paragraph (B) and succeeding subparagraphs as subpara-
22 graph (C) and succeeding subparagraphs and by inserting
23 after subparagraph (A) the following new subparagraph:
24 "(B) Section 1902(e)(13) (relating to the
25 State option to rely on findings from an Ex-

1 press Lane agency to help evaluate a child's eli-
2 gibility for medical assistance).''.
3 (c) ELECTRONIC TRANSMISSION OF INFORMATION.—
4 Section 1902 of such Act (42 U.S.C. 1396a) is amended
5 by adding at the end the following new subsection:
6 ''(dd) ELECTRONIC TRANSMISSION OF INFORMA-
7 TION.—If the State agency determining eligibility for med-
8 ical assistance under this title or child health assistance
9 under title XXI verifies an element of eligibility based on
10 information from an Express Lane Agency (as defined in
11 subsection (e)(13)(F)), or from another public agency,
12 then the applicant's signature under penalty of perjury
13 shall not be required as to such element. Any signature
14 requirement for an application for medical assistance may
15 be satisfied through an electronic signature, as defined in
16 section 1710(1) of the Government Paperwork Elimi-
17 nation Act (44 U.S.C. 3504 note). The requirements of
18 subparagraphs (A) and (B) of section 1137(d)(2) may be
19 met through evidence in digital or electronic form.''.
20 (d) AUTHORIZATION OF INFORMATION DISCLO-
21 SURE.—
22 (1) IN GENERAL.—Title XIX of the Social Se-
23 curity Act is amended—
24 (A) by redesignating section 1939 as sec-
25 tion 1940; and

1 (B) by inserting after section 1938 the fol-
2 lowing new section:

3 **"SEC. 1939. AUTHORIZATION TO RECEIVE PERTINENT IN-**
4 **FORMATION.**

5 "(a) IN GENERAL.—Notwithstanding any other pro-
6 vision of law, a Federal or State agency or private entity
7 in possession of the sources of data potentially pertinent
8 to eligibility determinations under this title (including eli-
9 gibility files maintained by Express Lane agencies de-
10 scribed in section 1902(e)(13)(F), information described
11 in paragraph (2) or (3) of section 1137(a), vital records
12 information about births in any State, and information de-
13 scribed in sections 453(i) and 1902(a)(25)(I)) is author-
14 ized to convey such data or information to the State agen-
15 cy administering the State plan under this title, to the
16 extent such conveyance meets the requirements of sub-
17 section (b).

18 "(b) REQUIREMENTS FOR CONVEYANCE.—Data or
19 information may be conveyed pursuant to subsection (a)
20 only if the following requirements are met:

21 "(1) The individual whose circumstances are
22 described in the data or information (or such indi-
23 vidual's parent, guardian, caretaker relative, or au-
24 thorized representative) has either provided advance
25 consent to disclosure or has not objected to disclo-

1 sure after receiving advance notice of disclosure and
2 a reasonable opportunity to object.
3 ''(2) Such data or information are used solely
4 for the purposes of—
5 ''(A) identifying individuals who are eligi-
6 ble or potentially eligible for medical assistance
7 under this title and enrolling or attempting to
8 enroll such individuals in the State plan; and
9 ''(B) verifying the eligibility of individuals
10 for medical assistance under the State plan.
11 ''(3) An interagency or other agreement, con-
12 sistent with standards developed by the Secretary—
13 ''(A) prevents the unauthorized use, disclo-
14 sure, or modification of such data and other-
15 wise meets applicable Federal requirements
16 safeguarding privacy and data security; and
17 ''(B) requires the State agency admin-
18 istering the State plan to use the data and in-
19 formation obtained under this section to seek to
20 enroll individuals in the plan.
21 ''(c) CRIMINAL PENALTY.—A private entity described
22 in the subsection (a) that publishes, discloses, or makes
23 known in any manner, or to any extent not authorized by
24 Federal law, any information obtained under this section
25 shall be fined not more than $1,000 or imprisoned not

more than 1 year, or both, for each such unauthorized publication or disclosure.

"(d) RULE OF CONSTRUCTION.—The limitations and requirements that apply to disclosure pursuant to this section shall not be construed to prohibit the conveyance or disclosure of data or information otherwise permitted under Federal law (without regard to this section).".

(2) CONFORMING AMENDMENT TO TITLE XXI.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)), as amended by subsection (b), is amended by adding at the end the following new subparagraph:

"(F) Section 1939 (relating to authorization to receive data potentially pertinent to eligibility determinations).".

(3) CONFORMING AMENDMENT TO PROVIDE ACCESS TO DATA ABOUT ENROLLMENT IN INSURANCE FOR PURPOSES OF EVALUATING APPLICATIONS AND FOR CHIP.—Section 1902(a)(25)(I)(i) of such Act (42 U.S.C. 1396a(a)(25)(I)(i)) is amended—

(A) by inserting "(and, at State option, individuals who are potentially eligible or who apply)" after "with respect to individuals who are eligible"; and

(B) by inserting ''under this title (and, at State option, child health assistance under title XXI)'' after ''the State plan''.

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

SEC. 113. APPLICATION OF MEDICAID OUTREACH PROCEDURES TO ALL CHILDREN AND PREGNANT WOMEN.

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

(1) in the matter before subparagraph (A), by striking ''individuals for medical assistance under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX)'' and inserting ''children and pregnant women for medical assistance under any provision of this title''; and

(2) in subparagraph (B), by inserting before the semicolon at the end the following: '', which need not be the same application form for all such individuals''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect on January 1, 2008.

1 **SEC. 114. ENCOURAGING CULTURALLY APPROPRIATE EN-**
2 **ROLLMENT AND RETENTION PRACTICES.**

3 (a) USE OF MEDICAID FUNDS.—Section 1903(a)(2)
4 of the Social Security Act (42 U.S.C. 1396b(a)(2)) is
5 amended by adding at the end the following new subpara-
6 graph:

7 ''(E) an amount equal to 75 percent of so much
8 of the sums expended during such quarter (as found
9 necessary by the Secretary for the proper and effi-
10 cient administration of the State plan) as are attrib-
11 utable to translation or interpretation services in
12 connection with the enrollment and retention under
13 this title of children of families for whom English is
14 not the primary language; plus''.

15 (b) USE OF COMMUNITY HEALTH WORKERS FOR
16 OUTREACH ACTIVITIES.—

17 (1) IN GENERAL.—Section 2102(c)(1) of such
18 Act (42 U.S.C. 1397bb(c)(1)) is amended by insert-
19 ing ''(through community health workers and oth-
20 ers)'' after ''Outreach''.

21 (2) IN FEDERAL EVALUATION.—Section
22 2108(c)(3)(B) of such Act (42 U.S.C.
23 1397hh(c)(3)(B)) is amended by inserting ''(such as
24 through community health workers and others)''
25 after ''including practices''.

Subtitle C—Coverage

SEC. 121. ENSURING CHILD-CENTERED COVERAGE.

(a) ADDITIONAL REQUIRED SERVICES.—

(1) CHILD-CENTERED COVERAGE.—Section 2103 of the Social Security Act (42 U.S.C. 1397cc) is amended——

(A) in subsection (a)—

(i) in the matter before paragraph (1), by striking ''subsection (c)(5)'' and inserting ''paragraphs (5) and (6) of subsection (c)''; and

(ii) in paragraph (1), by inserting ''at least'' after ''that is''; and

(B) in subsection (c)—

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

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

''(5) DENTAL, FQHC, AND RHC SERVICES.—The child health assistance provided to a targeted low-income child (whether through benchmark coverage or benchmark-equivalent coverage or otherwise) shall include coverage of the following:

''(A) Dental services necessary to prevent disease and promote oral health, restore oral

structures to health and function, and treat emergency conditions.

"(B) Federally-qualified health center services (as defined in section 1905(l)(2)) and rural health clinic services (as defined in section 1905(l)(1)).

Nothing in this section shall be construed as preventing a State child health plan from providing such services as part of benchmark coverage or in addition to the benefits provided through benchmark coverage.".

(2) REQUIRED PAYMENT FOR FQHC AND RHC SERVICES.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)), as amended by sections 112(b) and 112(d)(2), is amended by inserting after subparagraph (B) the following new subparagraph (and redesignating the succeeding subparagraphs accordingly):

"(C) Section 1902(bb) (relating to payment for services provided by Federally-qualified health centers and rural health clinics).".

(3) MENTAL HEALTH PARITY.—Section 2103(a)(2)(C) of such Act (42 U.S.C. 1397aa(a)(2)(C)) is amended by inserting "(or 100 percent in the case of the category of services de-

1 scribed in subparagraph (B) of such subsection)''
2 after ''75 percent''.
3 (4) EFFECTIVE DATE.—The amendments made
4 by this subsection and subsection (d) shall apply to
5 health benefits coverage provided on or after October
6 1, 2008.
7 (b) CLARIFICATION OF REQUIREMENT TO PROVIDE
8 EPSDT SERVICES FOR ALL CHILDREN IN BENCHMARK
9 BENEFIT PACKAGES UNDER MEDICAID .—
10 (1) IN GENERAL.—Section 1937(a)(1) of the
11 Social Security Act (42 U.S.C. 1396u-7(a)(1)) is
12 amended—
13 (A) in subparagraph (A)—
14 (i) in the matter before clause (i), by
15 striking ''Notwithstanding any other provi-
16 sion of this title'' and inserting ''Subject to
17 subparagraph (E)''; and
18 (ii) by striking ''enrollment in cov-
19 erage that provides'' and all that follows
20 and inserting ''benchmark coverage de-
21 scribed in subsection (b)(1) or benchmark
22 equivalent coverage described in subsection
23 (b)(2).'';
24 (B) by striking subparagraph (C) and in-
25 serting the following new subparagraph:

"(C) STATE OPTION TO PROVIDE ADDITIONAL BENEFITS.—A State, at its option, may provide such additional benefits to benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2) as the State may specify."; and

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

"(E) REQUIRING COVERAGE OF EPSDT SERVICES.—Nothing in this paragraph shall be construed as affecting a child's entitlement to care and services described in subsections (a)(4)(B) and (r) of section 1905 and provided in accordance with section 1902(a)(43) whether provided through benchmark coverage, benchmark equivalent coverage, or otherwise.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect as if included in the amendment made by section 6044(a) of the Deficit Reduction Act of 2005.

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

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

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

(d) ASSURING ACCESS TO CARE.—

(1) STATE CHILD HEALTH PLAN REQUIREMENT.—Section 2102(a)(7)(B) of such Act (42 U.S.C. 1397bb(c)(2)) is amended by inserting ''and services described in section 2103(c)(5)'' after ''emergency services''.

(2) REFERENCE TO EFFECTIVE DATE.—For the effective date for the amendments made by this subsection, see subsection (a)(5).

SEC. 122. IMPROVING BENCHMARK COVERAGE OPTIONS.

(a) LIMITATION ON SECRETARY-APPROVED COVERAGE.—

(1) UNDER CHIP.—Section 2103(a)(4) of the Social Security Act (42 U.S.C. 1397cc(a)(4)) is

1 amended by inserting before the period at the end
2 the following: ''if the health benefits coverage is at
3 least equivalent to the benefits coverage in a bench-
4 mark benefit package described in subsection (b)''.
5 (2) UNDER MEDICAID.—Section 1937(b)(1)(D)
6 of the Social Security Act (42 U.S.C. 1396u-
7 7(b)(1)(D)) is amended by inserting before the pe-
8 riod at the end the following: ''if the health benefits
9 coverage is at least equivalent to the benefits cov-
10 erage in benchmark coverage described in subpara-
11 graph (A), (B), or (C)''.
12 (b) REQUIREMENT FOR MOST POPULAR FAMILY
13 COVERAGE FOR STATE EMPLOYEE COVERAGE BENCH-
14 MARK.—
15 (1) CHIP.—Section 2103(b)(2) of such Act (42
16 U.S.C. 1397(b)(2)) is amended by inserting ''and
17 that has been selected most frequently by employees
18 seeking dependent coverage, among such plans that
19 provide such dependent coverage, in either of the
20 previous 2 plan years'' before the period at the end.
21 (2) MEDICAID.—Section 1937(b)(1)(B) of such
22 Act is amended by inserting ''and that has been se-
23 lected most frequently, by employees seeking depend-
24 ent coverage, among such plans that provide such

1 dependent coverage, in either of the previous 2 plan
2 years'' before the period at the end.
3 (c) EFFECTIVE DATE.—The amendments made by
4 this section shall apply to health benefits coverage pro-
5 vided on or after October 1, 2008.

6 **SEC. 123. PREMIUM GRACE PERIOD.**

7 (a) IN GENERAL.—Section 2103(e)(3) of the Social
8 Security Act (42 U.S.C. 1397cc(e)(3)) is amended by add-
9 ing at the end the following new subparagraph:
10 ''(C) PREMIUM GRACE PERIOD.—The State
11 child health plan—
12 ''(i) shall afford individuals enrolled
13 under the plan a grace period of at least
14 30 days from the beginning of a new cov-
15 erage period to make premium payments
16 before the individual's coverage under the
17 plan may be terminated; and
18 ''(ii) shall provide to such an indi-
19 vidual, not later than 7 days after the first
20 day of such grace period, notice—
21 ''(I) that failure to make a pre-
22 mium payment within the grace pe-
23 riod will result in termination of cov-
24 erage under the State child health
25 plan; and

"(II) of the individual's right to challenge the proposed termination pursuant to the applicable Federal regulations.

For purposes of clause (i), the term 'new coverage period' means the month immediately following the last month for which the premium has been paid.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to new coverage periods beginning on or after January 1, 2009.

Subtitle D—Populations

SEC. 131. OPTIONAL COVERAGE OF OLDER CHILDREN UNDER MEDICAID AND CHIP.

(a) MEDICAID.—

(1) IN GENERAL.—Section 1902(l)(1)(D) of the Social Security Act (42 U.S.C. 1396a(l)(1)(D)) is amended by striking "but have not attained 19 years of age" and inserting "but is under 19 years of age (or, at the option of a State and subject to section 131(d) of the Children's Health and Medicare Protection Act of 2007, under such higher age, not to exceed 25 years of age, as the State may elect)".

(2) CONFORMING AMENDMENTS.—

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
5 age as the State has elected under subsection
6 (l)(1)(D))'' after ''18 years of age''.
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
13 U.S.C. 1396d(a)) is amended, in clause (i), by
14 inserting ''or under such higher age as the
15 State has elected under subsection (l)(1)(D)''
16 after ''as the State may choose''.
17 (D) Section 1920A(b)(1) of such Act (42
18 U.S.C. 1396r–1a(b)(1)) is amended by insert-
19 ing ''or under such higher age as the State has
20 elected under section 1902(l)(1)(D)'' after ''19
21 years 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 in-
5 serting ''(or under such higher age as the State
6 has elected under section 1902(l)(1)(D))'' after
7 ''19 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
11 Children's Health and Medicare Protection Act of 2007,
12 under such higher age as the State has elected under sec-
13 tion 1902(l)(1)(D))''.
14 (c) EFFECTIVE DATE.—Subject to subsection (d),
15 the amendments made by this section take effect on Janu-
16 ary 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

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

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

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

SEC. 132. OPTIONAL COVERAGE OF LEGAL IMMIGRANTS UNDER THE MEDICAID PROGRAM AND CHIP.

(a) MEDICAID PROGRAM.—Section 1903(v) of the Social Security Act (42 U.S.C. 1396b(v)) is amended—

(1) in paragraph (1), by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (4)''; and

(2) by adding at the end the following new paragraph:

''(4)(A) A State may elect (in a plan amendment under this title) to provide medical assistance under this title, notwithstanding sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, for aliens who are lawfully residing in the United States (including battered aliens described in section 431(c) of such Act) and who are other-

1 wise eligible for such assistance, within either or both of
2 the following 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 sec-
8 tion 1902(l)(1)(D)), including optional targeted low-
9 income 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
14 of provision of medical assistance to such category and
15 the cost of such assistance shall not be considered as an
16 unreimbursed cost.".
17 (b) CHIP.—Section 2107(e)(1) of such Act (42
18 U.S.C. 1397gg(e)(1)), as amended by section 112(b),
19 112(d)(2),and 121(a)(2), is amended by redesignating
20 subparagraphs (E) through (G) as subparagraphs (G)
21 through (I), respectively, and by inserting after subpara-
22 graph (D) the following new subparagraphs:
23 "(E) Section 1903(v)(4)(A) (relating to
24 optional coverage of certain categories of law-
25 fully residing immigrants), insofar as it relates

to the category of pregnant women described in clause (i) of such section, but only if the State has elected to apply such section with respect to such women under title XIX and the State has elected the option under section 2111 to provide assistance for pregnant women under this title.

"(F) Section 1903(v)(4)(A) (relating to optional coverage of categories of lawfully residing immigrants), insofar as it relates to the category of children described in clause (ii) of such section, but only if the State has elected to apply such section with respect to such children under title XIX.".

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

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

(a) CHIP.—

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

"SEC. 2111. OPTIONAL COVERAGE OF TARGETED LOW-INCOME PREGNANT WOMEN.

"(a) OPTIONAL COVERAGE.—Notwithstanding any other provision of this title, a State may provide for coverage, through an amendment to its State child health plan under section 2102, of assistance for pregnant women for targeted low-income pregnant women in accordance with this section, but only if—

"(1) the State has established an income eligibility level—

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

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

"(2) the State does not impose, with respect to the enrollment under the State child health plan of targeted low-income children during the quarter, any

1 enrollment cap or other numerical limitation on en-
2 rollment, any waiting list, any procedures designed
3 to delay the consideration of applications for enroll-
4 ment, or similar limitation with respect to enroll-
5 ment.
6 ''(b) DEFINITIONS.—For purposes of this title:
7 ''(1) ASSISTANCE FOR PREGNANT WOMEN.—
8 The term 'assistance for pregnant women' has the
9 meaning given the term child health assistance in
10 section 2110(a) as if any reference to targeted low-
11 income children were a reference to targeted low-in-
12 come pregnant women.
13 ''(2) TARGETED LOW-INCOME PREGNANT
14 WOMAN.—The term 'targeted low-income pregnant
15 woman' means a woman—
16 ''(A) during pregnancy and through the
17 end of the month in which the 60-day period
18 (beginning on the last day of her pregnancy)
19 ends;
20 ''(B) whose family income exceeds 185 per-
21 cent (or, if higher, the percent applied under
22 subsection (a)(1)(A)) of the poverty level appli-
23 cable to a family of the size involved, but does
24 not exceed the income eligibility level estab-

lished under the State child health plan under this title for a targeted low-income child; and

"(C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of section 2110(b), applied as if any reference to a child was a reference to a pregnant woman.

"(c) REFERENCES TO TERMS AND SPECIAL RULES.—In the case of, and with respect to, a State providing for coverage of assistance for pregnant women to targeted low-income pregnant women under subsection (a), the following special rules apply:

"(1) Any reference in this title (other than in subsection (b)) to a targeted low-income child is deemed to include a reference to a targeted low-income pregnant woman.

"(2) Any reference in this title to child health assistance (other than with respect to the provision of early and periodic screening, diagnostic, and treatment services) with respect to such women is deemed a reference to assistance for pregnant women.

"(3) Any such reference (other than in section 2105(d)) to a child is deemed a reference to a woman during pregnancy and the period described in subsection (b)(2)(A).

1 ''(4) In applying section 2102(b)(3)(B), any
2 reference to children found through screening to be
3 eligible for medical assistance under the State med-
4 icaid plan under title XIX is deemed a reference to
5 pregnant women.
6 ''(5) There shall be no exclusion of benefits for
7 services described in subsection (b)(1) based on any
8 preexisting condition and no waiting period (includ-
9 ing any waiting period imposed to carry out section
10 2102(b)(3)(C)) shall apply.
11 ''(6) In applying section 2103(e)(3)(B) in the
12 case of a pregnant woman provided coverage under
13 this section, the limitation on total annual aggregate
14 cost-sharing shall be applied to such pregnant
15 woman.
16 ''(7) In applying section 2104(i)—
17 ''(A) in the case of a State which did not
18 provide for coverage for pregnant women under
19 this title (under a waiver or otherwise) during
20 fiscal year 2007, the allotment amount other-
21 wise computed for the first fiscal year in which
22 the State elects to provide coverage under this
23 section shall be increased by an amount (deter-
24 mined by the Secretary) equal to the enhanced
25 FMAP of the expenditures under this title for

1 such coverage, based upon projected enrollment
2 and per capita costs of such enrollment; and
3 "(B) in the case of a State which provided
4 for coverage of pregnant women under this title
5 for the previous fiscal year—
6 "(i) in applying paragraph (2)(B) of
7 such section, there shall also be taken into
8 account (in an appropriate proportion) the
9 percentage increase in births in the State
10 for the relevant period; and
11 "(ii) in applying paragraph (3), preg-
12 nant women (and per capita expenditures
13 for such women) shall be accounted for
14 separately from children, but shall be in-
15 cluded in the total amount of any allot-
16 ment adjustment under such paragraph.
17 "(d) AUTOMATIC ENROLLMENT FOR CHILDREN
18 BORN TO WOMEN RECEIVING ASSISTANCE FOR PREG-
19 NANT WOMEN.—If a child is born to a targeted low-in-
20 come pregnant woman who was receiving assistance for
21 pregnant women under this section on the date of the
22 child's birth, the child shall be deemed to have applied for
23 child health assistance under the State child health plan
24 and to have been found eligible for such assistance under
25 such plan or to have applied for medical assistance under

1 title XIX and to have been found eligible for such assist-
2 ance under such title on the date of such birth, based on
3 the mother's reported income as of the time of her enroll-
4 ment under this section and applicable income eligibility
5 levels under this title and title XIX, and to remain eligible
6 for such assistance until the child attains 1 year of age.
7 During the period in which a child is deemed under the
8 preceding sentence to be eligible for child health or med-
9 ical assistance, the assistance for pregnant women or med-
10 ical assistance eligibility identification number of the
11 mother shall also serve as the identification number of the
12 child, and all claims shall be submitted and paid under
13 such number (unless the State issues a separate identifica-
14 tion number for the child before such period expires).''.
15 (2) ADDITIONAL AMENDMENT.—Section
16 2107(e)(1)(H) of such Act (42 U.S.C.
17 1397gg(e)(1)(H)), as redesignated by section
18 133(b), is amended to read as follows:
19 ''(H) Sections 1920 and 1920A (relating
20 to presumptive eligibility for pregnant women
21 and children).''.
22 (b) AMENDMENTS TO MEDICAID.—
23 (1) ELIGIBILITY OF A NEWBORN.—Section
24 1902(e)(4) of the Social Security Act (42 U.S.C.
25 1396a(e)(4)) is amended in the first sentence by

striking ''so long as the child is a member of the woman's household and the woman remains (or would remain if pregnant) eligible for such assistance''.

(2) APPLICATION OF QUALIFIED ENTITIES TO PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN UNDER MEDICAID.—Section 1920(b) of the Social Security Act (42 U.S.C. 1396r–1(b)) is amended by adding after paragraph (2) the following flush sentence:

''The term 'qualified provider' also includes a qualified entity, as defined in section 1920A(b)(3).''.

SEC. 134. LIMITATION ON WAIVER AUTHORITY TO COVER ADULTS.

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

''(d) LIMITATION ON COVERAGE OF ADULTS.—Notwithstanding any other provision of this title, the Secretary may not, through the exercise of any waiver authority on or after January 1, 2008, provide for Federal financial participation to a State under this title for health care services for individuals who are not targeted low-income children or pregnant women unless the Secretary determines that no eligible targeted low-income child in the

State would be denied coverage under this title for health care services because of such eligibility. In making such determination, the Secretary must receive assurances that—

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

"(2) the State has in place an outreach program to reach all targeted low-income children in families with incomes less than 200 percent of the poverty line.".

Subtitle E—Access

SEC. 141. CHILDREN'S ACCESS, PAYMENT, AND EQUALITY COMMISSION.

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

"CHILDREN'S ACCESS, PAYMENT, AND EQUALITY COMMISSION

"SEC. 1900. (a) ESTABLISHMENT.—There is hereby established as an agency of Congress the Children's Access, Payment, and Equality Commission (in this section referred to as the 'Commission').

"(b) DUTIES.—

"(1) REVIEW OF PAYMENT POLICIES AND ANNUAL REPORTS.—The Commission shall—

1 "(A) review Federal and State payment
2 policies of the Medicaid program established
3 under this title (in this section referred to as
4 'Medicaid') and the State Children's Health In-
5 surance Program established under title XXI
6 (in this section referred to as 'CHIP'), includ-
7 ing topics described in paragraph (2);
8 "(B) review access to, and affordability of,
9 coverage and services for enrollees under Med-
10 icaid and CHIP;
11 "(C) make recommendations to Congress
12 concerning such policies;
13 "(D) by not later than March 1 of each
14 year, submit to Congress a report containing
15 the results of such reviews and its recommenda-
16 tions concerning such policies; and
17 "(E) by not later than June 1 of each
18 year, submit to Congress a report containing an
19 examination of issues affecting Medicaid and
20 CHIP, including the implications of changes in
21 health care delivery in the United States and in
22 the market for health care services on such pro-
23 grams.
24 "(2) SPECIFIC TOPICS TO BE REVIEWED.—Spe-
25 cifically, the Commission shall review the following:

1 "(A) The factors affecting expenditures for
2 services in different sectors (such as physician,
3 hospital and other sectors), payment methodolo-
4 gies, and their relationship to access and qual-
5 ity of care for Medicaid and CHIP beneficiaries.
6 "(B) The impact of Federal and State
7 Medicaid and CHIP payment policies on access
8 to services (including dental services) for chil-
9 dren (including children with disabilities) and
10 other Medicaid and CHIP populations.
11 "(C) The impact of Federal and State
12 Medicaid and CHIP policies on reducing health
13 disparities, including geographic disparities and
14 disparities among minority populations.
15 "(D) The overall financial stability of the
16 health care safety net, including Federally-
17 qualified health centers, rural health centers,
18 school-based clinics, disproportionate share hos-
19 pitals, public hospitals, providers and grantees
20 under section 2612(a)(5) of the Public Health
21 Service Act (popularly known as the Ryan
22 White CARE Act), and other providers that
23 have a patient base which includes a dispropor-
24 tionate number of uninsured or low-income in-

1 dividuals and the impact of CHIP and Medicaid
2 policies on such stability.
3 "(E) The relation (if any) between pay-
4 ment rates for providers and improvement in
5 care for children as measured under the chil-
6 dren's health quality measurement program es-
7 tablished under section 151 of the Children's
8 Health and Medicare Protection Act of 2007.
9 "(F) The affordability, cost effectiveness,
10 and accessibility of services needed by special
11 populations under Medicaid and CHIP as com-
12 pared with private-sector coverage.
13 "(G) The extent to which the operation of
14 Medicaid and CHIP ensures access, comparable
15 to access under employer-sponsored or other
16 private health insurance coverage (or in the
17 case of federally-qualified health center services
18 (as defined in section 1905(l)(2)) and rural
19 health clinic services (as defined in section
20 1905(l)(1)), access comparable to the access to
21 such services under title XIX), for targeted low-
22 income children.
23 "(H) The effect of demonstrations under
24 section 1115, benchmark coverage under section
25 1937, and other coverage under section 1938,

on access to care, affordability of coverage, provider ability to achieve children's health quality performance measures, and access to safety net services.

"(3) COMMENTS ON CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to payment policies under Medicaid or CHIP, the Secretary shall transmit a copy of the report to the Commission. The Commission shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as the Commission deems appropriate.

"(4) AGENDA AND ADDITIONAL REVIEWS.—The Commission shall consult periodically with the Chairmen and Ranking Minority Members of the appropriate committees of Congress regarding the Commission's agenda and progress towards achieving the agenda. The Commission may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under

this title or title XXI as may be requested by such Chairmen and Members and as the Commission deems appropriate.

"(5) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

"(6) APPROPRIATE COMMITTEE OF CONGRESS.—For purposes of this section, the term 'appropriate committees of Congress' means the Committees on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

"(7) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each member of the Commission shall vote on the recommendation, and the Commission shall include, by member, the results of that vote in the report containing the recommendation.

"(8) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, the Commission shall examine the budget consequences of such recommendations, directly or

through consultation with appropriate expert entities.

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

"(1) Subsection (c) (relating to membership), except that the membership of the Commission shall also include representatives of children, pregnant women, individuals with disabilities, seniors, low-income families, and other groups of CHIP and Medicaid beneficiaries.

"(2) Subsection (d) (relating to staff and consultants).

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

"(d) AUTHORIZATION OF APPROPRIATIONS.—

"(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

1 "(2) AUTHORIZATION.—There are authorized to
2 be appropriated such sums as may be necessary to
3 carry out the provisions of this section.".

4 **SEC. 142. MODEL OF INTERSTATE COORDINATED ENROLL-**
5 **MENT AND COVERAGE PROCESS.**

6 (a) IN GENERAL.—In order to assure continuity of
7 coverage of low-income children under the Medicaid pro-
8 gram and the State Children's Health Insurance Program
9 (CHIP), not later than 18 months after the date of the
10 enactment of this Act, the Comptroller General of the
11 United States, in consultation with State Medicaid and
12 CHIP directors and organizations representing program
13 beneficiaries, shall develop a model process for the coordi-
14 nation of the enrollment, retention, and coverage under
15 such programs of children who, because of migration of
16 families, emergency evacuations, educational needs, or
17 otherwise, frequently change their State of residency or
18 otherwise are temporarily located outside of the State of
19 their residency.

20 (b) REPORT TO CONGRESS.—After development of
21 such model process, the Comptroller General shall submit
22 to Congress a report describing additional steps or author-
23 ity needed to make further improvements to coordinate the
24 enrollment, retention, and coverage under CHIP and Med-
25 icaid of children described in subsection (a).

1 **SEC. 143. MEDICAID CITIZENSHIP DOCUMENTATION RE-**
2 **QUIREMENTS.**
3 (a) STATE OPTION TO REQUIRE CHILDREN TO
4 PRESENT SATISFACTORY DOCUMENTARY EVIDENCE OF
5 PROOF OF CITIZENSHIP OR NATIONALITY FOR PURPOSES
6 OF ELIGIBILITY FOR MEDICAID; REQUIREMENT FOR AU-
7 DITING.—
8 (1) IN GENERAL.—Section 1902 of the Social
9 Security Act (42 U.S.C. 1396a) is amended—
10 (A) in subsection (a)(46)—
11 (i) by inserting ''(A)'' after ''(46)'';
12 and
13 (B) by adding at the end the following new
14 sbparagraphs:
15 ''(B) at the option of the State, require that,
16 with respect to a child under 21 years of age (other
17 than an individual described in section 1903(x)(2))
18 who declares to be a citizen or national of the
19 United States for purposes of establishing initial eli-
20 gibility for medical assistance under this title (or, at
21 State option, for purposes of renewing or redeter-
22 mining such eligibility to the extent that such satis-
23 factory documentary evidence of citizenship or na-
24 tionality has not yet been presented), there is pre-
25 sented satisfactory documentary evidence of citizen-
26 ship or nationality of the individual (using criteria

1 determined by the State, which shall be no more re-
2 strictive than the documentation specified in section
3 1903(x)(3)); and
4 ''(C) comply with the auditing requirements of
5 section 1903(x)(4);''; and
6 (C) in subsection (b)(3), by inserting ''or
7 any citizenship documentation requirement for
8 a child under 21 years of age that is more re-
9 strictive than what a State may provide under
10 section 1903(x)'' before the period at the end.
11 (2) AUDITING REQUIREMENT.—Section 1903(x)
12 of such Act (as amended by section 405(c)(1)(A) of
13 division B of the Tax Relief and Health Care Act of
14 2006 (Public Law 109–432)) is amended by adding
15 at the end the following new paragraph:
16 ''(4)(A) Regardless of whether a State has chosen to
17 take the option specified in section 1902(a)(46)(B), each
18 State shall audit a statistically-based sample of cases of
19 children under 21 years of age in order to demonstrate
20 to the satisfaction of the Secretary that the percentage
21 of Federal Medicaid funds being spent for non-emergency
22 benefits for aliens described in subsection (v)(1) who are
23 under 21 years of age does not exceed 3 percent of total
24 expenditures for medical assistance under the plan for
25 items and services for individuals under 21 years of age

1 for the period for which the sample is taken. In conducting
2 such audits, a State may rely on case reviews regularly
3 conducted pursuant to their Medicaid Quality Control or
4 Payment Error Rate Measurement (PERM) eligibility re-
5 views under subsection (u).

6 ''(B) In conducting audits under subparagraph (A),
7 payments for non-emergency benefits shall be treated as
8 erroneous if the audit could not confirm the citizenship
9 of the individual based either on documentation in the case
10 file or on documentation obtained independently during
11 the audit.

12 ''(C) If the erroneous error rate described in subpara-
13 graph (A)—

14 ''(i) exceeds 3 percent, the State shall—

15 ''(I) remit to the Secretary the Federal
16 share of improper expenditures in excess of the
17 3 percent level described in such subparagraph;

18 ''(II) shall develop a corrective action plan;
19 and

20 ''(III) shall conduct another audit the fol-
21 lowing fiscal year, after the corrective action
22 plan is implemented; or

23 ''(ii) does not exceed 3 percent, the State is not
24 required to conduct another audit under subpara-

1 graph (A) until the third fiscal year succeeding the
2 fiscal year for which the audit was conducted.'';
3 (3) ELIMINATION OF DENIAL OF PAYMENTS
4 FOR CHILDREN.—Section 1903(i)(22) of such Act
5 (42 U.S.C. 1396b(i)(22)) is amended by inserting
6 ''(other than a child under the age of 21)'' after ''for
7 an individual''.
8 (b) CLARIFICATION OF RULES FOR CHILDREN BORN
9 IN THE UNITED STATES TO MOTHERS ELIGIBLE FOR
10 MEDICAID.—Section 1903(x)(2) of such Act (42 U.S.C.
11 1396b(x)(2)) is amended—
12 (1) in subparagraph (C), by striking ''or'' at
13 the end;
14 (2) by redesignating subparagraph (D) as sub-
15 paragraph (E); and
16 (3) by inserting after subparagraph (C) the fol-
17 lowing new subparagraph:
18 ''(D) pursuant to the application of section
19 1902(e)(4) (and, in the case of an individual who is
20 eligible for medical assistance on such basis, the in-
21 dividual shall be deemed to have provided satisfac-
22 tory documentary evidence of citizenship or nation-
23 ality and shall not be required to provide further
24 documentary evidence on any date that occurs dur-

1 ing or after the period in which the individual is eli-
2 gible for medical assistance on such basis; or''.
3 (c) DOCUMENTATION FOR NATIVE AMERICANS .—
4 Section 1903(x)(3)(B) of such Act is amended—
5 (1) by redesignating clause (v) as clause (vi);
6 and
7 (2) by inserting after clause (iv) the following
8 new clause:
9 ''(v) For an individual who is a member of,
10 or enrolled in or affiliated with, a federally-rec-
11 ognized Indian tribe, a document issued by such
12 tribe evidencing such membership, enrollment,
13 or affiliation with the tribe (such as a tribal en-
14 rollment card or certificate of degree of Indian
15 blood), and, only with respect to those federally-
16 recognized Indian tribes located within States
17 having an international border whose member-
18 ship includes individuals who are not citizens of
19 the United States, such other forms of docu-
20 mentation (including tribal documentation, if
21 appropriate) as the Secretary, after consulting
22 with such tribes, determines to be satisfactory
23 documentary evidence of citizenship or nation-
24 ality for purposes of satisfying the requirement
25 of this subparagraph.''.

1 (d) REASONABLE OPPORTUNITY.—Section 1903(x)
2 of such Act, as amended by subsection (a)(2), is further
3 amended by adding at the end the following new para-
4 graph:
5 ''(5) In the case of an individual declaring to be a
6 citizen or national of the United States with respect to
7 whom a State requires the presentation of satisfactory
8 documentary evidence of citizenship or nationality under
9 section 1902(a)(46)(B), the individual shall be provided
10 at least the reasonable opportunity to present satisfactory
11 documentary evidence of citizenship or nationality under
12 this subsection as is provided under clauses (i) and (ii)
13 of section 1137(d)(4)(A) to an individual for the submittal
14 to the State of evidence indicating a satisfactory immigra-
15 tion status and shall not be denied medical assistance on
16 the basis of failure to provide such documentation until
17 the individual has had such an opportunity.''.
18 (e) EFFECTIVE DATE.—
19 (1) RETROACTIVE APPLICATION.—The amend-
20 ments made by this section shall take effect as if in-
21 cluded in the enactment of the Deficit Reduction Act
22 of 2005 (Public Law 109–171; 120 Stat. 4).
23 (2) RESTORATION OF ELIGIBILITY.—In the
24 case of an individual who, during the period that
25 began on July 1, 2006, and ends on the date of the

1 enactment of this Act, was determined to be ineli-
2 gible for medical assistance under a State Medicaid
3 program solely as a result of the application of sub-
4 sections (i)(22) and (x) of section 1903 of the Social
5 Security Act (as in effect during such period), but
6 who would have been determined eligible for such as-
7 sistance if such subsections, as amended by this sec-
8 tion, had applied to the individual, a State may
9 deem the individual to be eligible for such assistance
10 as of the date that the individual was determined to
11 be ineligible for such medical assistance on such
12 basis.

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

14 (a) DENTAL EDUCATION FOR PARENTS OF
15 NEWBORNS.—The Secretary of Health and Human Serv-
16 ices shall develop and implement, through entities that
17 fund or provide perinatal care services to targeted low-
18 income children under a State child health plan under title
19 XXI of the Social Security Act, a program to deliver oral
20 health educational materials that inform new parents
21 about risks for, and prevention of, early childhood caries
22 and the need for a dental visit within their newborn's first
23 year of life.

24 (b) PROVISION OF DENTAL SERVICES THROUGH
25 FQHCS.—

1 (1) MEDICAID.—Section 1902(a) of the Social
2 Security Act (42 U.S.C. 1396a(a)) is amended—
3 (A) by striking ''and'' at the end of para-
4 graph (69);
5 (B) by striking the period at the end of
6 paragraph (70) and inserting ''; and''; and
7 (C) by inserting after paragraph (70) the
8 following new paragraph:
9 ''(71) provide that the State will not prevent a
10 Federally-qualified health center from entering into
11 contractual relationships with private practice dental
12 providers in the provision of Federally-qualified
13 health center services.''.
14 (2) CHIP.—Section 2107(e)(1) of such Act is
15 amended—
16 (A) by redesignating subparagraphs (B)
17 through (D) as subparagraphs (C) through (E);
18 and
19 (B) by inserting after subparagraph (A)
20 the following new subparagraph:
21 ''(B) Section 1902(a)(71) (relating to lim-
22 iting FQHC contracting for provision of dental
23 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
5 HEALTH.——
6 (1) MEDICAID.—Section 1902(a)(43)(D)(iii) of
7 such Act (42 U.S.C. 1396a(a)(43)(D)(iii)) is amend-
8 ed by inserting ''and other information relating to
9 the provision of dental services to such children de-
10 scribed in section 2108(e)'' after ''receiving dental
11 services,''.
12 (2) CHIP.—Section 2108 of such Act (42
13 U.S.C. 1397hh) is amended by adding at the end
14 the following new subsection:
15 ''(e) INFORMATION ON DENTAL CARE FOR CHIL-
16 DREN.—
17 ''(1) IN GENERAL.—Each annual report under
18 subsection (a) shall include the following information
19 with respect to care and services described in section
20 1905(r)(3) provided to targeted low-income children
21 enrolled in the State child health plan under this
22 title at any time during the year involved:
23 ''(A) The number of enrolled children by
24 age grouping used for reporting purposes under
25 section 1902(a)(43).

"(B) For children within each such age grouping, information of the type contained in questions 12(a)–(c) of CMS Form 416 (that consists of the number of enrolled targeted low income children who receive any, preventive, or restorative dental care under the State plan).

"(C) For the age grouping that includes children 8 years of age, the number of such children who have received a protective sealant on at least one permanent molar tooth.

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

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

(d) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States shall provide for a study that examines—

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

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

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

SEC. 145. PROHIBITING INITIATION OF NEW HEALTH OPPORTUNITY ACCOUNT DEMONSTRATION PROGRAMS.

After the date of the enactment of this Act, the Secretary of Health and Human Services may not approve any new demonstration programs under section 1938 of the Social Security Act (42 U.S.C. 1396u-8).

Subtitle F—Quality and Program Integrity

SEC. 151. PEDIATRIC HEALTH QUALITY MEASUREMENT PROGRAM.

(a) QUALITY MEASUREMENT OF CHILDREN'S HEALTH.—

1 (1) ESTABLISHMENT OF PROGRAM TO DEVELOP
2 QUALITY MEASURES FOR CHILDREN'S HEALTH.—
3 The Secretary of Health and Human Services (in
4 this section referred to as the ''Secretary'') shall es-
5 tablish a child health care quality measurement pro-
6 gram (in this subsection referred to as the ''chil-
7 dren's health quality measurement program'') to de-
8 velop and implement—
9 (A) pediatric quality measures on chil-
10 dren's health care that may be used by public
11 and private health care purchasers (and a sys-
12 tem for reporting such measures); and
13 (B) measures of overall program perform-
14 ance that may be used by public and private
15 health care purchasers.
16 The Secretary shall publish, not later than Sep-
17 tember 30, 2009, the recommended measures under
18 the program for application under the amendments
19 made by subsection (b) for years beginning with
20 2010.
21 (2) MEASURES.—
22 (A) SCOPE.—The measures developed
23 under the children's health quality measure-
24 ment program shall—

1 (i) provide comprehensive information
2 with respect to the provision and outcomes
3 of health care for young children, school
4 age children, and older children.
5 (ii) be designed to identify disparities
6 by pediatric characteristics (including, at a
7 minimum, those specified in subparagraph
8 (C)) in child health and the provision of
9 health care;
10 (iii) be designed to ensure that the
11 data required for such measures is col-
12 lected and reported in a standard format
13 that permits comparison at a State, plan,
14 and provider level, and between insured
15 and uninsured children;
16 (iv) take into account existing meas-
17 ures of child health quality and be periodi-
18 cally updated;
19 (v) include measures of clinical health
20 care quality which meet the requirements
21 for pediatric quality measures in para-
22 graph (1);
23 (vi) improve and augment existing
24 measures of clinical health care quality for

1 children's health care and develop new and
2 emerging measures; and
3 (vii) increase the portfolio of evidence-
4 based pediatric quality measures available
5 to public and private purchasers, providers,
6 and consumers.
7 (B) SPECIFIC MEASURES.—Such measures
8 shall include measures relating to at least the
9 following aspects of health care for children:
10 (i) The proportion of insured (and un-
11 insured) children who receive age-appro-
12 priate preventive health and dental care
13 (including age appropriate immunizations)
14 at each stage of child health development.
15 (ii) The proportion of insured (and
16 uninsured) children who receive dental care
17 for restoration of teeth, relief of pain and
18 infection, and maintenance of dental
19 health.
20 (iii) The effectiveness of early health
21 care interventions for children whose as-
22 sessments indicate the presence or risk of
23 physical or mental conditions that could
24 adversely affect growth and development.

1 (iv) The effectiveness of treatment to
2 ameliorate the effects of diagnosed physical
3 and mental health conditions, including
4 chronic conditions.
5 (v) The proportion of children under
6 age 21 who are continuously insured for a
7 period of 12 months or longer.
8 (vi) The effectiveness of health care
9 for children with disabilities.
10 In carrying out clause (vi), the Secretary shall
11 develop quality measures and best practices re-
12 lating to cystic fibrosis.
13 (C) REPORTING METHODOLOGY FOR ANAL-
14 YSIS BY PEDIATRIC CHARACTERISTICS.—The
15 children's health quality measurement program
16 shall describe with specificity such measures
17 and the process by which such measures will be
18 reported in a manner that permits analysis
19 based on each of the following pediatric charac-
20 teristics:
21 (i) Age.
22 (ii) Gender.
23 (iii) Race.
24 (iv) Ethnicity.

1 (v) Primary language of the child's
2 parents (or caretaker relative).
3 (vi) Disability or chronic condition
4 (including cystic fibrosis).
5 (vii) Geographic location.
6 (viii) Coverage status under public
7 and private health insurance programs.
8 (D) PEDIATRIC QUALITY MEASURE.—In
9 this subsection, the term ''pediatric quality
10 measure'' means a measurement of clinical care
11 that assesses one or more aspects of pediatric
12 health care quality (in various settings) includ-
13 ing the structure of the clinical care system, the
14 process and outcome of care, or patient experi-
15 ence in such care.
16 (3) CONSULTATION IN DEVELOPING QUALITY
17 MEASURES FOR CHILDREN'S HEALTH SERVICES.—In
18 developing and implementing the children's health
19 quality measurement program, the Secretary shall
20 consult with—
21 (A) States;
22 (B) pediatric hospitals, pediatricians, and
23 other primary and specialized pediatric health
24 care professionals (including members of the al-
25 lied health professions) who specialize in the

1 care and treatment of children, particularly
2 children with special physical, mental, and de-
3 velopmental health care needs;
4 (C) dental professionals;
5 (D) health care providers that furnish pri-
6 mary health care to children and families who
7 live in urban and rural medically underserved
8 communities or who are members of distinct
9 population sub-groups at heightened risk for
10 poor health outcomes;
11 (E) national organizations representing
12 children, including children with disabilities and
13 children with chronic conditions;
14 (F) national organizations and individuals
15 with expertise in pediatric health quality per-
16 formance measurement; and
17 (G) voluntary consensus standards setting
18 organizations and other organizations involved
19 in the advancement of evidence based measures
20 of health care.
21 (4) USE OF GRANTS AND CONTRACTS.—In car-
22 rying out the children's health quality measurement
23 program, the Secretary may award grants and con-
24 tracts to develop, test, validate, update, and dissemi-
25 nate quality measures under the program.

1 (5) TECHNICAL ASSISTANCE.—The Secretary
2 shall provide technical assistance to States to estab-
3 lish for the reporting of quality measures under ti-
4 tles XIX and XXI of the Social Security Act in ac-
5 cordance with the children's health quality measure-
6 ment program.
7 (b) DISSEMINATION OF INFORMATION ON THE QUAL-
8 ITY OF PROGRAM PERFORMANCE.—Not later than Janu-
9 ary 1, 2009, and annually thereafter, the Secretary shall
10 collect, analyze, and make publicly available on a public
11 website of the Department of Health and Human Services
12 in an online format—
13 (1) a complete list of all measures in use by
14 States as of such date and used to measure the
15 quality of medical and dental health services fur-
16 nished to children enrolled under title XIX of XXI
17 of the Social Security Act by participating providers,
18 managed care entities, and plan issuers; and
19 (2) information on health care quality for chil-
20 dren contained in external quality review reports re-
21 quired under section 1932(c)(2) of such Act (42
22 U.S.C. 1396u-2) or produced by States that admin-
23 ister separate plans under title XXI of such Act.
24 (c) REPORTS TO CONGRESS ON PROGRAM PERFORM-
25 ANCE.—Not later than January 1, 2010, and every 2

1 years thereafter, the Secretary shall report to Congress
2 on—
3 (1) the quality of health care for children en-
4 rolled under title XIX and XXI of the Social Secu-
5 rity Act under the children's health quality measure-
6 ment program; and
7 (2) patterns of health care utilization with re-
8 spect to the measures specified in subsection
9 (a)(2)(B) among children by the pediatric character-
10 istics listed in subsection (a)(2)(C).

11 **SEC. 152. APPLICATION OF CERTAIN MANAGED CARE**
12 **QUALITY SAFEGUARDS TO CHIP.**

13 (a) IN GENERAL.—Section 2103(f) of Social Security
14 Act (42 U.S.C. 1397bb(f)) is amended by adding at the
15 end the following new paragraph:
16 ''(3) COMPLIANCE WITH MANAGED CARE RE-
17 QUIREMENTS.—The State child health plan shall
18 provide for the application of subsections (a)(4),
19 (a)(5), (b), (c), (d), and (e) of section 1932 (relating
20 to requirements for managed care) to coverage,
21 State agencies, enrollment brokers, managed care
22 entities, and managed care organizations under this
23 title in the same manner as such subsections apply
24 to coverage and such entities and organizations
25 under title XIX.''.

1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall apply to contract years for health
3 plans beginning on or after July 1, 2008.

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

5 Section 2108(c) of the Social Security Act (42 U.S.C.
6 1397hh(c)) is amended by striking paragraph (5) and in-
7 serting the following:

8 "(5) SUBSEQUENT EVALUATION USING UP-
9 DATED INFORMATION.—

10 "(A) IN GENERAL.—The Secretary, di-
11 rectly or through contracts or interagency
12 agreements, shall conduct an independent sub-
13 sequent evaluation of 10 States with approved
14 child health plans.

15 "(B) SELECTION OF STATES AND MAT-
16 TERS INCLUDED.—Paragraphs (2) and (3) shall
17 apply to such subsequent evaluation in the
18 same manner as such provisions apply to the
19 evaluation conducted under paragraph (1).

20 "(C) SUBMISSION TO CONGRESS.—Not
21 later than December 31, 2010, the Secretary
22 shall submit to Congress the results of the eval-
23 uation conducted under this paragraph.

24 "(D) FUNDING.—Out of any money in the
25 Treasury of the United States not otherwise ap-

1 propriated, there are appropriated $10,000,000
2 for fiscal year 2009 for the purpose of con-
3 ducting the evaluation authorized under this
4 paragraph. Amounts appropriated under this
5 subparagraph shall remain available for expend-
6 iture through fiscal year 2011.'' .

7 **SEC. 154. ACCESS TO RECORDS FOR IG AND GAO AUDITS**
8 **AND EVALUATIONS.**

9 Section 2108(d) of the Social Security Act (42 U.S.C.
10 1397hh(d)) is amended to read as follows:

11 ''(d) ACCESS TO RECORDS FOR IG AND GAO AUDITS
12 AND EVALUATIONS.—For the purpose of evaluating and
13 auditing the program established under this title, the Sec-
14 retary, the Office of Inspector General, and the Comp-
15 troller General shall have access to any books, accounts,
16 records, correspondence, and other documents that are re-
17 lated to the expenditure of Federal funds under this title
18 and that are in the possession, custody, or control of
19 States receiving Federal funds under this title or political
20 subdivisions thereof, or any grantee or contractor of such
21 States or political subdivisions.''.

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

23 Section 704 of the Medicare, Medicaid, and SCHIP
24 Balanced Budget Refinement Act of 1999 (Appendix F,

1 113 Stat. 1501A–321), as enacted into law by section
2 1000(a)(6) of Public Law 106–113) is repealed.

3 **SEC. 156. RELIANCE ON LAW; EXCEPTION FOR STATE LEG-**
4 **ISLATION.**

5 (a) RELIANCE ON LAW.— With respect to amend-
6 ments made by this title or title VIII that become effective
7 as of a date—

8 (1) such amendments are effective as of such
9 date whether or not regulations implementing such
10 amendments have been issued; and

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

22 (b) EXCEPTION FOR STATE LEGISLATION.—In the
23 case of a State plan under title XIX or State child health
24 plan under XXI of the Social Security Act, which the Sec-
25 retary of Health and Human Services determines requires

State legislation in order for respective plan to meet one or more additional requirements imposed by amendments made by this title or title VIII, the respective State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet such an additional requirement before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

TITLE J—MEDICARE BENEFICIARY IMPROVEMENTS

Subtitle A—Improvements in Benefits

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

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

(1) in subsection (s)(2)—

(A) in subparagraph (Z), by striking ''and'' after the semicolon at the end;

1 (B) in subparagraph (AA), by adding
2 ''and'' after the semicolon at the end; and
3 (C) by adding at the end the following new
4 subparagraph:
5 ''(BB) additional pre-
6 ventive services (described in
7 subsection (ccc)(1)(M));'';
8 and
9 (2) by adding at the end the following new sub-
10 section:
11 ''Preventive Services
12 ''(ccc)(1) The term 'preventive services' means the
13 following:
14 ''(A) Prostate cancer screening tests (as
15 defined in subsection (oo)).
16 ''(B) Colorectal cancer screening tests (as
17 defined in subsection (pp)).
18 ''(C) Diabetes outpatient self-management
19 training services (as defined in subsection (qq)).
20 ''(D) Screening for glaucoma for certain
21 individuals (as described in subsection
22 (s)(2)(U)).
23 ''(E) Medical nutrition therapy services for
24 certain individuals (as described in subsection
25 (s)(2)(V)).

1 "(F) An initial preventive physical exam-
2 ination (as defined in subsection (ww)).
3 "(G) Cardiovascular screening blood tests
4 (as defined in subsection (xx)(1)).
5 "(H) Diabetes screening tests (as defined
6 in subsection described in subsection (s)(2)(Y)).
7 "(I) Ultrasound screening for abdominal
8 aortic aneurysm for certain individuals (as de-
9 scribed in described in subsection (s)(2)(AA)).
10 "(J) Pneumococcal and influenza vaccine
11 and their administration (as described in sub-
12 section (s)(10)(A)).
13 "(K) Hepatitis B vaccine and its adminis-
14 tration for certain individuals (as described in
15 subsection (s)(10)(B)).
16 "(L) Screening mammography (as defined
17 in subsection (jj)).
18 "(M) Screening pap smear and screening
19 pelvic exam (as described in subsection (s)(14)).
20 "(N) Bone mass measurement (as defined
21 in subsection (rr)).
22 "(O) Additional preventive services (as de-
23 termined under paragraph (2)).
24 "(2)(A) The term 'additional preventive serv-
25 ices' means items and services, including mental

1 health services, not described in subparagraphs (A)
2 through (N) of paragraph (1) that the Secretary de-
3 termines to be reasonable and necessary for the pre-
4 vention or early detection of an illness or disability.
5 ''(B) In making determinations under subpara-
6 graph (1), the Secretary shall—
7 ''(C) take into account evidence-based rec-
8 ommendations by the United States Preventive
9 Services Task Force and other appropriate or-
10 ganizations; and
11 ''(D) use the process for making national
12 coverage determinations (as defined in section
13 1869(f)(1)(B)) under this title.''.
14 (b) PAYMENT AND ELIMINATION OF COST-SHAR-
15 ING.—
16 (1) IN GENERAL.—
17 (A) IN GENERAL.—Section 1833(a)(1) of
18 the Social Security Act (42 U.S.C. 1395l(a)(1))
19 is amended—
20 (i) in clause (T), by striking ''80 per-
21 cent'' and inserting ''100 percent''; and
22 (ii) by striking ''and'' before ''(V)'';
23 and
24 (iii) by inserting before the semicolon
25 at the end the following: '', and (W) with

1 respect to additional preventive services (as
2 defined in section 1861(ccc)(2)) and other
3 preventive services for which a payment
4 rate is not otherwise established under this
5 section, the amount paid shall be 100 per-
6 cent of the lesser of the actual charge for
7 the services or the amount determined
8 under a fee schedule established by the
9 Secretary for purposes of this clause''.
10 (B) APPLICATION TO SIGMOIDOSCOPIES
11 AND COLONOSCOPIES.—Section 1834(d) of such
12 Act (42 U.S.C. 1395m(d)) is amended—
13 (i) in paragraph (2)(C), by amending
14 clause (ii) to read as follows:
15 ''(ii) NO COINSURANCE.—In the case
16 of a beneficiary who receives services de-
17 scribed in clause (i), there shall be no coin-
18 surance applied.''; and.
19 (ii) in paragraph (3)(C), by amending
20 clause (ii) to read as follows:
21 ''(ii) NO COINSURANCE.—In the case
22 of a beneficiary who receives services de-
23 scribed in clause (i), there shall be no coin-
24 surance applied.''.

1 (2) ELIMINATION OF COINSURANCE IN OUT-
2 PATIENT HOSPITAL SETTINGS.—
3 (A) EXCLUSION FROM OPD FEE SCHED-
4 ULE.—Section 1833(t)(1)(B)(iv) of the Social
5 Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is
6 amended by striking ''screening mammography
7 (as defined in section 1861(jj)) and diagnostic
8 mammography'' and inserting ''diagnostic
9 mammography and preventive services (as de-
10 fined in section 1861(ccc)(1))''.
11 (B) CONFORMING AMENDMENTS.—Section
12 1833(a)(2) of the Social Security Act (42
13 U.S.C. 1395l(a)(2)) is amended—
14 (i) in subparagraph (F), by striking
15 ''and'' after the semicolon at the end;
16 (ii) in subparagraph (G)(ii), by adding
17 ''and''at the end; and
18 (iii) by adding at the end the fol-
19 lowing new subparagraph:
20 ''(H) with respect to additional preventive
21 services (as defined in section 1861(ccc)(2))
22 furnished by an outpatient department of a hos-
23 pital, the amount determined under paragraph
24 (1)(W);''.

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

(A) in clause (1), by striking "items and services described in section 1861(s)(10)(A)" and inserting "preventive services (as defined in section 1861(ccc)(1))";

(B) by inserting "and" before "(4)"; and

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

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

"(M) Additional preventive services (as defined in subsection (ccc)(2)).".

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

SEC. 202. WAIVER OF DEDUCTIBLE FOR COLORECTAL CANCER SCREENING TESTS REGARDLESS OF CODING, SUBSEQUENT DIAGNOSIS, OR ANCILLARY TISSUE REMOVAL.

(a) IN GENERAL.—Section 1833(b)(8) of the Social Security Act (42 U.S.C. 1395l(b)(8)) is amended by in-

1 serting ", regardless of the code applied, of the establish-
2 ment of a diagnosis as a result of the test, or of the re-
3 moval of tissue or other matter or other procedure that
4 is performed in connection with and as a result of the
5 screening test" after "1861(pp)(1))".

6 (b) EFFECTIVE DATE.—The amendment made by
7 subsection (a) shall apply to items and services furnished
8 on or after January 1, 2008.

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

10 Section 1833(c) of the Social Security Act (42 U.S.C.
11 1395l(c)) is amended—

12 (1) in the first sentence, by striking "62–1/2
13 percent" and inserting "the incurred expense per-
14 centage (as specified in the last sentence)"; and

15 (2) by adding at the end the following: "For
16 purposes of this subsection, the 'incurred expense
17 percentage' is equal to 62–1/2 percent increased, for
18 each year beginning with 2008, by 6–1/4 percentage
19 points, but not to exceed 100 percent.".

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.

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

(1) TO FULL-PREMIUM SUBSIDY ELIGIBLE INDIVIDUALS.—Section 1860D–14(a) of the Social Security Act (42 U.S.C. 1395w-114(a)) is amended—

(A) in paragraph (1), in the matter before subparagraph (A), by inserting ''(or, beginning with 2009, paragraph (3)(E))'' after ''paragraph (3)(D)''; and

(B) in paragraph (3)(A)(iii), by striking ''(D) or''.

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

(A) by striking ''and'' at the end of subclause (I);

(B) in subclause (II), by inserting ''(before 2009)'' after ''subsequent year'';

(C) by striking the period at the end of subclause (II) and inserting a semicolon; and

(D) by inserting after subclause (II) the following new subclauses:

"(III) for 2009, $17,000 (or $34,000 in the case of the combined value of the individual's assets or resources and the assets or resources of the individual's spouse); and

"(IV) for a subsequent year, the dollar amounts specified in this subclause (or subclause (III)) for the previous year increased by $1,000 (or $2,000 in the case of the combined value referred to in subclause (III))."

(3) APPLICATION OF LIS TEST UNDER MEDICARE SAVINGS PROGRAM.—Section 1905(p)(1)(C) of such Act (42 U.S.C. 1396d(p)(1)(C)) is amended by inserting before the period at the end the following: "or, effective beginning with January 1, 2009, whose resources (as so determined) do not exceed the maximum resource level applied for the year under section 1860D–14(a)(3)(E) applicable to an individual or to the individual and the individual's spouse (as the case may be)".

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall apply to eligibility determinations for
3 income-related subsidies and medicare cost-sharing fur-
4 nished for periods beginning on or after January 1, 2009.

5 **SEC. 212. MAKING QI PROGRAM PERMANENT AND EXPAND-**
6 **ING ELIGIBILITY.**

7 (a) MAKING PROGRAM PERMANENT.—
8 (1) IN GENERAL.—Section 1902(a)(10)(E)(iv)
9 of the Social Security Act (42 U.S.C.
10 1396b(a)(10)(E)(iv)) is amended—
11 (A) by striking ''sections 1933 and'' and
12 by inserting ''section''; and
13 (B) by striking ''(but only with'' and all
14 that follows through ''September 2007)''.
15 (2) ELIMINATION OF FUNDING LIMITATION.—
16 (A) IN GENERAL.—Section 1933 of such
17 Act (42 U.S.C. 1396u-3) is amended—
18 (i) in subsection (a), by striking ''who
19 are selected to receive such assistance
20 under subsection (b)''
21 (ii) by striking subsections (b), (c),
22 (e), and (g);
23 (iii) in subsection (d), by striking
24 ''furnished in a State'' and all that follows
25 and inserting ''the Federal medical assist-

ance percentage shall be equal to 100 percent.''; and

(iv) by redesignating subsections (d) and (f) as subsections (b) and (c), respectively.

(B) CONFORMING AMENDMENT.—Section 1905(b) of such Act (42 U.S.C. 1396d(b)) is amended by striking ''1933(d)'' and inserting ''1933(b)''.

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

(b) INCREASE IN ELIGIBILITY TO 150 PERCENT OF THE FEDERAL POVERTY LEVEL.—Section 1902(a)(10)(E)(iv) of such Act is further amended by inserting ''(or, effective January 1, 2008, 150 percent)'' after ''135 percent''.

SEC. 213. ELIMINATING BARRIERS TO ENROLLMENT.

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

''(G) SELF-CERTIFICATION OF INCOME AND RESOURCES.—For purposes of applying

this section, an individual shall be permitted to qualify on the basis of self-certification of income and resources without the need to provide additional documentation.''.

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

''(H) AUTOMATIC REENROLLMENT.—For purposes of applying this section, in the case of an individual who has been determined to be a subsidy eligible individual (and within a particular class of such individuals, such as a full-subsidy eligible individual or a partial subsidy eligible individual), the individual shall be deemed to continue to be so determined without the need for any annual or periodic application unless and until the individual notifies a Federal or State official responsible for such determinations that the individual's eligibility conditions have changed so that the individual is no longer a subsidy eligible individual (or is no longer within such class of such individuals).''.

1 (c) ENCOURAGING APPLICATION OF PROCEDURES
2 UNDER MEDICARE SAVINGS PROGRAM.—Section 1905(p)
3 of such Act (42 U.S.C. 1396d(p)) is amended by adding
4 at the end the following new paragraph:
5 "(7) The Secretary shall take all reasonable
6 steps to encourage States to provide for administra-
7 tive verification of income and automatic reenroll-
8 ment (as provided under clauses (iii) and (iv) of sec-
9 tion 1860D–14(a)(3)(C) in the case of the low-in-
10 come subsidy program).".
11 (d) SSA ASSISTANCE WITH MEDICARE SAVINGS
12 PROGRAM AND LOW-INCOME SUBSIDY PROGRAM APPLI-
13 CATIONS.—Section 1144 of such Act (42 U.S.C. 1320b-
14 14) is amended by adding at the end the following new
15 subsection:
16 "(c) ASSISTANCE WITH MEDICARE SAVINGS PRO-
17 GRAM AND LOW-INCOME SUBSIDY PROGRAM APPLICA-
18 TIONS.—
19 "(1) DISTRIBUTION OF APPLICATIONS TO AP-
20 PLICANTS FOR MEDICARE.—In the case of each indi-
21 vidual applying for hospital insurance benefits under
22 section 226 or 226A, the Commissioner shall provide
23 the following:
24 "(A) Information describing the low-in-
25 come subsidy program under section 1860D–14

1 and the medicare savings program under title
2 XIX.
3 "(B) An application for enrollment under
4 such low-income subsidy program as well as an
5 application form (developed under section
6 1905(p)(5)) for medical assistance for medicare
7 cost-sharing under title XIX.
8 "(C) Information on how the individual
9 may obtain assistance in completing such appli-
10 cations, including information on how the indi-
11 vidual may contact the State health insurance
12 assistance program (SHIP) for the State in
13 which the individual is located.
14 The Commissioner shall make such application
15 forms available at local offices of the Social Security
16 Administration.
17 "(2) TRAINING PERSONNEL IN ASSISTING IN
18 COMPLETING APPLICATIONS.—The Commissioner
19 shall provide training to those employees of the So-
20 cial Security Administration who are involved in re-
21 ceiving applications for benefits described in para-
22 graph (1) in assisting applicants in completing a
23 medicare savings program application described in
24 paragraph (1). Such employees who are so trained
25 shall provide such assistance upon request.

1 "(3) TRANSMITTAL OF COMPLETED APPLICA-
2 TION.—If such an employee assists in completing
3 such an application, the employee, with the consent
4 of the applicant, shall transmit the completed appli-
5 cation to the appropriate State medicaid agency for
6 processing.
7 "(4) COORDINATION WITH OUTREACH.—The
8 Commissioner shall coordinate outreach activities
9 under this subsection with outreach activities con-
10 ducted by States in connection with the low-income
11 subsidy program and the medicare savings pro-
12 gram.".
13 (e) MEDICAID AGENCY CONSIDERATION OF APPLICA-
14 TIONS.—Section 1935(a) of such Act (42 U.S.C. 1396u-
15 5(a)) is amended by adding at the end the following new
16 paragraph:
17 "(4) CONSIDERATION OF MSP APPLICATIONS.—
18 The State shall accept medicare savings program ap-
19 plications transmitted under section 1144(c)(3) and
20 act on such applications in the same manner and
21 deadlines as if they had been submitted directly by
22 the applicant.".
23 (f) TRANSLATION OF MODEL FORM.—Section
24 1905(p)(5)(A) of the Social Security Act (42 U.S.C.
25 1396d(p)(5)(A)) is amended by adding at the end the fol-

1 lowing: ''The Secretary shall provide for the translation
2 of such application form into at least the 10 languages
3 (other than English) that are most often used by individ-
4 uals applying for hospital insurance benefits under section
5 226 or 226A and shall make the translated forms available
6 to the States and to the Commissioner of Social Secu-
7 rity.''.

8 (g) DISCLOSURE OF TAX RETURN INFORMATION FOR
9 PURPOSES OF PROVIDING LOW-INCOME SUBSIDIES
10 UNDER MEDICARE.—

11 (1) IN GENERAL.—Subsection (l) of section
12 6103 of the Internal Revenue Code of 1986 is
13 amended by adding at the end the following new
14 paragraph:

15 ''(21) DISCLOSURE OF RETURN INFORMATION
16 FOR PURPOSES OF PROVIDING LOW-INCOME SUB-
17 SIDIES UNDER MEDICARE.—

18 ''(A) RETURN INFORMATION FROM INTER-
19 NAL REVENUE SERVICE TO SOCIAL SECURITY
20 ADMINISTRATION.—The Secretary, upon writ-
21 ten request from the Commissioner of Social
22 Security, shall disclose to the officers and em-
23 ployees of the Social Security Administration
24 with respect to any individual identified by the
25 Commissioner as potentially eligible (based on

information other than return information) for low-income subsidies under section 1860D–14 of the Social Security Act—

"(i) whether the adjusted gross income for the applicable year is less than 135 percent of the poverty line (as specified by the Commissioner in such request),

"(ii) whether such adjusted gross income is between 135 percent and 150 percent of the poverty line (as so specified),

"(iii) whether any designated distributions (as defined in section 3405(e)(1)) were reported with respect to such individual under section 6047(d) for the applicable year, and the amount (if any) of the distributions so reported,

"(iv) whether the return was a joint return for the applicable year, and

"(v) the applicable year.

"(B) APPLICABLE YEAR.—

"(i) IN GENERAL.—For the purposes of this paragraph, the term 'applicable year' means the most recent taxable year for which information is available in the Internal Revenue Service's taxpayer data

information systems, or, if there is no return filed for the individual for such year, the prior taxable year.

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

"(C) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under this paragraph may be used only for the purpose of improving the efforts of the Social Security Administration to contact and assist eligible individuals for, and administering, low-income subsidies under section 1860D–14 of the Social Security Act.

"(D) TERMINATION.—No disclosure shall be made under this paragraph after the 2-year period beginning on the date of the enactment of this paragraph.".

(2) PROCEDURES AND RECORDKEEPING RELATED TO DISCLOSURES.—Paragraph (4) of section 6103(p) of such Code is amended by striking "or

1 (17)'' each place it appears and inserting ''(17), or
2 (21)''.
3 (3) REPORT.—Not later than 18 months after
4 the date of the enactment of this Act, the Secretary
5 of the Treasury, after consultation with the Commis-
6 sioner of Social Security, shall submit a written re-
7 port to Congress regarding the use of disclosures
8 made under section 6103(l)(21) of the Internal Rev-
9 enue Code of 1986, as added by this subsection, in
10 identifying individuals eligible for the low-income
11 subsidies under section 1860D–14 of the Social Se-
12 curity Act.
13 (4) EFFECTIVE DATE.—The amendment made
14 by this subsection shall apply to disclosures made
15 after the date of the enactment of this Act.
16 (h) EFFECTIVE DATE.—Except as otherwise pro-
17 vided, the amendments made by this section shall take ef-
18 fect on January 1, 2009.
19 **SEC. 214. ELIMINATING APPLICATION OF ESTATE RECOV-**
20 **ERY.**
21 (a) IN GENERAL.—Section 1917(b)(1)(B)(ii) of the
22 Social Security Act (42 U.S.C. 1396p(b)(1)(B)(ii)) is
23 amended by inserting ''(but not including medical assist-
24 ance for medicare cost-sharing or for benefits described
25 in section 1902(a)(10)(E))'' before the period at the end.

1 (b) EFFECTIVE DATE.—The amendment made by
2 subsection (a) shall take effect as of January 1, 2008.

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

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

9 (1) in the heading, by striking ''INSTITU-
10 TIONALIZED INDIVIDUALS.—In'' and inserting
11 ''ELIMINATION OF COST-SHARING FOR CERTAIN
12 FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

13 ''(I) INSTITUTIONALIZED INDI-
14 VIDUALS.—In''; and

15 (2) by adding at the end the following new sub-
16 clause:

17 ''(II) CERTAIN OTHER INDIVID-
18 UALS.—In the case of an individual
19 who is a full-benefit dual eligible indi-
20 vidual and with respect to whom there
21 has been a determination that but for
22 the provision of home and community
23 based care (whether under section
24 1915 or under a waiver under section
25 1115) the individual would require the

level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan under title XIX, the elimination of any beneficiary co-insurance described in section 1860D–2(b)(2) (for all amounts through the total amount of expenditures at which benefits are available under section 1860D–2(b)(4)).''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to drugs dispensed on or after January 1, 2009.

SEC. 216. EXEMPTIONS FROM INCOME AND RESOURCES FOR DETERMINATION OF ELIGIBILITY FOR LOW-INCOME SUBSIDY.

(a) IN GENERAL.—Section 1860D–14(a)(3) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)), as amended by subsections (a) and (b) of section 213, is further amended—

(1) in subparagraph (C)(i), by inserting ''and except that support and maintenance furnished in kind shall not be counted as income'' after ''section 1902(r)(2)'';

(2) in subparagraph (D), in the matter before clause (i), by inserting "subject to the additional exclusions provided under subparagraph (G)" before ")";

(3) in subparagraph (E)(i), in the matter before subclause (I), by inserting "subject to the additional exclusions provided under subparagraph (G)" before ")"; and

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

"(I) ADDITIONAL EXCLUSIONS.—In determining the resources of an individual (and the eligible spouse of the individual, if any) under section 1613 for purposes of subparagraphs (D) and (E) the following additional exclusions shall apply:

"(i) LIFE INSURANCE POLICY.—No part of the value of any life insurance policy shall be taken into account.

"(ii) PENSION OR RETIREMENT PLAN.—No balance in any pension or retirement plan shall be taken into account.".

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2009, and shall

1 apply to determinations of eligibility for months beginning
2 with January 2009.

3 **SEC. 217. COST-SHARING PROTECTIONS FOR LOW-INCOME**
4 **SUBSIDY-ELIGIBLE INDIVIDUALS.**

5 (a) IN GENERAL.—Section 1860D–14(a) of the So-
6 cial Security Act (42 U.S.C. 1395w-114(a)) is amended—
7 (1) in paragraph (1)(D), by adding at the end
8 the following new clause:
9 ''(iv) OVERALL LIMITATION ON COST-
10 SHARING.—In the case of all such individ-
11 uals, a limitation on aggregate cost-sharing
12 under this part for a year not to exceed
13 2.5 percent of income.''; and
14 (2) in paragraph (2), by adding at the end the
15 following new subparagraph:
16 ''(F) OVERALL LIMITATION ON COST-SHAR-
17 ING.—A limitation on aggregate cost-sharing
18 under this part for a year not to exceed 2.5 per-
19 cent of income.''.

20 (b) EFFECTIVE DATE.—The amendments made by
21 subsection (a) shall apply as of January 1, 2009.

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

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

1 (1) in the second sentence of subparagraph (C),
2 by inserting ", subject to subparagraph (D)," before
3 "on a random basis"; and
4 (2) by adding at the end the following new sub-
5 paragraph:".
6 "(D) INTELLIGENT ASSIGNMENT.—In the
7 case of any auto-enrollment under subpara-
8 graph (C), no part D eligible individual de-
9 scribed in such subparagraph shall be enrolled
10 in a prescription drug plan which does not meet
11 the following requirements:
12 "(i) FORMULARY.—The plan has a
13 formulary that covers at least—
14 "(I) 95 percent of the 100 most
15 commonly prescribed non-duplicative
16 generic covered part D drugs for the
17 population of individuals entitled to
18 benefits under part A or enrolled
19 under part B; and
20 "(II) 95 percent of the 100 most
21 commonly prescribed non-duplicative
22 brand name covered part D drugs for
23 such population.
24 "(ii) PHARMACY NETWORK.—The
25 plan has a network of pharmacies that

1 substantially exceeds the minimum require-
2 ments for prescription drug plans in the
3 State and that provides access in areas
4 where lower income individuals reside.
5 ''(iii) QUALITY.—
6 ''(I) IN GENERAL.—Subject to
7 subclause (I), the plan has an above
8 average score on quality ratings of the
9 Secretary of prescription drug plans
10 under this part.
11 ''(II) EXCEPTION.—Subclause (I)
12 shall not apply to a plan that is a new
13 plan (as defined by the Secretary),
14 with respect to the plan year involved.
15 ''(iv) LOW COST.—The total cost
16 under this title of providing prescription
17 drug coverage under the plan consistent
18 with the previous clauses of this subpara-
19 graph is among the lowest 25th percentile
20 of prescription drug plans under this part
21 in the State.
22 In the case that no plan meets the requirements
23 under clauses (i) through (iv), the Secretary
24 shall implement this subparagraph to the great-
25 est extent possible with the goal of protecting

1 beneficiary access to drugs without increasing
2 the cost relative to the enrollment process under
3 subparagraph (C) as in existence before the
4 date of the enactment of this subparagraph.''.
5 (b) EFFECTIVE DATE.—The amendment made by
6 subsection (a) shall take effect for enrollments effected on
7 or after November 15, 2009.

8 Subtitle C—Part D Beneficiary 9 Improvements

**10 SEC. 221. INCLUDING COSTS INCURRED BY AIDS DRUG AS-
11 SISTANCE PROGRAMS AND INDIAN HEALTH
12 SERVICE IN PROVIDING PRESCRIPTION
13 DRUGS TOWARD THE ANNUAL OUT OF POCK-
14 ET THRESHOLD UNDER PART D.**

15 (a) IN GENERAL.—Section 1860D–2(b)(4)(C) of the
16 Social Security Act (42 U.S.C. 1395w-102(b)(4)(C)) is
17 amended—
18 (1) in clause (i), by striking ''and'' at the end;
19 (2) in clause (ii)—
20 (A) by striking ''such costs shall be treated
21 as incurred only if'' and inserting ''subject to
22 clause (iii), such costs shall be treated as in-
23 curred only if'';

1 (B) by striking ", under section 1860D–
2 14, or under a State Pharmaceutical Assistance
3 Program"; and
4 (C) by striking the period at the end and
5 inserting "; and"; and
6 (3) by inserting after clause (ii) the following
7 new clause:
8 "(iii) such costs shall be treated as in-
9 curred and shall not be considered to be
10 reimbursed under clause (ii) if such costs
11 are borne or paid—
12 "(I) under section 1860D–14;
13 "(II) under a State Pharma-
14 ceutical Assistance Program;
15 "(III) by the Indian Health Serv-
16 ice, an Indian tribe or tribal organiza-
17 tion, or an urban Indian organization
18 (as defined in section 4 of the Indian
19 Health Care Improvement Act); or
20 "(IV) under an AIDS Drug As-
21 sistance Program under part B of
22 title XXVI of the Public Health Serv-
23 ice Act.".

1 (b) EFFECTIVE DATE.—The amendments made by
2 subsection (a) shall apply to costs incurred on or after
3 January 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
11 IN INCREASE IN COST-SHARING.—

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

22 ''(ii) EXCEPTION.—Clause (i) shall
23 not apply in the case that a drug is re-
24 moved from the formulary of a plan be-
25 cause of a recall or withdrawal of the drug

issued by the Food and Drug Administration.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to contract years beginning on or after January 1, 2009.

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

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

(1) by striking ''subparagraph (E)'' and inserting ''subparagraphs (E) and (J)''; and

(2) by inserting ''and benzodiazepines, respectively'' after ''smoking cessation agents''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to prescriptions dispensed on or after January 1, 2009.

SEC. 224. PERMITTING UPDATING DRUG COMPENDIA UNDER PART D USING PART B UPDATE PROCESS.

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

1 "(iv) UPDATING DRUG COMPENDIA
2 USING PART B PROCESS.—The Secretary
3 may apply under this subparagraph the
4 same process for updating drug compendia
5 that is used for purposes of section
6 1861(t)(2)(B)(ii).".

7 **SEC. 225. CODIFICATION OF SPECIAL PROTECTIONS FOR**
8 **SIX PROTECTED DRUG CLASSIFICATIONS.**

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

12 (1) in subparagraph (C)(i), by inserting ", ex-
13 cept as provided in subparagraph (G)," after "al-
14 though"; and

15 (2) by inserting after subparagraph (F) the fol-
16 lowing new subparagraph:

17 "(G) REQUIRED INCLUSION OF DRUGS IN
18 CERTAIN THERAPEUTIC CLASSES.—

19 "(i) IN GENERAL.—The formulary
20 must include all or substantially all covered
21 part D drugs in each of the following
22 therapeutic classes of covered part D
23 drugs:

24 "(I) Anticonvulsants.

25 "(II) Antineoplastics.

1 ''(III) Antiretrovirals.
2 ''(IV) Antidepressants.
3 ''(V) Antipsychotics.
4 ''(VI) Immunosuppresessants.
5 ''(ii) USE OF UTILIZATION MANAGE-
6 MENT TOOLS.—A PDP sponsor of a pre-
7 scription drug plan may use prior author-
8 ization or step therapy for the initiation of
9 medications within one of the classifica-
10 tions specified in clause (i) but only when
11 approved by the Secretary, except that
12 such prior authorization or step therapy
13 may not be used in the case of
14 antiretrovirals and in the case of individ-
15 uals who already are stabilized on a drug
16 treatment regimen.''.
17 (b) EFFECTIVE DATE.—The amendment made by
18 subsection (a) shall apply for plan years beginning on or
19 after January 1, 2009.
20 **SEC. 226. ELIMINATION OF MEDICARE PART D LATE EN-**
21 **ROLLMENT PENALTIES PAID BY LOW-INCOME**
22 **SUBSIDY-ELIGIBLE INDIVIDUALS.**
23 (a) INDIVIDUALS WITH INCOME BELOW 135 PER-
24 CENT OF POVERTY LINE.—Paragraph (1)(A)(ii) of sec-

1 tion 1860D–14(a) of the Social Security Act (42 U.S.C.
2 1395w-114(a)) is amended to read as follows:
3 ''(ii) 100 percent of any late enrollment penalties im-
4 posed under section 1860D–13(b) for such individual.''.
5 (b) INDIVIDUALS WITH INCOME BETWEEN 135 AND
6 150 PERCENT OF POVERTY LINE.—Paragraph (2)(A) of
7 such section is amended—
8 (1) by inserting ''equal to (i) an amount'' after
9 ''premium subsidy'';
10 (2) by striking ''paragraph (1)(A)'' and insert-
11 ing ''clause (i) of paragraph (1)(A)''; and
12 (3) by adding at the end before the period the
13 following: '', plus (ii) 100 percent of the amount de-
14 scribed in clause (ii) of such paragraph for such in-
15 dividual''.
16 (c) EFFECTIVE DATE.—The amendments made by
17 this section shall apply to subsidies for months beginning
18 with January 2008.

19 **SEC. 227. SPECIAL ENROLLMENT PERIOD FOR SUBSIDY EL-**
20 **IGIBLE INDIVIDUALS.**

21 (a) IN GENERAL.—Section 1860D–1(b)(3) of the So-
22 cial Security Act (42 U.S.C. 1395w–101(b)(3)), as amend-
23 ed by section 222(a), is further amended by adding at the
24 end the following new subparagraph:

1 "(G) ELIGIBILITY FOR LOW-INCOME SUB-
2 SIDY.—
3 "(i) IN GENERAL.—In the case of an
4 applicable subsidy eligible individual (as
5 defined in clause (ii)), the special enroll-
6 ment period described in clause (iii).
7 "(ii) APPLICABLE SUBSIDY ELIGIBLE
8 INDIVIDUAL DEFINED.—For purposes of
9 this subparagraph, the term 'applicable
10 subsidy eligible individual' means a part D
11 eligible individual who is determined under
12 subparagraph (B) of section 1860D–
13 14(a)(3) to be a subsidy eligible individual
14 (as defined in subparagraph (A) of such
15 section), and includes such an individual
16 who was enrolled in a prescription drug
17 plan or an MA–PD plan on the date of
18 such determination.
19 "(iii) SPECIAL ENROLLMENT PERIOD
20 DESCRIBED.—The special enrollment pe-
21 riod described in this clause, with respect
22 to an applicable subsidy eligible individual,
23 is the 90-day period beginning on the date
24 the individual receives notification that
25 such individual has been determined under

1 section 1860D–14(a)(3)(B) to be a subsidy
2 eligible individual (as so defined).''.
3 (b) AUTOMATIC ENROLLMENT PROCESS FOR CER-
4 TAIN SUBSIDY ELIGIBLE INDIVIDUALS.—Section 1860D–
5 1(b)(1) of the Social Security Act (42 U.S.C. 1395w-
6 101(b)(1)), as amended by section 218(a)(2), is further
7 amended by adding at the end the following new subpara-
8 graph:
9 ''(E) SPECIAL RULE FOR SUBSIDY ELIGI-
10 BLE INDIVIDUALS.—The process established
11 under subparagraph (A) shall include, in the
12 case of an applicable subsidy eligible individual
13 (as defined in clause (ii) of paragraph (3)(F))
14 who fails to enroll in a prescription drug plan
15 or an MA–PD plan during the special enroll-
16 ment period described in clause (iii) of such
17 paragraph applicable to such individual, a proc-
18 ess for the facilitated enrollment of the indi-
19 vidual in the prescription drug plan or MA–PD
20 plan that is most appropriate for such indi-
21 vidual (as determined by the Secretary). Noth-
22 ing in the previous sentence shall prevent an in-
23 dividual described in such sentence from declin-
24 ing enrollment in a plan determined appropriate

by the Secretary (or in the program under this part) or from changing such enrollment.''.

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

Subtitle D—Reducing Health Disparities

SEC. 231. MEDICARE DATA ON RACE, ETHNICITY, AND PRIMARY LANGUAGE.

(a) REQUIREMENTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary'') shall—

(A) collect data on the race, ethnicity, and primary language of each applicant for and recipient of benefits under title XVIII of the Social Security Act—

(i) using, at a minimum, the categories for race and ethnicity described in the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity;

1 (ii) using the standards developed
2 under subsection (e) for the collection of
3 language data;
4 (iii) where practicable, collecting data
5 for additional population groups if such
6 groups can be aggregated into the min-
7 imum race and ethnicity categories; and
8 (iv) where practicable, through self-re-
9 porting;
10 (B) with respect to the collection of the
11 data described in subparagraph (A) for appli-
12 cants and recipients who are minors or other-
13 wise legally incapacitated, require that—
14 (i) such data be collected from the
15 parent or legal guardian of such an appli-
16 cant or recipient; and
17 (ii) the preferred language of the par-
18 ent or legal guardian of such an applicant
19 or recipient be collected;
20 (C) systematically analyze at least annually
21 such data using the smallest appropriate units
22 of analysis feasible to detect racial and ethnic
23 disparities in health and health care and when
24 appropriate, for men and women separately;

1 (D) report the results of analysis annually
2 to the Director of the Office for Civil Rights,
3 the Committee on Health, Education, Labor,
4 and Pensions and the Committee on Finance of
5 the Senate, and the Committee on Energy and
6 Commerce and the Committee on Ways and
7 Means of the House of Representatives; and
8 (E) ensure that the provision of assistance
9 to an applicant or recipient of assistance is not
10 denied or otherwise adversely affected because
11 of the failure of the applicant or recipient to
12 provide race, ethnicity, and primary language
13 data.
14 (2) RULES OF CONSTRUCTION.—Nothing in
15 this subsection shall be construed—
16 (A) to permit the use of information col-
17 lected under this subsection in a manner that
18 would adversely affect any individual providing
19 any such information; and
20 (B) to require health care providers to col-
21 lect data.
22 (b) PROTECTION OF DATA.—The Secretary shall en-
23 sure (through the promulgation of regulations or other-
24 wise) that all data collected pursuant to subsection (a) is
25 protected—

1 (1) under the same privacy protections as the
2 Secretary applies to other health data under the reg-
3 ulations promulgated under section 264(c) of the
4 Health Insurance Portability and Accountability Act
5 of 1996 (Public Law 104–191; 110 Stat. 2033) re-
6 lating to the privacy of individually identifiable
7 health information and other protections; and
8 (2) from all inappropriate internal use by any
9 entity that collects, stores, or receives the data, in-
10 cluding use of such data in determinations of eligi-
11 bility (or continued eligibility) in health plans, and
12 from other inappropriate uses, as defined by the
13 Secretary.
14 (c) COLLECTION PLAN.—In carrying out the duties
15 specified in subsection (a), the Secretary shall develop and
16 implement a plan to improve the collection, analysis, and
17 reporting of racial, ethnic, and primary language data
18 within the programs administered under title XVIII of the
19 Social Security Act, and, in consultation with the National
20 Committee on Vital Health Statistics, the Office of Minor-
21 ity Health, and other appropriate public and private enti-
22 ties, shall make recommendations on how to—
23 (1) implement subsection (a) while minimizing
24 the cost and administrative burdens of data collec-
25 tion and reporting;

1 (2) expand awareness that data collection, anal-
2 ysis, and reporting by race, ethnicity, and primary
3 language is legal and necessary to assure equity and
4 non-discrimination in the quality of health care serv-
5 ices;
6 (3) ensure that future patient record systems
7 have data code sets for racial, ethnic, and primary
8 language identifiers and that such identifiers can be
9 retrieved from clinical records, including records
10 transmitted electronically;
11 (4) improve health and health care data collec-
12 tion and analysis for more population groups if such
13 groups can be aggregated into the minimum race
14 and ethnicity categories;
15 (5) provide researchers with greater access to
16 racial, ethnic, and primary language data, subject to
17 privacy and confidentiality regulations; and
18 (6) safeguard and prevent the misuse of data
19 collected under subsection (a).
20 (d) COMPLIANCE WITH STANDARDS.—Data collected
21 under subsection (a) shall be obtained, maintained, and
22 presented (including for reporting purposes and at a min-
23 imum) in accordance with the 1997 Office of Management
24 and Budget Standards for Maintaining, Collecting, and
25 Presenting Federal Data on Race and Ethnicity.

1 (e) LANGUAGE COLLECTION STANDARDS.—Not later
2 than 1 year after the date of enactment of this Act, the
3 Director of the Office of Minority Health, in consultation
4 with the Office for Civil Rights of the Department of
5 Health and Human Services, shall develop and dissemi-
6 nate Standards for the Classification of Federal Data on
7 Preferred Written and Spoken Language.
8 (f) TECHNICAL ASSISTANCE FOR THE COLLECTION
9 AND REPORTING OF DATA.—
10 (1) IN GENERAL.—The Secretary may, either
11 directly or through grant or contract, provide tech-
12 nical assistance to enable a health care provider or
13 plan operating under the Medicare program to com-
14 ply with the requirements of this section.
15 (2) TYPES OF ASSISTANCE.—Assistance pro-
16 vided under this subsection may include assistance
17 to—
18 (A) enhance or upgrade computer tech-
19 nology that will facilitate racial, ethnic, and pri-
20 mary language data collection and analysis;
21 (B) improve methods for health data col-
22 lection and analysis including additional popu-
23 lation groups beyond the Office of Management
24 and Budget categories if such groups can be

1 aggregated into the minimum race and ethnicity
2 categories;
3 (C) develop mechanisms for submitting col-
4 lected data subject to existing privacy and con-
5 fidentiality regulations; and
6 (D) develop educational programs to raise
7 awareness that data collection and reporting by
8 race, ethnicity, and preferred language are legal
9 and essential for eliminating health and health
10 care disparities.
11 (g) ANALYSIS OF RACIAL AND ETHNIC DATA.—The
12 Secretary, acting through the Director of the Agency for
13 Health Care Research and Quality and in coordination
14 with the Administrator of the Centers for Medicare &
15 Medicaid Services, shall—
16 (1) identify appropriate quality assurance mech-
17 anisms to monitor for health disparities under the
18 Medicare program;
19 (2) specify the clinical, diagnostic, or thera-
20 peutic measures which should be monitored;
21 (3) develop new quality measures relating to ra-
22 cial and ethnic disparities in health and health care;
23 (4) identify the level at which data analysis
24 should be conducted; and

1 (5) share data with external organizations for
2 research and quality improvement purposes, in com-
3 pliance with applicable Federal privacy laws.
4 (h) REPORT.—Not later than 2 years after the date
5 of enactment of this Act, and biennially thereafter, the
6 Secretary shall submit to the appropriate committees of
7 Congress a report on the effectiveness of data collection,
8 analysis, and reporting on race, ethnicity, and primary
9 language under the programs administered through title
10 XVIII of the Social Security Act. The report shall evaluate
11 the progress made with respect to the plan under sub-
12 section (c) or subsequent revisions thereto.
13 (i) AUTHORIZATION OF APPROPRIATIONS.—There is
14 authorized to be appropriated to carry out this section,
15 such sums as may be necessary for each of fiscal years
16 2008 through 2012.

17 **SEC. 232. ENSURING EFFECTIVE COMMUNICATION IN MEDI-**
18 **CARE.**

19 (a) ENSURING EFFECTIVE COMMUNICATION BY THE
20 CENTERS FOR MEDICARE & MEDICAID SERVICES.—
21 (1) STUDY ON MEDICARE PAYMENTS FOR LAN-
22 GUAGE SERVICES.—The Secretary of Health and
23 Human Services shall conduct a study that examines
24 ways that Medicare should develop payment systems

1 for language services using the results of the dem-
2 onstration program conducted under section 233.
3 (2) ANALYSES.— The study shall include an
4 analysis of each of the following:
5 (A) How to develop and structure appro-
6 priate payment systems for language services
7 for all Medicare service providers.
8 (B) The feasibility of adopting a payment
9 methodology for on-site interpreters, including
10 interpreters who work as independent contrac-
11 tors and interpreters who work for agencies
12 that provide on-site interpretation, pursuant to
13 which such interpreters could directly bill Medi-
14 care for services provided in support of physi-
15 cian office services for an LEP Medicare pa-
16 tient.
17 (C) The feasibility of Medicare contracting
18 directly with agencies that provide off-site inter-
19 pretation including telephonic and video inter-
20 pretation pursuant to which such contractors
21 could directly bill Medicare for the services pro-
22 vided in support of physician office services for
23 an LEP Medicare patient.
24 (D) The feasibility of modifying the exist-
25 ing Medicare resource-based relative value scale

1 (RBRVS) by using adjustments (such as multi-
2 pliers or add-ons) when a patient is LEP.
3 (E) How each of options described in a
4 previous paragraph would be funded and how
5 such funding would affect physician payments,
6 a physician's practice, and beneficiary cost-
7 sharing.
8 (3) VARIATION IN PAYMENT SYSTEM DE-
9 SCRIBED.—The payment systems described in sub-
10 section (b) may allow variations based upon types of
11 service providers, available delivery methods, and
12 costs for providing language services including such
13 factors as—
14 (A) the type of language services provided
15 (such as provision of health care or health care
16 related services directly in a non-English lan-
17 guage by a bilingual provider or use of an inter-
18 preter);
19 (B) type of interpretation services provided
20 (such as in-person, telephonic, video interpreta-
21 tion);
22 (C) the methods and costs of providing
23 language services (including the costs of pro-
24 viding language services with internal staff or

1 through contract with external independent con-
2 tractors and/or agencies);
3 (D) providing services for languages not
4 frequently encountered in the United States;
5 and
6 (E) providing services in rural areas.

7 (4) REPORT.—The Secretary shall submit a re-
8 port on the study conducted under subsection (a) to
9 appropriate committees of Congress not later than 1
10 year after the expiration of the demonstration pro-
11 gram conducted under section 3.
12 (b) HEALTH PLANS.—Section 1857(g)(1) of the So-
13 cial Security Act (42 U.S.C. 1395w-27(g)(1)) is amend-
14 ed—
15 (1) by striking ''or'' at the end of subparagraph
16 (F);
17 (2) by adding ''and'' at the end of subpara-
18 graph (G); and
19 (3) by inserting after subparagraph (G) the fol-
20 lowing new subparagraph:
21 ''(H) fails substantially to provide lan-
22 guage services to limited English proficient
23 beneficiaries enrolled in the plan that are re-
24 quired under law;''.

1 **SEC. 233. DEMONSTRATION TO PROMOTE ACCESS FOR**
2 **MEDICARE BENEFICIARIES WITH LIMITED**
3 **ENGLISH PROFICIENCY BY PROVIDING REIM-**
4 **BURSEMENT FOR CULTURALLY AND LINGUIS-**
5 **TICALLY APPROPRIATE SERVICES.**

6 (a) IN GENERAL.—Within one year after the date of
7 the enactment of this Act the Secretary, acting through
8 the Centers for Medicare & Medicaid Services, shall award
9 24 3-year demonstration grants to eligible Medicare serv-
10 ice providers to improve effective communication between
11 such providers and Medicare beneficiaries who are limited
12 English proficient. The Secretary shall not authorize a
13 grant larger than $500,000 over three years for any grant-
14 ee.

15 (b) ELIGIBILITY; PRIORITY.—

16 (1) ELIGIBILITY.—To be eligible to receive a
17 grant under subsection (1) an entity shall—

18 (A) be—

19 (i) a provider of services under part A
20 of title XVIII of the Social Security Act;

21 (ii) a service provider under part B of
22 such title;

23 (iii) a part C organization offering a
24 Medicare part C plan under part C of such
25 title; or

1 (iv) a PDP sponsor of a prescription
2 drug plan under part D of such title; and
3 (B) prepare and submit to the Secretary
4 an application, at such time, in such manner,
5 and accompanied by such additional informa-
6 tion as the Secretary may require.
7 (2) PRIORITY.—
8 (A) DISTRIBUTION.—To the extent fea-
9 sible, in awarding grants under this section, the
10 Secretary shall award—
11 (i) 6 grants to providers of services
12 described in paragraph (1)(A)(i);
13 (ii) 6 grants to service providers de-
14 scribed in paragraph (1)(A)(ii);
15 (iii) 6 grants to organizations de-
16 scribed in paragraph (1)(A)(iii); and
17 (iv) 6 grants to sponsors described in
18 paragraph (1)(A)(iv).
19 (B) FOR COMMUNITY ORGANIZATIONS.—
20 The Secretary shall give priority to applicants
21 that have developed partnerships with commu-
22 nity organizations or with agencies with experi-
23 ence in language access.
24 (C) VARIATION IN GRANTEES.—The Sec-
25 retary shall also ensure that the grantees under

this section represent, among other factors, variations in—

(i) different types of service providers and organizations under parts A through D of title XVIII of the Social Security Act;

(ii) languages needed and their frequency of use;

(iii) urban and rural settings;

(iv) at least two geographic regions; and

(v) at least two large metropolitan statistical areas with diverse populations.

(c) USE OF FUNDS.—

(1) IN GENERAL.—A grantee shall use grant funds received under this section to pay for the provision of competent language services to Medicare beneficiaries who are limited English proficient. Competent interpreter services may be provided through on-site interpretation, telephonic interpretation, or video interpretation or direct provision of health care or health care related services by a bilingual health care provider. A grantee may use bilingual providers, staff, or contract interpreters. A grantee may use grant funds to pay for competent translation services. A grantee may use up to 10

1 percent of the grant funds to pay for administrative
2 costs associated with the provision of competent lan-
3 guage services and for reporting required under sub-
4 section (E).

5 (2) ORGANIZATIONS.—Grantees that are part C
6 organizations or PDP sponsors must ensure that
7 their network providers receive at least 50 percent of
8 the grant funds to pay for the provision of com-
9 petent language services to Medicare beneficiaries
10 who are limited English proficient, including physi-
11 cians and pharmacies.

12 (3) DETERMINATION OF PAYMENTS FOR LAN-
13 GUAGE SERVICES.—Payments to grantees shall be
14 calculated based on the estimated numbers of LEP
15 Medicare beneficiaries in a grantee's service area
16 utilizing—

17 (A) data on the numbers of limited
18 English proficient individuals who speak
19 English less than ''very well'' from the most re-
20 cently available data from the Bureau of the
21 Census or other State-based study the Sec-
22 retary determines likely to yield accurate data
23 regarding the number of LEP individuals
24 served by the grantee; or

1 (B) the grantee's own data if the grantee
2 routinely collects data on Medicare bene-
3 ficiaries' primary language in a manner deter-
4 mined by the Secretary to yield accurate data
5 and such data shows greater numbers of LEP
6 individuals than the data listed in subparagraph
7 (A).
8 (4) LIMITATIONS.—
9 (A) REPORTING.—Payments shall only be
10 provided under this section to grantees that re-
11 port their costs of providing language services
12 as required under subsection (e). If a grantee
13 fails to provide the reports under such section
14 for the first year of a grant, the Secretary may
15 terminate the grant and solicit applications
16 from new grantees to participate in the subse-
17 quent two years of the demonstration program.
18 (B) TYPE OF SERVICES.—
19 (i) IN GENERAL.—Subject to clause
20 (ii), payments shall be provided under this
21 section only to grantees that utilize com-
22 petent bilingual staff or competent inter-
23 preter or translation services which—
24 (I) if the grantee operates in a
25 State that has statewide health care

1 interpreter standards, meet the State
2 standards currently in effect; or
3 (II) if the grantee operates in a
4 State that does not have statewide
5 health care interpreter standards, uti-
6 lizes competent interpreters who fol-
7 low the National Council on Inter-
8 preting in Health Care's Code of Eth-
9 ics and Standards of Practice.
10 (ii) EXEMPTIONS.—The requirements
11 of clause (i) shall not apply—
12 (I) in the case of a Medicare ben-
13 eficiary who is limited English pro-
14 ficient (who has been informed in the
15 beneficiary's primary language of the
16 availability of free interpreter and
17 translation services) and who requests
18 the use of family, friends, or other
19 persons untrained in interpretation or
20 translation and the grantee documents
21 the request in the beneficiary's record;
22 and
23 (II) in the case of a medical
24 emergency where the delay directly as-
25 sociated with obtaining a competent

1 interpreter or translation services
2 would jeopardize the health of the pa-
3 tient.
4 Nothing in clause (ii)(II) shall be con-
5 strued to exempt an emergency rooms or
6 similar entities that regularly provide
7 health care services in medical emergencies
8 from having in place systems to provide
9 competent interpreter and translation serv-
10 ices without undue delay.
11 (d) ASSURANCES.—Grantees under this section
12 shall—
13 (1) ensure that appropriate clinical and support
14 staff receive ongoing education and training in lin-
15 guistically appropriate service delivery; ensure the
16 linguistic competence of bilingual providers;
17 (2) offer and provide appropriate language serv-
18 ices at no additional charge to each patient with lim-
19 ited English proficiency at all points of contact, in
20 a timely manner during all hours of operation;
21 (3) notify Medicare beneficiaries of their right
22 to receive language services in their primary lan-
23 guage;

1 (4) post signage in the languages of the com-
2 monly encountered group or groups present in the
3 service area of the organization; and
4 (5) ensure that—
5 (A) primary language data are collected
6 for recipients of language services; and
7 (B) consistent with the privacy protections
8 provided under the regulations promulgated
9 pursuant to section 264(c) of the Health Insur-
10 ance Portability and Accountability Act of 1996
11 (42 U.S.C. 1320d–2 note), if the recipient of
12 language services is a minor or is incapacitated,
13 the primary language of the parent or legal
14 guardian is collected and utilized.
15 (e) REPORTING REQUIREMENTS.—Grantees under
16 this section shall provide the Secretary with reports at the
17 conclusion of the each year of a grant under this section.
18 each report shall include at least the following informa-
19 tion:
20 (1) The number of Medicare beneficiaries to
21 whom language services are provided.
22 (2) The languages of those Medicare bene-
23 ficiaries.
24 (3) The types of language services provided
25 (such as provision of services directly in non-English

1 language by a bilingual health care provider or use
2 of an interpreter).
3 (4) Type of interpretation (such as in-person,
4 telephonic, or video interpretation).
5 (5) The methods of providing language services
6 (such as staff or contract with external independent
7 contractors or agencies).
8 (6) The length of time for each interpretation
9 encounter.
10 (7) The costs of providing language services
11 (which may be actual or estimated, as determined by
12 the Secretary).
13 (f) NO COST SHARING.—LEP Beneficiaries shall not
14 have to pay cost-sharing or co-pays for language services
15 provided through this demonstration program.
16 (g) EVALUATION AND REPORT,.—The Secretary shall
17 conduct an evaluation of the demonstration program
18 under this section and shall submit to the appropriate
19 committees of Congress a report not later than 1 year
20 after the completion of the program. The report shall in-
21 clude the following:
22 (1) An analysis of the patient outcomes and
23 costs of furnishing care to the LEP Medicare bene-
24 ficiaries participating in the project as compared to

1 such outcomes and costs for limited English pro-
2 ficient Medicare 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 satisfac-
7 tion, and select health outcomes.
8 (3) Recommendations regarding the extension
9 of such project to the entire Medicare program.
10 (h) GENERAL PROVISIONS.—Nothing in this section
11 shall be construed to limit otherwise existing obligations
12 of recipients of Federal financial assistance under title VI
13 of the Civil Rights Act of 1964 (42 U.S.C. 2000(d) et.
14 seq.) or any other statute.
15 (i) AUTHORIZATION OF APPROPRIATIONS.—There
16 are 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
21 date of enactment of this Act, the Secretary shall establish
22 a demonstration project to determine the greatest needs
23 and most effective methods of outreach to medicare bene-
24 ficiaries who 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
11 demonstration 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 sub-
15 mit 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
24 access to care, utilization of services, efficiency and

1 cost-effectiveness of health care delivery, patient sat-
2 isfaction, and select health outcomes.

3 **SEC. 235. OFFICE OF THE INSPECTOR GENERAL REPORT**
4 **ON COMPLIANCE WITH AND ENFORCEMENT**
5 **OF NATIONAL STANDARDS ON CULTURALLY**
6 **AND LINGUISTICALLY APPROPRIATE SERV-**
7 **ICES (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 Or-
16 igin 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
24 on improving enforcement of CLAS Standards.

1 (b) IMPLEMENTATION.—Not later than one year
2 after the date of publication of the report under subsection
3 (a), the Department of Health and Human Services shall
4 implement changes responsive to any deficiencies identi-
5 fied in 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 under which the Institute will prepare
11 and publish, not later than 3 years after the date of the
12 enactment of this Act, a report on the impact of language
13 access services on the health and health care of limited
14 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
22 access 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
7 languages.

8 (2) COMPETENT INTERPRETER SERVICES.—The
9 term ''competent interpreter services'' means a
10 trans-language rendition of a spoken message in
11 which the interpreter comprehends the source lan-
12 guage and can speak comprehensively in the target
13 language to convey the meaning intended in the
14 source language. The interpreter knows health and
15 health-related terminology and provides accurate in-
16 terpretations by choosing equivalent expressions that
17 convey the best matching and meaning to the source
18 language and captures, to the greatest possible ex-
19 tent, all nuances intended in the source message.

20 (3) COMPETENT TRANSLATION SERVICES.—The
21 term ''competent translation services'' means a
22 trans-language rendition of a written document in
23 which the translator comprehends the source lan-
24 guage and can write comprehensively in the target
25 language to convey the meaning intended in the
26 source language. The translator knows health and

1 health-related terminology and provides accurate
2 translations by choosing equivalent expressions that
3 convey the best matching and meaning to the source
4 language and captures, to the greatest possible ex-
5 tent, all nuances intended in the source document.
6 (4) EFFECTIVE COMMUNICATION.—The term
7 ''effective communication'' means an exchange of in-
8 formation between the provider of health care or
9 health care-related services and the limited English
10 proficient recipient of such services that enables lim-
11 ited English proficient individuals to access, under-
12 stand, and benefit from health care or health care-
13 related services.
14 (5) INTERPRETING/INTERPRETATION.—The
15 terms ''interpreting'' and ''interpretation'' mean the
16 transmission of a spoken message from one language
17 into another, faithfully, accurately, and objectively.
18 (6) HEALTH CARE SERVICES.—The term
19 ''health care services'' means services that address
20 physical as well as mental health conditions in all
21 care settings.
22 (7) HEALTH CARE-RELATED SERVICES.—The
23 term ''health care-related services'' means human or
24 social services programs or activities that provide ac-
25 cess, referrals or links to health care.

1 (8) LANGUAGE ACCESS.—The term ''language
2 access'' means the provision of language services to
3 an LEP individual designed to enhance that individ-
4 ual's access to, understanding of or benefit from
5 health care or health care-related services.
6 (9) LANGUAGE SERVICES.—The term ''lan-
7 guage services'' means provision of health care serv-
8 ices directly in a non-English language, interpreta-
9 tion, translation, and non-English signage.
10 (10) LIMITED ENGLISH PROFICIENT.—The
11 term ''limited English proficient'' or ''LEP'' with re-
12 spect to an individual means an individual who
13 speaks a primary language other than English and
14 who cannot speak, read, write or understand the
15 English language at a level that permits the indi-
16 vidual to effectively communicate with clinical or
17 nonclinical staff at an entity providing health care or
18 health care related services.
19 (11) MEDICARE PROGRAM.—The term ''Medi-
20 care program'' means the programs under parts A
21 through 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

or services under any part of title XVIII of the Social Security Act.

TITLE K—PHYSICIANS' SERVICE PAYMENT REFORM

SEC. 301. ESTABLISHMENT OF SEPARATE TARGET GROWTH RATES FOR SERVICE CATEGORIES.

(a) ESTABLISHMENT OF SERVICE CATEGORIES.—Subsection (j) of section 1848 of the Social Security Act (42 U.S.C. 1395w-4) is amended by adding at the end the following new paragraph:

"(5) SERVICE CATEGORIES.—For services furnished on or after January 1, 2008, each of the following categories of physicians' services shall be treated as a separate 'service category':

"(A) Evaluation and management services for primary care (including new and established patient office visits delivered by physicians who the Secretary determines provide accessible, continuous, coordinated, and comprehensive care for Medicare beneficiaries, emergency department visits, and home visits), and for preventive services (including screening mammography, colorectal cancer screening, and other services as defined by the Secretary, limited to

1 the recommendations of the United States Pre-
2 ventive 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
10 regulations promulgated to carry out this sec-
11 tion) to a 10-day or 90-day global period (in
12 this paragraph referred to as 'major proce-
13 dures'), except that the Secretary may reclas-
14 sify as minor procedures under subparagraph
15 (F) any procedures that would otherwise be in-
16 cluded in this category if the Secretary deter-
17 mines that such procedures are not major pro-
18 cedures.
19 ''(E) Anesthesia services that are paid on
20 the basis of the separate conversion factor for
21 anesthesia services determined under subsection
22 (d)(1)(D).
23 ''(F) Minor procedures and any other phy-
24 sicians' services that are not described in a pre-
25 ceding subparagraph.''.

1 (b) ESTABLISHMENT OF SEPARATE CONVERSION
2 FACTORS FOR EACH SERVICE CATEGORY.—Subsection
3 (d)(1) of section 1848 of the Social Security Act (42
4 U.S.C. 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''
11 and inserting ''Subject to clause (ii), the con-
12 version 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
17 2008.—
18 ''(I) IN GENERAL.—In applying
19 clause (i) for years beginning with
20 2008, separate conversion factors
21 shall be established for each service
22 category of physicians' services (as de-
23 fined in subsection (j)(5)) and any
24 reference in this section to a conver-
25 sion factor for such years shall be

1 deemed to be a reference to the con-
2 version factor for each of such cat-
3 egories.
4 "(II) INITIAL CONVERSION FAC-
5 TORS; SPECIAL RULE FOR ANES-
6 THESIA SERVICES.— Such factors for
7 2008 shall be based upon the single
8 conversion factor for 2007 multiplied
9 by the update established under para-
10 graph (8) for such category for 2008.
11 In the case of the service category de-
12 scribed in subsection (j)(5)(F) (relat-
13 ing to anesthesia services), the conver-
14 sion factor for 2008 shall be based on
15 the separate conversion factor speci-
16 fied in subparagraph (D) for 2007
17 multiplied by the update established
18 under paragraph (8) for such category
19 for 2008.
20 "(III) UPDATING OF CONVER-
21 SION FACTORS.— Such factor for a
22 service category for a subsequent year
23 shall be based upon the conversion
24 factor for such category for the pre-
25 vious year and adjusted by the update

1 established for such category under
2 paragraph (8) for the year involved.''; 3 and
4 (2) in subparagraph (D), by inserting ''(before
5 2008)'' after ''for a year''.
6 (c) ESTABLISHING UPDATES FOR CONVERSION FAC-
7 TORS FOR SERVICE CATEGORIES.—Section 1848(d) of the
8 Social Security Act (42 U.S.C. 1395w-4(d)) is amended—
9 (1) in paragraph (4)(B), by striking ''and (6)''
10 and inserting '', (6), and (8)'';
11 (2) in paragraph (4)(C)(iii), by striking ''The
12 allowed'' and inserting ''Subject to paragraph
13 (8)(B), the allowed'';
14 (3) in paragraph (4)(D), by striking ''The up-
15 date'' and inserting ''Subject to paragraph (8)(E),
16 the update''; and
17 (4) by adding at the end the following new
18 paragraphs:
19 ''(8) UPDATES FOR SERVICE CATEGORIES BE-
20 GINNING WITH 2008.—
21 ''(A) IN GENERAL.—In applying paragraph
22 (4) for a year beginning with 2008, the fol-
23 lowing rules apply:
24 ''(i) APPLICATION OF SEPARATE UP-
25 DATE ADJUSTMENTS FOR EACH SERVICE

1 CATEGORY.—Pursuant to paragraph
2 (1)(A)(ii)(I), the update shall be made to
3 the conversion factor for each service cat-
4 egory (as defined in subsection (j)(5))
5 based upon an update adjustment factor
6 for the respective category and year and
7 the update adjustment factor shall be com-
8 puted, for a year, separately for each serv-
9 ice category.
10 ''(ii) COMPUTATION OF ALLOWED AND
11 ACTUAL EXPENDITURES BASED ON SERV-
12 ICE CATEGORIES.—In computing the prior
13 year adjustment component and the cumu-
14 lative adjustment component under clauses
15 (i) and (ii) of paragraph (4)(B), the fol-
16 lowing rules apply:
17 ''(I) APPLICATION BASED ON
18 SERVICE CATEGORIES.—The allowed
19 expenditures and actual expenditures
20 shall be the allowed and actual ex-
21 penditures for the service category, as
22 determined under subparagraph (B).
23 ''(II) LIMITATION TO PHYSICIAN
24 FEE-SCHEDULE SERVICES.—Actual
25 expenditures shall only take into ac-

1 count expenditures for services fur-
2 nished under the physician fee sched-
3 ule.
4 "(III) APPLICATION OF CAT-
5 EGORY SPECIFIC TARGET GROWTH
6 RATE.—The growth rate applied
7 under clause (ii)(II) of such para-
8 graph shall be the target growth rate
9 for the service category involved under
10 subsection (f)(5).
11 "(IV) ALLOCATION OF CUMU-
12 LATIVE OVERHANG.—There shall be
13 substituted for the difference de-
14 scribed in subparagraph (B)(ii)(I) of
15 such paragraph the amount described
16 in subparagraph (C)(i) for the service
17 category involved.
18 "(B) DETERMINATION OF ALLOWED EX-
19 PENDITURES.—In applying paragraph (4) for a
20 year beginning with 2008, notwithstanding sub-
21 paragraph (C)(iii) of such paragraph, the al-
22 lowed expenditures for a service category for a
23 year is an amount computed by the Secretary
24 as follows:
25 "(i) FOR 2008.—For 2008:

1 "(I) TOTAL 2007 ALLOWED EX-
2 PENDITURES.—Compute the total al-
3 lowed expenditures for services fur-
4 nished under the physician fee sched-
5 ule under such paragraph for 2007.
6 "(II) INCREASE BY GROWTH
7 RATE.—Increase the total under sub-
8 clause (I) by the target growth rate
9 for such category under subsection (f)
10 for 2008.
11 "(III) ALLOCATION TO SERVICE
12 CATEGORY.—Multiply the increased
13 total under subclause (II) by the over-
14 hang allocation factor for the service
15 category (as defined in subparagraph
16 (C)(iii)).
17 "(ii) FOR SUBSEQUENT YEARS.—For
18 a subsequent year, take the amount of al-
19 lowed expenditures for such category for
20 the preceding year (under clause (i) or this
21 clause) and increase it by the target
22 growth rate determined under subsection
23 (f) for such category and year.

1 "(C) COMPUTATION AND APPLICATION OF
2 CUMULATIVE OVERHANG AMONG CAT-
3 EGORIES.—
4 "(i) IN GENERAL.—For purposes of
5 applying paragraph (4)(B)(ii)(II) under
6 clause (ii)(IV), the amount described in
7 this clause for a year (beginning with
8 2008) is the sum of the following:
9 "(I) PRE-2008 CUMULATIVE
10 OVERHANG.—The amount of the pre-
11 2008 cumulative excess spending (as
12 defined in clause (ii)) multiplied by
13 the overhang allocation factor for the
14 service category (under clause (iii)).
15 "(II) POST-2007 CUMULATIVE
16 AMOUNTS.—For a year beginning
17 with 2009, the difference (which may
18 be positive or negative) between the
19 amount of the allowed expenditures
20 for physicians' services (as determined
21 under paragraph (4)(C)) in the serv-
22 ice category from January 1, 2008,
23 through the end of the prior year and
24 the amount of the actual expenditures

for such services in such category during that period.

"(ii) PRE-2008 CUMULATIVE EXCESS SPENDING DEFINED.—For purposes of clause (i)(I), the term 'pre-2008 cumulative excess spending' means the difference described in paragraph (4)(B)(ii)(I) as determined for the year 2008, taking into account expenditures through December 31, 2007. Such difference takes into account expenditures included in subsection (f)(4)(A).

"(iii) OVERHANG ALLOCATION FACTOR.—For purposes of this paragraph, the term 'overhang allocation factor' means, for a service category, the proportion, as determined by the Secretary of total actual expenditures under this part for items and services in such category during 2007 to the total of such actual expenditures for all the service categories. In calculating such proportion, the Secretary shall only take into account services furnished under the physician fee schedule.

"(D) FLOOR FOR UPDATES FOR 2008 AND 2009.—The update to the conversion factors for each service category for each of 2008 and 2009 shall be not less than 0.5 percent.

"(E) CHANGE IN RESTRICTION ON UPDATE ADJUSTMENT FACTOR FOR 2010 AND 2011.—The update adjustment factor determined under subparagraph (4)(B), as modified by this paragraph, for a service category for a year (beginning with 2010 and ending with 2011) may be less than -0.07, but may not be less than -0.14.".

(d) APPLICATION OF SEPARATE TARGET GROWTH RATES FOR EACH CATEGORY.—

(1) IN GENERAL.—Section 1848(f) of the Social Security Act (42 U.S.C. 1395w-4(f)) is amended by adding at the end the following new paragraph:

"(5) APPLICATION OF SEPARATE TARGET GROWTH RATES FOR EACH SERVICE CATEGORY BEGINNING WITH 2008.—The target growth rate for a year beginning with 2008 shall be computed and applied separately under this subsection for each service category (as defined in subsection (j)(5)) and shall be computed using the same method for com-

1 puting the sustainable growth rate except for the fol-
2 lowing:
3 ''(A) The reference in paragraphs (2)(A)
4 and (2)(D) to 'all physicians' services' is
5 deemed a reference to the physicians' services
6 included in such category but shall not take
7 into account items and services included in phy-
8 sicians' services through the operation of para-
9 graph (4)(A).
10 ''(B) The factor described in paragraph
11 (2)(C) for the service category described in sub-
12 section (j)(5)(A) shall be increased by 0.03.
13 ''(C) A national coverage determination (as
14 defined in section 1869(f)(1)(B)) shall be treat-
15 ed as a change in regulation described in para-
16 graph (2)(D).''.
17 (2) USE OF TARGET GROWTH RATES.—Section
18 1848 of such Act is further amended—
19 (A) in subsection (d)—
20 (i) in paragraph (1)(E)(ii), by insert-
21 ing ''or target'' after ''sustainable''; and
22 (ii) in paragraph (4)(B)(ii)(II), by in-
23 serting ''or target'' after ''sustainable'';
24 and
25 (B) in subsection (f)—

1 (i) in the heading by inserting ''; TAR-
2 GET GROWTH RATE'' after ''SUSTAINABLE
3 GROWTH RATE''
4 (ii) in paragraph (1)—
5 (I) by striking ''and'' at the end
6 of subparagraph (A);
7 (II) in subparagraph (B), by in-
8 serting ''before 2008'' after ''each
9 succeeding year'' and by striking the
10 period at the end and inserting ''
11 and''; and
12 (III) by adding at the end the
13 following new subparagraph:
14 ''(C) November 1 of each succeeding year
15 the target growth rate for such succeeding year
16 and each of the 2 preceding years.''; and
17 (iii) in paragraph (2), in the matter
18 before subparagraph (A), by inserting after
19 ''beginning with 2000'' the following: ''and
20 ending with 2007'' .
21 (e) REPORTS ON EXPENDITURES FOR PART B
22 DRUGS AND CLINICAL DIAGNOSTIC LABORATORY
23 TESTS.—
24 (1) REPORTING REQUIREMENT.—The Secretary
25 of Health and Human Services shall include infor-

1 mation in the annual physician fee schedule pro-
2 posed rule on the change in the annual rate of
3 growth of actual expenditures for clinical diagnostic
4 laboratory tests or drugs, biologicals, and radio-
5 pharmaceuticals for which payment is made under
6 part B of title XVIII of the Social Security Act.
7 (2) RECOMMENDATIONS.—The report sub-
8 mitted under paragraph (1) shall include an analysis
9 of the reasons for such excess expenditures and rec-
10 ommendations for addressing them in the future.

11 **SEC. 302. IMPROVING ACCURACY OF RELATIVE VALUES**
12 **UNDER THE MEDICARE PHYSICIAN FEE**
13 **SCHEDULE.**

14 (a) USE OF EXPERT PANEL TO IDENTIFY
15 MISVALUED PHYSICIANS' SERVICES.—Section 1848(c) of
16 the Social Security Act (42 U.S.C. 1395w(c)) is amended
17 by adding at the end the following new paragraph:
18 ''(7) USE OF EXPERT PANEL TO IDENTIFY
19 MISVALUED PHYSICIANS' SERVICES.—
20 ''(A) IN GENERAL.—The Secretary shall
21 establish an expert panel (in this paragraph re-
22 ferred to as the 'expert panel')—
23 ''(i) to identify, through data analysis,
24 physicians' services for which the relative
25 value under this subsection is potentially

1 misvalued, particularly those services for
2 which such relative value may be over-
3 valued;
4 "(ii) to assess whether those
5 misvalued services warrant review using
6 existing processes (referred to in para-
7 graph (2)(J)(ii)) for the consideration of
8 coding changes; and
9 "(iii) to advise the Secretary con-
10 cerning the exercise of authority under
11 clauses (ii)(III) and (vi) of paragraph
12 (2)(B).
13 "(B) COMPOSITION OF PANEL.—The ex-
14 pert panel shall be appointed by the Secretary
15 and composed of—
16 "(i) members with expertise in med-
17 ical economics and technology diffusion;
18 "(ii) members with clinical expertise;
19 "(iii) physicians, particularly physi-
20 cians (such as a physician employed by the
21 Veterans Administration or a physician
22 who has a full time faculty appointment at
23 a medical school) who are not directly af-
24 fected by changes in the physician fee
25 schedule under this section;

1 "(iv) carrier medical directors; and
2 "(v) representatives of private payor
3 health plans.
4 "(C) APPOINTMENT CONSIDERATIONS.—In
5 appointing members to the expert panel, the
6 Secretary shall assure racial and ethnic diver-
7 sity on the panel and may consider appointing
8 a liaison from organizations with experience in
9 the consideration of coding changes to the
10 panel.".
11 (b) EXAMINATION OF SERVICES WITH SUBSTANTIAL
12 CHANGES.—Such section is further amended by adding at
13 the end the following new paragraph:
14 "(8) EXAMINATION OF SERVICES WITH SUB-
15 STANTIAL CHANGES.—The Secretary, in consultation
16 with the expert panel under paragraph (7), shall—
17 "(A) conduct a five-year review of physi-
18 cians' services in conjunction with the RUC 5-
19 year review, particularly for services that have
20 experienced substantial changes in length of
21 stay, site of service, volume, practice expense,
22 or other factors that may indicate changes in
23 physician work;
24 "(B) identify new services to determine if
25 they are likely to experience a reduction in rel-

1 ative value over time and forward a list of the
2 services so identified for such five-year review;
3 and
4 "(C) for physicians' services that are oth-
5 erwise unreviewed under the process the Sec-
6 retary has established, periodically review a
7 sample of relative value units within different
8 types of services to assess the accuracy of the
9 relative values contained in the Medicare physi-
10 cian fee schedule.".
11 (c) AUTHORITY TO REDUCE WORK COMPONENT FOR
12 SERVICES WITH ACCELERATED VOLUME GROWTH.—
13 (1) IN GENERAL.—Paragraph (2)(B) of such
14 section is amended—
15 (A) in clause (v), by adding at the end the
16 following new subclause:
17 "(III) REDUCTIONS IN WORK
18 VALUE UNITS FOR SERVICES WITH AC-
19 CELERATED VOLUME GROWTH.—Ef-
20 fective January 1, 2009, reduced ex-
21 penditures attributable to clause
22 (vi).''; and
23 (B) by adding at the end the following new
24 clauses:

1 "(vi) AUTHORIZING REDUCTION IN
2 WORK VALUE UNITS FOR SERVICES WITH
3 ACCELERATED VOLUME GROWTH.—The
4 Secretary may provide (without using ex-
5 isting processes the Secretary has estab-
6 lished for review of relative value) for a re-
7 duction in the work value units for a par-
8 ticular physician's service if the annual
9 rate of growth in the expenditures for such
10 service for which payment is made under
11 this part for individuals for 2006 or a sub-
12 sequent year exceeds the average annual
13 rate of growth in expenditures of all physi-
14 cians' services for which payment is made
15 under this part by more than 10 percent-
16 age points for such year.
17 "(vii) CONSULTATION WITH EXPERT
18 PANEL AND BASED ON CLINICAL EVI-
19 DENCE.—The Secretary shall exercise au-
20 thority under clauses (ii)(III) and (vi) in
21 consultation with the expert panel estab-
22 lished under paragraph (7) and shall take
23 into account clinical evidence supporting or
24 refuting the merits of such accelerated
25 growth".

1 (2) EFFECTIVE DATE.—The amendments made
2 by paragraph (1) shall apply with respect to pay-
3 ment for services furnished on or after January 1,
4 2009.
5 (d) ADJUSTMENT AUTHORITY FOR EFFICIENCY
6 GAINS FOR NEW PROCEDURES.—Paragraph (2)(B)(ii) of
7 such section is amended by adding at the end the following
8 new subclause:
9 ''(III) ADJUSTMENT AUTHORITY
10 FOR EFFICIENCY GAINS FOR NEW
11 PROCEDURES.—In carrying out sub-
12 clauses (I) and (II), the Secretary
13 may apply a methodology, based on
14 supporting evidence, under which
15 there is imposed a reduction over a
16 period of years in specified relative
17 value units in the case of a new (or
18 newer) procedure to take into account
19 inherent efficiencies that are typically
20 or likely to be gained during the pe-
21 riod of initial increased application of
22 the procedure.''.
23 **SEC. 303. FEEDBACK MECHANISM ON PRACTICE PATTERNS.**
24 By not later than July 1, 2008, the Secretary of
25 Health and Human Services shall develop and implement

1 a mechanism to measure resource use on a per capita and
2 an episode basis in order to provide confidential feedback
3 to physicians in the Medicare program on how their prac-
4 tice patterns compare to physicians generally, both in the
5 same locality as well as nationally. Such feedback shall
6 not be subject to disclosure under section 552 of title 5,
7 United States Code). The Secretary shall consider extend-
8 ing such mechanism to other suppliers as necessary.

9 **SEC. 304. PAYMENTS FOR EFFICIENT AREAS.**

10 Section 1833 of the Social Security Act (42 U.S.C.
11 1395l) is amended by adding at the end the following new
12 subsection:

13 ''(v) INCENTIVE PAYMENTS FOR EFFICIENT
14 AREAS.—

15 ''(1) IN GENERAL.—In the case of services fur-
16 nished under the physician fee schedule under sec-
17 tion 1848 on or after January 1, 2009, and before
18 January 1, 2011, by a supplier that is paid under
19 such fee schedule in an efficient area (as identified
20 under paragraph (2)), in addition to the amount of
21 payment that would otherwise be made for such
22 services under this part, there also shall be paid an
23 amount equal to 5 percent of the payment amount
24 for the services under this part.

25 ''(2) IDENTIFICATION OF EFFICIENT AREAS.—

1 "(A) IN GENERAL.—Based upon available
2 data, the Secretary shall identify those counties
3 or equivalent areas in the United States in the
4 lowest fifth percentile of utilization based on
5 per capita spending for services provided in
6 2007 under this part and part A.
7 "(B) IDENTIFICATION OF COUNTIES
8 WHERE SERVICE IS FURNISHED..—For pur-
9 poses of paying the additional amount specified
10 in paragraph (1), if the Secretary uses the 5-
11 digit postal ZIP Code where the service is fur-
12 nished, the dominant county of the postal ZIP
13 Code (as determined by the United States Post-
14 al Service, or otherwise) shall be used to deter-
15 mine whether the postal ZIP Code is in a coun-
16 ty described in subparagraph (A).
17 "(C) JUDICIAL REVIEW.— There shall be
18 no administrative or judicial review under sec-
19 tion 1869, 1878, or otherwise, respecting—
20 "(i) the identification of a county or
21 other area under subparagraph (A); or
22 "(ii) the assignment of a postal ZIP
23 Code to a county or other area under sub-
24 paragraph (B).

1 "(D) PUBLICATION OF LIST OF COUNTIES;
2 POSTING ON WEBSITE.—With respect to a year
3 for which a county or area is identified under
4 this paragraph, the Secretary shall identify
5 such counties or areas as part of the proposed
6 and final rule to implement the physician fee
7 schedule under section 1848 for the applicable
8 year. The Secretary shall post the list of coun-
9 ties identified under this paragraph on the
10 Internet website of the Centers for Medicare
11 & Medicaid Services.".

12 **SEC. 305. RECOMMENDATIONS ON REFINING THE PHYSI-**
13 **CIAN FEE SCHEDULE.**

14 (a) RECOMMENDATIONS ON CONSOLIDATED CODING
15 FOR SERVICES COMMONLY PERFORMED TOGETHER.—
16 Not later than December 31, 2008, the Comptroller Gen-
17 eral of the United States shall—

18 (1) complete an analysis of codes paid under
19 the Medicare physician fee schedule to determine
20 whether the codes for procedures that are commonly
21 furnished together should be combined; and

22 (2) submit to Congress a report on such anal-
23 ysis and include in the report recommendations on
24 whether an adjustment should be made to the rel-
25 ative value units for such combined code.

1 (b) RECOMMENDATIONS ON INCREASED USE OF
2 BUNDLED PAYMENTS.—Not later than December 31,
3 2008, the Comptroller General of the United States
4 shall—
5 (1) complete an analysis of those procedures
6 under the Medicare physician fee schedule for which
7 no global payment methodology is applied but for
8 which a ''bundled'' payment methodology would be
9 appropriate; and
10 (2) submit to Congress a report on such anal-
11 ysis and include in the report recommendations on
12 increasing the use of ''bundled'' payment method-
13 ology under such schedule.
14 (c) MEDICARE PHYSICIAN FEE SCHEDULE.—In this
15 section, the term ''Medicare physician fee schedule'' means
16 the fee schedule established under section 1848 of the So-
17 cial Security Act (42 U.S.C. 1395w-4).

18 **SEC. 306. IMPROVED AND EXPANDED MEDICAL HOME DEM-**
19 **ONSTRATION PROJECT.**

20 (a) IN GENERAL.—The Secretary of Health and
21 Human Services (in this section referred to as the ''Sec-
22 retary'') shall establish under title XVIII of the Social Se-
23 curity Act an expanded medical home demonstration
24 project (in this section referred to as the ''expanded
25 project'') under this section. The expanded project super-

1 sedes the project that was initiated under section 204 of
2 the Medicare Improvement and Extension Act of 2006 (di-
3 vision B of Public Law 109–432). The purpose of the ex-
4 panded project is—
5 (1) to guide the redesign of the health care de-
6 livery system to provide accessible, continuous, com-
7 prehensive, and coordinated, care to Medicare bene-
8 ficiaries; and
9 (2) to provide care management fees to per-
10 sonal physicians delivering continuous and com-
11 prehensive care in qualified medical homes.
12 (b) NATURE AND SCOPE OF PROJECT.—
13 (1) DURATION; SCOPE.—The expanded project
14 shall operate during a period of three years, begin-
15 ning not later than October 1, 2009, and shall in-
16 clude a nationally representative sample of physi-
17 cians serving urban, rural, and underserved areas
18 throughout the United States.
19 (2) ENCOURAGING PARTICIPATION OF SMALL
20 PHYSICIAN PRACTICES.—
21 (A) IN GENERAL.—The expanded project
22 shall be designed to include the participation of
23 physicians in practices with fewer than four
24 full-time equivalent physicians, as well as physi-

1 cians in larger practices particularly in rural
2 and underserved areas.
3 (B) TECHNICAL ASSISTANCE.— In order to
4 facilitate the participation under the expanded
5 project of physicians in such practices, the Sec-
6 retary shall make available additional technical
7 assistance to such practices during the first
8 year of the expanded project.
9 (3) SELECTION OF HOMES TO PARTICIPATE.—
10 The Secretary shall select up to 500 medical homes
11 to participate in the expanded project and shall give
12 priority to—
13 (A) the selection of up to 100 HIT-en-
14 hanced medical homes; and
15 (B) the selection of other medical homes
16 that serve communities whose populations are
17 at higher risk for health disparities,
18 (4) BENEFICIARY PARTICIPATION.—The Sec-
19 retary shall establish a process for any Medicare
20 beneficiary who is served by a medical home partici-
21 pating in the expanded project to elect to participate
22 in the project. Each beneficiary who elects to so par-
23 ticipate shall be eligible—

1 (A) for enhanced medical home services
2 under the project with no cost sharing for the
3 additional services; and
4 (B) for a reduction of up to 50 percent in
5 the coinsurance for services furnished under the
6 physician fee schedule under section 1848 of
7 the Social Security Act by the medical home.
8 The Secretary shall develop standard recruitment
9 materials and election processes for Medicare bene-
10 ficiaries who are electing to participate in the ex-
11 panded project.
12 (c) STANDARDS FOR MEDICAL HOMES, HIT-EN-
13 HANCED MEDICAL HOMES.—
14 (1) STANDARD SETTING AND CERTIFICATION
15 PROCESS.—The Secretary shall establish a process
16 for selection of a qualified standard setting and cer-
17 tification organization—
18 (A) to establish standards, consistent with
19 this section, for medical practices to qualify as
20 medical homes or as HIT-enhanced medical
21 homes; and
22 (B) to provide for the review and certifi-
23 cation of medical practices as meeting such
24 standards.

1 (2) BASIC STANDARDS FOR MEDICAL HOMES.—
2 For purposes of this subsection, the term ''medical
3 home'' means a physician-directed practice that has
4 been certified, under paragraph (1), as meeting the
5 following standards:
6 (A) ACCESS AND COMMUNICATION WITH
7 PATIENTS.—The practice applies standards for
8 access to care and communication with partici-
9 pating beneficiaries.
10 (B) MANAGING PATIENT INFORMATION
11 AND USING INFORMATION IN MANAGEMENT TO
12 SUPPORT PATIENT CARE.—The practice has
13 readily accessible, clinically useful information
14 on participating beneficiaries that enables the
15 practice to treat such beneficiaries comprehen-
16 sively and systematically.
17 (C) MANAGING AND COORDINATING CARE
18 ACCORDING TO INDIVIDUAL NEEDS.—The prac-
19 tice maintains continuous relationships with
20 participating beneficiaries by implementing evi-
21 dence-based guidelines and applying them to
22 the identified needs of individual beneficiaries
23 over time and with the intensity needed by such
24 beneficiaries.

1 (D) PROVIDING ONGOING ASSISTANCE AND
2 ENCOURAGEMENT IN PATIENT SELF-MANAGE-
3 MENT.—The practice—
4 (i) collaborates with participating
5 beneficiaries to pursue their goals for opti-
6 mal achievable health; and
7 (ii) assesses patient-specific barriers
8 to communication and conducts activities
9 to support patient self-management.
10 (E) RESOURCES TO MANAGE CARE.—The
11 practice has in place the resources and proc-
12 esses necessary to achieve improvements in the
13 management and coordination of care for par-
14 ticipating beneficiaries.
15 (F) MONITORING PERFORMANCE.—The
16 practice monitors its clinical process and per-
17 formance (including outcome measures) in
18 meeting the applicable standards under this
19 subsection and provides information in a form
20 and manner specified by the Secretary with re-
21 spect to such process and performance.
22 (3) ADDITIONAL STANDARDS FOR HIT-EN-
23 HANCED MEDICAL HOME.—For purposes of this sub-
24 section, the term ''HIT-enhanced medical home''
25 means a medical home that has been certified, under

1 paragraph (1), as using a health information tech-
2 nology system that includes at least the following
3 elements:
4 (A) ELECTRONIC HEALTH RECORD
5 (EHR).—The system uses, for participating
6 beneficiaries, an electronic health record that
7 meets the following standards:
8 (i) IN GENERAL.—The record—
9 (I) has the capability of inter-
10 operability with secure data acquisi-
11 tion from health information tech-
12 nology systems of other health care
13 providers in the area served by the
14 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 labora-
2 tory information.
3 (iv) The record is integrated with de-
4 cision 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 sup-
10 ports e-prescribing and computerized physician
11 order entry.
12 (C) OUTCOME MEASUREMENT.—The sys-
13 tem supports the secure, confidential provision
14 of clinical process and outcome measures ap-
15 proved by the National Quality Forum to the
16 Secretary for use in confidential manner for
17 provider feedback and peer review and for out-
18 comes and clinical effectiveness research.
19 (D) PATIENT EDUCATION CAPABILITY.—
20 The system actively facilitates participating
21 beneficiaries engaging in the management of
22 their own health through education and support
23 systems and tools for shared decision-making.
24 (E) SUPPORT OF BASIC STANDARDS.—
25 The elements of such system, such as the elec-

1 tronic health record, email communications, pa-
2 tient registries, and clinical-decision support
3 tools, are integrated in a manner to better
4 achieve the basic standards specified in para-
5 graph (2) for a 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 effec-
10 tiveness research. After the first two years of the ex-
11 panded project, these data may be used for adjust-
12 ment in the monthly medical home care management
13 fee under 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
21 the amount of such fee, the Secretary shall consider
22 the following:
23 (A) OPERATING EXPENSES.—The addi-
24 tional practice expenses for the delivery of serv-
25 ices through a medical home, taking into ac-

1 count the additional expenses for an HIT-en-
2 hanced medical home. Such expenses include
3 costs associated 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
16 improvement 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
21 of additional physician work, such as aug-
22 mented care plan oversight, expanded e-mail
23 and telephonic consultations, extended patient
24 medical data review (including data stored and
25 transmitted electronically), and physician super-

1 vision of enhanced self management education,
2 and expanded follow-up accomplished by non-
3 physician personnel, in a medical home that is
4 not adequately taken into account in the estab-
5 lishment of the physician fee schedule under
6 section 1848 of the Social Security Act.
7 (C) RISK ADJUSTMENT.—The development
8 of an appropriate risk adjustment mechanism
9 to account for the varying costs of medical
10 homes based upon characteristics of partici-
11 pating beneficiaries.
12 (D) HIT ADJUSTMENT.—Variation of the
13 fee based on the extensiveness of use of the
14 health information technology in the medical
15 home.
16 (E) PERFORMANCE-BASED.—After the
17 first two years of the expanded project, an ad-
18 justment of the fee based on performance of the
19 medical home in achieving quality or outcomes
20 standards.
21 (3) PERSONAL PHYSICIAN DEFINED.—For pur-
22 poses of this subsection, the term ''personal physi-
23 cian'' means, with respect to a participating Medi-
24 care beneficiary, a physician (as defined in section
25 1861(r)(1) of the Social Security Act (42 U.S.C.

1395x(r)(1)) who provides accessible, continuous, coordinated, and comprehensive care for the beneficiary as part of a medical practice that is a qualified medical home. Such a physician may be a specialist for a beneficiary requiring ongoing care for a chronic condition or multiple chronic conditions (such as severe asthma, complex diabetes, cardiovascular disease, rheumatologic disorder) or for a beneficiary with a prolonged illness.

(e) FUNDING.—

(1) USE OF CURRENT PROJECT FUNDING.—Funds otherwise applied to the demonstration under section 204 of the Medicare Improvement and Extension Act of 2006 (division B of Public Law 109–432) shall be available to carry out the expanded project

(2) ADDITIONAL FUNDING FROM SMI TRUST FUND.—

(A) IN GENERAL.—In addition to the funds provided under paragraph (1), there shall be available, from the Federal Supplementary Medical Insurance Trust Fund (under section 1841 of the Social Security Act), the amount of $500,000,000 to carry out the expanded project, including payments to of monthly med-

1 ical home care management fees under sub-
2 section (d), reductions in coinsurance for par-
3 ticipating beneficiaries under subsection
4 (b)(4)(B), and funds for the design, implemen-
5 tation, and evaluation of the expanded project.
6 (B) MONITORING EXPENDITURES; EARLY
7 TERMINATION.—The Secretary shall monitor
8 the expenditures under the expanded project
9 and may terminate the project early in order
10 that expenditures not exceed the amount of
11 funding provided for the project under subpara-
12 graph (A).
13 (f) EVALUATIONS AND REPORTS.—.
14 (1) ANNUAL INTERIM EVALUATIONS AND RE-
15 PORTS.—For each year of the expanded project, the
16 Secretary shall provide for an evaluation of the
17 project and shall submit to Congress, by a date spec-
18 ified by the Secretary, a report on the project and
19 on the evaluation of the project for each such year.
20 (2) FINAL EVALUATION AND REPORT.—The
21 Secretary shall provide for an evaluation of the ex-
22 panded project and shall submit to Congress, not
23 later than 18 months after the date of completion of
24 the project, a report on the project and on the eval-
25 uation of the project.

1 **SEC. 307. REPEAL OF PHYSICIAN ASSISTANCE AND QUAL-**
2 **ITY 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
14 1, 2008, the Secretary shall revise the fee
15 schedule areas used for payment under
16 this section applicable to the State of Cali-
17 fornia using the county-based geographic
18 adjustment factor as specified in option 3
19 (table 9) in the proposed rule for the 2008
20 physician fee schedule published at 72
21 Fed. Reg. 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,
25 2010, after calculating the work, practice
26 expense, and malpractice geographic indi-

1 ces described in clauses (i), (ii), and (iii) of
2 paragraph (1)(A) that would otherwise
3 apply, the Secretary shall increase any
4 such geographic index for any county in
5 California that is lower than the geo-
6 graphic index used for payment for serv-
7 ices under this section as of December 31,
8 2007, in such county to such geographic
9 index level.
10 ''(B) SUBSEQUENT REVISIONS.—
11 ''(i) TIMING.—Not later than January
12 1, 2011, the Secretary shall review and
13 make revisions to fee schedule areas in all
14 States for which more than one fee sched-
15 ule area is used for payment of services
16 under this section. The Secretary may re-
17 vise fee schedule areas in States in which
18 a single fee schedule area is used for pay-
19 ment for services under this section using
20 the same methodology applied in the pre-
21 vious sentence.
22 ''(ii) LINK WITH GEOGRAPHIC INDEX
23 DATA REVISION.—The revision described in
24 clause (i) shall be made effective concur-
25 rently with the application of the periodic

1 review of geographic adjustment factors re-
2 quired under paragraph (1)(C) for 2011
3 and subsequent periods.''.

4 **SEC. 309. PAYMENT FOR IMAGING SERVICES.**

5 (a) PAYMENT UNDER PART B OF THE MEDICARE
6 PROGRAM FOR DIAGNOSTIC IMAGING SERVICES FUR-
7 NISHED IN FACILITIES CONDITIONED ON ACCREDITATION
8 OF FACILITIES.—

9 (1) SPECIAL PAYMENT RULE.—

10 (A) IN GENERAL.—Section 1848(b)(4) of
11 the Social Security Act (42 U.S.C. 1395w-
12 4(b)(4)) is amended—

13 (i) in the heading, by striking ''RULE''
14 and inserting ''RULES'';

15 (ii) in subparagraph (A), by striking
16 ''IN GENERAL'' and inserting ''LIMITA-
17 TION''; and

18 (iii) by adding at the end the fol-
19 lowing new subparagraph:

20 ''(C) PAYMENT ONLY FOR SERVICES PRO-
21 VIDED IN ACCREDITED FACILITIES.—

22 ''(i) IN GENERAL.—In the case of im-
23 aging services that are diagnostic imaging
24 services described in clause (ii), the pay-
25 ment amount for the technical component

1 and the professional component of the
2 services established for a year under the
3 fee schedule described in paragraph (1)
4 shall each be zero, unless the services are
5 furnished at a diagnostic imaging services
6 facility that meets the certificate require-
7 ment described in section 354(b)(1) of the
8 Public Health Service Act, as applied
9 under subsection (m). The previous sen-
10 tence shall not apply with respect to the
11 technical component if the imaging equip-
12 ment meets certification standards and the
13 professional component of a diagnostic im-
14 aging service that is furnished by a physi-
15 cian.

16 ''(ii) DIAGNOSTIC IMAGING SERV-
17 ICES.—For purposes of clause (i) and sub-
18 section (m), the term 'diagnostic imaging
19 services' means all imaging modalities, in-
20 cluding diagnostic magnetic resonance im-
21 aging ('MRI'), computed tomography
22 ('CT'), positron emission tomography
23 ('PET'), nuclear medicine procedures, x-
24 rays, sonograms, ultrasounds, echocardio-
25 grams, and such emerging diagnostic im-

1 aging technologies as specified by the Sec-
2 retary.''.
3 (B) EFFECTIVE DATE.—
4 (i) IN GENERAL.—Subject to clause
5 (ii), the amendments made by subpara-
6 graph (A) shall apply to diagnostic imag-
7 ing services furnished on or after January
8 1, 2010.
9 (ii) EXTENSION FOR ULTRASOUND
10 SERVICES.—The amendments made by
11 subparagraph (A) shall apply to diagnostic
12 imaging services that are ultrasound serv-
13 ices on or after January 1, 2012.
14 (2) CERTIFICATION OF FACILITIES THAT FUR-
15 NISH DIAGNOSTIC IMAGING SERVICES.—Section
16 1848 of the Social Security Act (42 U.S.C. 1395w-
17 4) is amended by adding at the end the following
18 new subsection:
19 ''(m) CERTIFICATION OF FACILITIES THAT FURNISH
20 DIAGNOSTIC IMAGING SERVICES.—
21 ''(1) IN GENERAL.—For purposes of subsection
22 (b)(4)(C)(i), except as provided under paragraphs
23 (2) through (8), the provisions of section 354 of the
24 Public Health Service Act (as in effect as of June
25 1, 2007), relating to the certification of mammog-

1 raphy facilities, shall apply, with respect to the pro-
2 vision of diagnostic imaging services (as defined in
3 subsection (b)(4)(C)(ii)) and to a diagnostic imaging
4 services facility defined in paragraph (8) (and to the
5 process of accrediting such facilities) in the same
6 manner that such provisions apply, with respect to
7 the provision of mammograms and to a facility de-
8 fined in subsection (a)(3) of such section (and to the
9 process of accrediting such mammography facilities).
10 "(2) TERMINOLOGY AND REFERENCES.—For
11 purposes of applying section 354 of the Public
12 Health Service Act under paragraph (1)—
13 "(A) any reference to 'mammography', or
14 'breast imaging' is deemed a reference to 'diag-
15 nostic imaging services (as defined in section
16 1848(b)(4)(C)(ii) of the Social Security Act)';
17 "(B) any reference to a mammogram or
18 film is deemed a reference to an image, as de-
19 fined in paragraph (8);
20 "(C) any reference to 'mammography facil-
21 ity' or to a 'facility' under such section 354 is
22 deemed a reference to a diagnostic imaging
23 services facility, as defined in paragraph (8);
24 "(D) any reference to radiological equip-
25 ment used to image the breast is deemed a ref-

1 erence to medical imaging equipment used to
2 provide diagnostic imaging services;
3 ''(E) any reference to radiological proce-
4 dures or radiological is deemed a reference to
5 medical imaging services, as defined in para-
6 graph (8) or medical imaging, respectively;
7 ''(F) any reference to an inspection (as de-
8 fined in subsection (a)(4) of such section) or in-
9 spector is deemed a reference to an audit (as
10 defined in paragraph (8)) or auditor, respec-
11 tively;
12 ''(G) any reference to a medical physicist
13 (as described in subsection (f)(1)(E) of such
14 section) is deemed to include a reference to a
15 magnetic resonance scientist or the appropriate
16 qualified expert as determined by the accred-
17 iting body;
18 ''(H) in applying subsection (d)(1)(A)(i) of
19 such section, the reference to 'type of each x-
20 ray machine, image receptor, and processor' is
21 deemed a reference to 'type of imaging equip-
22 ment';
23 ''(I) in applying subsection (d)(1)(B) of
24 such section, the reference that 'the person or
25 agent submits to the Secretary' is deemed a ref-

1 erence that 'the person or agent submits to the
2 Secretary, through the appropriate accredita-
3 tion body';
4 ''(J) in applying subsection (d)(1)(B)(i) of
5 such section, the reference to standards estab-
6 lished by the Secretary is deemed a reference to
7 standards established by an accreditation body
8 and approved by the Secretary;
9 ''(K) in applying subsection (e) of such
10 section, relating to an accreditation body—
11 ''(i) in paragraph (1)(A), the ref-
12 erence to 'may' is deemed a reference to
13 'shall';
14 ''(ii) in paragraph (1)(B)(i)(II), the
15 reference to 'a random sample of clinical
16 images from such facilities' is deemed a
17 reference to 'a statistically significant ran-
18 dom sample of clinical images from a sta-
19 tistically significant random sample of fa-
20 cilities';
21 ''(iii) in paragraph (3)(A) of such sec-
22 tion—
23 ''(I) the reference to 'paragraph
24 (1)(B)' in such subsection is deemed

1 to be a reference to 'paragraph (1)(B)
2 and subsection (f)'; and
3 ''(II) the reference to the 'Sec-
4 retary' is deemed a reference to 'an
5 accreditation body, with the approval
6 of the Secretary'; and
7 ''(iv) in paragraph (6)(B), the ref-
8 erence to the Committee on Labor and
9 Human Resources of the Senate is deemed
10 to be the Committee on Finance of the
11 Senate and the reference to the Committee
12 on Energy and Commerce of the House of
13 Representatives is deemed to include a ref-
14 erence to the Committee on Ways and
15 Means of the House of Representatives;
16 ''(L) in applying subsection (f), relating to
17 quality standards—
18 ''(i) each reference to standards estab-
19 lished by the Secretary is deemed a ref-
20 erence to standards established by an ac-
21 creditation body involved and approved by
22 the Secretary under subsection (d)(1)(B)(i)
23 of such section

1 ''(ii) in paragraph (1)(A), the ref-
2 erence to 'radiation dose' is deemed a ref-
3 erence to 'radiation dose, as appropriate';
4 ''(iii) in paragraph (1)(B), the ref-
5 erence to 'radiological standards' is deemed
6 a reference to 'medical imaging standards,
7 as appropriate';
8 ''(iv) in paragraphs (1)(D)(ii) and
9 (1)(E)(iii), the reference to 'the Secretary'
10 is deemed a reference to 'an accreditation
11 body with the approval of the Secretary';
12 ''(v) in each of subclauses (III) and
13 (IV) of paragraph (1)(G)(ii), each ref-
14 erence to 'patient' is deemed a reference to
15 'patient, if requested by the patient'; and
16 ''(M) in applying subsection (g), relating to
17 inspections—
18 ''(i) each reference to the 'Secretary
19 or State or local agency acting on behalf of
20 the Secretary' is deemed to include a ref-
21 erence to an accreditation body involved;
22 ''(ii) in the first sentence of para-
23 graph (1)(F), the reference to 'annual in-
24 spections required under this paragraph' is
25 deemed a reference to 'the audits carried

1 out in facilities at least every three years
2 from the date of initial accreditation under
3 this paragraph'; and
4 ''(iii) in the second sentence of para-
5 graph (1)(F), the reference to 'inspections
6 carried out under this paragraph' is
7 deemed a reference to 'audits conducted
8 under this paragraph during the previous
9 year'.
10 ''(3) DATES AND PERIODS.—For purposes of
11 paragraph (1), in applying section 354 of the Public
12 Health Service Act, the following applies:
13 ''(A) IN GENERAL.—Except as provided in
14 subparagraph (B)—
15 ''(i) any reference to 'October 1,
16 1994' shall be deemed a reference to 'Jan-
17 uary 1, 2010';
18 ''(ii) the reference to 'the date of the
19 enactment of this section' in each of sub-
20 sections (e)(1)(D) and (f)(1)(E)(iii) is
21 deemed to be a reference to 'the date of
22 the enactment of the Children's Health
23 and Medicare Protection Act of 2007';

1 "(iii) the reference to 'annually' in
2 subsection (g)(1)(E) is deemed a reference
3 to 'every three years';
4 "(iv) the reference to 'October 1,
5 1996' in subsection (l) is deemed to be a
6 reference to 'January 1, 2011';
7 "(v) the reference to 'October 1,
8 1999' in subsection (n)(3)(H) is deemed to
9 be a reference to 'January 1, 2012'; and
10 "(vi) the reference to 'October 1,
11 1993' in the matter following paragraph
12 (3)(J) of subsection (n) is deemed to be a
13 reference 'January 1, 2010'.
14 "(B) ULTRASOUND SERVICES.—With re-
15 spect to diagnostic imaging services that are
16 ultrasounds—
17 "(i) any reference to 'October 1,
18 1994' shall be deemed a reference to 'Jan-
19 uary 1, 2012';
20 "(ii) the reference to 'the date of the
21 enactment of this section' in subsection
22 (f)(1)(E)(iii) is deemed to be a reference to
23 '7 years after the date of the enactment of
24 the Children's Health and Medicare Pro-
25 tection Act of 2007';

1 "(iii) the reference to 'October 1,
2 1996' in subsection (l) is deemed to be a
3 reference to 'January 1, 2013';
4 "(4) PROVISIONS NOT APPLICABLE.—For pur-
5 poses of paragraph (1), in applying section 354 of
6 the Public Health Service Act, the following provi-
7 sion shall not apply:
8 "(A) Subsections (e) and (f) of such sec-
9 tion, in so far as the respective subsection im-
10 poses any requirement for a physician to be cer-
11 tified, accredited, or otherwise meet require-
12 ments, with respect to the provision of any di-
13 agnostic imaging services, as a condition of pay-
14 ment under subsection (b)(4)(C)(i), with re-
15 spect to the professional or technical compo-
16 nent, for such service.
17 "(B) Subsection (e)(1)(B)(iv) of such sec-
18 tion, insofar as it applies to a facility with re-
19 spect to the provision of ultrasounds.
20 "(C) Subsection (e)(1)(B)(v).
21 "(D) Subsection (f)(1)(H) of such section,
22 relating to standards for special techniques for
23 mammograms of patients with breast implants.
24 "(E) Subsection (g)(6) of such section, re-
25 lating to an inspection demonstration program.

1 "(F) Subsection (n)(3)(G) of such section,
2 relating to the national advisory committee.
3 "(G) Subsection (p) of such section, relat-
4 ing to breast cancer screening surveillance re-
5 search grants.
6 "(H) Paragraphs (1)(B) and (2) of sub-
7 section (r) of such section, related to funding.
8 "(5) ACCREDITATION BODIES.—For purposes
9 of paragraph (1), in applying section 354(e)(1) of
10 the Public Health Service, the following shall apply:
11 "(A) APPROVAL OF TWO ACCREDITATION
12 BODIES FOR EACH TREATMENT MODALITY.—In
13 the case that there is more than one accredita-
14 tion body for a treatment modality that quali-
15 fies for approval under this subsection, the Sec-
16 retary shall approve at least two accreditation
17 bodies for such treatment modality.
18 "(B) ADDITIONAL ACCREDITATION BODY
19 STANDARDS.—In addition to the standards de-
20 scribed in subparagraph (B) of such section for
21 accreditation bodies, the Secretary shall estab-
22 lish standards that require—
23 "(i) the timely integration of new
24 technology by accreditation bodies for pur-

1 poses of accrediting facilities under this
2 subsection; and
3 ''(ii) the accreditation body involved to
4 evaluate the annual medical physicist sur-
5 vey (or annual medical survey of another
6 appropriate qualified expert chosen by the
7 accreditation body) of a facility upon on-
8 site review of such facility.
9 ''(6) ADDITIONAL QUALITY STANDARDS.—For
10 purposes of paragraph (1), in applying subsection
11 (f)(1) of section 354 of the Public Health Service—
12 ''(A) the quality standards under such sub-
13 section shall, with respect to a facility include—
14 ''(i) standards for qualifications of
15 medical personnel who are not physicians
16 and who perform diagnostic imaging serv-
17 ices at the facility that require such per-
18 sonnel to ensure that individuals, prior to
19 performing medical imaging, demonstrate
20 compliance with the standards established
21 under subsection (a) through successful
22 completion of certification by a nationally
23 recognized professional organization, licen-
24 sure, completion of an examination, perti-
25 nent coursework or degree program,

1 verified pertinent experience, or through
2 other ways determined appropriate by an
3 accreditation body (with the approval of
4 the Secretary, or through some combina-
5 tion thereof);
6 ''(ii) standards requiring the facility
7 to maintain records of the credentials of
8 physicians and other medical personnel de-
9 scribed in clause (i);
10 ''(iii) standards for qualifications and
11 responsibilities of medical directors and
12 other personnel with supervising roles at
13 the facility;
14 ''(iv) standards that require the facil-
15 ity has procedures to ensure the safety of
16 patients of the facility; and
17 ''(v) standards for the establishment
18 of a quality control program at the facility
19 to be implemented as described in subpara-
20 graph (E) of such subsection;
21 ''(B) the quality standards described in
22 subparagraph (B) of such subsection shall be
23 deemed to include standards that require the
24 establishment and maintenance of a quality as-
25 surance and quality control program at each fa-

1 cility that is adequate and appropriate to en-
2 sure the reliability, clarity, and accuracy of the
3 technical quality of diagnostic images produced
4 at such facilities; and
5 "(C) the quality standard described in sub-
6 paragraph (C) of such subsection, relating to a
7 requirement for personnel who perform speci-
8 fied services, shall include in such requirement
9 that such personnel must meet continuing med-
10 ical education standards as specified by an ac-
11 creditation body (with the approval of the Sec-
12 retary) and update such standards at least once
13 every three years.
14 "(7) ADDITIONAL REQUIREMENTS.—Notwith-
15 standing any provision of section 354 of the Public
16 Health Service Act, the following shall apply to the
17 accreditation process under this subsection for pur-
18 poses of subsection (b)(4)(C)(i):
19 "(A) Any diagnostic imaging services facil-
20 ity accredited before January 1, 2010 (or Janu-
21 ary 1, 2012 in the case of ultrasounds), by an
22 accrediting body approved by the Secretary
23 shall be deemed a facility accredited by an ap-
24 proved accreditation body for purposes of such
25 subsection as of such date if the facility submits

1 to the Secretary proof of such accreditation by
2 transmittal of the certificate of accreditation,
3 including by electronic means.
4 "(B) The Secretary may require the ac-
5 creditation under this subsection of an emerg-
6 ing technology used in the provision of a diag-
7 nostic imaging service as a condition of pay-
8 ment under subsection (b)(4)(C)(i) for such
9 service at such time as the Secretary deter-
10 mines there is sufficient empirical and scientific
11 information to properly carry out the accredita-
12 tion process for such technology.
13 "(8) DEFINITIONS.—For purposes of this sub-
14 section:
15 "(A) AUDIT.—The term 'audit' means an
16 onsite evaluation, with respect to a diagnostic
17 imaging services facility, by the Secretary, State
18 or local agency on behalf of the Secretary, or
19 accreditation body approved under this sub-
20 section that includes the following:
21 "(i) Equipment verification.
22 "(ii) Evaluation of policies and proce-
23 dures for compliance with accreditation re-
24 quirements.

1 "(iii) Evaluation of personnel quali-
2 fications and credentialing.
3 "(iv) Evaluation of the technical qual-
4 ity of images.
5 "(v) Evaluation of patient reports.
6 "(vi) Evaluation of peer-review mech-
7 anisms and other quality assurance activi-
8 ties.
9 "(vii) Evaluation of quality control
10 procedures, results, and follow-up actions.
11 "(viii) Evaluation of medical physi-
12 cists (or other appropriate professionals
13 chosen by the accreditation body) and
14 magnetic resonance scientist surveys.
15 "(ix) Evaluation of consumer com-
16 plaint mechanisms.
17 "(x) Provision of recommendations for
18 improvement based on findings with re-
19 spect to clauses (i) through (ix).
20 "(B) DIAGNOSTIC IMAGING SERVICES FA-
21 CILITY.—The term 'diagnostic imaging services
22 facility' has the meaning given the term 'facil-
23 ity' in section 354(a)(3) of the Public Health
24 Service Act (42 U.S.C. 263b(a)(3)) subject to
25 the reference changes specified in paragraph

1 (2), but does not include any facility that does
2 not furnish diagnostic imaging services for
3 which payment may be made under this section.
4 ''(C) IMAGE.—The term 'image' means the
5 portrayal of internal structures of the human
6 body for the purpose of detecting and deter-
7 mining the presence or extent of disease or in-
8 jury and may be produced through various
9 techniques or modalities, including radiant en-
10 ergy or ionizing radiation and ultrasound and
11 magnetic resonance. Such term does not include
12 image guided procedures.
13 ''(D) MEDICAL IMAGING SERVICE.—The
14 term 'medical imaging service' means a service
15 that involves the science of an image.''.
16 (b) ADJUSTMENT IN PRACTICE EXPENSE TO RE-
17 FLECT HIGHER PRESUMED UTILIZATION.—Section 1848
18 of the Social Security Act (42 U.S.C. 1395w(b)(4)) is
19 amended—
20 (1) in subsection (b)(4)—
21 (A) in the heading, by striking ''RULE''
22 and inserting ''RULES'';
23 (B) in subparagraph (B), by striking ''sub-
24 paragraph (A)'' and inserting ''this paragraph'';
25 and

1 (C) by adding at the end the following new
2 subparagraph:
3 "(C) ADJUSTMENT IN PRACTICE EXPENSE
4 TO REFLECT HIGHER PRESUMED UTILIZA-
5 TION.—In computing the number of practice
6 expense relative value units under subsection
7 (c)(2)(C)(ii) with respect to imaging services
8 described in subparagraph (B), the Secretary
9 shall adjust such number of units so it reflects
10 a 75 percent (rather than 50 percent) presumed
11 rate of utilization of imaging equipment."; and
12 (2) in subsection (c)(2)(B)(v)(II), by inserting
13 "AND OTHER PROVISIONS" after "OPD PAYMENT
14 CAP"
15 (c) ADJUSTMENT IN TECHNICAL COMPONENT "DIS-
16 COUNT" ON SINGLE-SESSION IMAGING TO CONSECUTIVE
17 BODY PARTS.—Section 1848(b)(4) of such Act is further
18 amended by adding at the end the following new subpara-
19 graph:
20 "(D) ADJUSTMENT IN TECHNICAL COMPO-
21 NENT DISCOUNT ON SINGLE-SESSION IMAGING
22 INVOLVING CONSECUTIVE BODY PARTS.—The
23 Secretary shall increase the reduction in ex-
24 penditures attributable to the multiple proce-
25 dure payment reduction applicable to the tech-

1 nical component for imaging under the final
2 rule published by the Secretary in the Federal
3 Register on November 21, 2005 (42 CFR 405,
4 et al.) from 25 percent to 50 percent.''.
5 (d) ADJUSTMENT IN ASSUMED INTEREST RATE FOR
6 CAPITAL PURCHASES.—Section 1848(b)(4) of such Act is
7 further amended by adding at the end the following new
8 subparagraph:
9 ''(E) ADJUSTMENT IN ASSUMED INTEREST
10 RATE FOR CAPITAL PURCHASES.—In computing
11 the practice expense component for imaging
12 services under this section, the Secretary shall
13 change the interest rate assumption for capital
14 purchases of imaging devices to reflect the pre-
15 vailing rate in the market, but in no case higher
16 than 11 percent.''.
17 (e) DISALLOWANCE OF GLOBAL BILLING.—Effective
18 for claims filed for imaging services (as defined in sub-
19 section (b)(4)(B) of section 1848 of the Social Security
20 Act) furnished on or after the first day of the first month
21 that begins more than 1 year after the date of the enact-
22 ment of this Act, the Secretary of Health and Human
23 Services shall not accept (or pay) a claim under such sec-
24 tion unless the claim is made separately for each compo-
25 nent of such services.

(f) EFFECTIVE DATE.—Except as otherwise provided, this section, and the amendments made by this section, shall apply to services furnished on or after January 1, 2008.

SEC. 310. REPEAL OF PHYSICIANS ADVISORY COUNCIL.

Section 1868(a) of the Social Security Act (42 U.S.C. 1395ee(a)), relating to the Practicing Physicians Advisory Council, is repealed.

TITLE L—MEDICARE ADVANTAGE REFORMS

Subtitle A—Payment Reform

SEC. 401. EQUALIZING PAYMENTS BETWEEN MEDICARE ADVANTAGE PLANS AND FEE-FOR-SERVICE MEDICARE.

(a) PHASE IN OF PAYMENT BASED ON FEE-FOR-SERVICE COSTS.—Section 1853 of the Social Security Act (42 U.S.C. 1395w-23) is amended—

(1) in subsection (j)(1)(A)—

(A) by striking ''beginning with 2007'' and inserting ''for 2007 and 2008''; and

(B) by inserting after ''(k)(1)'' the following: '', or, beginning with 2009, 1/12 of the blended benchmark amount determined under subsection (l)(1)''; and

1 (2) by adding at the end the following new sub-
2 section:
3 "(l) DETERMINATION OF BLENDED BENCHMARK
4 AMOUNT.—
5 "(1) IN GENERAL.—For purposes of subsection
6 (j), subject to paragraphs (2) and (3), the term
7 'blended benchmark amount' means for an area—
8 "(A) for 2009 the sum of—
9 "(i) ⅔ of the applicable amount (as
10 defined in subsection (k)(1)) for the area
11 and year; and
12 "(ii) ⅓ of the amount specified in
13 subsection (c)(1)(D)(i) for the area and
14 year;
15 "(B) for 2010 the sum of—
16 "(i) ⅓ of the applicable amount for
17 the area and year; and
18 "(ii) ⅔ of the amount specified in
19 subsection (c)(1)(D)(i) for the area and
20 year; and
21 "(C) for a subsequent year the amount
22 specified in subsection (c)(1)(D)(i) for the area
23 and year.
24 "(2) FEE-FOR-SERVICE PAYMENT FLOOR.—In
25 no case shall the blended benchmark amount for an

1 area and year be less than the amount specified in
2 subsection (c)(1)(D)(i) for the area and year.
3 "(3) EXCEPTION FOR PACE PLANS.—This sub-
4 section shall not apply to payments to a PACE pro-
5 gram under section 1894.".
6 (b) PHASE IN OF PAYMENT BASED ON IME
7 COSTS.—
8 (1) IN GENERAL.—Section 1853(c)(1)(D)(i) of
9 such Act (42 U.S.C. 1395w-23(c)(1)(D)(i)) is
10 amended by inserting "and costs attributable to pay-
11 ments under section 1886(d)(5)(B)" after
12 "1886(h)".
13 (2) EFFECTIVE DATE.—The amendment made
14 by paragraph (1) shall apply to the capitation rate
15 for years beginning with 2009.
16 (c) LIMITATION ON PLAN ENROLLMENT IN CASES OF
17 EXCESS BIDS FOR 2009 AND 2010.—
18 (1) IN GENERAL.—In the case of a Medicare
19 Part C organization that offers a Medicare Part C
20 plan in the 50 States or the District of Columbia for
21 which—
22 (A) bid amount described in paragraph (2)
23 for a Medicare Part C plan for 2009 or 2010,
24 exceeds

1 (B) the percent specified in paragraph (4)
2 of the fee-for-service amount described in para-
3 graph (3),
4 the Medicare Part C plan may not enroll any new
5 enrollees in the plan during the annual, coordinated
6 election period (under section 1851(e)(3)(B) of such
7 Act (42 U.S.C. 1395w-21(e)(3)(B)) for the year or
8 during the year (if the enrollment becomes effective
9 during the year).
10 (2) BID AMOUNT FOR PART A AND B SERV-
11 ICES.—
12 (A) IN GENERAL.—Except as provided in
13 subparagraph (B), the bid amount described in
14 this paragraph is the unadjusted Medicare Part
15 C statutory non-drug monthly bid amount (as
16 defined in section 1854(b)(2)(E) of the Social
17 Security Act (42 U.S.C. 1395w-24(b)(2)(E)).
18 (B) TREATMENT OF MSA PLANS.—In the
19 case of an MSA plan (as defined in section
20 1859(b)(3) of the Social Security Act, 42
21 U.S.C. 1935w-28(b)(3)), the bid amount de-
22 scribed in this paragraph is the amount de-
23 scribed in section 1854(a)(3)(A) of such Act
24 (42 U.S.C. 1395w-24(a)(3)(A)).
25 (3) FEE-FOR-SERVICE AMOUNT DESCRIBED.—

1 (A) IN GENERAL.—Subject to subpara-
2 graph (B), the fee-for-service amount described
3 in this paragraph for an Medicare Part C local
4 area is the amount described in section
5 1853(c)(1)(D)(i) of the Social Security Act (42
6 U.S.C. 1395w-23) for such area.
7 (B) TREATMENT OF MULTI-COUNTY
8 PLANS.—In the case of an MA plan the service
9 area for which covers more than one Medicare
10 Part C local area, the fee-for-service amount
11 described in this paragraph is the amount de-
12 scribed in section 1853(c)(1)(D)(i) of the Social
13 Security Act for each such area served, weight-
14 ed for each such area by the proportion of the
15 enrollment of the plan that resides in the coun-
16 ty (as determined based on amounts posted by
17 the Administrator of the Centers for Medicare
18 & Medicaid Services in the April bid notice
19 for the year involved).
20 (4) PERCENTAGE PHASE DOWN.—For purposes
21 of paragraph (1), the percentage specified in this
22 paragraph—
23 (A) for 2009 is 106 percent; and
24 (B) for 2010 is 103 percent.

1 (5) EXEMPTION OF AGE-INS.—For purposes of
2 paragraph (1), the term ''new enrollee'' with respect
3 to a Medicare Part C plan offered by a Medicare
4 Part C organization, does not include an individual
5 who was enrolled in a plan offered by the organiza-
6 tion in the month immediately before the month in
7 which the individual was eligible to enroll in such a
8 Medicare Part C plan offered by the organization.
9 (d) ANNUAL REBASING OF FEE-FOR-SERVICE
10 RATES.—Section 1853(c)(1)(D)(ii) of the Social Security
11 Act (42 U.S.C. 1395w-23(c)(1)(D)(ii)) is amended—
12 (1) by inserting ''(before 2009)'' after ''for sub-
13 sequent years''; and
14 (2) by inserting before the period at the end the
15 following: ''and for each year beginning with 2009''.
16 (e) REPEAL OF PPO STABILIZATION FUND.—Sec-
17 tion 1858 of the Social Security Act (42 U.S.C. 1395) is
18 amended—
19 (1) by striking subsection (e); and
20 (2) in subsection (f)(1), by striking ''subject to
21 subsection (e),''.

Subtitle B—Beneficiary Protections

SEC. 411. NAIC DEVELOPMENT OF MARKETING, ADVERTISING, AND RELATED PROTECTIONS.

(a) IN GENERAL.—Section 1852 of the Social Security Act (42 U.S.C. 1395w-22) is amended by adding at the end the following new subsection:

"(m) APPLICATION OF MODEL MARKETING AND ENROLLMENT STANDARDS.—

"(1) IN GENERAL.—The National Association of Insurance Commissioners (in this subsection referred to as the 'NAIC') is requested to develop, and to submit to the Secretary of Health and Human Services not later than 12 months after the date of the enactment of this Act, model regulations (in this section referred to as 'model regulations') regarding Medicare plan marketing, enrollment, broker and agent training and certification, agent and broker commissions, and market conduct by plans, agents and brokers for implementation (under paragraph (7)) under this part and part D, including for enforcement by States under section 1856(b)(3).

"(2) MARKETING GUIDELINES.—

"(A) IN GENERAL.—The model regulations shall address the sales and advertising techniques used by Medicare private plans, agents

1 and brokers in selling plans, including defining
2 and prohibiting cold calls, unsolicited door-to-
3 door sales, cross-selling, and co-branding.
4 "(B) SPECIAL CONSIDERATIONS.—The
5 model regulations shall specifically address the
6 marketing—
7 "(i) of plans to full benefit dual-eligi-
8 ble individuals and qualified medicare
9 beneficiaries;
10 "(ii) of plans to populations with lim-
11 ited English proficiency;
12 "(iii) of plans to beneficiaries in sen-
13 ior living facilities; and
14 "(iv) of plans at educational events.
15 "(3) ENROLLMENT GUIDELINES.—
16 "(A) IN GENERAL.—The model regulations
17 shall address the disclosures Medicare private
18 plans, agents, and brokers must make when en-
19 rolling beneficiaries, and a process—
20 "(i) for affirmative beneficiary sign
21 off before enrollment in a plan; and
22 "(ii) in the case of Medicare Part C
23 plans, for plans to conduct a beneficiary
24 call-back to confirm beneficiary sign off
25 and enrollment.

1 "(B) SPECIFIC CONSIDERATIONS.—The
2 model regulations shall specially address bene-
3 ficiary understanding of the Medicare plan
4 through required disclosure (or beneficiary
5 verification) of each of the following:
6 "(i) The type of Medicare private plan
7 involved.
8 "(ii) Attributes of the plan, including
9 premiums, cost sharing, formularies (if ap-
10 plicable), benefits, and provider access lim-
11 itations in the plan.
12 "(iii) Comparative quality of the plan.
13 "(iv) The fact that plan attributes
14 may change annually.
15 "(4) APPOINTMENT, CERTIFICATION AND
16 TRAINING OF AGENTS AND BROKERS.—The model
17 regulations shall establish procedures and require-
18 ments for appointment, certification (and periodic
19 recertification), and training of agents and brokers
20 that market or sell Medicare private plans consistent
21 with existing State appointment and certification
22 procedures and with this paragraph.
23 "(5) AGENT AND BROKER COMMISSIONS.—
24 "(A) IN GENERAL.—The model regulations
25 shall establish standards for fair and appro-

1 priate commissions for agents and brokers con-
2 sistent with this paragraph.
3 "(B) LIMITATION ON TYPES OF COMMIS-
4 SION.—The model regulations shall specifically
5 prohibit the following:
6 "(i) Differential commissions—
7 "(I) for Medicare Part C plans
8 based on the type of Medicare private
9 plan; or
10 "(II) prescription drug plans
11 under part D based on the type of
12 prescription drug plan.
13 "(ii) Commissions in the first year
14 that are more than 200 percent of subse-
15 quent year commissions.
16 "(iii) The payment of extra bonuses
17 or incentives (such as trips, gifts, and
18 other non-commission cash payments).
19 "(C) AGENT DISCLOSURE.—In developing
20 the model regulations, the NAIC shall consider
21 requiring agents and brokers to disclose com-
22 missions to a beneficiary upon request of the
23 beneficiary before enrollment.
24 "(D) PREVENTION OF FRAUD.—The model
25 regulations shall consider the opportunity for

1 fraud and abuse and beneficiary steering in set-
2 ting standards under this paragraph and shall
3 provide for the ability of State commissioners to
4 investigate commission structures.
5 ''(6) MARKET CONDUCT.—
6 ''(A) IN GENERAL.—The model regulations
7 shall establish standards for the market con-
8 duct of organizations offering Medicare private
9 plans, and of agents and brokers selling such
10 plans, and for State review of plan market con-
11 duct.
12 ''(B) MATTERS TO BE INCLUDED.—Such
13 standards shall include standards for—
14 ''(i) timely payment of claims;
15 ''(ii) beneficiary complaint reporting
16 and disclosure; and
17 ''(iii) State reporting of market con-
18 duct violations and sanctions.
19 ''(7) IMPLEMENTATION.—
20 ''(A) PUBLICATION OF NAIC MODEL REGU-
21 LATIONS.—If the model regulations are sub-
22 mitted on a timely basis under paragraph (1)—
23 ''(i) the Secretary shall publish them
24 in the Federal Register upon receipt and
25 request public comment on the issue of

1 whether such regulations are consistent
2 with the requirements established in this
3 subsection for such regulations;
4 ''(ii) not later than 6 months after the
5 date of such publication, the Secretary
6 shall determine whether such regulations
7 are so consistent with such requirements
8 and shall publish notice of such determina-
9 tion in the Federal Register; and
10 ''(iii) if the Secretary makes the de-
11 termination under clause (ii) that such reg-
12 ulations are consistent with such require-
13 ments, in the notice published under clause
14 (ii) the Secretary shall publish notice of
15 adoption of such model regulations as con-
16 stituting the marketing and enrollment
17 standards adopted under this subsection to
18 be applied under this title; and
19 ''(iv) if the Secretary makes the deter-
20 mination under such clause that such regu-
21 lations are not consistent with such re-
22 quirements, the procedures of clauses (ii)
23 and (iii) of subparagraph (B) shall apply
24 (in relation to the notice published under
25 clause (ii)), in the same manner as such

1 clauses would apply in the case of publica-
2 tion of a notice under subparagraph (B)(i).
3 "(B) NO MODEL REGULATIONS.—If the
4 model regulations are not submitted on a timely
5 basis under paragraph (1)—
6 "(i) the Secretary shall publish notice
7 of such fact in the Federal Register;
8 "(ii) not later than 6 months after the
9 date of publication of such notice, the Sec-
10 retary shall propose regulations that pro-
11 vide for marketing and enrollment stand-
12 ards that incorporate the requirements of
13 this subsection for the model regulations
14 and request public comments on such pro-
15 posed regulations; and
16 "(iii) not later than 6 months after
17 the date of publication of such proposed
18 regulations, the Secretary shall publish
19 final regulations that shall constitute the
20 marketing and enrollment standards
21 adopted under this subsection to be applied
22 under this title.
23 "(C) REFERENCES TO MARKETING AND
24 ENROLLMENT STANDARDS.—In this title, a ref-
25 erence to marketing and enrollment standards

1 adopted under this subsection is deemed a ref-
2 erence to the regulations constituting such
3 standards adopted under subparagraph (A) or
4 (B), as the case may be.

5 ''(D) EFFECTIVE DATE OF STANDARDS.—
6 In order to provide for the orderly and timely
7 implementation of marketing and enrollment
8 standards adopted under this subsection, the
9 Secretary, in consultation with the NAIC, shall
10 specify (by program instruction or otherwise)
11 effective dates with respect to all components of
12 such standards consistent with the following:

13 ''(i) In the case of components that
14 relate predominantly to operations in rela-
15 tion to Medicare private plans, the effective
16 date shall be for plan years beginning on
17 or after such date (not later than 1 year
18 after the date of promulgation of the
19 standards) as the Secretary specifies.

20 ''(ii) In the case of other components,
21 the effective date shall be such date, not
22 later than 1 year after the date of promul-
23 gation of the standards, as the Secretary
24 specifies.

1 "(E) CONSULTATION.— In promulgating
2 marketing and enrollment standards under this
3 paragraph, the NAIC or Secretary shall consult
4 with a working group composed of representa-
5 tives of issuers of Medicare private plans, con-
6 sumer groups, medicare beneficiaries, State
7 Health Insurance Assistance Programs, and
8 other qualified individuals. Such representatives
9 shall be selected in a manner so as to assure
10 balanced representation among the interested
11 groups.
12 "(8) ENFORCEMENT.—
13 "(A) IN GENERAL.—Any Medicare private
14 plan that violates marketing and enrollment
15 standards is subject to sanctions under section
16 1857(g).
17 "(B) STATE RESPONSIBILITIES.—Nothing
18 in this subsection or section 1857(g) shall pro-
19 hibit States from imposing sanctions against
20 Medicare private plans, agents, or brokers for
21 violations of the marketing and enrollment
22 standards adopted under section 1852(m).
23 States shall have the sole authority to regulate
24 agents and brokers.

1 "(9) MEDICARE PRIVATE PLAN DEFINED.—In
2 this subsection, the term 'Medicare private plan'
3 means a Medicare Part C plan and a prescription
4 drug plan under part D.".
5 (b) EXPANSION OF EXCEPTION TO PREEMPTION OF
6 STATE ROLE.—
7 (1) IN GENERAL.—Section 1856(b)(3) of the
8 Social Security Act (42 U.S.C. 1395w-26(b)(3)) is
9 amended by striking "(other than State licensing
10 laws or State laws relating to plan solvency)" and
11 inserting "(other than State laws relating to licens-
12 ing or plan solvency and State laws or regulations
13 adopting the marketing and enrollment standards
14 adopted under section 1852(m)).".
15 (2) EFFECTIVE DATE.—The amendment made
16 by paragraph (1) shall apply to plans offered on or
17 after July 1, 2008.
18 (c) APPLICATION TO PRESCRIPTION DRUG PLANS.—
19 (1) IN GENERAL.—Section 1860D–1 of such
20 Act is amended by adding at the end the following
21 new subsection:
22 "(d) APPLICATION OF MARKETING AND ENROLL-
23 MENT STANDARDS.—The marketing and enrollment
24 standards adopted under section 1852(m) shall apply to
25 prescription drug plans (and sponsors of such plans) in

1 the same manner as they apply to Medicare Part C plans
2 and organizations offering such plans.''.
3 (2) REFERENCE TO CURRENT LAW PROVI-
4 SIONS.—The amendment made by subsection (a)
5 and (b) apply, pursuant to section 1860D–
6 1(b)(1)(B)(ii) of the Social Security Act (42 U.S.C.
7 1395w–101(b)(1)(B)(ii)), to prescription drug plans
8 under part D of title XVIII of such Act.
9 (d) CONTRACT REQUIREMENT TO MEET MARKETING
10 AND ADVERTISING STANDARDS.—
11 (1) IN GENERAL.—Section 1857(d) of the So-
12 cial Security Act (42 U.S.C. 1395w-27(d)), as
13 amended by subsection (b)(1), is further amended by
14 adding at the end the following new paragraph:
15 ''(7) MARKETING AND ADVERTISING STAND-
16 ARDS.—The contract shall require the organization
17 to meet all standards adopted under section
18 1852(m) (including those enforced by the State in-
19 volved pursuant to section 1856(b)(3)) relating to
20 marketing and advertising conduct''.
21 (2) EFFECTIVE DATE.—The amendment made
22 by paragraph (1) shall apply to contracts for plan
23 years beginning on or after January 1, 2011.
24 (e) APPLICATION OF SANCTIONS.—

1 (1) APPLICATION TO VIOLATION OF MARKETING
2 AND ENROLLMENT STANDARDS.—Section 1857(g) of
3 such Act (42 U.S.C. 1395w-27(g)) is amended—
4 (A) by striking ''or'' at the end of subpara-
5 graph (F);
6 (B) by adding ''or'' at the end of subpara-
7 graph (G); and
8 (C) by inserting after subparagraph (G)
9 the following new subparagraph:
10 ''(H) violates marketing and enrollment
11 standards adopted under section 1852(m);''.
12 (2) ENHANCED CIVIL MONEY SANCTIONS.—
13 Such section is further amended—
14 (A) in paragraph (2)(A), by striking
15 ''$25,000'', ''$100,000'', and ''$15,000'' and
16 inserting ''$50,000'', ''$200,000'', and
17 ''$30,000'', respectively; and
18 (B) in subparagraphs (A), (B), and (D) of
19 paragraph (3), by striking ''$25,000'',
20 ''$10,000'', and ''$100,000'', respectively, and
21 inserting ''$50,000'', ''$20,000'', and
22 ''$200,000'', respectively.
23 (3) EFFECTIVE DATE.—The amendments made
24 by paragraph (2) shall apply to violations occurring
25 on or after the date of the enactment of this Act.

1 (f) DISCLOSURE OF MARKET AND ADVERTISING
2 CONTRACT VIOLATIONS AND IMPOSED SANCTIONS.—Sec-
3 tion 1857 of such Act is amended by adding at the end
4 the following new subsection
5 "(j) DISCLOSURE OF MARKET AND ADVERTISING
6 CONTRACT VIOLATIONS AND IMPOSED SANCTIONS.—For
7 years beginning with 2009, the Secretary shall post on its
8 public website for the Medicare program an annual report
9 that—
10 "(1) lists each MA organization for which the
11 Secretary made during the year a determination
12 under subsection (c)(2) the basis of which is de-
13 scribed in paragraph (1)(E); and
14 "(2) that describes any applicable sanctions
15 under subsection (g) applied to such organization
16 pursuant to such determination.".
17 (g) STANDARD DEFINITIONS OF BENEFITS AND
18 FORMATS FOR USE IN MARKETING MATERIALS.—Section
19 1851(h) of such Act (42 U.S.C. 1395w-21(h)) is amended
20 by adding at the end the following new paragraph:
21 "(6) STANDARD DEFINITIONS OF BENEFITS
22 AND FORMATS FOR USE IN MARKETING MATE-
23 RIALS.—
24 "(A) IN GENERAL.—Not later than Janu-
25 ary 1, 2010, the Secretary, in consultation with

1 the National Association of Insurance Commis-
2 sioners and a working group of the type de-
3 scribed in section 1852(m)(7)(E), shall develop
4 standard descriptions and definitions for bene-
5 fits under this title for use in marketing mate-
6 rial distributed by Medicare Part C organiza-
7 tions and formats for including such descrip-
8 tions in such marketing material.
9 "(B) REQUIRED USE OF STANDARD DEFI-
10 NITIONS.— For plan years beginning on or
11 after January 1, 2011, the Secretary shall dis-
12 approve the distribution of marketing material
13 under paragraph (1)(B) if such marketing ma-
14 terial does not use, without modification, the
15 applicable descriptions and formats specified
16 under subparagraph (A).".
17 (h) SUPPORT FOR STATE HEALTH INSURANCE AS-
18 SISTANCE PROGRAMS (SHIPS).—Section 1857(e)(2) of
19 the Social Security Act (42 U.S.C. 1395w-27(e)(2)) is
20 amended—
21 (1) in subparagraph (B), by adding at the end
22 the following: "Of the amounts so collected, no less
23 than $55,000,000 for fiscal year 2009, $65,000,000
24 for fiscal year 2010, $75,000,000 for fiscal year
25 2011, and $85,000,000 for fiscal year 2012 and

1 each succeeding fiscal year shall be used to support
2 Medicare Part C and Part D counseling and assist-
3 ance provided by State Health Insurance Assistance
4 Programs.";
5 (2) in subparagraph (C)—
6 (A) by striking "and" after
7 "$100,000,000";
8 (B) by striking "an amount equal to
9 $200,000,000" and inserting "and ending with
10 fiscal year 2008 an amount equal to
11 $200,000,000, for fiscal year 2009 an amount
12 equal to $255,000,000, for fiscal year 2010 an
13 amount equal to $265,000,000, for fiscal year
14 2011 an amount equal to $275,000,000, and
15 for fiscal year 2012 and each succeeding fiscal
16 year an amount equal to $285,000,000"; and
17 (C) by adding at the end the following:
18 "The amounts in excess of $200,000,000 in any
19 fiscal year shall be used to support State
20 Health Insurance Assistance Programs under
21 subparagraph (B) and the remaining amount
22 used to support activities related to enrollment
23 and dissemination of information"; and
24 (3) in subparagraph (D)(ii)—

(A) by striking ''and'' at the end of subclause (IV);

(B) in subclause (V), by striking the period at the end and inserting ''before fiscal year 2009; and''; and

(C) by adding at the end the following new subclauses:

''(VI) for fiscal year 2009 and each succeeding fiscal year the applicable portion (as so defined) of the amount specified in subparagraph (C) for that fiscal year.''.

SEC. 412. LIMITATION ON OUT-OF-POCKET COSTS FOR INDIVIDUAL HEALTH SERVICES.

(a) IN GENERAL.—Section 1852(a)(1) of the Social Security Act (42 U.S.C. 1395w-22(a)(1)) is amended—

(1) in subparagraph (A), by inserting before the period at the end the following: ''with cost-sharing that is no greater (and may be less) than the cost-sharing that would otherwise be imposed under such program option'';

(2) in subparagraph (B)(i), by striking '' or an actuarially equivalent level of cost-sharing as determined in this part''; and

(3) by amending clause (ii) of subparagraph (B) to read as follows:

1 "(ii) PERMITTING USE OF FLAT CO-
2 PAYMENT OR PER DIEM RATE.—Nothing in
3 clause (i) shall be construed as prohibiting
4 a Medicare part C plan from using a flat
5 copayment or per diem rate, in lieu of the
6 cost-sharing that would be imposed under
7 part A or B, so long as the amount of the
8 cost-sharing imposed does not exceed the
9 amount of the cost-sharing that would be
10 imposed under the respective part if the in-
11 dividual were not enrolled in a plan under
12 this part.".
13 (b) LIMITATION FOR DUAL ELIGIBLES AND QUALI-
14 FIED MEDICARE BENEFICIARIES.—Section 1852(a) of
15 such Act is amended by adding at the end the following
16 new paragraph:
17 "(7) LIMITATION ON COST-SHARING FOR DUAL
18 ELIGIBLES AND QUALIFIED MEDICARE BENE-
19 FICIARIES.—In the case of a individual who is a full-
20 benefit dual eligible individual (as defined in section
21 1935(c)(6)) or a qualified medicare beneficiary (as
22 defined in section 1905(p)(1)) who is enrolled in a
23 Medicare Part C plan, the plan may not impose
24 cost-sharing that exceeds the amount of cost-sharing
25 that would be permitted with respect to the indi-

1 vidual under this title and title XIX if the individual
2 were not enrolled with such plan.''.
3 (c) EFFECTIVE DATES.—
4 (1) The amendments made by subsection (a)
5 shall apply to plan years beginning on or after Janu-
6 ary 1, 2009.
7 (2) The amendments made by subsection (b)
8 shall apply to plan years beginning on or after Janu-
9 ary 1, 2008.
10 **SEC. 413. MA PLAN ENROLLMENT MODIFICATIONS.**
11 (a) IMPROVED PLAN ENROLLMENT,
12 DISENROLLMENT, AND CHANGE OF ENROLLMENT.—
13 (1) CONTINUOUS OPEN ENROLLMENT FOR
14 FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS AND
15 QUALIFIED MEDICARE BENEFICIARIES (QMB).—Sec-
16 tion 1851(e)(2)(D) of the Social Security Act (42
17 U.S.C. 1395w-21(e)(2)(D)) is amended—
18 (A) in the heading, by inserting ;'', FULL-
19 BENEFIT DUAL ELIGIBLE INDIVIDUALS, AND
20 QUALIFIED MEDICARE BENEFICIARIES'' after
21 ''INSTITUTIONALIZED INDIVIDUALS''; and
22 (B) in the matter before clause (i), by in-
23 serting '', a full-benefit dual eligible individual
24 (as defined in section 1935(c)(6)), or a quali-
25 fied medicare beneficiary (as defined in section

1905(p)(1))'' after ''institutionalized (as defined by the Secretary)''; and

(C) in clause (i), by inserting ''or disenroll'' after ''enroll''.

(2) SPECIAL ELECTION PERIODS FOR ADDITIONAL CATEGORIES OF INDIVIDUALS.—Section 1851(e)(4) of such Act (42 U.S.C. 1395w(e)(4)) is amended—

(A) in subparagraph (C), by striking at the end ''or'';

(B) in subparagraph (D), by inserting '', taking into account the health or well-being of the individual'' before the period and redesignating such subparagraph as subparagraph (G); and

(C) by inserting after subparagraph (C) the following new subparagraphs:

''(D) the individual is described in section 1902(a)(10)(E)(iii) (relating to specified low-income medicare beneficiaries); or

''(E) the individual is enrolled in an MA plan and enrollment in the plan is suspended under paragraph (2)(B) or (3)(C) of section 1857(g) because of a failure of the plan to meet applicable requirements.''.

1 (3) EFFECTIVE DATE.—The amendments made
2 by this subsection shall take effect on the date of the
3 enactment of this Act.
4 (b) ACCESS TO MEDIGAP COVERAGE FOR INDIVID-
5 UALS WHO LEAVE MA PLANS.—
6 (1) IN GENERAL.—Section 1882(s)(3) of the
7 Social Security Act (42 U.S.C. 1395ss(s)(3)) is
8 amended—
9 (A) in each of clauses (v)(III) and (vi) sub-
10 paragraph (B), by striking ''12 months'' and
11 inserting ''24 months''; and
12 (B) in each of subclauses (I) and (II) of
13 subparagraph (F)(i), by striking ''12 months''
14 and inserting ''24 months''.
15 (2) EFFECTIVE DATE.—The amendments made
16 by paragraph (1) shall apply to terminations of en-
17 rollments in MA plans occurring on or after the date
18 of the enactment of this Act.
19 (c) IMPROVED ENROLLMENT POLICIES.—
20 (1) NO AUTO-ENROLLMENT OF MEDICAID
21 BENEFICIARIES.—
22 (A) IN GENERAL.—Section 1851(e) of such
23 Act (42 U.S.C. 1395w-21(e)) is amended by
24 adding at the end the following new paragraph:

1 "(7) NO AUTO-ENROLLMENT OF MEDICAID
2 BENEFICIARIES.—In no case may the Secretary pro-
3 vide for the enrollment in a MA plan of a Medicare
4 Advantage eligible individual who is eligible to re-
5 ceive medical assistance under title XIX as a full-
6 benefit dual eligible individual or a qualified medi-
7 care beneficiary, without the affirmative application
8 of such individual (or authorized representative of
9 the individual) to be enrolled in such plan.".
10 (B) NO APPLICATION TO PRESCRIPTION
11 DRUG PLANS.—Section 1860D–1(b)(1)(B)(iii)
12 of such Act (42 U.S.C. 1395w-
13 101(b)(1)(B)(iii)) is amended—
14 (i) by striking "paragraph (2) and"
15 and by inserting "paragraph (2),"; and
16 (ii) by inserting ", and paragraph
17 (7)," after "paragraph (4)".
18 (C) EFFECTIVE DATE.—The amendments
19 made by this paragraph shall apply to enroll-
20 ments that are effective on or after the date of
21 the enactment of this Act.
22 **SEC. 414. INFORMATION FOR BENEFICIARIES ON MA PLAN**
23 **ADMINISTRATIVE COSTS.**
24 (a) DISCLOSURE OF MEDICAL LOSS RATIOS AND
25 OTHER EXPENSE DATA.—Section 1851 of the Social Se-

1 curity Act (42 U.S.C. 1395w-21) is amended by adding
2 at the end the following new subsection:
3 "(j) PUBLICATION OF MEDICAL LOSS RATIOS AND
4 OTHER COST-RELATED INFORMATION.—
5 "(1) IN GENERAL.—The Secretary shall pub-
6 lish, not later than October 1 of each year (begin-
7 ning with 2009), for each Medicare Part C plan con-
8 tract, the following:
9 "(A) The medical loss ratio of the plan in
10 the previous year.
11 "(B) The per enrollee payment under this
12 part to the plan, as adjusted to reflect a risk
13 score (based on factors described in section
14 1853(a)(1)(C)(i)) of 1.0.
15 "(C) The average risk score (as so based).
16 "(2) SUBMISSION OF DATA.—
17 "(A) IN GENERAL.—Each Medicare Part C
18 organization shall submit to the Secretary, in a
19 form and manner specified by the Secretary,
20 data necessary for the Secretary to publish the
21 information described in paragraph (1) on a
22 timely basis, including the information de-
23 scribed in paragraph (3).
24 "(B) DATA FOR 2008 AND 2009.—The data
25 submitted under subparagraph (A) for 2008

1 and for 2009 shall be consistent in content with
2 the data reported as part of the Medicare Part
3 C plan bid in June 2007 for 2008.
4 "(C) MEDICAL LOSS RATIO DATA.—The
5 data to be submitted under subparagraph (A)
6 relating to medical loss ratio for a year—
7 "(i) shall be submitted not later than
8 June 1 of the following year; and
9 "(ii) beginning with 2010, shall be
10 submitted based on the standardized ele-
11 ments and definitions developed under
12 paragraph (4).
13 "(D) AUDITED DATA.—Data submitted
14 under this paragraph shall be data that has
15 been audited by an independent third party
16 auditor.
17 "(3) MLR INFORMATION.—The information de-
18 scribed in this paragraph with respect to a Medicare
19 Part C plan for a year is as follows:
20 "(A) The costs for the plan in the previous
21 year for each of the following:
22 "(i) Total medical expenses, sepa-
23 rately indicated for benefits for the original
24 medicare fee-for-service program option
25 and for supplemental benefits.

1 "(ii) Non-medical expenses, shown
2 separately for each of the following cat-
3 egories of expenses:
4 "(I) Marketing and sales.
5 "(II) Direct administration.
6 "(III) Indirect administration.
7 "(IV) Net cost of private reinsur-
8 ance.
9 "(B) Gain or loss margin.
10 "(C) Total revenue requirement, computed
11 as the total of medical and nonmedical expenses
12 and gain or loss margin, multiplied by the gain
13 or loss margin.
14 "(D) Percent of revenue ratio, computed
15 as the total revenue requirement expressed as a
16 percentage of revenue.
17 "(4) DEVELOPMENT OF DATA REPORTING
18 STANDARDS.—
19 "(A) IN GENERAL.—The Secretary shall
20 develop and implement standardized data ele-
21 ments and definitions for reporting under this
22 subsection, for contract years beginning with
23 2010, of data necessary for the calculation of
24 the medical loss ratio for Medicare Part C
25 plans. Not later than December 31, 2008, the

1 Secretary shall publish a report describing the
2 elements and definitions so developed.
3 "(B) CONSULTATION.—The Secretary
4 shall consult with representatives of Medicare
5 Part C organizations, experts on health plan ac-
6 counting systems, and representatives of the
7 National Association of Insurance Commis-
8 sioners, in the development of such data ele-
9 ments and definitions
10 "(5) MEDICAL LOSS RATIO DEFINED.—For
11 purposes of this part, the term 'medical loss ratio'
12 means, with respect to an MA plan for a year, the
13 ratio of—
14 "(A) the aggregate benefits (excluding
15 nonmedical expenses described in paragraph
16 (3)(A)(ii)) paid under the plan for the year, to
17 "(B) the aggregate amount of premiums
18 (including basic and supplemental beneficiary
19 premiums) and payments made under sections
20 1853 and 1860D–15) collected for the plan and
21 year.
22 Such ratio shall be computed without regard to
23 whether the benefits or premiums are for required or
24 supplemental benefits under the plan.".

1 (b) AUDIT OF ADMINISTRATIVE COSTS AND COMPLI-
2 ANCE WITH THE FEDERAL ACQUISITION REGULATION.—
3 (1) IN GENERAL.—Section 1857(d)(2)(B) of
4 such Act (42 U.S.C. 1395w-27(d)(2)(B)) is amend-
5 ed—
6 (A) by striking ''or (ii)'' and inserting
7 ''(ii)''; and
8 (B) by inserting before the period at the
9 end the following: '', or (iii) to compliance with
10 the requirements of subsection (e)(4) and the
11 extent to which administrative costs comply
12 with the applicable requirements for such costs
13 under the Federal Acquisition Regulation''.
14 (2) EFFECTIVE DATE.—The amendments made
15 by this subsection shall apply for contract years be-
16 ginning after the date of the enactment of this Act.
17 (c) MINIMUM MEDICAL LOSS RATIO.—Section
18 1857(e) of the Social Security Act (42 U.S.C. 1395w-
19 27(e)) is amended by adding at the end the following new
20 paragraph:
21 ''(4) REQUIREMENT FOR MINIMUM MEDICAL
22 LOSS RATIO.—If the Secretary determines for a con-
23 tract year (beginning with 2010) that an MA plan
24 has failed to have a medical loss ratio (as defined in
25 section 1851(j)(4)) of at least .85—

1 "(A) for that contract year, the Secretary
2 shall reduce the blended benchmark amount
3 under subsection (l) for the second succeeding
4 contract year by the numer of percentage points
5 by which such loss ratio was less than 85 per-
6 cent;
7 "(B) for 3 consecutive contract years, the
8 Secretary shall not permit the enrollment of
9 new enrollees under the plan for coverage dur-
10 ing the second succeeding contract year; and
11 "(C) the Secretary shall terminate the plan
12 contract if the plan fails to have such a medical
13 loss ratio for 5 consecutive contract years.".
14 (d) INFORMATION ON MEDICARE PART C PLAN EN-
15 ROLLMENT AND SERVICES.—Section 1851 of such Act, as
16 amended by subsection (a), is further amended by adding
17 at the end the following new subsection:
18 "(k) PUBLICATION OF ENROLLMENT AND OTHER IN-
19 FORMATION.—
20 "(1) MONTHLY PUBLICATION OF PLAN-SPE-
21 CIFIC ENROLLMENT DATA.—The Secretary shall
22 publish (on the public website of the Centers for
23 Medicare & Medicaid Services or otherwise) not later
24 than 30 days after the end of each month (beginning

1 with January 2008) on the actual enrollment in each
2 Medicare Part C plan by contract and by county.
3 ''(2) AVAILABILITY OF OTHER INFORMATION.—
4 The Secretary shall make publicly available data and
5 other information in a format that may be readily
6 used for analysis of the Medicare Part C program
7 under this part and will contribute to the under-
8 standing of the organization and operation of such
9 program.''.
10 (e) MEDPAC REPORT ON VARYING MINIMUM MED-
11 ICAL LOSS RATIOS.—
12 (1) STUDY.—The Medicare Payment Advisory
13 Commission shall conduct a study of the need and
14 feasibility ofproviding for different minimum medical
15 loss ratios for different types of Medicare Part C
16 plans, including coordinated care plans, group model
17 plans, coordinated care independent practice associa-
18 tion plans, preferred provider organization plans,
19 and private fee-for-services plans.
20 (2) REPORT.—Not later than 1 year after the
21 date of the enactment of this Act, submit to Con-
22 gress a report on the study conducted under para-
23 graph (1).

Subtitle C—Quality and Other Provisions

SEC. 421. REQUIRING ALL MA PLANS TO MEET EQUAL STANDARDS.

(a) COLLECTION AND REPORTING OF INFORMATION.—

(1) IN GENERAL.—Section 1852(e)(1) of the Social Security Act (42 U.S.C. 1395w-112(e)(1)) is amended by striking ''(other than an MA private fee-for-service plan or an MSA plan)''.

(2) REPORTING FOR PRIVATE FEE-FOR-SERVICES AND MSA PLANS.—Section 1852(e)(3) of such Act is amended by adding at the end the following new subparagraph:

''(C) DATA COLLECTION REQUIREMENTS BY PRIVATE FEE-FOR-SERVICE PLANS AND MSA PLANS.—

''(i) USING MEASURES FOR PPOS FOR CONTRACT YEAR 2009.—For contract year 2009, the Medicare Part C organization offering a private fee-for-service plan or an MSA plan shall submit to the Secretary for such plan the same information on the same performance measures for which such information is required to be submitted for

1 Medicare Part C plans that are preferred
2 provider organization plans for that year.
3 "(ii) APPLICATION OF SAME MEAS-
4 URES AS COORDINATED CARE PLANS BE-
5 GINNING IN CONTRACT YEAR 2010.—For a
6 contract year beginning with 2010, a Medi-
7 care Part C organization offering a private
8 fee-for-service plan or an MSA plan shall
9 submit to the Secretary for such plan the
10 same information on the same performance
11 measures for which such information is re-
12 quired to be submitted for such contract
13 year Medicare Part C plans described in
14 section 1851(a)(2)(A)(i) for contract year
15 such contract year.".
16 (3) EFFECTIVE DATE.—The amendment made
17 by paragraph (1) shall apply to contract years begin-
18 ning on or after January 1, 2009.
19 (b) EMPLOYER PLANS.—
20 (1) IN GENERAL.—The first sentence of para-
21 graph (2) of section 1857(i) of such Act (42 U.S.C.
22 1395w-27(i)) is amended by inserting before the pe-
23 riod at the end the following: ", but only if 90 per-
24 cent of the Medicare part C eligible individuals en-
25 rolled under such plan reside in a county in which

1 the Medicare Part C organization offers a Medicare
2 Part C local plan''.
3 (2) LIMITATION ON APPLICATION OF WAIVER
4 AUTHORITY.—Paragraphs (1) and (2) of such sec-
5 tion are each amended by inserting ''that were in ef-
6 fect before the date of the enactment of the Chil-
7 dren's Health and Medicare Protection Act of 2007''
8 after ''waive or modify requirements''.
9 (3) EFFECTIVE DATES.—The amendment made
10 by paragraph (1) shall apply for plan years begin-
11 ning on or after January 1, 2009, and the amend-
12 ments made by paragraph (2) shall take effect on
13 the date of the enactment of this Act.

14 **SEC. 422. DEVELOPMENT OF NEW QUALITY REPORTING**
15 **MEASURES ON RACIAL DISPARITIES.**

16 (a) NEW QUALITY REPORTING MEASURES.—
17 (1) IN GENERAL.—Section 1852(e)(3) of the
18 Social Security Act (42 U.S.C. 1395w-22(e)(3)), as
19 amended by section 421(a)(2), is amended—
20 (A) in subparagraph (B)—
21 (i) in clause (i), by striking ''The Sec-
22 retary'' and inserting ''Subject to subpara-
23 graph (D), the Secretary''; and
24 (ii) in clause (ii), by inserting ''and
25 subparagraph (C)'' after ''clause (iii)''; and

1 (B) by adding at the end the following new
2 subparagraph:
3 ''(D) ADDITIONAL QUALITY REPORTING
4 MEASURES.—
5 ''(i) IN GENERAL.—The Secretary
6 shall develop by October 1, 2009, quality
7 measures for Medicare Part C plans that
8 measure disparities in the amount and
9 quality of health services provided to racial
10 and ethnic minorities.
11 ''(ii) DATA TO MEASURE RACIAL AND
12 ETHNIC DISPARITIES IN THE AMOUNT AND
13 QUALITY OF CARE PROVIDED TO ENROLL-
14 EES.—The Secretary shall provide for
15 Medicare Part C organizations to submit
16 data under this paragraph, including data
17 similar to those submitted for other quality
18 measures, that permits analysis of dispari-
19 ties among racial and ethnic minorities in
20 health services, quality of care, and health
21 status among Medicare Part C plan enroll-
22 ees for use in submitting the reports under
23 paragraph (5).''.
24 (2) EFFECTIVE DATE.—The amendments made
25 by this subsection shall apply to reporting of quality

1 measures for plan years beginning on or after Janu-
2 ary 1, 2010.
3 (b) BIENNIAL REPORT ON RACIAL AND ETHNIC MI-
4 NORITIES.—Section 1852(e) of such Act (42 U.S.C.
5 1395w∓22(e)) is amended by adding at the end the fol-
6 lowing new paragraph:
7 ''(5) REPORT TO CONGRESS.—
8 ''(A) IN GENERAL.—Not later than 2 years
9 after the date of the enactment of this para-
10 graph, and biennially thereafter, the Secretary
11 shall submit to Congress a report regarding
12 how quality assurance programs conducted
13 under this subsection measure and report on
14 disparities in the amount and quality of health
15 care services furnished to racial and ethnic mi-
16 norities.
17 ''(B) CONTENTS OF REPORT.—Each such
18 report shall include the following:
19 ''(i) A description of the means by
20 which such programs focus on such racial
21 and ethnic minorities.
22 ''(ii) An evaluation of the impact of
23 such programs on eliminating health dis-
24 parities and on improving health outcomes,
25 continuity and coordination of care, man-

1 agement of chronic conditions, and con-
2 sumer satisfaction.
3 ''(iii) Recommendations on ways to re-
4 duce clinical outcome disparities among ra-
5 cial and ethnic minorities.
6 ''(iv) Data for each MA plan from
7 HEDIS and other source reporting the dis-
8 parities in the amount and quality of
9 health services furnished to racial and eth-
10 nic minorities.''.

11 **SEC. 423. STRENGTHENING AUDIT AUTHORITY.**

12 (a) FOR PART C PAYMENTS RISK ADJUSTMENT.—
13 Section 1857(d)(1) of the Social Security Act (42 U.S.C.
14 1395w-27(d)(1)) is amended by inserting after ''section
15 1858(c))'' the following: '', and data submitted with re-
16 spect to risk adjustment under section 1853(a)(3)''. .

17 (b) ENFORCEMENT OF AUDITS AND DEFI-
18 CIENCIES.—
19 (1) IN GENERAL.—Section 1857(e) of such Act
20 is amended by adding at the end the following new
21 paragraph:
22 ''(4) ENFORCEMENT OF AUDITS AND DEFI-
23 CIENCIES.—
24 ''(A) INFORMATION IN CONTRACT.—The
25 Secretary shall require that each contract with

1 a Medicare Part C organization under this sec-
2 tion shall include terms that inform the organi-
3 zation of the provisions in subsection (d).
4 "(B) ENFORCEMENT AUTHORITY.—The
5 Secretary is authorized, in connection with con-
6 ducting audits and other activities under sub-
7 section (d), to take such actions, including pur-
8 suit of financial recoveries, necessary to address
9 deficiencies identified in such audits or other
10 activities.".
11 (2) APPLICATION UNDER PART D.—For provi-
12 sion applying the amendment made by paragraph
13 (1) to prescription drug plans under part D, see sec-
14 tion 1860D–12(b)(3)(D) of the Social Security Act.
15 (c) EFFECTIVE DATE.—The amendments made by
16 this section shall take effect the date of the enactment
17 of this Act and shall apply to audits and activities con-
18 ducted for contract years beginning on or after January
19 1, 2009.

20 **SEC. 424. IMPROVING RISK ADJUSTMENT FOR MA PAY-**
21 **MENTS.**

22 (a) IN GENERAL.—Not later than 1 year after the
23 date of the enactment of this Act, the Secretary of Health
24 and Human Services shall submit to Congress a report
25 that evaluates the adequacy of the Medicare Advantage

1 risk adjustment system under section 1853(a)(1)(C) of the
2 Social Security Act (42 U.S.C. 1395–23(a)(1)(C)).
3 (b) PARTICULARS.—The report under subsection (a)
4 shall include an evaluation of at least the following:
5 (1) The need and feasibility of improving the
6 adequacy of the risk adjustment system in predicting
7 costs for beneficiaries with co-morbid conditions and
8 associated cognitive impairments.
9 (2) The need and feasibility of including further
10 gradations of diseases and conditions (such as the
11 degree of severity of congestive heart failure).
12 (3) The feasibility of measuring difference in
13 coding over time between Medicare part C plans and
14 the medicare traditional fee-for-service program and,
15 to the extent this difference exists, the options for
16 addressing it.
17 (4) The feasibility and value of including part
18 D and other drug utilization data in the risk adjust-
19 ment model.

20 **SEC. 425. ELIMINATING SPECIAL TREATMENT OF PRIVATE**
21 **FEE-FOR-SERVICE PLANS.**

22 (a) ELIMINATION OF EXTRA BILLING PROVISION.—
23 Section 1852(k)(2) of the Social Security Act (42 U.S.C.
24 1395w-22(k)(2)) is amended—

1 (1) in subparagraph (A)(i), by striking ''115
2 percent'' and inserting ''100 percent''; and
3 (2) in subparagraph (C)(i), by striking '' (in-
4 cluding any liability for balance billing consistent
5 with this subsection)''.
6 (b) REVIEW OF BID INFORMATION.—Section
7 1854(a)(6)(B) of such Act (42 U.S.C. 1395w-
8 24(a)(6)(B)) is amended—
9 (1) in clause (i), by striking ''clauses (iii) and
10 (iv)'' and inserting ''clause (iii)''; and
11 (2) by striking clause (iv).
12 (c) EFFECTIVE DATE.—The amendments made by
13 this section shall apply to contract years beginning with
14 2009.
15 **SEC. 426. RENAMING OF MEDICARE ADVANTAGE PROGRAM.**
16 (a) IN GENERAL.—The program under part C of title
17 XVIII of the Social Security Act is henceforth to be known
18 as the ''Medicare Part C program''.
19 (b) CHANGE IN REFERENCES.—
20 (1) AMENDING SOCIAL SECURITY ACT.—The
21 Social Security Act is amended by striking ''Medi-
22 care Advantage'', ''MA'', and ''Medicare+Choice''
23 and inserting ''Medicare Part C'' each place it ap-
24 pears, with the appropriate, respective typographic
25 formatting, including typeface and capitalization.

(2) ADDITIONAL REFERENCES.—Notwithstanding section 201(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173), any reference to the program under part C of title XVIII of the Social Security Act shall be deemed a reference to the ''Medicare Part C'' program and, with respect to such part, any reference to ''Medicare+Choice''. ''Medicare Advantage'', or ''MA'' is deemed a reference to the program under such part.

Subtitle D—Extension of Authorities

SEC. 431. EXTENSION AND REVISION OF AUTHORITY FOR SPECIAL NEEDS PLANS (SNPS).

(a) EXTENDING RESTRICTION ON ENROLLMENT AUTHORITY FOR SNPS FOR 3 YEARS.—Subsection (f) of section 1859 of the Social Security Act (42 U.S.C. 1395w-28) is amended by striking ''2009'' and inserting ''2012''.

(b) STRUCTURE OF AUTHORITY FOR SNPS.—

(1) IN GENERAL.—Such section is further amended—

(A) in subsection (b)(6)(A), by striking all that follows ''means'' and inserting the following: ''an MA plan—

1 "(i) that serves special needs individ-
2 uals (as defined in subparagraph (B));
3 "(ii) as of January 1, 2009, either—
4 "(I) at least 90 percent of the
5 enrollees in which are described in
6 subparagraph (B)(i), as determined
7 under regulations in effect as of July
8 1, 2007; or
9 "(II) at least 90 percent of the
10 enrollees in which are described in
11 subparagraph (B)(ii) and are full-ben-
12 efit dual eligible individuals (as de-
13 fined in section 1935(c)(6)) or quali-
14 fied medicare beneficiaries (as defined
15 in section 1905(p)(1)); and
16 "(iii) as of January 1, 2009, meets
17 the applicable requirements of paragraph
18 (2) or (3) of subsection (f), as the case
19 may be.";
20 (B) in subsection (b)(6)(B)(iii), by insert-
21 ing "only for contract years beginning before
22 January 1, 2009," after "(iii)";
23 (C) in subsection (f)—
24 (i) by amending the heading to read
25 as follows: "REQUIREMENTS FOR ENROLL-

1 MENT IN PART C PLANS FOR SPECIAL
2 NEEDS BENEFICIARIES'';
3 (ii) by designating the sentence begin-
4 ning ''In the case of'' as paragraph (1)
5 with the heading ''REQUIREMENTS FOR
6 ENROLLMENT'' and with appropriate in-
7 dentation; and
8 (iii) by adding at the end the fol-
9 lowing new paragraphs:
10 ''(2) ADDITIONAL REQUIREMENTS FOR INSTI-
11 TUTIONAL SNPS.—In the case of a specialized MA
12 plan for special needs individuals described in sub-
13 section (b)(6)(A)(ii)(I), the applicable requirements
14 of this subsection are as follows:
15 ''(A) The plan has an agreement with the
16 State that includes provisions regarding co-
17 operation on the coordination of care for such
18 individuals. Such agreement shall include a de-
19 scription of the manner that the State Medicaid
20 program under title XIX will pay for the costs
21 of services for individuals eligible under such
22 title for medical assistance for acute care and
23 long-term care services.
24 ''(B) The plan has a contract with long-
25 term care facilities and other providers in the

1 area sufficient to provide care for enrollees de-
2 scribed in subsection (b)(6)(B)(i).
3 "(C) The plan reports to the Secretary in-
4 formation on additional quality measures speci-
5 fied by the Secretary under section
6 1852(e)(3)(D)(iv)(I) for such plans.
7 "(3) ADDITIONAL REQUIREMENTS FOR DUAL
8 SNPS.—In the case of a specialized MA plan for spe-
9 cial needs individuals described in subsection
10 (b)(6)(A)(ii)(II), the applicable requirements of this
11 subsection are as follows:
12 "(A) The plan has an agreement with the
13 State Medicaid agency that—
14 "(i) includes provisions regarding co-
15 operation on the coordination of the fi-
16 nancing of care for such individuals;
17 "(ii) includes a description of the
18 manner that the State Medicaid program
19 under title XIX will pay for the costs of
20 cost-sharing and supplemental services for
21 individuals enrolled in the plan eligible
22 under such title for medical assistance for
23 acute and long-term care services; and
24 "(iii) effective January 1, 2011, pro-
25 vides for capitation payments to cover

1 costs of supplemental benefits for individ-
2 uals described in subsection
3 (b)(6)(A)(ii)(II).
4 ''(B) The out-of-pocket costs for services
5 under parts A and B that are charged to enroll-
6 ees may not exceed the out-of-pocket costs for
7 same services permitted for such individuals
8 under title XIX.
9 ''(C) The plan reports to the Secretary in-
10 formation on additional quality measures speci-
11 fied by the Secretary under section
12 1852(e)(3)(D)(iv)(II) for such plans.''.
13 (2) QUALITY STANDARDS AND QUALITY RE-
14 PORTING.—Section 1852(e)(3) of such Act (42
15 U.S.C. 1395w-22(e)(3) is amended—
16 (A) in subparagraph (A)(i), by adding at
17 the end the following: ''In the case of a special-
18 ized Medicare Part C plan for special needs in-
19 dividuals described in paragraph (2) or (3) of
20 section 1859(f), the organization shall provide
21 for the reporting on quality measures developed
22 for the plan under subparagraph (D)(iii).''; and
23 (B) in subparagraph (D), as added by sec-
24 tion 422(a)(1), by adding at the end the fol-
25 lowing new clause:

1 "(iii) SPECIFICATION OF ADDITIONAL
2 QUALITY MEASUREMENTS FOR SPECIAL-
3 IZED PART C PLANS.—For implementation
4 for plan years beginning not later than
5 January 1, 2010, the Secretary shall de-
6 velop new quality measures appropriate to
7 meeting the needs of—
8 "(I) beneficiaries enrolled in spe-
9 cialized Medicare Part C plans for
10 special needs individuals (described in
11 section 1859(b)(6)(A)(ii)(I)) that
12 serve predominantly individuals who
13 are dual-eligible individuals eligible for
14 medical assistance under title XIX by
15 measuring the special needs for care
16 of individuals who are both Medicare
17 and Medicaid beneficiaries; and
18 "(II) beneficiaries enrolled in
19 specialized Medicare Part C plans for
20 special needs individuals (described in
21 section 1859(b)(6)(A)(ii)(II)) that
22 serve predominantly institutionalized
23 individuals by measuring the special
24 needs for care of individuals who are

1 a resident in long-term care institu-
2 tion.''.
3 (3) EFFECTIVE DATE; GRANDFATHER.—The
4 amendments made by paragraph (1) shall take effect
5 for enrollments occurring on or after January 1,
6 2009, and shall not apply—
7 (A) to plans with a contract with a State
8 Medicaid agency to operate an integrated Med-
9 icaid-Medicare program, that had been ap-
10 proved by Centers for Medicare & Medicaid
11 Services on January 1, 2004; and
12 (B) to plans that are operational as of the
13 date of the enactment of this Act as approved
14 Medicare demonstration projects and that pro-
15 vide services predominantly to individuals with
16 end-stage renal disease.
17 (4) TRANSITION FOR NON-QUALIFYING SNPS.—
18 (A) RESTRICTIONS IN 2008 FOR CHRONIC
19 CARE SNPS.—In the case of a specialized MA
20 plan for special needs individuals (as defined in
21 section 1859(b)(6)(A) of the Social Security Act
22 (42 U.S.C. 1395w-28(b)(6)(A)) that, as of De-
23 cember 31, 2007, is not described in either sub-
24 clause (I) or subclause (II) of clause (ii) of such

1 section, as amended by paragraph (1), then as
2 of January 1, 2008—
3 (i) the plan may not be offered unless
4 it was offered before such date;
5 (ii) no new members may be enrolled
6 with the plan; and
7 (iii) there may be no expansion of the
8 service area of such plan.
9 (B) TRANSITION OF ENROLLEES.—The
10 Secretary of Health and Human Services shall
11 provide for an orderly transition of those spe-
12 cialized MA plans for special needs individuals
13 (as defined in section 1859(b)(6)(A) of the So-
14 cial Security Act (42 U.S.C. 1395w-
15 28(b)(6)(A)), as of the date of the enactment of
16 this Act), and their enrollees, that no longer
17 qualify as such plans under such section, as
18 amended by this subsection.

19 **SEC. 432. EXTENSION AND REVISION OF AUTHORITY FOR**
20 **MEDICARE REASONABLE COST CONTRACTS.**

21 (a) EXTENSION FOR 3 YEARS OF PERIOD REASON-
22 ABLE COST PLANS CAN REMAIN IN THE MARKET.—Sec-
23 tion 1876(h)(5)(C)(ii) of the Social Security Act (42
24 U.S.C. 1395mm(h)(5)(C)(ii)) is amended, in the matter

1 preceding subclause (I), by striking ''January 1, 2008''
2 and inserting ''January 1, 2011''.
3 (b) APPLICATION OF CERTAIN MEDICARE ADVAN-
4 TAGE REQUIREMENTS TO COST CONTRACTS EXTENDED
5 OR RENEWED AFTER ENACTMENT.—Section 1876(h) of
6 such Act (42 U.S.C. 1395mm(h)), as amended by sub-
7 section (a), is amended—
8 (1) by redesignating paragraph (5) as para-
9 graph (6); and
10 (2) by inserting after paragraph (4) the fol-
11 lowing new paragraph:
12 ''(5)(A) Any reasonable cost reimbursement
13 contract with an eligible organization under this sub-
14 section that is extended or renewed on or after the
15 date of enactment of the Children's Health and
16 Medicare Protection Act of 2007 shall provide that
17 the provisions of the Medicare Part C program de-
18 scribed in subparagraph (B) shall apply to such or-
19 ganization and such contract in a substantially simi-
20 lar manner as such provisions apply to Medicare
21 Part C organizations and Medicare Part C plans
22 under part C.
23 ''(B) The provisions described in this sub-
24 paragraph are as follows:

1 ''(i) Section 1851(h) (relating to the
2 approval of marketing material and appli-
3 cation forms).
4 ''(ii) Section 1852(e) (relating to the
5 requirement of having an ongoing quality
6 improvement program and treatment of ac-
7 creditation in the same manner as such
8 provisions apply to Medicare Part C local
9 plans that are preferred provider organiza-
10 tion plans).
11 ''(iii) Section 1852(f) (relating to
12 grievance mechanisms).
13 ''(iv) Section 1852(g) (relating to cov-
14 erage determinations, reconsiderations, and
15 appeals).
16 ''(v) Section 1852(j)(4) (relating to
17 limitations on physician incentive plans).
18 ''(vi) Section 1854(c) (relating to the
19 requirement of uniform premiums among
20 individuals enrolled in the plan).
21 ''(vii) Section 1854(g) (relating to re-
22 strictions on imposition of premium taxes
23 with respect to payments to organizations).
24 ''(viii) Section 1856(b)(3) (relating to
25 relation to State laws).

"(ix) The provisions of part C relating to timelines for contract renewal and beneficiary notification.".

TITLE M—PROVISIONS RELATING TO MEDICARE PART A

SEC. 501. INPATIENT HOSPITAL PAYMENT UPDATES.

(a) FOR ACUTE HOSPITALS.—Clause (i) of section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)) is amended—

(1) in subclause (XIX), by striking "and";

(2) by redesignating subclause (XX) as subclause (XXII); and

(3) by inserting after subclause (XIX) the following new subclauses:

"(XX) for fiscal year 2007, subject to clause (viii), the market basket percentage increase for hospitals in all areas,

"(XXI) for fiscal year 2008, subject to clause (viii), the market basket percentage increase minus 0.25 percentage point for hospitals in all areas, and".

(b) FOR OTHER HOSPITALS.—Clause (ii) of such section is amended—

(1) in subclause (VII) by striking ''and'';

(2) by redesignating subclause (VIII) as subclause (X); and

(3) by inserting after subclause (VII) the following new subclauses:

''(VIII) fiscal years 2003 through 2007, is the market basket percentage increase,

''(IX) fiscal year 2008, is the market basket percentage increase minus 0.25 percentage point, and''.

(c) DELAYED EFFECTIVE DATE.—

(1) ACUTE CARE HOSPITALS.—The amendments made by subsection (a) shall not apply to discharges occurring before January 1, 2008.

(2) OTHER HOSPITALS.—The amendments made by subsection (b) shall be applied, only with respect to cost reporting periods beginning during fiscal year 2008 and not with respect to the computation for any succeeding cost reporting period, by substituting ''0.1875 percentage point'' for ''0.25 percentage point''.

1 **SEC. 502. PAYMENT FOR INPATIENT REHABILITATION FA-**
2 **CILITY (IRF) SERVICES.**
3 (a) PAYMENT UPDATE.—
4 (1) IN GENERAL.—Section 1886(j)(3)(C) of the
5 Social Security Act (42 U.S.C. 1395ww(j)(3)(C)) is
6 amended by adding at the end the following: ''The
7 increase factor to be applied under this subpara-
8 graph for fiscal year 2008 shall be 1 percent.''
9 (2) DELAYED EFFECTIVE DATE.—The amend-
10 ment made by paragraph (1) shall not apply to pay-
11 ment units occurring before January 1, 2008.
12 (b) INPATIENT REHABILITATION FACILITY CLASSI-
13 FICATION CRITERIA.—
14 (1) IN GENERAL.—Section 5005 of the Deficit
15 Reduction Act of 2005 (Public Law 109–171) is
16 amended—
17 (A) in subsection (a), by striking ''apply
18 the applicable percent specified in subsection
19 (b)'' and inserting ''require a compliance rate
20 that is no greater than the 60 percent compli-
21 ance rate that became effective for cost report-
22 ing periods beginning on or after July 1,
23 2006,''; and
24 (B) by amending subsection (b) to read as
25 follows:

1 "(b) CONTINUED USE OF COMORBIDITIES.—For por-
2 tions of cost reporting periods occurring on or after the
3 date of the enactment of the Children's Health and Medi-
4 care Protection Act of 2007, the Secretary shall include
5 patients with comorbidities as described in section
6 412.23(b)(2)(i) of title 42, Code of Federal Regulations
7 (as in effect as of January 1, 2007), in the inpatient popu-
8 lation that counts towards the percent specified in sub-
9 section (a).".
10 (2) EFFECTIVE DATE.—The amendment made
11 by paragraph (1)(A) shall apply to portions of cost
12 reporting periods beginning on or after the date of
13 the enactment of this Act.
14 (c) PAYMENT FOR CERTAIN MEDICAL CONDITIONS
15 TREATED IN INPATIENT REHABILITATION FACILITIES.—
16 (1) IN GENERAL.—Section 1886(j) of the Social
17 Security Act (42 U.S.C. 1395ww(j)) is amended—
18 (A) by redesignating paragraph (7) as
19 paragraph (8);
20 (B) by inserting after paragraph (6) the
21 following new paragraph:
22 "(7) SPECIAL PAYMENT RULE FOR CERTAIN
23 MEDICAL CONDITIONS.—
24 "(A) IN GENERAL.—Subject to subpara-
25 graph (H), in the case of discharges occurring

1 on or after October 1, 2008, in lieu of the
2 standardized payment amount (as determined
3 pursuant to the preceding provisions of this
4 subsection) that would otherwise be applicable
5 under this subsection, the Secretary shall sub-
6 stitute, for payment units with respect to an
7 applicable medical condition (as defined in sub-
8 paragraph (G)(i)) that is treated in an inpa-
9 tient rehabilitation facility, the modified stand-
10 ardized payment amount determined under sub-
11 paragraph (B).
12 "(B) MODIFIED STANDARDIZED PAYMENT
13 AMOUNT.—The modified standardized payment
14 amount for an applicable medical condition
15 shall be based on the amount determined under
16 subparagraph (C) for such condition, as ad-
17 justed under subparagraphs (D), (E), and (F).
18 "(C) AMOUNT DETERMINED.—
19 "(i) IN GENERAL.—The amount de-
20 termined under this subparagraph for an
21 applicable medical condition shall be based
22 on the sum of the following:
23 "(I) An amount equal to the av-
24 erage per stay skilled nursing facility
25 payment rate for the applicable med-

1 ical condition (as determined under
2 clause (ii)).
3 ''(II) An amount equal to 25 per-
4 cent of the difference between the
5 overhead costs (as defined in subpara-
6 graph (G)(ii)) component of the aver-
7 age inpatient rehabilitation facility per
8 stay payment amount for the applica-
9 ble medical condition (as determined
10 under the preceding paragraphs of
11 this subsection) and the overhead
12 costs component of the average per
13 stay skilled nursing facility payment
14 rate for such condition (as determined
15 under clause (ii)).
16 ''(III) An amount equal to 33
17 percent of the difference between the
18 patient care costs (as defined in sub-
19 paragraph (G)(iii)) component of the
20 average inpatient rehabilitation facil-
21 ity per stay payment amount for the
22 applicable medical condition (as deter-
23 mined under the preceding para-
24 graphs of this subsection) and the pa-
25 tient care costs component of the av-

1 erage per stay skilled nursing facility
2 payment rate for such condition (as
3 determined under clause (ii)).
4 "(ii) DETERMINATION OF AVERAGE
5 PER STAY SKILLED NURSING FACILITY
6 PAYMENT RATE.—For purposes of clause
7 (i), the Secretary shall convert skilled
8 nursing facility payment rates for applica-
9 ble medical conditions, as determined
10 under section 1888(e), to average per stay
11 skilled nursing facility payment rates for
12 each such condition.
13 "(D) ADJUSTMENTS.—The Secretary shall
14 adjust the amount determined under subpara-
15 graph (C) for an applicable medical condition
16 using the adjustments to the prospective pay-
17 ment rates for inpatient rehabilitation facilities
18 described in paragraphs (2), (3), (4), and (6).
19 "(E) UPDATE FOR INFLATION.—Except in
20 the case of a fiscal year for which the Secretary
21 rebases the amounts determined under subpara-
22 graph (C) for applicable medical conditions pur-
23 suant to subparagraph (F), the Secretary shall
24 annually update the amounts determined under
25 subparagraph (C) for each applicable medical

1 condition by the increase factor for inpatient re-
2 habilitation facilities (as described in paragraph
3 (3)(C)).
4 ''(F) REBASING.—The Secretary shall pe-
5 riodically (but in no case less than once every
6 5 years) rebase the amounts determined under
7 subparagraph (C) for applicable medical condi-
8 tions using the methodology described in such
9 subparagraph and the most recent and complete
10 cost report and claims data available.
11 ''(G) DEFINITIONS.—In this paragraph:
12 ''(i) APPLICABLE MEDICAL CONDI-
13 TION.—The term 'applicable medical condi-
14 tion' means—
15 ''(I) unilateral knee replacement;
16 ''(II) unilateral hip replacement;
17 and
18 ''(III) unilateral hip fracture.
19 ''(ii) OVERHEAD COSTS.—The term
20 'overhead costs' means those Medicare-al-
21 lowable costs that are contained in the
22 General Service cost centers of the Medi-
23 care cost reports for inpatient rehabilita-
24 tion facilities and for skilled nursing facili-

1 ties, respectively, as determined by the
2 Secretary.
3 "(iii) PATIENT CARE COSTS.—The
4 term 'patient care costs' means total Medi-
5 care-allowable costs minus overhead costs.
6 "(H) SUNSET.—The provisions of this
7 paragraph shall cease to apply as of the date
8 the Secretary implements an integrated, site-
9 neutral payment methodology under this title
10 for post-acute care."; and
11 (C) in paragraph (8), as redesignated by
12 paragraph (1)—
13 (i) in subparagraph (C), by striking
14 "and" at the end;
15 (ii) in subparagraph (D), by striking
16 the period at the end and inserting ",
17 and"; and
18 (iii) by adding at the end the fol-
19 lowing new subparagraph:
20 "(E) modified standardized payment
21 amounts under paragraph (7).".
22 (2) SPECIAL RULE FOR DISCHARGES OCCUR-
23 RING IN THE SECOND HALF OF FISCAL YEAR 2008.—
24 (A) IN GENERAL.—In the case of dis-
25 charges from an inpatient rehabilitation facility

1 occurring during the period beginning on April
2 1, 2008, and ending on September 30, 2008,
3 for applicable medical conditions (as defined in
4 paragraph (7)(G)(i) of section 1886(j) of the
5 Social Security Act (42 U.S.C. 1395ww(j)), as
6 inserted by paragraph (1)(B), in lieu of the
7 standardized payment amount determined pur-
8 suant to such section, the standardized payment
9 amount shall be $9,507 for unilateral knee re-
10 placement, $10,398 for unilateral hip replace-
11 ment, and $10,958 for unilateral hip fracture.
12 Such amounts are the amounts that are esti-
13 mated would be determined under paragraph
14 (7)(C) of such section 1886(j) for such condi-
15 tions if such paragraph applied for such period.
16 Such standardized payment amounts shall be
17 multiplied by the relative weights for each case-
18 mix group and tier, as published in the final
19 rule of the Secretary of Health and Human
20 Services for inpatient rehabilitation facility
21 services prospective payment for fiscal year
22 2008, to obtain the applicable payment
23 amounts for each such condition for each case-
24 mix group and tier.

1 (B) IMPLEMENTATION.—Notwithstanding
2 any other provision of law, the Secretary of
3 Health and Human Services may implement
4 this subsection by program instruction or other-
5 wise. Paragraph (8)(E) of such section 1886(j)
6 of the Social Security Act, as added by para-
7 graph (1)(C), shall apply for purposes of this
8 subsection in the same manner as such para-
9 graph applies for purposes of paragraph (7) of
10 such section 1886(j).
11 (d) RECOMMENDATIONS FOR CLASSIFYING INPA-
12 TIENT REHABILITATION HOSPITALS AND UNITS.—
13 (1) REPORT TO CONGRESS.—Not later than 12
14 months after the date of the enactment of this Act,
15 the Secretary of Health and Human Services, in
16 consultation with physicians (including geriatricians
17 and physiatrists), administrators of inpatient reha-
18 bilitation, acute care hospitals, skilled nursing facili-
19 ties, and other settings providing rehabilitation serv-
20 ices, Medicare beneficiaries, trade organizations rep-
21 resenting inpatient rehabilitation hospitals and units
22 and skilled nursing facilities, and the Medicare Pay-
23 ment Advisory Commission, shall submit to the
24 Committee on Ways and Means of the House of

1 Representatives and the Committee on Finance of
2 the Senate a report that includes—
3 (A) an examination of Medicare bene-
4 ficiaries' access to medically necessary rehabili-
5 tation services;
6 (B) alternatives or refinements to the 75
7 percent rule policy for determining exclusion
8 criteria for inpatient rehabilitation hospital and
9 unit designation under the Medicare program,
10 including determining clinical appropriateness
11 of inpatient rehabilitation hospital and unit ad-
12 missions and alternative criteria which would
13 consider a patient's functional status, diagnosis,
14 co-morbidities, and other relevant factors; and
15 (C) an examination that identifies any con-
16 dition for which individuals are commonly ad-
17 mitted to inpatient rehabilitation hospitals that
18 is not included as a condition described in sec-
19 tion 412.23(b)(2)(iii) of title 42, Code of Fed-
20 eral Regulations, to determine the appropriate
21 setting of care, and any variation in patient
22 outcomes and costs, across settings of care, for
23 treatment of such conditions.
24 For the purposes of this subsection, the term ''75
25 percent rule'' means the requirement of section

1 412.23(b)(2) of title 42, Code of Federal Regula-
2 tions, that 75 percent of the patients of a rehabilita-
3 tion hospital or converted rehabilitation unit are in
4 1 or more of 13 listed treatment categories.
5 (2) CONSIDERATIONS.—In developing the re-
6 port described in paragraph (1), the Secretary shall
7 include the following:
8 (A) The potential effect of the 75 percent
9 rule on access to rehabilitation care by Medi-
10 care beneficiaries for the treatment of a condi-
11 tion, whether or not such condition is described
12 in section 412.23(b)(2)(iii) of title 42, Code of
13 Federal Regulations.
14 (B) An analysis of the effectiveness of re-
15 habilitation care for the treatment of condi-
16 tions, whether or not such conditions are de-
17 scribed in section 412.23(b)(2)(iii) of title 42,
18 Code of Federal Regulations, available to Medi-
19 care beneficiaries in various health care set-
20 tings, taking into account variation in patient
21 outcomes and costs across different settings of
22 care, and which may include whether the Medi-
23 care program and Medicare beneficiaries may
24 incur higher costs of care for the entire episode

of illness due to readmissions, extended lengths of stay, and other factors.

SEC. 503. LONG-TERM CARE HOSPITALS.

(a) LONG-TERM CARE HOSPITAL PAYMENT UPDATE.—

(1) IN GENERAL.—Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended by adding at the end the following new subsection:

''(m) PROSPECTIVE PAYMENT FOR LONG-TERM CARE HOSPITALS.—

''(1) REFERENCE TO ESTABLISHMENT AND IMPLEMENTATION OF SYSTEM.—For provisions related to the establishment and implementation of a prospective payment system for payments under this title for inpatient hospital services furnished by a long-term care hospital described in subsection (d)(1)(B)(iv), see section 123 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 and section 307(b) of Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

''(2) UPDATE FOR RATE YEAR 2008.—In implementing the system described in paragraph (1) for discharges occurring during the rate year ending in 2008 for a hospital, the base rate for such dis-

1 charges for the hospital shall be the same as the
2 base rate for discharges for the hospital occurring
3 during the previous rate year.''.
4 (2) DELAYED EFFECTIVE DATE.—Subsection
5 (m)(2) of section 1886 of the Social Security Act, as
6 added by paragraph (1), shall not apply to dis-
7 charges occurring on or after July 1, 2007, and be-
8 fore January 1, 2008.
9 (b) PAYMENT FOR LONG-TERM CARE HOSPITAL
10 SERVICES; PATIENT AND FACILITY CRITERIA.—
11 (1) DEFINITION OF LONG-TERM CARE HOS-
12 PITAL.—
13 (A) DEFINITION.—Section 1861 of the So-
14 cial Security Act (42 U.S.C. 1395x) is amended
15 by adding at the end the following new sub-
16 section:
17 ''Long-Term Care Hospital
18 ''(ccc) The term 'long-term care hospital' means an
19 institution which—
20 ''(1) is primarily engaged in providing inpatient
21 services, by or under the supervision of a physician,
22 to Medicare beneficiaries whose medically complex
23 conditions require a long hospital stay and programs
24 of care provided by a long-term care hospital;

1 "(2) has an average inpatient length of stay (as
2 determined by the Secretary) for Medicare bene-
3 ficiaries of greater than 25 days, or as otherwise de-
4 fined in section 1886(d)(1)(B)(iv);
5 "(3) satisfies the requirements of subsection
6 (e);
7 "(4) meets the following facility criteria:
8 "(A) the institution has a patient review
9 process, documented in the patient medical
10 record, that screens patients prior to admission
11 for appropriateness of admission to a long-term
12 care hospital, validates within 48 hours of ad-
13 mission that patients meet admission criteria
14 for long-term care hospitals, regularly evaluates
15 patients throughout their stay for continuation
16 of care in a long-term care hospital, and as-
17 sesses the available discharge options when pa-
18 tients no longer meet such continued stay cri-
19 teria;
20 "(B) the institution has active physician
21 involvement with patients during their treat-
22 ment through an organized medical staff, physi-
23 cian-directed treatment with physician on-site
24 availability on a daily basis to review patient
25 progress, and consulting physicians on call and

capable of being at the patient's side within a moderate period of time, as determined by the Secretary;

"(C) the institution has interdisciplinary team treatment for patients, requiring interdisciplinary teams of health care professionals, including physicians, to prepare and carry out an individualized treatment plan for each patient; and

"(5) meets patient criteria relating to patient mix and severity appropriate to the medically complex cases that long-term care hospitals are designed to treat, as measured under section 1886(m).".

(B) NEW PATIENT CRITERIA FOR LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT.—Section 1886 of such Act (42 U.S.C. 1395ww), as amended by subsection (a), is further amended by adding at the end the following new subsection:

"(n) PATIENT CRITERIA FOR PROSPECTIVE PAYMENT TO LONG-TERM CARE HOSPITALS.—

"(1) IN GENERAL.—To be eligible for prospective payment under this section as a long-term care hospital, a long-term care hospital must admit not less than a majority of patients who have a high

1 level of severity, as defined by the Secretary, and
2 who are assigned to one or more of the following
3 major diagnostic categories:
4 ''(A) Circulatory diagnoses.
5 ''(B) Digestive, endocrine, and metabolic
6 diagnoses.
7 ''(C) Infection disease diagnoses.
8 ''(D) Neurological diagnoses.
9 ''(E) Renal diagnoses.
10 ''(F) Respiratory diagnoses.
11 ''(G) Skin diagnoses.
12 ''(H) Other major diagnostic categories as
13 selected by the Secretary.
14 ''(2) MAJOR DIAGNOSTIC CATEGORY DE-
15 FINED.—In paragraph (1), the term 'major diag-
16 nostic category' means the medical categories formed
17 by dividing all possible principle diagnosis into mu-
18 tually exclusive diagnosis areas which are referred to
19 in 67 Federal Register 49985 (August 1, 2002).''.
20 (C) ESTABLISHMENT OF REHABILITATION
21 UNITS WITHIN CERTAIN LONG-TERM CARE HOS-
22 PITALS.—If the Secretary of Health and
23 Human Services does not include rehabilitation
24 services within a major diagnostic category
25 under section 1886(n)(2) of the Social Security

1 Act, as added by subparagraph (B), the Sec-
2 retary shall approve for purposes of title XVIII
3 of such Act distinct part inpatient rehabilitation
4 hospital units in long-term care hospitals con-
5 sistent with the following:
6 (i) A hospital that, on or before Octo-
7 ber 1, 2004, was classified by the Sec-
8 retary as a long-term care hospital, as de-
9 scribed in section 1886(d)(1)(B)(iv)(I) of
10 such Act (42 U.S.C.
11 1395ww(d)(1)(V)(iv)(I)), and was accred-
12 ited by the Commission on Accreditation of
13 Rehabilitation Facilities, may establish a
14 hospital rehabilitation unit that is a dis-
15 tinct part of the long-term care hospital, if
16 the distinct part meets the requirements
17 (including conditions of participation) that
18 would otherwise apply to a distinct-part re-
19 habilitation unit if the distinct part were
20 established by a subsection (d) hospital in
21 accordance with the matter following
22 clause (v) of section 1886(d)(1)(B) of such
23 Act, including any regulations adopted by
24 the Secretary in accordance with this sec-
25 tion, except that the one-year waiting pe-

1 riod described in section 412.30(c) of title
2 42, Code of Federal Regulations, applica-
3 ble to the conversion of hospital beds into
4 a distinct-part rehabilitation unit shall not
5 apply to such units.
6 (ii) Services provided in inpatient re-
7 habilitation units established under clause
8 (i) shall not be reimbursed as long-term
9 care hospital services under section 1886
10 of such Act and shall be subject to pay-
11 ment policies established by the Secretary
12 to reimburse services provided by inpatient
13 hospital rehabilitation units.
14 (D) EFFECTIVE DATE.—The amendments
15 made by subparagraphs (A) and (B), and the
16 provisions of subparagraph (C), shall apply to
17 discharges occurring on or after January 1,
18 2008.
19 (2) IMPLEMENTATION OF FACILITY AND PA-
20 TIENT CRITERIA.—
21 (A) REPORT.—No later than 1 year after
22 the date of the enactment of this Act, the Sec-
23 retary of Health and Human Services (in this
24 section referred to as the ''Secretary'') shall
25 submit to the appropriate committees of Con-

1 gress a report containing recommendations re-
2 garding the promulgation of the national long-
3 term care hospital facility and patient criteria
4 for application under paragraphs (4) and (5) of
5 section 1861(ccc) and section 1886(n) of the
6 Social Security Act, as added by subparagraphs
7 (A) and (B), respectively, of paragraph (1). In
8 the report, the Secretary shall consider rec-
9 ommendations contained in a report to Con-
10 gress by the Medicare Payment Advisory Com-
11 mission in June 2004 for long-term care hos-
12 pital-specific facility and patient criteria to en-
13 sure that patients admitted to long-term care
14 hospitals are medically complex and appropriate
15 to receive long-term care hospital services.
16 (B) IMPLEMENTATION.—No later than 1
17 year after the date of submittal of the report
18 under subparagraph (A), the Secretary shall,
19 after rulemaking, implement the national long-
20 term care hospital facility and patient criteria
21 referred to in such subparagraph. Such long-
22 term care hospital facility and patient criteria
23 shall be used to screen patients in determining
24 the medical necessity and appropriateness of a
25 Medicare beneficiary's admission to, continued

1 stay at, and discharge from, long-term care hos-
2 pitals under the Medicare program and shall
3 take into account the medical judgment of the
4 patient's physician, as provided for under sec-
5 tions 1814(a)(3) and 1835(a)(2)(B) of the So-
6 cial Security Act (42 U.S.C. 1395f(a)(3),
7 1395n(a)(2)(B)).
8 (3) EXPANDED REVIEW OF MEDICAL NECES-
9 SITY.—
10 (A) IN GENERAL.—The Secretary of
11 Health and Human Services shall provide,
12 under contracts with one or more appropriate
13 fiscal intermediaries or medicare administrative
14 contractors under section 1874A(a)(4)(G) of
15 the Social Security Act (42 U.S.C.
16 1395kk(a)(4)(G)), for reviews of the medical
17 necessity of admissions to long-term care hos-
18 pitals (described in section 1886(d)(1)(B)(iv) of
19 such Act) and continued stay at such hospitals,
20 of individuals entitled to, or enrolled for, bene-
21 fits under part A of title XVIII of such Act on
22 a hospital-specific basis consistent with this
23 paragraph. Such reviews shall be made for dis-
24 charges occurring on or after October 1, 2007.

1 (B) REVIEW METHODOLOGY.—The medical
2 necessity reviews under paragraph (A) shall be
3 conducted for each such long-term care hospital
4 on an annual basis in accordance with rules (in-
5 cluding a sample methodology) specified by the
6 Secretary. Such sample methodology shall—
7 (i) provide for a statistically valid and
8 representative sample of admissions of
9 such individuals sufficient to provide re-
10 sults at a 95 percent confidence interval;
11 and
12 (ii) guarantee that at least 75 percent
13 of overpayments received by long-term care
14 hospitals for medically unnecessary admis-
15 sions and continued stays of individuals in
16 long-term care hospitals will be identified
17 and recovered and that related days of care
18 will not be counted toward the length of
19 stay requirement contained in section
20 1886(d)(1)(B)(iv) of the Social Security
21 Act (42 U.S.C. 1395ww(d)(1)(B)(iv)).
22 (C) CONTINUATION OF REVIEWS.—Under
23 contracts under this paragraph, the Secretary
24 shall establish a denial rate with respect to such
25 reviews that, if exceeded, could require further

1 review of the medical necessity of admissions
2 and continued stay in the hospital involved.
3 (D) TERMINATION OF REQUIRED RE-
4 VIEWS.—
5 (i) IN GENERAL.—Subject to clause
6 (iii), the previous provisions of this sub-
7 section shall cease to apply as of the date
8 specified in clause (ii).
9 (ii) DATE SPECIFIED.—The date spec-
10 ified in this clause is the later of January
11 1, 2013, or the date of implementation of
12 national long-term care hospital facility
13 and patient criteria under section para-
14 graph (2)(B).
15 (iii) CONTINUATION.—As of the date
16 specified in clause (ii), the Secretary shall
17 determine whether to continue to guar-
18 antee, through continued medical review
19 and sampling under this paragraph, recov-
20 ery of at least 75 percent of overpayments
21 received by long-term care hospitals due to
22 medically unnecessary admissions and con-
23 tinued stays.
24 (E) FUNDING.—The costs to fiscal inter-
25 mediaries or medicare administrative contrac-

1 tors conducting the medical necessity reviews
2 under subparagraph (A) shall be funded from
3 the aggregate overpayments recouped by the
4 Secretary of Health and Human Services from
5 long-term care hospitals due to medically un-
6 necessary admissions and continued stays.
7 (4) LIMITED, QUALIFIED MORATORIUM OF
8 LONG-TERM CARE HOSPITALS.—
9 (A) IN GENERAL.—Subject to subpara-
10 graph (B), the Secretary shall impose a tem-
11 porary moratorium on the certification of new
12 long-term care hospitals (and satellite facilities),
13 and new long-term care hospital and satellite
14 facility beds, for purposes of the Medicare pro-
15 gram under title XVIII of the Social Security
16 Act. The moratorium shall terminate at the end
17 of the 4-year period beginning on the date of
18 the enactment of this Act.
19 (B) EXCEPTIONS.—
20 (i) IN GENERAL.—The moratorium
21 under subparagraph (A) shall not apply as
22 follows:
23 (I) To a long-term care hospital,
24 satellite facility, or additional beds

1 under development as of the date of
2 the enactment of this Act.
3 (II) To an existing long-term
4 care hospital that requests to increase
5 its number of long-term care hospital
6 beds, if the Secretary determines
7 there is a need at the long-term care
8 hospital for additional beds to accom-
9 modate—
10 (aa) infectious disease issues
11 for isolation of patients;
12 (bb) bedside dialysis serv-
13 ices;
14 (cc) single-sex accommoda-
15 tion issues;
16 (dd) behavioral issues; or
17 (ee) any requirements of
18 State or local law.
19 (III) To an existing long-term
20 care hospital that requests an increase
21 in beds because of the closure of a
22 long-term care hospital or significant
23 decrease in the number of long-term
24 care hospital beds, in a State where

there is only one other long-term care hospital.

There shall be no administrative or judicial review from a decision of the Secretary under this subparagraph.

(ii) ''UNDER DEVELOPMENT'' DEFINED.—For purposes of clause (i)(I), a long-term care hospital or satellite facility is considered to be ''under development'' as of a date if any of the following have occurred on or before such date :

(I) The hospital or a related party has a binding written agreement with an outside, unrelated party for the construction, reconstruction, lease, rental, or financing of the long-term care hospital and the hospital has expended, before the date of the enactment of this Act, at least 10 percent of the estimated cost of the project (or, if less, $2,500,000).

(II) Actual construction, renovation or demolition for the long-term care hospital has begun and the hospital has expended, before the date of

1 the enactment of this Act, at least 10
2 percent of the estimated cost of the
3 project (or, if less, $2,500,000).
4 (III) A certificate of need has
5 been approved in a State where one is
6 required or other necessary approvals
7 from appropriate State agencies have
8 been received for the operation of the
9 hospital.
10 (IV) The hospital documents
11 that, within 3 months after the date
12 of the enactment of this Act, it is
13 within a 6-month long-term care hos-
14 pital demonstration period required by
15 section 412.23(e)(1)–(3) of title 42,
16 Code of Federal Regulations, to dem-
17 onstrate that it has a greater than 25
18 day average length of stay.
19 (5) NO APPLICATION OF 25 PERCENT PATIENT
20 THRESHOLD PAYMENT ADJUSTMENT TO FREE-
21 STANDING AND GRANDFATHERED LTCHS.—The Sec-
22 retary shall not apply, during the 5-year period be-
23 ginning on the date of the enactment of this Act,
24 section 412.536 of title 42, Code of Federal Regula-
25 tions, or any similar provision, to freestanding long-

1 term care hospitals and the Secretary shall not apply
2 such section or section 412.534 of title 42, Code of
3 Federal Regulations, or any similar provisions, to a
4 long-term care hospital identified by section 4417(a)
5 of the Balanced Budget Act of 1997 (Public Law
6 105–33). A long-term care hospital identified by
7 such section 4417(a) shall be deemed to be a free-
8 standing long-term care hospital for the purpose of
9 this section. Section 412.536 of title 42, Code of
10 Federal Regulations, shall be void and of no effect.
11 (6) PAYMENT FOR HOSPITALS-WITHIN-HOS-
12 PITALS.—
13 (A) IN GENERAL.—Payments to an appli-
14 cable long-term care hospital or satellite facility
15 which is located in a rural area or which is co-
16 located with an urban single or MSA dominant
17 hospital under paragraphs (d)(1), (e)(1), and
18 (e)(4) of section 412.534 of title 42, Code of
19 Federal Regulations, shall not be subject to any
20 payment adjustment under such section if no
21 more than 75 percent of the hospital's Medicare
22 discharges (other than discharges described in
23 paragraphs (d)(2) or (e)(3) of such section) are
24 admitted from a co-located hospital.

1 (B) CO-LOCATED LONG-TERM CARE HOS-
2 PITALS AND SATELLITE FACILITIES.—
3 (i) IN GENERAL.—Payment to an ap-
4 plicable long-term care hospital or satellite
5 facility which is co-located with another
6 hospital shall not be subject to any pay-
7 ment adjustment under section 412.534 of
8 title 42, Code of Federal Regulations, if no
9 more than 50 percent of the hospital's
10 Medicare discharges (other than discharges
11 described in section 412.534(c)(3) of such
12 title) are admitted from a co-located hos-
13 pital.
14 (ii) APPLICABLE LONG-TERM CARE
15 HOSPITAL OR SATELLITE FACILITY DE-
16 FINED.—In this paragraph, the term ''ap-
17 plicable long-term care hospital or satellite
18 facility'' means a hospital or satellite facil-
19 ity that is subject to the transition rules
20 under section 412.534(g) of title 42, Code
21 of Federal Regulations.
22 (C) EFFECTIVE DATE.—Subparagraphs
23 (A) and (B) shall apply to discharges occurring
24 on or after October 1, 2007, and before October
25 1, 2012.

(7) NO APPLICATION OF VERY SHORT-STAY OUTLIER POLICY.—The Secretary shall not apply, during the 5-year period beginning on the date of the enactment of this Act, the amendments finalized on May 11, 2007 (72 Federal Register 26904) made to the short-stay outlier payment provision for long-term care hospitals contained in section 412.529(c)(3)(i) of title 42, Code of Federal Regulations, or any similar provision.

(8) NO APPLICATION OF ONE TIME ADJUSTMENT TO STANDARD AMOUNT.—The Secretary shall not, during the 5-year period beginning on the date of the enactment of this Act, make the one-time prospective adjustment to long-term care hospital prospective payment rates provided for in section 412.523(d)(3) of title 42, Code of Federal Regulations, or any similar provision.

(c) SEPARATE CLASSIFICATION FOR CERTAIN LONG-STAY CANCER HOSPITALS.—

(1) IN GENERAL.—Subsection (d)(1)(B) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended—

(A) in clause (iv)—

1 (i) in subclause (I), by striking
2 ''(iv)(I)'' and inserting ''(iv)'' and by strik-
3 ing ''or'' at the end; and
4 (ii) in subclause (II)—
5 (I) by striking '', or'' at the end
6 and inserting a semicolon; and
7 (II) by redesignating such sub-
8 clause as clause (vi) and by moving it
9 to immediately follow clause (v); and
10 (B) in clause (v), by striking the semicolon
11 at the end and inserting '', or''.
12 (2) CONFORMING PAYMENT REFERENCES.—
13 Subsection (b) of such section is amended—
14 (A) in paragraph (2)(E)(ii), by adding at
15 the end the following new subclause:
16 ''(III) Hospitals described in
17 clause (vi) of such subsection.'';
18 (B) in paragraph (3)(F)(iii), by adding at
19 the end the following new subclause:
20 ''(VI) Hospitals described in
21 clause (vi) of such subsection.'';
22 (C) in paragraphs (3)(G)(ii), (3)(H)(i),
23 and (3)(H)(ii)(I), by inserting ''or (vi)'' after
24 ''clause (iv)'' each place it appears;

(D) in paragraph (3)(H)(iv), by adding at the end the following new subclause:

"(IV) Hospitals described in clause (vi) of such subsection.";

(E) in paragraph (3)(J), by striking "subsection (d)(1)(B)(iv)" and inserting "clause (iv) or (vi) of subsection (d)(1)(B)"; and

(F) in paragraph (7)(B), by adding at the end the following new clause:

"(iv) Hospitals described in clause (vi) of such subsection.".

(3) ADDITIONAL CONFORMING AMENDMENTS.—The second sentence of subsection (d)(1)(B) of such section is amended—

(A) by inserting "(as in effect as of such date)" after "clause (iv)"; and

(B) by inserting "(or, in the case of a hospital classified under clause (iv)(II), as so in effect, shall be classified under clause (vi) on and after the effective date of such clause)" after "so classified".

(4) TRANSITION RULE.—In the case of a hospital that is classified under clause (iv)(II) of section 1886(d)(1)(B) of the Social Security Act immediately before the date of the enactment of this Act

1 and which is classified under clause (vi) of such sec-
2 tion after such date of enactment, payments under
3 section 1886 of such Act for cost reporting periods
4 beginning after the date of the enactment of this Act
5 shall be based upon payment rates in effect for the
6 cost reporting period for such hospital beginning
7 during fiscal year 2001, increased for each suc-
8 ceeding cost reporting period (beginning before the
9 date of the enactment of this Act) by the applicable
10 percentage increase under section 1886(b)(3)(B)(ii)
11 of such Act.

12 (5) CLARIFICATION OF TREATMENT OF SAT-
13 ELLITE FACILITIES AND REMOTE LOCATIONS.—A
14 long-stay cancer hospital described in section
15 1886(d)(1)(B)(vi) of the Social Security Act, as des-
16 ignated under paragraph (1), shall include satellites
17 or remote site locations for such hospital established
18 before or after the date of the enactment of this Act
19 if the provider-based requirements under section
20 413.65 of title 42, Code of Federal Regulations, ap-
21 plicable certification requirements under title XVIII
22 of the Social Security, and such other applicable
23 State licensure and certificate of need requirements
24 are met with respect to such satellites or remote site
25 locations.

SEC. 504. INCREASING THE DSH ADJUSTMENT CAP.

Section 1886(d)(5)(F)(xiv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)(xiv)) is amended—

(1) subclause (II), by striking ''12 percent'' and inserting ''the percent specified in subclause (III)''; and

(2) by adding at the end the following new subclause:

''(III) The percent specified in this subclause is, in the case of discharges occurring—

''(a) before October 1, 2007, 12 percent;

''(b) during fiscal year 2008, 16 percent;

''(c) during fiscal year 2009, 18 percent; and

''(d) on or after October 1, 2009, 12 percent.''.

SEC. 505. PPS-EXEMPT CANCER HOSPITALS.

(a) AUTHORIZING REBASING FOR PPS-EXEMPT CANCER HOSPITALS.—Section 1886(b)(3)(F) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(F)) is amended by adding at the end the following new clause:

''(iv) In the case of a hospital (or unit described in the matter following clause (v) of subsection (d)(1)(B)) that received payment under this subsection for inpatient hospital services furnished during cost re-

1 porting periods beginning before October
2 1, 1999, that is within a class of hospital
3 described in clause (iii) (other than sub-
4 clause (IV), relating to long-term care hos-
5 pitals, and that requests the Secretary (in
6 a form and manner specified by the Sec-
7 retary) to effect a rebasing under this
8 clause for the hospital, the Secretary may
9 compute the target amount for the hos-
10 pital's 12-month cost reporting period be-
11 ginning during fiscal year 2008 as an
12 amount equal to the average described in
13 clause (ii) but determined as if any ref-
14 erence in such clause to 'the date of the
15 enactment of this subparagraph' were a
16 reference to 'the date of the enactment of
17 this clause'.''.
18 (b) ADDITIONAL CANCER HOSPITAL PROVISIONS.—
19 (1) IN GENERAL.—Section 1886(d)(1) of the
20 Social Security Act (42 U.S.C. 1395ww(d)(1)) is
21 amended—
22 (A) in subparagraph (B)—
23 (i) by striking ''or'' at the end of
24 clause (iv); and
25 (ii) in clause (v)—

1 (I) by striking ''or'' at the end of
2 subclause (II),
3 (II) by striking the semicolon at
4 the end of subclause (III) and insert-
5 ing a comma; and
6 (III) by adding at the end the
7 following:
8 ''(IV) a hospital that is a nonprofit corporation,
9 the sole member of which is affiliated with a univer-
10 sity that has been the recipient of a cancer center
11 support grant from the National Cancer Institute of
12 the National Institutes of Health, and which sole
13 member (or its predecessors or such university) was
14 recognized as a comprehensive cancer center by the
15 National Cancer Institute of the National Institutes
16 of Health as of April 20, 1983, if the hospital's arti-
17 cles of incorporation specify that at least 50 percent
18 of its total discharges have a principal finding of
19 neoplastic disease (as defined in subparagraph (E))
20 and if, of December 31, 2005, the hospital was li-
21 censed for less than 150 acute care beds, or
22 ''(V) a hospital that is a nonprofit corporation,
23 the sole member of which is affiliated with a univer-
24 sity that has been the recipient of a cancer center
25 support grant from the National Cancer Institute of

1 the National Institutes of Health, and which sole
2 member (or its predecessors or such university) was
3 recognized as a comprehensive cancer center by the
4 National Cancer Institute of the National Institutes
5 of Health as of April 20, 1983, if the hospital's arti-
6 cles of incorporation specify that at least 50 percent
7 of its total discharges have a principal finding of
8 neoplastic disease (as defined in subparagraph (E))
9 and if, of December 31, 2005, the hospital was li-
10 censed for less than 150 acute care beds;''; and
11 (B) by striking the semicolon at the end of
12 clause (v) and inserting '', or''; and
13 (C) by inserting after clause (v) the fol-
14 lowing new clause:
15 ''(vi) a hospital that—
16 ''(I) is located in a State which ranks (ac-
17 cording to the National Cancer Institute's sta-
18 tistics published in May of 2005) among the
19 top ten States in the incidence of non-Hodgkins
20 lymphoma, ovarian cancer, thyroid cancer, and
21 cervical cancer and among the top ten States
22 with the highest death rate for breast cancer
23 and uterine cancer;
24 ''(II) is located in a State that as of De-
25 cember 31, 2006, had only one center under

1 section 414 of the Public Health Service Act
2 that has been designated by the National Can-
3 cer Institute as a comprehensive center cur-
4 rently serving all 21 counties in the most dense-
5 ly populated State in the nation (U.S. Census
6 estimate for 2005: 8,717,925 persons; 1,134.5
7 persons per square mile), serving more than
8 70,000 patient visits annually;
9 ''(III) as of December 31, 2006, served as
10 the teaching and clinical care, research and
11 training hospital for the Center described in
12 subclause (II), providing significant financial
13 and operational support to such Center;
14 ''(IV) as of December 31, 2006, served as
15 a core and essential element in such Center
16 which conducts more than 130 clinical trial ac-
17 tivities, national cooperative group studies, in-
18 vestigator-initiated and peer review studies and
19 has received as of 2005 at least $93,000,000 in
20 research grant awards;
21 ''(V) as of December 31, 2006, can dem-
22 onstrate that it has been a unique and an inte-
23 gral component of such Center since such Cen-
24 ter's inception;

1 "(VI) as of December 31, 2006, includes
2 dedicated patient care units organized primarily
3 for the treatment of and research on cancer
4 with approximately 125 beds, 75 percent of
5 which are dedicated to cancer patients, and con-
6 tains a radiation oncology department as well
7 as specialized emergency services for oncology
8 patients;
9 "(VII) as of December 31, 2004, is identi-
10 fied as the focus of the Center's inpatient ac-
11 tivities in the Center's application as a NCI-
12 designated comprehensive cancer center and
13 shares the NCI comprehensive cancer designa-
14 tion with the Center; and
15 "(VIII) as of December 31, 2006, has been
16 recognized with a certificate of approval with
17 commendation by the American College of Sur-
18 geons Commission on Cancer;"; and
19 (D) in subparagraph (E)—
20 (i) by striking "clause (v)" and insert-
21 ing "clauses (v) and (vi); and"
22 (ii) by striking "subclauses (II) and
23 (III)" and inserting "subclauses (II), (III),
24 and (IV)".
25 (2) EFFECTIVE DATES; PAYMENTS.—

1 (A) APPLICATION TO COST REPORTING PE-
2 RIODS.—
3 (i) Any classification by reason of sec-
4 tion 1886(d)(1)(B)(vi) of the Social Secu-
5 rity Act (42 U.S.C. 1395ww(d)(1)(B)(vi)),
6 as inserted by paragraph (1), shall apply
7 to cost reporting periods beginning on or
8 after January 1, 2006.
9 (ii) The provisions of section
10 1886(d)(1)(B)(v)(IV) of the Social Secu-
11 rity Act, as added by paragraph (1), shall
12 take effect on January 1, 2008.
13 (B) BASE TARGET AMOUNT.—Notwith-
14 standing subsection (b)(3)(E) of section 1886
15 of the Social Security Act (42 U.S.C. 1395ww),
16 in the case of a hospital described in subsection
17 (d)(1)(B)(vi) of such section, as inserted by
18 paragraph (1)—
19 (i) the hospital shall be permitted to
20 resubmit the 2006 Medicare 2552 cost re-
21 port incorporating a cancer hospital sub-
22 provider number and to apply the Medicare
23 ratio-of-cost-to-charge settlement method-
24 ology for outpatient cancer services; and

1 (ii) the hospital's target amount under
2 subsection (b)(3)(E)(i) of such section for
3 the first cost reporting period beginning on
4 or after January 1, 2006, shall be the al-
5 lowable operating costs of inpatient hos-
6 pital services (referred to in subclause (I)
7 of such subsection) for such first cost re-
8 porting period.
9 (C) DEADLINE FOR PAYMENTS.—Any pay-
10 ments owed to a hospital as a result of this sub-
11 section for periods occurring before the date of
12 the enactment of this Act shall be made expedi-
13 tiously, but in no event later than 1 year after
14 such date of enactment.
15 (3) APPLICATION TO CERTAIN HOSPITALS.—
16 (A) INAPPLICABILITY OF CERTAIN RE-
17 QUIREMENTS.—The provisions of section
18 412.22(e) of title 42, Code of Federal Regula-
19 tions, shall not apply to a hospital described in
20 section 1886(d)(1)(B)(v)(V) of the Social Secu-
21 rity Act, as added by paragraph (1).
22 (B) APPLICATION TO COST REPORTING PE-
23 RIODS.—If the Secretary makes a determina-
24 tion that a hospital is described in section
25 1886(d)(1)(B)(v)(V) of the Social Security Act,

as added by paragraph (1), such determination shall apply as of the first cost reporting period beginning on or after the date of such determination.

(C) BASE PERIOD.—Notwithstanding the provisions of section 1886(b)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(E)) or any other provision of law, the base cost reporting period for purposes of determining the target amount for any hospital for which a determination described in subparagraph (B) has been made shall be the first full 12-month cost reporting period beginning on or after the date of such determination.

(D) RULE.—A hospital described in subclause (V) of section 1886(b)(1)(B)(v) of the Social Security Act, as added by paragraph (1), shall not qualify as a hospital described in such subclause for any cost reporting period in which less than 50 percent of its total discharges have a principal finding of neoplastic disease. With respect to the first cost reporting period for which a determination described in subparagraph (B) has been made, the Secretary shall accept a self-certification by the hospital, which

1 shall be applicable to such first cost reporting
2 period, that the hospital intends to have total
3 discharges during such first cost reporting pe-
4 riod of which 50 percent or more have a prin-
5 cipal finding of neoplastic disease.

6 (c) MEDPAC REPORT ON PPS-EXEMPT CANCER
7 HOSPITALS.—Not later than March 1, 2009, the Medicare
8 Payment Advisory Commission (established under section
9 1805 of the Social Security Act (42 U.S.C. 1395b-6)) shall
10 submit to the Secretary and Congress a report evaluating
11 the following:

12 (1) Measures of payment adequacy and Medi-
13 care margins for PPS-exempt cancer hospitals, as
14 established under section 1886(d)(1)(B)(v) of the
15 Social Security Act (42 U.S.C.
16 1395ww(d)(1)(B)(v)).

17 (2) To the extent a PPS-exempt cancer hospital
18 was previously affiliated with another hospital, the
19 margins of the PPS-exempt hospital and the other
20 hospital as separate entities and the margins of such
21 hospitals that existed when the hospitals were pre-
22 viously affiliated.

23 (3) Payment adequacy for cancer discharges
24 under the Medicare inpatient hospital prospective
25 payment system.

SEC. 506. SKILLED NURSING FACILITY PAYMENT UPDATE.

(a) IN GENERAL.—Section 1888(e)(4)(E)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(E)(ii)) is amended—

(1) in subclause (III), by striking ''and'';

(2) by redesignating subsection (IV) as subclause (VI); and

(3) by inserting after subclause (III) the following new subclauses:

''(IV) for each of fiscal years 2004, 2005, 2006, and 2007, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved;

''(V) for fiscal year 2008, the rate computed for the previous fiscal year; and''.

(b) DELAYED EFFECTIVE DATE.—Section 1888(e)(4)(E)(ii)(V) of the Social Security Act, as inserted by subsection (a)(3), shall not apply to payment for days before January 1, 2008.

SEC. 507. REVOCATION OF UNIQUE DEEMING AUTHORITY OF THE JOINT COMMISSION FOR THE ACCREDITATION OF HEALTHCARE ORGANIZATIONS.

(a) REVOCATION.—Section 1865 of the Social Security Act (42 U.S.C. 1395bb) is amended—

(1) by striking subsection (a); and

(2) by redesignating subsections (b), (c), (d), and (e) as subsections (a), (b), (c), and (d), respectively.

(b) CONFORMING AMENDMENTS.—(1) Such section is further amended—

(A) in subsection (a)(1), as so redesignated, by striking ''In addition, if'' and inserting ''If'';

(B) in subsection (b), as so redesignated—

(i) by striking ''released to him by the Joint Commission on Accreditation of Hospitals,'' and inserting ''released to the Secretary by''; and

(ii) by striking the comma after ''Association'';

(C) in subsection (c), as so redesignated, by striking ''pursuant to subsection (a) or (b)(1)'' and inserting ''pursuant to subsection (a)(1)''; and

(D) in subsection (d), as so redesignated, by striking ''pursuant to subsection (a) or (b)(1)'' and inserting ''pursuant to subsection (a)(1)''.

(2) Section 1861(e) of such Act (42 U.S.C. 1395x(e)) is amended in the fourth sentence by striking ''and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals'' and inserting ''and (ii) is accredited by a national accreditation body recognized by the Secretary under section 1865(a), or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of such a national accreditation body.''.

(3) Section 1864(c) of such Act (42 U.S.C. 1395aa(c)) is amended by striking ''pursuant to subsection (a) or (b)(1) of section 1865'' and inserting ''pursuant to section 1865(a)(1)''.

(4) Section 1875(b) of such Act (42 U.S.C. 1395ll(b)) is amended by striking ''the Joint Commission on Accreditation of Hospitals,'' and inserting ''national accreditation bodies under section 1865(a)''.

(5) Section 1834(a)(20)(B) of such Act (42 U.S.C. 1395m(a)(20)(B)) is amended by striking ''section 1865(b)'' and inserting ''section 1865(a)''.

(6) Section 1852(e)(4)(C) of such Act (42 U.S.C. 1395w-22(e)(4)(C)) is amended by striking ''section 1865(b)(2)'' and inserting ''section 1865(a)(2)''.

(c) AUTHORITY TO RECOGNIZE JCAHO AS A NATIONAL ACCREDITATION BODY.—The Secretary of Health and Human Services may recognize the Joint Commission on Accreditation of Healthcare Organizations as a national accreditation body under section 1865 of the Social Security Act (42 U.S.C. 1395bb), as amended by this section, upon such terms and conditions, and upon submission of such information, as the Secretary may require.

(d) EFFECTIVE DATE; TRANSITION RULE.—(1) Subject to paragraph (2), the amendments made by this section shall apply with respect to accreditations of hospitals granted on or after the date that is 18 months after the date of the enactment of this Act.

1 (2) For purposes of title XVIII of the Social Security
2 Act (42 U.S.C. 1395 et seq.), the amendments made by
3 this section shall not effect the accreditation of a hospital
4 by the Joint Commission on Accreditation of Healthcare
5 Organizations, or under accreditation or comparable ap-
6 proval standards found to be essentially equivalent to ac-
7 creditation or approval standards of the Joint Commission
8 on Accreditation of Healthcare Organizations, for the pe-
9 riod of time applicable under such accreditation.

10 **SEC. 508. TREATMENT OF MEDICARE HOSPITAL RECLASSI-**
11 **FICATIONS.**

12 (a) EXTENDING CERTAIN MEDICARE HOSPITAL
13 WAGE INDEX RECLASSIFICATIONS THROUGH FISCAL
14 YEAR 2009.—

15 (1) IN GENERAL.—Section 106(a) of the Medi-
16 care Improvements and Extension Act of 2006 (divi-
17 sion B of public Law 109–432) is amended by strik-
18 ing ''September 30, 2007'' and inserting ''September
19 30, 2009''.

20 (2) SPECIAL EXCEPTION RECLASSIFICATIONS.—
21 The Secretary of Health and Human Services shall
22 extend for discharges occurring through September
23 30, 2009, the special exception reclassification made
24 under the authority of section 1886(d)(5)(I)(i) of
25 the Social Security Act (42 U.S.C.

1395ww(d)(5)(I)(i)) and contained in the final rule promulgated by the Secretary in the Federal Register on August 11, 2004 (69 Fed. Reg. 49105, 49107).

(b) DISREGARDING SECTION 508 HOSPITAL RECLASSIFICATIONS FOR PURPOSES OF GROUP RECLASSIFICATIONS.—Section 508 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173, 42 U.S.C. 1395ww note) is amended by adding at the end the following new subsection:

''(g) DISREGARDING HOSPITAL RECLASSIFICATIONS FOR PURPOSES OF GROUP RECLASSIFICATIONS.—For purposes of the reclassification of a group of hospitals in a geographic area under section 1886(d), a hospital reclassified under this section (including any such reclassification which is extended under section 106(a) of the Medicare Improvements and Extension Act of 2006) shall not be taken into account and shall not prevent the other hospitals in such area from establishing such a group for such purpose.''.

(c) APPLICATION OF MEDICARE RURAL MINIMUM HOSPITAL WAGE INDEX OF NON-LOCATION STATES TO HOSPITALS RECLASSIFIED TO URBAN AREAS IN SUCH STATES.—Section 1886(d)(8)(C) of the Social Security Act (42 U.S.C. 1395ww(d)(8)(C)) is amended—

1 (1) by redesignating clause (v) as clause (vi);
2 and
3 (2) by inserting after clause (iv) the following
4 new clause:
5 ''(v) Notwithstanding the previous provisions of this
6 subparagraph, in the case that the application of subpara-
7 graph (B) or a decision of the Medicare Geographic Classi-
8 fication Review Board or the Secretary under paragraph
9 (10) results in the redesignation of a rural hospital that
10 is classified as a rural referral center under paragraph
11 (5)(C) and sole community hospital under paragraph
12 (5)(D)(iii) and that has at least 250 beds to an urban
13 area that is in a non-location State, for which the com-
14 bined average hourly wage of all hospitals located in such
15 area is less than the combined average hourly wage of all
16 hospitals located in the rural area of such State, and
17 which was not reclassified under section 508 of the Medi-
18 care Prescription Drug, Improvement, and Modernization
19 Act of 2003, the wage index applicable to such hospital
20 may not be less than the area wage index otherwise appli-
21 cable to a hospital located in the rural area in the non-
22 location State (or, if the non-location State has no rural
23 area, the minimum wage index that the Secretary estab-
24 lishes for such State). For purposes of this clause, the
25 term 'non-location State' means, with respect to a hos-

1 pital, a State other than the State in which the hospital
2 is located.''.
3 (d) APPLICATION OF FLOOR ON AREA WAGE INDEX
4 IN CASE OF RECLASSIFIED HOSPITALS.—
5 (1) IN GENERAL.—Section 4410 of the Bal-
6 anced Budget Act of 1997 (Public Law 105-33) is
7 amended by adding at the end the following new
8 subsection:
9 ''(d) APPLICATION TO RECLASSIFIED HOSPITALS.—
10 In the case of a hospital that is reclassified based on wages
11 under paragraph (8) or (10) of section 1886(d) of the So-
12 cial Security Act into an area the area wage index for
13 which is increased under subsection (a), such increased
14 area wage index shall also apply to such hospital.''.
15 (2) EFFECTIVE DATE.—The amendment made
16 by paragraph (1) shall apply to payments for dis-
17 charges occurring on or after October 1, 2008.
18 (e) OTHER HOSPITAL RECLASSIFICATION PROVI-
19 SIONS.—Notwithstanding any other provision of law—
20 (1) In the case of a subsection (d) hospital (as
21 defined for purposes of section 1886 of the Social
22 Security Act (42 U.S.C. 1395ww)) located in Put-
23 nam County, Tennessee with respect to which a re-
24 classification of its wage index for purposes of such
25 section would (but for this subsection) expire on

1 September 30, 2007, such reclassification of such
2 hospital shall be extended through September 30,
3 2008.
4 (2) For purposes of making payments under
5 section 1886(d) of the Social Security Act (42
6 U.S.C. 1395ww(d)), the Secretary of Health and
7 Human Services shall classify any hospital located in
8 Orange County, New York that was reclassified
9 under the authority of section 508 of the the Medi-
10 care Prescription Drug, Improvement and Mod-
11 ernization Act of 2003 (Public Law 108-173) as
12 being located in the New York-White Plains-Wayne,
13 NY-NJ Core Based Statistical Area. Any reclassi-
14 fication under this subsection shall be treated as a
15 reclassification under section 1886(d)(8) of such
16 Act.
17 (3) For purposes of making payments under
18 section 1886(d) of the Social Security Act (42
19 U.S.C. 1395ww(d)), the large urban area of New
20 York, New York is deemed to include hospitals, re-
21 quired by State law enacted prior to June 30, 2007,
22 to join under a single unified governance structure
23 if—

1 (A) such hospitals are located in a city
2 with a population of no less than 20,000 and no
3 than 30,000; and
4 (B) such hospitals are less than 3/4 miles
5 apart.
6 (4) For purposes of making payments under
7 section 1886(d) of the Social Security Act (42
8 U.S.C. 1395ww(d)) the large urban area of Buffalo-
9 Niagara Falls, New York is deemed to include Chau-
10 tauqua County, New York. Notwithstanding para-
11 graph (6), in no case shall there be a reduction in
12 the hospital wage index for Erie County, New York,
13 or any adjoining county, as a result of the applica-
14 tion of this section (other than as a result of a gen-
15 eral reduction required to carry out paragraph
16 (8)(D) of that section).
17 (5) For purposes of making payments under
18 section 1886(d) of the Social Security Act (42
19 U.S.C. 1395ww(d)) a hospital shall be reclassified
20 into the New York-White Plains-Wayne, New York-
21 New Jersey core based statistical area (CBSA code
22 35644) if the hospital is a subsection (d) hospital
23 (as defined in section 1886(d)(1)(B) of the Social
24 Security Act (42 U.S.C. 1395ww(d)(1)(B)) that——

1 (A) is licensed by the State in which it is
2 located as a specialty hospital;
3 (B) specializes in the treatment of cardiac,
4 vascular, and pulmonary diseases;
5 (C) provides at least 100 beds; and
6 (D) is located in Burlington County, New
7 Jersey.
8 (6)(A) Any hospital described in paragraph (2)
9 shall be treated as located in the core based statis-
10 tical area described in subparagraph (C) for pur-
11 poses of making payments under section 1886(d) of
12 the Social Security Act (42 U.S.C. 1395ww(d)).
13 (B) A hospital described in this subparagraph
14 is any hospital that—
15 (i) is located in a core based statistical
16 area (CBSA) that—
17 (I) had a population (as reported in
18 the decennial census for the year 2000) of
19 at least 500,000, but not more than
20 750,000;
21 (II) had a population (as reported in
22 such census) that was at least 10,000
23 below the population for the area as re-
24 ported in the previous decennial census;
25 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
6 section 1886(d)(10)(D)(vi) of the Social Secu-
7 rity Act is not less than 96 percent of such av-
8 erage hourly wage amount rate for all sub-
9 section (d) hospitals located in same core base
10 statistical 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 ad-
15 jacent to, the core based statistical area in
16 which 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 the previous provisions of
22 this subsection (other than paragraph (1))—
23 (A) any reclassification effected under such
24 provisions shall be treated as a decision of the
25 Medicare Geographic Classification Review

Board under section 1886(d) of the Social Security Act and subject to budget neutrality under paragraph (8)(D) of such section.; and

(B) such provisions shall only apply to discharges occurring on or after October 1, 2008, during the 3-year reclassification period beginning on such date.

SEC. 509. MEDICARE CRITICAL ACCESS HOSPITAL DESIGNATIONS.

(a) IN GENERAL.—

(1) Section 405(h) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2269) is amended by adding at the end the following new paragraph:

"(3) EXCEPTION.—

"(A) IN GENERAL.—The amendment made by paragraph (1) shall not apply to the certification by the State of Minnesota on or after January 1, 2006, under section 1820(c)(2)(B)(i)(II) of the Social Security Act (42 U.S.C. 1395i–4(c)(2)(B)(i)(II)) of one hospital that meets the criteria described in subparagraph (B) and is located in Cass County, Minnesota, as a necessary provider of health

1 care services to residents in the area of the hos-
2 pital.
3 "(B) CRITERIA DESCRIBED.—A hospital
4 meets the criteria described in this subpara-
5 graph if the hospital
6 "(i) has been granted an exception by
7 the State to an otherwise applicable statu-
8 tory restriction on hospital construction or
9 licensing prior to the date of enactment of
10 this subparagraph; and
11 "(ii) is located on property which the
12 State has approved for conveyance to a
13 county within the State prior to such date
14 of enactment.".
15 (2) Section 1820(c)(2)(B)(i)(I) of the Social Se-
16 curity Act (42 U.S.C. 1395i-4(c)(2)(B)(i)(I)) is
17 amended by striking "or," and inserting "or, in the
18 case of a hospital that is located in the county seat
19 of Butler, Alabama, a 32-mile drive, or,".
20 (b) EFFECTIVE DATE.—The amendment made by
21 subsection (a)(2) shall apply to cost reporting periods be-
22 ginning on or after the date of the enactment of this Act.

TITLE N—OTHER PROVISIONS RELATING TO MEDICARE PART B

Subtitle A—Payment and Coverage Improvements

SEC. 601. PAYMENT FOR THERAPY SERVICES.

(a) EXTENSION OF EXCEPTIONS PROCESS FOR MEDICARE THERAPY CAPS.—Section 1833(g)(5) of the Social Security Act (42 U.S.C. 1395l(g)(5)), as amended by section 201 of the Medicare Improvements and Extension Act of 2006 (division B of Public Law 109–432), is amended by striking ''2007'' and inserting ''2009''.

(b) STUDY AND REPORT.—

(1) STUDY.—The Secretary of Health and Human Services, in consultation with appropriate stakeholders, shall conduct a study on refined and alternative payment systems to the Medicare payment cap under section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) for physical therapy services and speech-language pathology services, described in paragraph (1) of such section and occupational therapy services described in paragraph (3) of such section. Such study shall consider, with respect to payment amounts under Medicare, the following:

(A) The creation of multiple payment caps for such services to better reflect costs associated with specific health conditions.

(B) The development of a prospective payment system, including an episode-based system of payments, for such services.

(C) The data needed for the development of a system of multiple payment caps (or an alternative payment methodology) for such services and the availability of such data.

(2) REPORT.—Not later than January 1, 2009, the Secretary shall submit to Congress a report on the study conducted under paragraph (1).

SEC. 602. MEDICARE SEPARATE DEFINITION OF OUTPATIENT SPEECH-LANGUAGE PATHOLOGY SERVICES.

(a) IN GENERAL.—Section 1861(ll) of the Social Security Act (42 U.S.C. 1395x(ll)) is amended—

(1) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively; and

(2) by inserting after paragraph (1) the following new paragraph:

''(2) The term 'outpatient speech-language pathology services' has the meaning given the term

1 'outpatient physical therapy services' in subsection
2 (p), except that in applying such subsection—
3 ''(A) 'speech-language pathology' shall be
4 substituted for 'physical therapy' each place it
5 appears; and
6 ''(B) 'speech-language pathologist' shall be
7 substituted for 'physical therapist' each place it
8 appears.''.
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 period 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)
18 applies through the application of section
19 1861(ll)(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 out-
23 patient speech-language pathology services)'' and in-
24 serting '', outpatient speech-language pathology
25 services,''.

(3) Section 1833(g)(1) of such Act (42 U.S.C. 1395l(g)(1)) is amended—

(A) by inserting ''and speech-language pathology services of the type described in such section through the application of section 1861(ll)(2)'' after ''1861(p)''; and

(B) by inserting ''and speech-language pathology services'' after ''and physical therapy services''.

(4) The second sentence of section 1835(a) of such Act (42 U.S.C. 1395n(a)) is amended—

(A) by striking ''section 1861(g)'' and inserting ''subsection (g) or (ll)(2) of section 1861'' each place it appears; and

(B) by inserting ''or outpatient speech-language pathology services, respectively'' after ''occupational therapy services''.

(5) Section 1861(p) of such Act (42 U.S.C. 1395x(p)) is amended by striking the fourth sentence.

(6) Section 1861(s)(2)(D) of such Act (42 U.S.C. 1395x(s)(2)(D)) is amended by inserting '', outpatient speech-language pathology services,'' after ''physical therapy services''.

(7) Section 1862(a)(20) of such Act (42 U.S.C. 1395y(a)(20)) is amended—

(A) by striking ''outpatient occupational therapy services or outpatient physical therapy services'' and inserting ''outpatient physical therapy services, outpatient speech-language pathology services, or outpatient occupational therapy services''; and

(B) by striking ''section 1861(g)'' and inserting ''subsection (g) or (ll)(2) of section 1861''.

(8) Section 1866(e)(1) of such Act (42 U.S.C. 1395cc(e)(1)) is amended—

(A) by striking ''section 1861(g)'' and inserting ''subsection (g) or (ll)(2) of section 1861'' the first two places it appears;

(B) by striking ''defined) or'' and inserting ''defined),''; and

(C) by inserting before the semicolon at the end the following: '', or (through the operation of section 1861(ll)(2)) with respect to the furnishing of outpatient speech-language pathology''.

1 (c) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to services furnished on or after
3 January 1, 2008.
4 (d) CONSTRUCTION.—Nothing in this section shall be
5 construed to affect existing regulations and policies of the
6 Centers for Medicare & Medicaid Services that require
7 physician oversight of care as a condition of payment for
8 speech-language pathology services under part B of the
9 medicare program.

10 **SEC. 603. INCREASED REIMBURSEMENT RATE FOR CER-**
11 **TIFIED NURSE-MIDWIVES.**

12 (a) IN GENERAL.—Section 1833(a)(1)(K) of the So-
13 cial Security Act (42 U.S.C.1395l(a)(1)(K)) is amended
14 by striking ''(but in no event'' and all that follows through
15 ''performed by a physician)''.
16 (b) EFFECTIVE DATE.—The amendment made by
17 subsection (a) shall apply to services furnished on or after
18 April 1, 2008.

19 **SEC. 604. ADJUSTMENT IN OUTPATIENT HOSPITAL FEE**
20 **SCHEDULE INCREASE FACTOR.**

21 The first sentence of section 1833(t)(3)(C)(iv) of the
22 Social Security Act (42 U.S.C. 1395l(t)(3)(C)(iv)) is
23 amended by inserting before the period at the end the fol-
24 lowing: ''and reduced by 0.25 percentage point for such
25 factor for such services furnished in 2008''.

SEC. 605. EXCEPTION TO 60-DAY LIMIT ON MEDICARE SUBSTITUTE BILLING ARRANGEMENTS IN CASE OF PHYSICIANS ORDERED TO ACTIVE DUTY IN THE ARMED FORCES.

(a) IN GENERAL.—Section 1842(b)(6)(D)(iii) of the Social Security Act (42 U.S.C. 1395u(b)(6)(D)(iii)) is amended by inserting after ''of more than 60 days'' the following: ''or are provided over a longer continuous period during all of which the first physician has been called or ordered to active duty as a member of a reserve component of the Armed Forces''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after the date of the enactment of this section.

SEC. 606. EXCLUDING CLINICAL SOCIAL WORKER SERVICES FROM COVERAGE UNDER THE MEDICARE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM AND CONSOLIDATED PAYMENT.

(a) IN GENERAL.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting ''clinical social worker services,'' after ''qualified psychologist services,''..

(b) CONFORMING AMENDMENT.—Section 1861(hh)(2) of the Social Security Act (42 U.S.C. 1395x(hh)(2)) is amended by striking ''and other than

1 services furnished to an inpatient of a skilled nursing facil-
2 ity which the facility is required to provide as a require-
3 ment for participation''.

4 (c) EFFECTIVE DATE.—The amendments made by
5 this section shall apply to items and services furnished on
6 or after January 1, 2008.

7 **SEC. 607. COVERAGE OF MARRIAGE AND FAMILY THERA-**
8 **PIST SERVICES AND MENTAL HEALTH COUN-**
9 **SELOR SERVICES.**

10 (a) COVERAGE OF MARRIAGE AND FAMILY THERA-
11 PIST SERVICES.—

12 (1) COVERAGE OF SERVICES.—Section
13 1861(s)(2) of the Social Security Act (42 U.S.C.
14 1395x(s)(2)) is amended—

15 (A) in subparagraph (Z), by striking
16 ''and'' at the end;

17 (B) in subparagraph (AA), by adding
18 ''and'' at the end; and

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

21 ''(BB) marriage and family therapist services
22 (as defined in subsection (ccc));''.

23 (2) DEFINITION.—Section 1861 of the Social
24 Security Act (42 U.S.C. 1395x) is amended by add-
25 ing at the end the following new subsection:

1 ''(ccc) MARRIAGE AND FAMILY THERAPIST SERV-
2 ICES.—(1) The term 'marriage and family therapist serv-
3 ices' means services performed by a marriage and family
4 therapist (as defined in paragraph (2)) for the diagnosis
5 and treatment of mental illnesses, which the marriage and
6 family therapist is legally authorized to perform under
7 State law (or the State regulatory mechanism provided by
8 State law) of the State in which such services are per-
9 formed, provided such services are covered under this title,
10 as would otherwise be covered if furnished by a physician
11 or as incident to a physician's professional service, but
12 only if no facility or other provider charges or is paid any
13 amounts with respect to the furnishing of such services.
14 ''(2) The term 'marriage and family therapist' means
15 an individual who—
16 ''(A) possesses a master's or doctoral degree
17 which qualifies for licensure or certification as a
18 marriage and family therapist pursuant to State
19 law;
20 ''(B) after obtaining such degree has performed
21 at least 2 years of clinical supervised experience in
22 marriage and family therapy; and
23 ''(C) is licensed or certified as a marriage and
24 family therapist in the State in which marriage and
25 family therapist services are performed.''.

(3) PROVISION FOR PAYMENT UNDER PART b.—Section 1832(a)(2)(B) of the Social Security Act (42 U.S.C. 1395k(a)(2)(B)) is amended by adding at the end the following new clause:

"(v) marriage and family therapist services;".

(4) AMOUNT OF PAYMENT.—

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

(i) by striking "and" before "(V)"; and

(ii) by inserting before the semicolon at the end the following: ", and (W) with respect to marriage and family therapist services under section 1861(s)(2)(BB), the amounts paid shall be 80 percent of the lesser of (i) the actual charge for the services or (ii) 75 percent of the amount determined for payment of a psychologist under subparagraph (L)".

(B) DEVELOPMENT OF CRITERIA WITH RESPECT TO CONSULTATION WITH A PHYSICIAN.—The Secretary of Health and Human Services shall, taking into consideration concerns for pa-

1 tient confidentiality, develop criteria with re-
2 spect to payment for marriage and family ther-
3 apist services for which payment may be made
4 directly to the marriage and family therapist
5 under part B of title XVIII of the Social Secu-
6 rity Act (42 U.S.C. 1395j et seq.) under which
7 such a therapist must agree to consult with a
8 patient's attending or primary care physician in
9 accordance with such criteria.

10 (5) EXCLUSION OF MARRIAGE AND FAMILY
11 THERAPIST SERVICES FROM SKILLED NURSING FA-
12 CILITY PROSPECTIVE PAYMENT SYSTEM.—Section
13 1888(e)(2)(A)(ii) of the Social Security Act (42
14 U.S.C. 1395yy(e)(2)(A)(ii)), is amended by inserting
15 ''marriage and family therapist services (as defined
16 in subsection (ccc)(1)),'' after ''qualified psychologist
17 services,''.

18 (6) COVERAGE OF MARRIAGE AND FAMILY
19 THERAPIST SERVICES PROVIDED IN RURAL HEALTH
20 CLINICS AND FEDERALLY QUALIFIED HEALTH CEN-
21 TERS.—Section 1861(aa)(1)(B) of the Social Secu-
22 rity Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by
23 striking ''or by a clinical social worker (as defined
24 in subsection (hh)(1)),'' and inserting '', by a clinical
25 social worker (as defined in subsection (hh)(1)), or

1 by a marriage and family therapist (as defined in
2 subsection (ccc)(2)),''.
3 (7) INCLUSION OF MARRIAGE AND FAMILY
4 THERAPISTS AS PRACTITIONERS FOR ASSIGNMENT
5 OF CLAIMS.—Section 1842(b)(18)(C) of the Social
6 Security Act (42 U.S.C. 1395u(b)(18)(C)) is amend-
7 ed by adding at the end the following new clause:
8 ''(vii) A marriage and family therapist (as de-
9 fined in section 1861(ccc)(2)).''.
10 (b) COVERAGE OF MENTAL HEALTH COUNSELOR
11 SERVICES.—
12 (1) COVERAGE OF SERVICES.—Section
13 1861(s)(2) of the Social Security Act (42 U.S.C.
14 1395x(s)(2)), as amended in subsection (a)(1), is
15 further amended—
16 (A) in subparagraph (AA), by striking
17 ''and'' at the end;
18 (B) in subparagraph (BB), by inserting
19 ''and'' at the end; and
20 (C) by adding at the end the following new
21 subparagraph:
22 ''(CC) mental health counselor services (as
23 defined in subsection (ddd)(2));''.
24 (2) DEFINITION.—Section 1861 of the Social
25 Security Act (42 U.S.C. 1395x), as amended by sub-

1 section (a)(2), is further amended by adding at the
2 end the following new subsection:
3 "(ddd) MENTAL HEALTH COUNSELOR; MENTAL
4 HEALTH COUNSELOR SERVICES.—(1) The term 'mental
5 health counselor' means an individual who—
6 "(A) possesses a master's or doctor's degree
7 which qualifies the individual for licensure or certifi-
8 cation for the practice of mental health counseling in
9 the State in which the services are performed;
10 "(B) after obtaining such a degree has per-
11 formed at least 2 years of supervised mental health
12 counselor practice; and
13 "(C) is licensed or certified as a mental health
14 counselor or professional counselor by the State in
15 which the services are performed.
16 "(2) The term 'mental health counselor services'
17 means services performed by a mental health counselor (as
18 defined in paragraph (1)) for the diagnosis and treatment
19 of mental illnesses which the mental health counselor is
20 legally authorized to perform under State law (or the
21 State regulatory mechanism provided by the State law) of
22 the State in which such services are performed, provided
23 such services are covered under this title, as would other-
24 wise be covered if furnished by a physician or as incident
25 to a physician's professional service, but only if no facility

1 or other provider charges or is paid any amounts with re-
2 spect to the furnishing of such services.''.
3 (3) PROVISION FOR PAYMENT UNDER PART
4 b.—Section 1832(a)(2)(B) of the Social Security Act
5 (42 U.S.C. 1395k(a)(2)(B)), as amended by sub-
6 section (a)(3), is further amended by adding at the
7 end the following new clause:
8 ''(vi) mental health counselor serv-
9 ices;''.
10 (4) AMOUNT OF PAYMENT.—
11 (A) IN GENERAL.—Section 1833(a)(1) of
12 the Social Security Act (42 U.S.C.
13 1395*l*(a)(1)), as amended by subsection (a)(4),
14 is further amended—
15 (i) by striking ''and'' before ''(W)'';
16 and
17 (ii) by inserting before the semicolon
18 at the end the following: '', and (X) with
19 respect to mental health counselor services
20 under section 1861(s)(2)(CC), the amounts
21 paid shall be 80 percent of the lesser of (i)
22 the actual charge for the services or (ii) 75
23 percent of the amount determined for pay-
24 ment of a psychologist under subparagraph
25 (L)''.

1 (B) DEVELOPMENT OF CRITERIA WITH RE-
2 SPECT TO CONSULTATION WITH A PHYSICIAN.—
3 The Secretary of Health and Human Services
4 shall, taking into consideration concerns for pa-
5 tient confidentiality, develop criteria with re-
6 spect to payment for mental health counselor
7 services for which payment may be made di-
8 rectly to the mental health counselor under part
9 B of title XVIII of the Social Security Act (42
10 U.S.C. 1395j et seq.) under which such a coun-
11 selor must agree to consult with a patient's at-
12 tending or primary care physician in accordance
13 with such criteria.
14 (5) EXCLUSION OF MENTAL HEALTH COUN-
15 SELOR SERVICES FROM SKILLED NURSING FACILITY
16 PROSPECTIVE PAYMENT SYSTEM.—Section
17 1888(e)(2)(A)(ii) of the Social Security Act (42
18 U.S.C. 1395yy(e)(2)(A)(ii)), as amended by sub-
19 section (a)(5), is amended by inserting ''mental
20 health counselor services (as defined in section
21 1861(ddd)(2)),'' after ''marriage and family thera-
22 pist services (as defined in subsection (ccc)(1)),''.
23 (6) COVERAGE OF MENTAL HEALTH COUN-
24 SELOR SERVICES PROVIDED IN RURAL HEALTH
25 CLINICS AND FEDERALLY QUALIFIED HEALTH CEN-

1 TERS.—Section 1861(aa)(1)(B) of the Social Secu-
2 rity Act (42 U.S.C. 1395x(aa)(1)(B)), as amended
3 by subsection (a)(6), is amended by striking ''or by
4 a marriage and family therapist (as defined in sub-
5 section (ccc)(2)),'' and inserting ''by a marriage and
6 family therapist (as defined in subsection (ccc)(2)),
7 or a mental health counselor (as defined in sub-
8 section (ddd)(1)),''.

9 (7) INCLUSION OF MENTAL HEALTH COUN-
10 SELORS AS PRACTITIONERS FOR ASSIGNMENT OF
11 CLAIMS.—Section 1842(b)(18)(C) of the Social Se-
12 curity Act (42 U.S.C. 1395u(b)(18)(C)), as amended
13 by subsection (a)(7), is amended by adding at the
14 end the following new clause:

15 ''(viii) A mental health counselor (as defined in
16 section 1861(fff)(1)).''.

17 (c) EFFECTIVE DATE.—The amendments made by
18 this section shall apply to items and services furnished on
19 or after January 1, 2008.

20 **SEC. 608. RENTAL AND PURCHASE OF POWER-DRIVEN**
21 **WHEELCHAIRS.**

22 (a) IN GENERAL.—Section 1834(a)(7) of the Social
23 Security Act (42 U.S.C. 1395m(a)(7)) is amended—

24 (1) in subparagraph (A)—

(A) clause (i)(I), by striking ''Except as provided in clause (iii), payment'' and inserting ''Payment'';

(B) by striking clause (iii); and

(C) in clause (iv)—

(i) by redesignating such clause as clause (iii); and

(ii) by striking ''or in the case of a power-driven wheelchair for which a purchase agreement has been entered into under clause (iii)''; and

(2) in subparagraph (C)(ii)(II), by striking ''or (A)(iii)''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (1), the amendments made by subsection (a) shall take effect on January 1, 2008, and shall apply to power-driven wheelchairs furnished on or after such date.

(2) APPLICATION TO COMPETITIVE ACQUISITION.—The amendments made by subsection (a) shall not apply to contracts entered into under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) pursuant to a bid submitted under such section before July 21, 2007.

SEC. 609. RENTAL AND PURCHASE OF OXYGEN EQUIPMENT.

(a) IN GENERAL.—Section 1834(a)(5)(F) of the Social Security Act (42 U.S.C. 1395m(a)(5)(F)) is amended—

(1) in clause (i)—

(A) by striking ''Payment'' and inserting ''Subject to clause (iii), payment''; and

(B) by striking ''36 months'' and inserting ''18 months'';

(2) in clause (ii)(I), by striking ''36th continuous month'' and inserting ''18th continuous month''; and

(3) by adding at the end the following new clause:

''(iii) SPECIAL RULE FOR OXYGEN GENERATING PORTABLE EQUIPMENT.—In the case of oxygen generating portable equipment referred to in the final rule published in the Federal Register on November 9, 2006 (71 Fed. Reg. 65897–65899), in applying clauses (i) and (ii)(I) each reference to '13 months' is deemed a reference to '18 months'.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (3), the amendments made by subsection (a) shall apply

1 to oxygen equipment furnished on or after January
2 1, 2008.
3 (2) TRANSITION.—In the case of an individual
4 receiving oxygen equipment on December 31, 2007,
5 for which payment is made under section 1834(a) of
6 the Social Security Act (42 U.S.C. 1395m(a)), the
7 18-month period described in paragraph (5)(F)(i) of
8 such section, as amended by subsection (a), shall
9 begin on January 1, 2008, but in no case shall the
10 rental period for such equipment exceed 36 months.
11 (3) APPLICATION TO COMPETITIVE ACQUISI-
12 TION.—The amendments made by subsection (a)
13 shall not apply to contracts entered into under sec-
14 tion 1847 of the Social Security Act (42 U.S.C.
15 1395w–3) pursuant to a bid submitted under such
16 section before July 21, 2007.
17 (c) STUDY AND REPORT.—
18 (1) STUDY.—The Secretary of Health and
19 Human Services shall conduct a study to examine
20 the service component and the equipment component
21 of the provision of oxygen to Medicare beneficiaries.
22 The study shall assess—
23 (A) the type of services provided and vari-
24 ation across suppliers in providing such serv-
25 ices;

(B) whether the services are medically necessary or affect patient outcomes;

(C) whether the Medicare program pays appropriately for equipment in connection with the provision of oxygen;

(D) whether such program pays appropriately for necessary services;

(E) whether such payment in connection with the provision of oxygen should be divided between equipment and services, and if so, how; and

(F) how such payment rate compares to a competitively bid rate.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the study conducted under paragraph (1).

SEC. 610. ADJUSTMENT FOR MEDICARE MENTAL HEALTH SERVICES.

(a) IN GENERAL.—For purposes of payment for services furnished under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w-4) during the applicable period, the Secretary of Health

1 and Human Services shall increase the amount otherwise
2 payable for applicable services by 5 percent.
3 (b) DEFINITIONS.—For purposes of subsection (a):
4 (1) APPLICABLE PERIOD.—The term ''applica-
5 ble period'' means the period beginning on January
6 1, 2008, and ending on December 31 of the year be-
7 fore the effective date of the first review after Janu-
8 ary 1, 2008, of work relative value units conducted
9 under section 1848(c)(2)(B)(i) of the Social Security
10 Act.
11 (2) APPLICABLE SERVICES.—The term ''appli-
12 cable services'' means procedure codes for services—
13 (A) in the categories of psychiatric thera-
14 peutic procedures furnished in office or other
15 outpatient facility settings, or inpatient hos-
16 pital, partial hospital or residential care facility
17 settings; and
18 (B) which cover insight oriented, behavior
19 modifying, or supportive psychotherapy and
20 interactive psychotherapy services in the
21 Healthcare Common Procedure Coding System
22 established by the Secretary of Health and
23 Human Services under section 1848(c)(5) of
24 such Act.

(c) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement this section by program instruction or otherwise.

SEC. 611. EXTENSION OF BRACHYTHERAPY SPECIAL RULE.

Section 1833(t)(16)(C) of the Social Security Act (42 U.S.C. 1395l(t)(16)(C)) is amended by striking ''2008'' and inserting ''2009''.

SEC. 612. PAYMENT FOR PART B DRUGS.

(a) APPLICATION OF CONSISTENT VOLUME WEIGHTING IN COMPUTATION OF ASP.—In order to assure that payments for drugs and biologicals under section 1847A of the Social Security Act (42 U.S.C. 1395w-3a) are correct and consistent with law, the Secretary of Health and Human Services shall, for payment for drugs and biologicals furnished on or after July 1, 2008, compute the volume-weighted average sales price using equation #2 (specified in appendix A of the report of the Inspector General of the Department of Health and Human Services on ''Calculation of Volume-Weighted Average Sales Price for Medicare Part B Prescription Drugs'' (February 2006; OEI–03-05-00310)) used by the Office of Inspector General to calculate a volume-weighted ASP.

(b) IMPROVEMENTS IN THE COMPETITIVE ACQUISITION PROGRAM (CAP).—

1 (1) CONTINUOUS OPEN ENROLLMENT; AUTO-
2 MATIC REENROLLMENT WITHOUT NEED FOR RE-
3 APPLICATION.—Subsection (a)(1)(A) of section
4 1847B of the Social Security Act (42 U.S.C. 1395w-
5 3b) is amended—
6 (A) in clause (ii), by striking ''annually''
7 and inserting ''on an ongoing basis'';
8 (B) in clause (iii), by striking ''an annual
9 selection'' and inserting ''a selection (which
10 may be changed on an annual basis)'' ; and
11 (C) by adding at the end the following:
12 ''An election and selection described in clauses
13 (ii) and (iii) shall continue to be effective with-
14 out the need for any periodic reelection or re-
15 application or selection.''.
16 (2) PERMITTING VENDER TO DELIVER DRUGS
17 TO SITE OF ADMINISTRATION.—Subsection (b)(4)(E)
18 of such section is amended—
19 (A) by striking ''or'' at the end of clause
20 (I);
21 (B) by striking the period at the end of
22 clause (ii) and inserting ''; or''; and
23 (C) by adding at the end the following new
24 clause:

1 ''(iii) prevent a contractor from deliv-
2 ering drugs and biologicals to the site in
3 which the drugs or biologicals will be ad-
4 ministered.''.
5 (3) PHYSICIAN OUTREACH AND EDUCATION.—
6 Subsection (a)(1) of such section is amended by add-
7 ing at the end the following new subparagraph:
8 ''(E) PHYSICIAN OUTREACH AND EDU-
9 CATION.—The Secretary shall conduct a pro-
10 gram of outreach to education physicians con-
11 cerning the program and the ongoing oppor-
12 tunity of physicians to elect to obtain drugs and
13 biologicals under the program.''.
14 (4) REBIDDING OF CONTRACTS.—The Secretary
15 of Health and Human Services shall provide for the
16 rebidding of contracts under section 1847B(c) of the
17 Social Security Act (42 U.S.C. 1395w-3b(c)) only
18 for periods on or after the expiration of the contract
19 in effect under such section as of the date of the en-
20 actment of this Act.
21 (c) TREATMENT OF CERTAIN DRUGS.—Section
22 1847A(b) of the Social Security Act (42 U.S.C. 1395w-
23 3a(b)) is amended—
24 (1) in paragraph (1), by inserting ''paragraph
25 (6) and'' after ''Subject to''; and

(2) by adding at the end the following new paragraph:

"(6) SPECIAL RULE.—.In applying subsection (c)(6)(C)(ii), beginning with January 1, 2008, the average sales price for drugs or biologicals described in section 1842(o)(1)(G) is the lower of the average sales price calculated including drugs or biologicals to which such subsection applies and the average sales price that would have been calculated if such subsection were not applied.".

(d) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall apply to drugs furnished on or after January 1, 2008.

Subtitle B—Extension of Medicare Rural Access Protections

SEC. 621. 2-YEAR EXTENSION OF FLOOR ON MEDICARE WORK GEOGRAPHIC ADJUSTMENT.

Section 1848(e)(1)(E) of such Act (42 U.S.C. 1395w–4(e)(1)(E)) is amended by striking "2008" and inserting "2010".

SEC. 622. 2-YEAR EXTENSION OF SPECIAL TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE.

Section 542(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of

2000, as amended by section 732 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and section 104 of the Medicare Improvements and Extension Act of 2006 (division B of Public Law 109–432), is amended by striking ''and 2007'' and inserting ''2007, 2008, and 2009''.

SEC. 623. 2-YEAR EXTENSION OF MEDICARE REASONABLE COSTS PAYMENTS FOR CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITAL PATIENTS IN CERTAIN RURAL AREAS.

Section 416(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2282; 42 U.S.C. 1395l–4(b)), as amended by section 105 of the Medicare Improvement and Extension Act of 2006 (division B of Public Law 109–432), is amended by striking ''3-year'' and inserting ''5-year''.

SEC. 624. 2-YEAR EXTENSION OF MEDICARE INCENTIVE PAYMENT PROGRAM FOR PHYSICIAN SCARCITY AREAS .

(a) IN GENERAL.—Section 1833(u)(1) of the Social Security Act (42 U.S.C. 1395l(u)(1)) is amended by striking ''2008'' and inserting ''2010''.

1 (b) TRANSITION.—With respect to physicians' serv-
2 ices furnished during 2008 and 2009, for purposes of sub-
3 section (a), the Secretary of Health and Human Services
4 shall use the primary care scarcity areas and the specialty
5 care scarcity areas (as identified in section 1833(u)(4))
6 that the Secretary was using under such subsection with
7 respect to physicians' services furnished on December 31,
8 2007.

9 **SEC. 625. 2-YEAR EXTENSION OF MEDICARE INCREASE PAY-**
10 **MENTS FOR GROUND AMBULANCE SERVICES**
11 **IN RURAL AREAS.**

12 Section 1834(l)(13) of the Social Security Act (42
13 U.S.C. 1395m(l)(13)) is amended—
14 (1) in subparagraph (A)—
15 (A) in the matter before clause (i), by
16 striking ''furnished on or after July 1, 2004,
17 and before January 1, 2007,'';
18 (B) in clause (i), by inserting ''for services
19 furnished on or after July 1, 2004, and before
20 January 1, 2007, and on or after January 1,
21 2008, and before January 1, 2010,'' after ''in
22 such paragraph,''; and
23 (C) in clause (ii), by inserting ''for services
24 furnished on or after July 1, 2004, and before
25 January 1, 2007,'' after ''in clause (i),''; and

(2) in subparagraph (B)—

(A) in the heading, by striking ''AFTER 2006'' and inserting ''FOR SUBSEQUENT PERIODS'';

(B) by inserting ''clauses (i) and (ii) of'' before ''subparagraph (A)''; and

(C) by striking ''in such subparagraph'' and inserting ''in the respective clause''.

SEC. 626. EXTENDING HOLD HARMLESS FOR SMALL RURAL HOSPITALS UNDER THE HOPD PROSPECTIVE PAYMENT SYSTEM.

Section 1833(t)(7)(D)(i)(II) of the Social Security Act (42 U.S.C. 1395l(t)(7)(D)(I)(II)) is amended—

(1) by striking ''January 1, 2009'' and inserting ''January 1, 2010'';

(2) by striking ''2007, or 2008,''; and

(3) by striking ''90 percent, and 85 percent, respectively,'' and inserting '', and with respect to such services furnished after 2006 the applicable percentage shall be 90 percent.''.

Subtitle C—End Stage Renal Disease Program

SEC. 631. CHRONIC KIDNEY DISEASE DEMONSTRATION PROJECTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), acting through the Director of the National Institutes of Health, shall establish demonstration projects to—

(1) increase public and medical community awareness (particularly of those who treat patients with diabetes and hypertension) about the factors that lead to chronic kidney disease, how to prevent it, how to diagnose it, and how to treat it;

(2) increase screening and use of prevention techniques for chronic kidney disease for Medicare beneficiaries and the general public (particularly among patients with diabetes and hypertension, where prevention techniques are well established and early detection makes prevention possible); and

(3) enhance surveillance systems and expand research to better assess the prevalence and incidence of chronic kidney disease, (building on work done by Centers for Disease Control and Prevention).

(b) SCOPE AND DURATION.—

1 (1) SCOPE.—The Secretary shall select at least
2 3 States in which to conduct demonstration projects
3 under this section. In selecting the States under this
4 paragraph, the Secretary shall take into account the
5 size of the population of individuals with end-stage
6 renal disease who are enrolled in part B of title
7 XVIII of the Social Security Act and ensure the par-
8 ticipation of individuals who reside in rural and
9 urban areas.
10 (2) DURATION.—The demonstration projects
11 under this section shall be conducted for a period
12 that is not longer than 5 years and shall begin on
13 January 1, 2009.
14 (c) EVALUATION AND REPORT.—
15 (1) EVALUATION.—The Secretary shall conduct
16 an evaluation of the demonstration projects con-
17 ducted under this section.
18 (2) REPORT.—Not later than 12 months after
19 the date on which the demonstration projects under
20 this section are completed, the Secretary shall sub-
21 mit to Congress a report on the evaluation con-
22 ducted under paragraph (1) together with rec-
23 ommendations for such legislation and administra-
24 tive action as the Secretary determines appropriate.

1 **SEC. 632. MEDICARE COVERAGE OF KIDNEY DISEASE PA-**
2 **TIENT EDUCATION SERVICES.**
3 (a) COVERAGE OF KIDNEY DISEASE EDUCATION
4 SERVICES.—
5 (1) COVERAGE.—Section 1861(s)(2) of the So-
6 cial Security Act (42 U.S.C. 1395x(s)(2)) is amend-
7 ed—
8 (A) in subparagraph (Z), by striking
9 ''and'' after the semicolon at the end;
10 (B) in subparagraph (AA), by adding
11 ''and'' after the semicolon at the end; and
12 (C) by adding at the end the following new
13 subparagraph:
14 ''(BB) kidney disease education services
15 (as defined in subsection (ccc));''.
16 (2) SERVICES DESCRIBED.—Section 1861 of
17 the Social Security Act (42 U.S.C. 1395x) is amend-
18 ed by adding at the end the following new sub-
19 section:
20 ''Kidney Disease Education Services
21 ''(ccc)(1) The term 'kidney disease education serv-
22 ices' means educational services that are—
23 ''(A) furnished to an individual with stage IV
24 chronic kidney disease who, according to accepted
25 clinical guidelines identified by the Secretary, will re-
26 quire dialysis or a kidney transplant;

1 "(B) furnished, upon the referral of the physi-
2 cian managing the individual's kidney condition, by
3 a qualified person (as defined in paragraph (2)); and
4 "(C) designed—
5 "(i) to provide comprehensive information
6 (consistent with the standards developed under
7 paragraph (3)) regarding—
8 "(I) the management of comorbidities,
9 including for purposes of delaying the need
10 for dialysis;
11 "(II) the prevention of uremic com-
12 plications; and
13 "(III) each option for renal replace-
14 ment therapy (including hemodialysis and
15 peritoneal dialysis at home and in-center
16 as well as vascular access options and
17 transplantation);
18 "(ii) to ensure that the individual has the
19 opportunity to actively participate in the choice
20 of therapy; and
21 "(iii) to be tailored to meet the needs of
22 the individual involved.
23 "(2) The term 'qualified person' means a physician,
24 physician assistant, nurse practitioner, or clinical nurse
25 specialist who furnishes services for which payment may

be made under the fee schedule established under section 1848. Such term does not include a renal dialysis facility.

"(3) The Secretary shall set standards for the content of such information to be provided under paragraph (1)(C)(i) after consulting with physicians, other health professionals, health educators, professional organizations, accrediting organizations, kidney patient organizations, dialysis facilities, transplant centers, network organizations described in section 1881(c)(2), and other knowledgeable persons. To the extent possible the Secretary shall consult with a person or entity described in the previous sentence, other than a dialysis facility, that has not received industry funding from a drug or biological manufacturer or dialysis facility.

"(4) In promulgating regulations to carry out this subsection, the Secretary shall ensure that each individual who is eligible for benefits for kidney disease education services under this title receives such services in a timely manner to maximize the benefit of those services.

"(5) The Secretary shall monitor the implementation of this subsection to ensure that individuals who are eligible for benefits for kidney disease education services receive such services in the manner described in paragraph (4).

1 "(6) No individual shall be eligible to be provided
2 more than 6 sessions of kidney disease education services
3 under this title.".

4 (3) PAYMENT UNDER THE PHYSICIAN FEE
5 SCHEDULE.—Section 1848(j)(3) of the Social Secu-
6 rity Act (42 U.S.C. 1395w–4(j)(3)) is amended by
7 inserting "(2)(BB)," after "(2)(AA),".

8 (4) LIMITATION ON NUMBER OF SESSIONS.—
9 Section 1862(a)(1) of the Social Security Act (42
10 U.S.C. 1395y(a)(1)) is amended—

11 (A) in subparagraph (M), by striking
12 "and" at the end;

13 (B) in subparagraph (N), by striking the
14 semicolon at the end and inserting ", and"; and

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

17 "(O) in the case of kidney disease edu-
18 cation services (as defined in section
19 1861(ccc)), which are furnished in excess of the
20 number of sessions covered under such sec-
21 tion;".

22 (5) GAO REPORT.—Not later than September
23 1, 2010, the Comptroller General of the United
24 States shall submit to Congress a report on the fol-
25 lowing:

1 (A) The number of Medicare beneficiaries
2 who are eligible to receive benefits for kidney
3 disease education services (as defined in section
4 1861(ccc) of the Social Security Act, as added
5 by paragraph (2)) under title XVIII of such Act
6 and who receive such services.
7 (B) The extent to which there is a suffi-
8 cient amount of physicians, physician assist-
9 ants, nurse practitioners, and clinical nurse spe-
10 cialists to furnish kidney disease education serv-
11 ices (as so defined) under such title and wheth-
12 er or not renal dialysis facilities (and appro-
13 priate employees of such facilities) should be in-
14 cluded as an entity eligible under such section
15 to furnish such services.
16 (C) Recommendations, if appropriate, for
17 renal dialysis facilities (and appropriate employ-
18 ees of such facilities) to structure kidney dis-
19 ease education services (as so defined) in a
20 manner that is objective and unbiased and that
21 provides a range of options and alternative loca-
22 tions for renal replacement therapy and man-
23 agement of co-morbidities that may delay the
24 need for dialysis.

1 (b) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to services furnished on or after
3 January 1, 2009.

4 **SEC. 633. REQUIRED TRAINING FOR PATIENT CARE DIALY-**
5 **SIS TECHNICIANS.**

6 Section 1881 of the Social Security Act (42 U.S.C.
7 1395rr) is amended by adding the following new sub-
8 section:

9 ''(h)(1) Except as provided in paragraph (2), a pro-
10 vider of services or a renal dialysis facility may not use,
11 for more than 12 months during 2009, or for any period
12 beginning on January 1, 2010, any individual as a patient
13 care dialysis technician unless the individual—

14 ''(A) has completed a training program in the
15 care and treatment of an individual with chronic
16 kidney failure who is undergoing dialysis treatment;
17 and

18 ''(B) has been certified by a nationally recog-
19 nized certification entity for dialysis technicians.

20 ''(2)(A) A provider of services or a renal dialysis facil-
21 ity may permit an individual enrolled in a training pro-
22 gram described in paragraph (1)(A) to serve as a patient
23 care dialysis technician while they are so enrolled.

24 ''(B) The requirements described in subparagraphs
25 (A), (B), and (C) of paragraph (1) do not apply to an

1 individual who has performed dialysis-related services for
2 at least 5 years.
3 ''(3) For purposes of paragraph (1), if, since the most
4 recent completion by an individual of a training program
5 described in paragraph (1)(A), there has been a period
6 of 24 consecutive months during which the individual has
7 not furnished dialysis-related services for monetary com-
8 pensation, such individual shall be required to complete
9 a new training program or become recertified as described
10 in paragraph (1)(B).
11 ''(4) A provider of services or a renal dialysis facility
12 shall provide such regular performance review and regular
13 in-service education as assures that individuals serving as
14 patient care dialysis technicians for the provider or facility
15 are competent to perform dialysis-related services.''.
16 **SEC. 634. MEDPAC REPORT ON TREATMENT MODALITIES**
17 **FOR PATIENTS WITH KIDNEY FAILURE.**
18 (a) EVALUATION.—
19 (1) IN GENERAL.—Not later than March 1,
20 2009, the Medicare Payment Advisory Commission
21 (established under section 1805 of the Social Secu-
22 rity Act) shall submit to the Secretary and Congress
23 a report evaluating the barriers that exist to increas-
24 ing the number of individuals with end-stage renal
25 disease who elect to receive home dialysis services

1 under the Medicare program under title XVIII of
2 the Social Security Act (42 U.S.C. 1395 et seq.).
3 (2) REPORT DETAILS.—The report shall include
4 the following:
5 (A) A review of Medicare home dialysis
6 demonstration projects initiated before the date
7 of the enactment of this Act, and the results of
8 such demonstration projects and recommenda-
9 tions for future Medicare home dialysis dem-
10 onstration projects or Medicare program
11 changes that will test models that can improve
12 Medicare beneficiary access to home dialysis.
13 (B) A comparison of current Medicare
14 home dialysis costs and payments with current
15 in-center and hospital dialysis costs and pay-
16 ments.
17 (C) An analysis of the adequacy of Medi-
18 care reimbursement for patient training for
19 home dialysis (including hemodialysis and peri-
20 toneal dialysis) and recommendations for ensur-
21 ing appropriate payment for such home dialysis
22 training.
23 (D) A catalogue and evaluation of the in-
24 centives and disincentives in the current reim-
25 bursement system that influence whether pa-

1 tients receive home dialysis services or other
2 treatment modalities.
3 (E) An evaluation of patient education
4 services and how such services impact the treat-
5 ment choices made by patients.
6 (F) Recommendations for implementing in-
7 centives to encourage patients to elect to receive
8 home dialysis services or other treatment mo-
9 dalities under the Medicare program
10 (3) SCOPE OF REVIEW.—In preparing the re-
11 port under paragraph (1), the Medicare Payment
12 Advisory Commission shall consider a variety of per-
13 spectives, including the perspectives of physicians,
14 other health care professionals, hospitals, dialysis fa-
15 cilities, health plans, purchasers, and patients.

16 **SEC. 635. ADJUSTMENT FOR ERYTHROPOIETIN STIMU-**
17 **LATING AGENTS (ESAS).**

18 (a) IN GENERAL.—Subsection (b)(13) of section
19 1881 of the Social Security Act (42 U.S.C. 1395rr) is
20 amended—
21 (1) in subparagraph (A)(iii), by striking ''For
22 such drugs'' and inserting ''Subject to subparagraph
23 (C), for such drugs''; and
24 (2) by adding at the end the following new sub-
25 paragraph:

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 fa-
4 cility (as defined in subparagraph (D)) (whether to indi-
5 viduals in the facility or at home), in an amount equal
6 to $8.75 per thousand units (rounded to the nearest 100
7 units) or, if less, 102 percent of the average sales price
8 (as determined under section 1847A) for such drug or bio-
9 logical.

10 "(ii) The payment amounts under this title for
11 darbepoetin alfa furnished during 2008 or 2009 to an in-
12 dividual with end stage renal disease by a large dialysis
13 facility (as defined in clause (iii)) (whether to individuals
14 in the facility or at home), in an amount equal to $2.92
15 per microgram or, if less, 102 percent of the average sales
16 price (as determined under section 1847A) for such drug
17 or biological.

18 "(iii) For purposes of this subparagraph, the term
19 'large dialysis facility' means a provider of services or
20 renal dialysis facility that is owned or managed by a cor-
21 porate entity that, as of July 24, 2007, owns or manages
22 300 or more such providers or facilities, and includes a
23 successor to such a corporate entity".

24 (b) NO IMPACT ON DRUG ADD-ON PAYMENT.—Noth-
25 ing in the amendments made by subsection (a) shall be

1 construed to affect the amount of any payment adjust-
2 ment made under section 1881(b)(12)(B)(ii) of the Social
3 Security Act (42 U.S.C. 1395rr(b)(12)(B)(ii)).

4 **SEC. 636. SITE NEUTRAL COMPOSITE RATE.**

5 Subsection (b)(12)(A) of section 1881 of the Social
6 Security Act (42 U.S.C. 1395rr) is amended by adding
7 at the end the following new sentence: ''Under such sys-
8 tem the payment rate for dialysis services furnished on
9 or after January 1, 2008, by providers of such services
10 for hospital-based facilities shall be the same as the pay-
11 ment rate (computed without regard to this sentence) for
12 such services furnished by renal dialysis facilities that are
13 not hospital-based, except that in applying the geographic
14 index under subparagraph (D) to hospital-based facilities,
15 the labor share shall be based on the labor share otherwise
16 applied for such facilities.''.

17 **SEC. 637. DEVELOPMENT OF ESRD BUNDLING SYSTEM AND**
18 **QUALITY INCENTIVE PAYMENTS.**

19 (a) DEVELOPMENT OF ESRD BUNDLING SYSTEM.—
20 Subsection (b) of section 1881 of the Social Security Act
21 (42 U.S.C. 1395rr) is further amended—

22 (1) in paragraph (12)(A), by striking ''In lieu
23 of payment'' and inserting ''Subject to paragraph
24 (14), in lieu of payment'';

1 (2) in the second sentence of paragraph
2 (12)(F)—
3 (A) by inserting ''or paragraph (14)'' after
4 ''this paragraph''; and
5 (B) by inserting ''or under the system
6 under paragraph (14)'' after ''subparagraph
7 (B)'';
8 (3) in paragraph (12)(H)—
9 (A) by inserting ''or paragraph (14)'' after
10 ''under this paragraph'' the first place it ap-
11 pears; and
12 (B) by inserting before the period at the
13 end the following: ''or, under paragraph (14),
14 the identification of renal dialysis services in-
15 cluded in the bundled payment, the adjustment
16 for outliers, the identification of facilities to
17 which the phase-in may apply, and the deter-
18 mination of payment amounts under subpara-
19 graph (A) under such paragraph, and the appli-
20 cation of paragraph (13)(C)(iii))'';
21 (4) in paragraph (13)—
22 (A) in subparagraph (A), by striking ''The
23 payment amounts'' and inserting ''subject to
24 paragraph (14), the payment amounts''; and
25 (B) in subparagraph (B)—

1 (i) in clause (i), by striking ''(i)'' after
2 ''(B)'' and by inserting '', subject to para-
3 graph (14)'' before the period at the end;
4 and
5 (ii) by striking clause (ii); and
6 (5) by adding at the end the following new
7 paragraph:
8 ''(14)(A) Subject to subparagraph (E), for services
9 furnished on or after January 1, 2010, the Secretary shall
10 implement a payment system under which a single pay-
11 ment is made under this title for renal dialysis services
12 (as defined in subparagraph (B)) in lieu of any other pay-
13 ment (including a payment adjustment under paragraph
14 (12)(B)(ii)) for such services and items furnished pursu-
15 ant to paragraph (4). In implementing the system the Sec-
16 retary shall ensure that the estimated total amount of pay-
17 ments under this title for 2010 for renal dialysis services
18 shall equal 96 percent of the estimated amount of pay-
19 ments for such services, including payments under para-
20 graph (12)(B)(ii), that would have been made if such sys-
21 tem had not been implemented.
22 ''(B) For purposes of this paragraph, the term 'renal
23 dialysis services' includes—

1 "(i) items and services included in the
2 composite rate for renal dialysis services as of
3 December 31, 2009;
4 "(ii) erythropoietin stimulating agents fur-
5 nished to individuals with end stage renal dis-
6 ease;
7 "(iii) other drugs and biologicals and diag-
8 nostic laboratory tests, that the Secretary iden-
9 tifies as commonly used in the treatment of
10 such patients and for which payment was (be-
11 fore the application of this paragraph) made
12 separately under this title, and any oral equiva-
13 lent form of such drugs and biologicals or of
14 drugs and biologicals described in clause (ii);
15 and
16 "(iv) home dialysis training for which pay-
17 ment was (before the application of this para-
18 graph) made separately under this section.
19 Such term does not include vaccines.
20 "(C) The system under this paragraph may provide
21 for payment on the basis of services furnished during a
22 week or month or such other appropriate unit of payment
23 as the Secretary specifies.
24 "(D) Such system—

1 ''(i) shall include a payment adjustment based
2 on case mix that may take into account patient
3 weight, body mass index, comorbidities, length of
4 time on dialysis, age, race, ethnicity, and other ap-
5 propriate factors;
6 ''(ii) shall include a payment adjustment for
7 high cost outliers due to unusual variations in the
8 type or amount of medically necessary care, includ-
9 ing variations in the amount of erythropoietin stimu-
10 lating agents necessary for anemia management; and
11 ''(iii) may include such other payment adjust-
12 ments as the Secretary determines appropriate, such
13 as a payment adjustment—
14 ''(I) by a geographic index, such as the
15 index referred to in paragraph (12)(D), as the
16 Secretary determines to be appropriate;
17 ''(II) for pediatric providers of services and
18 renal dialysis facilities;
19 ''(III) for low volume providers of services
20 and renal dialysis facilities;
21 ''(IV) for providers of services or renal di-
22 alysis facilities located in rural areas; and
23 ''(V) for providers of services or renal di-
24 alysis facilities that are not large dialysis facili-
25 ties.

1 ''(E) The Secretary may provide for a phase-in of the
2 payment system described in subparagraph (A) for serv-
3 ices furnished by a provider of services or renal dialysis
4 facility described in any of subclauses (II) through (V) of
5 subparagraph (D)(iii), but such payment system shall be
6 fully implemented for services furnished in the case of any
7 such provider or facility on or after January 1, 2013.
8 ''(F) The Secretary shall apply the annual increase
9 that would otherwise apply under subparagraph (F) of
10 paragraph (12) to payment amounts established under
11 such paragraph (if this paragraph did not apply) in an
12 appropriate manner under this paragraph.''.
13 (6) PROHIBITION OF UNBUNDLING.—Section
14 1862(a) of such Act (42 U.S.C. 1395y(a)) is amend-
15 ed—
16 (A) by striking ''or'' at the end of para-
17 graph (21);
18 (B) by striking the period at the end of
19 paragraph (22) and inserting ''; or''; and
20 (C) by inserting after paragraph (22) the
21 following new paragraph:
22 ''(23) where such expenses are for renal dialysis
23 services (as defined in subparagraph (B) of section
24 1881(b)(14)) for which payment is made under such
25 section (other than under subparagraph (E) of such

1 section) unless such payment is made under such
2 section to a provider of services or a renal dialysis
3 facility for such services.''.
4 (b) QUALITY INCENTIVE PAYMENTS.—Section 1881
5 of such Act is amended by adding at the end the following
6 new subsection:
7 ''(i) QUALITY INCENTIVE PAYMENTS IN THE END-
8 STAGE RENAL DISEASE PROGRAM.—
9 ''(1) QUALITY INCENTIVE PAYMENTS FOR
10 SERVICES FURNISHED IN 2008, 2009, AND 2010.—
11 ''(A) IN GENERAL.—With respect to renal
12 dialysis services furnished during a performance
13 period (as defined in subparagraph (B)) by a
14 provider of services or renal dialysis facility that
15 the Secretary determines meets the applicable
16 performance standard for the period under sub-
17 paragraph (C) and reports on measures for
18 2009 and 2010 under subparagraph (D) for
19 such services, in addition to the amount other-
20 wise paid under this section, subject to sub-
21 paragraph (G), there also shall be paid to the
22 provider or facility an amount equal to the ap-
23 plicable percentage (specified in subparagraph
24 (E) for the period) of the Secretary's estimate
25 (based on claims submitted not later than two

1 months after the end of the performance pe-
2 riod) of the amount specified in subparagraph
3 (F) for such period.
4 "(B) PERFORMANCE PERIOD.—In this
5 paragraph, the term 'performance period'
6 means each of the following:
7 "(i) The period beginning on July 1,
8 2008, and ending on December 31, 2008.
9 "(ii) 2009.
10 "(iii) 2010.
11 "(C) PERFORMANCE STANDARD.—
12 "(i) 2008.—For the performance pe-
13 riod occurring in 2008, the applicable per-
14 formance standards for a provider or facil-
15 ity under this subparagraph are—
16 "(I) 92 percent or more of indi-
17 viduals with end stage renal disease
18 receiving erythopoetin stimulating
19 agents who have an average hemato-
20 crit of 33.0 percent or more; and
21 "(II) less than a percentage,
22 specified by the Secretary, of individ-
23 uals with end stage renal disease re-
24 ceiving erythopoetin stimulating

1 agents who have an average hemato-
2 crit of 39.0 percent or more.
3 "(ii) 2009 AND 2010.—For the 2009
4 and 2010 performance periods, the appli-
5 cable performance standard for a provider
6 or facility under this subparagraph is suc-
7 cessful performance (relative to national
8 average) on—
9 "(I) such measures of anemia
10 management as the Secretary shall
11 specify, including measures of hemo-
12 globin levels or hematocrit levels for
13 erythropoietin stimulating agents that
14 are consistent with the labeling for
15 dosage of erythropoietin stimulating
16 agents approved by the Food and
17 Drug Administration for treatment of
18 anemia in patients with end stage
19 renal disease, taking into account
20 variations in hemoglobin ranges or
21 hematocrit levels of patients; and
22 "(II) such other measures, relat-
23 ing to subjects described in subpara-
24 graph (D)(i), as the Secretary may
25 specify.

1 "(D) REPORTING PERFORMANCE MEAS-
2 URES.—The performance measures under this
3 subparagraph to be reported shall include—
4 "(i) such measures as the Secretary
5 specifies, before the beginning of the per-
6 formance period involved and taking into
7 account measures endorsed by the Na-
8 tional Quality Forum, including, to the ex-
9 tent feasible measures on—
10 "(I) iron management;
11 "(II) dialysis adequacy; and
12 "(III) vascular access, including
13 for maximizing the placement of arte-
14 rial venous fistula; and
15 "(ii) to the extent feasible, such meas-
16 ure (or measures) of patient satisfaction as
17 the Secretary shall specify.
18 The provider or facility submitting information
19 on such measures shall attest to the complete-
20 ness and accuracy of such information.
21 "(E) APPLICABLE PERCENTAGE.—The ap-
22 plicable percentage specified in this subpara-
23 graph for—
24 "(i) the performance period occurring
25 in 2008, is 1.0 percent;

1 "(ii) the 2009 performance period, is
2 2.0 percent; and
3 "(iii) the 2010 performance period, is
4 3.0 percent.
5 In the case of any performance period which is
6 less than an entire year, the applicable percent-
7 age specified in this subparagraph shall be mul-
8 tiplied by the ratio of the number of months in
9 the year to the number of months in such per-
10 formance period. In the case of 2010, the appli-
11 cable percentage specified in this subparagraph
12 shall be multiplied by the Secretary's estimate
13 of the ratio of the aggregate payment amount
14 described in subparagraph (F)(i) that would
15 apply in 2010 if paragraph (14) did not apply,
16 to the aggregate payment base under subpara-
17 graph (F)(ii) for 2010.
18 "(F) PAYMENT BASE.—The payment base
19 described in this subparagraph for a provider or
20 facility is—
21 "(i) for performance periods before
22 2010, the payment amount determined
23 under paragraph (12) for services fur-
24 nished by the provider or facility during
25 the performance period, including the drug

1 payment adjustment described in subpara-
2 graph (B)(ii) of such paragraph; and
3 ''(ii) for the 2010 performance period
4 is the amount determined under paragraph
5 (14) for services furnished by the provider
6 or facility during the period.
7 ''(G) LIMITATION ON FUNDING.—
8 ''(i) IN GENERAL.—If the Secretary
9 determines that the total payments under
10 this paragraph for a performance period is
11 projected to exceed the dollar amount spec-
12 ified in clause (ii) for such period, the Sec-
13 retary shall reduce, in a pro rata manner,
14 the amount of such payments for each pro-
15 vider or facility for such period to elimi-
16 nate any such projected excess for the pe-
17 riod.
18 ''(ii) DOLLAR AMOUNT.—The dollar
19 amount specified in this clause—
20 ''(I) for the performance period
21 occurring in 2008, is $50,000,000;
22 ''(II) for the 2009 performance
23 period is $100,000,000; and
24 ''(III) for the 2010 performance
25 period is $150,000,000.

1 "(H) FORM OF PAYMENT.—The payment
2 under this paragraph shall be in the form of a
3 single consolidated payment.
4 "(2) QUALITY INCENTIVE PAYMENTS FOR FA-
5 CILITIES AND PROVIDERS FOR 2011.—
6 "(A) INCREASED PAYMENT.—For 2011, in
7 the case of a provider or facility that, for the
8 performance period (as defined in subparagraph
9 (B))—
10 "(i) meets (or exceeds) the perform-
11 ance standard for anemia management
12 specified in paragraph (1)(C)(ii)(I);
13 "(ii) has substantially improved per-
14 formance or exceeds a performance stand-
15 ard (as determined under subparagraph
16 (E)); and
17 "(iii) reports measures specified in
18 paragraph (1)(D),
19 with respect to renal dialysis services furnished
20 by the provider or facility during the quality
21 bonus payment period (as specified in subpara-
22 graph (C)) the payment amount otherwise made
23 to such provider or facility under subsection
24 (b)(14) shall be increased, subject to subpara-
25 graph (F), by the applicable percentage speci-

1 fied in subparagraph (D). Payment amounts
2 under paragraph (1) shall not be counted for
3 purposes of applying the previous sentence.
4 "(B) PERFORMANCE PERIOD.—In this
5 paragraph, the term 'performance period'
6 means a multi-month period specified by the
7 Secretary .
8 "(C) QUALITY BONUS PAYMENT PERIOD.—
9 In this paragraph, the term 'quality bonus pay-
10 ment period' means, with respect to a perform-
11 ance period, a multi-month period beginning on
12 January 1, 2011, specified by the Secretary
13 that begins at least 3 months (but not more
14 than 9 months) after the end of the perform-
15 ance period.
16 "(D) APPLICABLE PERCENTAGE.—The ap-
17 plicable percentage specified in this subpara-
18 graph is a percentage, not to exceed the 4.0
19 percent, specified by the Secretary consistent
20 with subparagraph (F). Such percentage may
21 vary based on the level of performance and im-
22 provement. The applicable percentage specified
23 in this subparagraph shall be multiplied by the
24 ratio applied under the third sentence of para-
25 graph (1)(E) for 2010.

1 "(E) PERFORMANCE STANDARD.—Based
2 on performance of a provider of services or a
3 renal dialysis facility on performance measures
4 described in paragraph (1)(D) for a perform-
5 ance period, the Secretary shall determine a
6 composite score for such period.
7 "(F) LIMITATION ON FUNDING.—If the
8 Secretary determines that the total amount to
9 be paid under this paragraph for a quality
10 bonus payment period is projected to exceed
11 $200,000,000, the Secretary shall reduce, in a
12 uniform manner, the applicable percentage oth-
13 erwise applied under subparagraph (D) for
14 services furnished during the period to elimi-
15 nate any such projected excess.
16 "(3) APPLICATION.—
17 "(A) IMPLEMENTATION.—Notwithstanding
18 any other provision of law, the Secretary may
19 implement by program instruction or otherwise
20 this subsection.
21 "(B) LIMITATIONS ON REVIEW.—
22 "(i) IN GENERAL.—There shall be no
23 administrative or judicial review under sec-
24 tion 1869 or 1878 or otherwise of—

1 "(I) the determination of per-
2 formance measures and standards
3 under this subsection;
4 "(II) the determination of suc-
5 cessful reporting, including a deter-
6 mination of composite scores; and
7 "(III) the determination of the
8 quality incentive payments made
9 under this subsection.
10 "(ii) TREATMENT OF DETERMINA-
11 TIONS.—A determination under this sub-
12 paragraph shall not be treated as a deter-
13 mination for purposes of section 1869.
14 "(4) TECHNICAL ASSISTANCE.—The Secretary
15 shall identify or establish an appropriately skilled
16 group or organization, such as the ESRD Networks,
17 to provide technical assistance to consistently low-
18 performing facilities or providers that are in the bot-
19 tom quintile.
20 "(5) PUBLIC REPORTING.—
21 "(A) ANNUAL NOTICE.—The Secretary
22 shall provide an annual written notification to
23 each individual who is receiving renal dialysis
24 services from a provider of services or renal di-
25 alysis facility that—

1 "(i) informs such individual of the
2 composite scores described in subpara-
3 graph (A) and other relevant quality meas-
4 ures with respect to providers of services
5 or renal dialysis facilities in the local area;
6 "(ii) compares such scores and meas-
7 ures to the average local and national
8 scores and measures; and
9 "(iii) provides information on how to
10 access additional information on quality of
11 such services furnished and options for al-
12 ternative providers and facilities.
13 "(B) CERTIFICATES.—The Secretary shall
14 provide certificates to facilities and providers
15 who provide services to individuals with end-
16 stage renal disease under this title to display in
17 patient areas. The certificate shall indicate the
18 composite score obtained by the facility or pro-
19 vider under the quality initiative.
20 "(C) WEB-BASED QUALITY LIST.—The
21 Secretary shall establish a web-based list of fa-
22 cilities and providers who furnish renal dialysis
23 services under this section that indicates their
24 composite score of each provider and facility.

1 "(6) RECOMMENDATIONS FOR REPORTING AND
2 QUALITY INCENTIVE INTITIATIVE FOR PHYSI-
3 CIANS.—The Secretary shall develop recommenda-
4 tions for applying quality incentive payments under
5 this subsection to physicians who receive the month-
6 ly capitated payment under this title. Such rec-
7 ommendations shall include the following:
8 "(A) Recommendations to include pediatric
9 specific measures for physicians with at least
10 50 percent of their patients with end stage
11 renal disease being individuals under 18 years
12 of age.
13 "(B) Recommendations on how to struc-
14 ture quality incentive payments for physicians
15 who demonstrate improvements in quality or
16 who attain quality standards, as specified by
17 the Secretary.
18 "(7) REPORTS.—
19 "(A) INITIAL REPORT.—Not later than
20 January 1, 2013, the Secretary shall submit to
21 Congress a report on the implementation of the
22 bundled payment system under subsection
23 (b)(14) and the quality initiative under this
24 subsection. Such report shall include the fol-
25 lowing information:

1 "(i) A comparison of the aggregate
2 payments under subsection (b)(14) for
3 items and services to the cost of such items
4 and services.
5 "(ii) The changes in utilization rates
6 for erythropoietin stimulating agents.
7 "(iii) The mode of administering such
8 agents, including information on the pro-
9 portion of such individuals receiving such
10 agents intravenously as compared to
11 subcutaneously.
12 "(iv) The frequency of dialysis.
13 "(v) Other differences in practice pat-
14 terns, such as the adoption of new tech-
15 nology, different modes of practice, and
16 variations in use of drugs other than drugs
17 described in clause (iii).
18 "(vi) The performance of facilities and
19 providers under paragraph (2).
20 "(vii) Other recommendations for leg-
21 islative and administrative actions deter-
22 mined appropriate by the Secretary.
23 "(B) SUBSEQUENT REPORT.—Not later
24 than January 1, 2015, the Secretary shall sub-
25 mit to Congress a report that contains the in-

1 formation described in each of clauses (ii)
2 through (vii) of subparagraph (A) and a com-
3 parison of the results of the payment system
4 under subsection (b)(14) for renal dialysis serv-
5 ices furnished during the 2-year period begin-
6 ning on January 1, 2013, and the results of
7 such payment system for such services fur-
8 nished during the previous two-year period.''.

9 **SEC. 638. MEDPAC REPORT ON ESRD BUNDLING SYSTEM.**

10 Not later than March 1, 2012, the Medicare Payment
11 Advisory Commission (established under section 1805 of
12 the Social Security Act) shall submit to Congress a report
13 on the implementation of the payment system under sec-
14 tion 1881(b)(14) of the Social Security Act (as added by
15 section 7) for renal dialysis services and related services
16 (defined in subparagraph (B) of such section). Such report
17 shall include, with respect to such payment system for
18 such services, an analysis of each of the following:

19 (1) An analysis of the overall adequacy of pay-
20 ment under such system for all such services.

21 (2) An analysis that compares the adequacy of
22 payment under such system for services furnished
23 by—

1 (A) a provider of services or renal dialysis
2 facility that is described in section
3 1881(b)(13)(C)(iv) of the Social Security Act;
4 (B) a provider of services or renal dialysis
5 facility not described in such section;
6 (C) a hospital-based facility;
7 (D) a freestanding renal dialysis facility;
8 (E) a renal dialysis facility located in an
9 urban area; and
10 (F) a renal dialysis facility located in a
11 rural area.
12 (3) An analysis of the financial status of pro-
13 viders of such services and renal dialysis facilities,
14 including access to capital, return on equity, and re-
15 turn on capital.
16 (4) An analysis of the adequacy of payment
17 under such method and the adequacy of the quality
18 improvement payments under section 1881(i) of the
19 Social Security Act in ensuring that payments for
20 such services under the Medicare program are con-
21 sistent with costs for such services.
22 (5) Recommendations, if appropriate, for modi-
23 fications to such payment system.

1 **SEC. 639. OIG STUDY AND REPORT ON ERYTHROPOIETIN.**

2 (a) STUDY.—The Inspector General of the Depart-
3 ment of Health and Human Services shall conduct a study
4 on the following:

5 (1) The dosing guidelines, standards, protocols,
6 and alogorithms for erythropoietin stimulating
7 agents recommended or used by providers of services
8 and renal dialysis facilities that are described in sec-
9 tion 1881(b)(13)(C)(iv) of the Social Security Act
10 and providers and facilities that are not described in
11 such section.

12 (2) The extent to which such guidelines, stand-
13 ards, protocols, and algorithms are consistent with
14 the labeling of the Food and Drug Administration
15 for such agents.

16 (3) The extent to which physicians sign stand-
17 ing orders for such agents that are consistent with
18 such guidelines, standards, protocols, and algorithms
19 recommended or used by the provider or facility in-
20 volved.

21 (4) The extent to which the prescribing deci-
22 sions of physicians, with respect to such agents, are
23 independent of—

24 (A) such relevant guidelines, standards,
25 protocols, and algorithms; or

(B) recommendations of an anemia management nurse or other appropriate employee of the provider or facility involved.

(5) The role of medical directors of providers of services and renal dialysis facilities and the financial relationships between such providers and facilities and the physicians hired as medical directors of such providers and facilities, respectively.

(b) REPORT.—Not later than January 1, 2009, the Inspector General of the Department of Health and Human Services shall submit to Congress a report on the study conducted under subsection (a), together with such recommendations as the Inspector General determines appropriate.

Subtitle D—Miscellaneous

SEC. 651. LIMITATION ON EXCEPTION TO THE PROHIBITION ON CERTAIN PHYSICIAN REFERRALS FOR HOSPITALS.

(a) IN GENERAL.—Section 1877 of the Social Security Act (42 U.S.C. 1395) is amended—

(1) in subsection (d)(2)—

(A) in subparagraph (A), by striking ''and'' at the end;

(B) in subparagraph (B), by striking the period at the end and inserting ''; and''; and

1 (C) by adding at the end the following new
2 subparagraph:
3 ''(C) if the entity is a hospital, the hospital
4 meets the requirements of paragraph (3)(D).'';
5 (2) in subsection (d)(3)—
6 (A) in subparagraph (B), by striking
7 ''and'' at the end;
8 (B) in subparagraph (C), by striking the
9 period at the end and inserting ''; and''; and
10 (C) by adding at the end the following new
11 subparagraph:
12 ''(D) the hospital meets the requirements
13 described in subsection (i)(1) not later than 18
14 months after the date of the enactment of this
15 subparagraph.''; and
16 (3) by adding at the end the following new sub-
17 section:
18 ''(i) REQUIREMENTS FOR HOSPITALS TO QUALIFY
19 FOR HOSPITAL EXCEPTION TO OWNERSHIP OR INVEST-
20 MENT PROHIBITION.—
21 ''(1) REQUIREMENTS DESCRIBED.—For pur-
22 poses of paragraphs subsection (d)(3)(D), the re-
23 quirements described in this paragraph for a hos-
24 pital are as follows:

1 "(A) PROVIDER AGREEMENT.—The hos-
2 pital had a provider agreement under section
3 1866 in effect on July 24, 2007.
4 "(B) PROHIBITION OF EXPANSION OF FA-
5 CILITY CAPACITY.—The number of operating
6 rooms and beds of the hospital at any time on
7 or after the date of the enactment of this sub-
8 section are no greater than the number of oper-
9 ating rooms and beds as of such date.
10 "(C) PREVENTING CONFLICTS OF INTER-
11 EST.—
12 "(i) The hospital submits to the Sec-
13 retary an annual report containing a de-
14 tailed description of—
15 "(I) the identity of each physi-
16 cian owner and any other owners of
17 the hospital; and
18 "(II) the nature and extent of all
19 ownership interests in the hospital.
20 "(ii) The hospital has procedures in
21 place to require that any referring physi-
22 cian owner discloses to the patient being
23 referred, by a time that permits the pa-
24 tient to make a meaningful decision re-

1 garding the receipt of care ,as determined
2 by the Secretary—
3 "(I) the ownership interest of
4 such referring physician in the hos-
5 pital; and
6 "(II) if applicable, any such own-
7 ership interest of the treating physi-
8 cian.
9 "(iii) The hospital does not condition
10 any physician ownership interests either di-
11 rectly or indirectly on the physician owner
12 making or influencing referrals to the hos-
13 pital or otherwise generating business for
14 the hospital.
15 "(D) ENSURING BONA FIDE INVEST-
16 MENT.—
17 "(i) Physician owners in the aggregate
18 do not own more than 40 percent of the
19 total value of the investment interests held
20 in the hospital or in an entity whose assets
21 include the hospital.
22 "(ii) The investment interest of any
23 individual physician owner does not exceed
24 2 percent of the total value of the invest-

1 ment interests held in the hospital or in an
2 entity whose assets include the hospital.
3 ''(iii) Any ownership or investment in-
4 terests that the hospital offers to a physi-
5 cian owner are not offered on more favor-
6 able terms than the terms offered to a per-
7 son who is not a physician owner.
8 ''(iv) The hospital does not directly or
9 indirectly provide loans or financing for
10 any physician owner investments in the
11 hospital.
12 ''(v) The hospital does not directly or
13 indirectly guarantee a loan, make a pay-
14 ment toward a loan, or otherwise subsidize
15 a loan, for any individual physician owner
16 or group of physician owners that is re-
17 lated to acquiring any ownership interest
18 in the hospital.
19 ''(vi) Investment returns are distrib-
20 uted to investors in the hospital in an
21 amount that is directly proportional to the
22 investment of capital by the physician
23 owner in the hospital.
24 ''(vii) Physician owners do not receive,
25 directly or indirectly, any guaranteed re-

1 ceipt of or right to purchase other business
2 interests related to the hospital, including
3 the purchase or lease of any property
4 under the control of other investors in the
5 hospital or located near the premises of the
6 hospital.
7 ''(viii) The hospital does not offer a
8 physician owner the opportunity to pur-
9 chase or lease any property under the con-
10 trol of the hospital or any other investor in
11 the hospital on more favorable terms than
12 the terms offered to an individual who is
13 not a physician owner.
14 ''(E) PATIENT SAFETY.—
15 ''(i) Insofar as the hospital admits a
16 patient and does not have any physician
17 available on the premises to provide serv-
18 ices during all hours in which the hospital
19 is providing services to such patient, before
20 admitting the patient—
21 ''(I) the hospital discloses such
22 fact to a patient; and
23 ''(II) following such disclosure,
24 the hospital receives from the patient

1 a signed acknowledgment that the pa-
2 tient understands such fact.
3 ''(ii) The hospital has the capacity
4 to—
5 ''(I) provide assessment and ini-
6 tial treatment for patients; and
7 ''(II) refer and transfer patients
8 to hospitals with the capability to
9 treat the needs of the patient in-
10 volved.
11 ''(2) PUBLICATION OF INFORMATION RE-
12 PORTED.—The Secretary shall publish, and update
13 on an annual basis, the information submitted by
14 hospitals under paragraph (1)(A)(i) on the public
15 Internet website of the Centers for Medicare & Med-
16 icaid Services.
17 ''(3) COLLECTION OF OWNERSHIP AND INVEST-
18 MENT INFORMATION.—For purposes of clauses (i)
19 and (ii) of paragraph (1)(D), the Secretary shall col-
20 lect physician ownership and investment information
21 for each hospital as it existed on the date of the en-
22 actment of this subsection.
23 ''(4) PHYSICIAN OWNER DEFINED.—For pur-
24 poses of this subsection, the term 'physician owner'
25 means a physician (or an immediate family member

of such physician) with a direct or an indirect ownership interest in the hospital.''.

(b) ENFORCEMENT.—

(1) ENSURING COMPLIANCE.—The Secretary of Health and Human Services shall establish policies and procedures to ensure compliance with the requirements described in such section 1877(i)(1) of the Social Security Act, as added by subsection (a)(3), beginning on the date such requirements first apply. Such policies and procedures may include unannounced site reviews of hospitals.

(2) AUDITS.—Beginning not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall conduct audits to determine if hospitals violate the requirements referred to in paragraph (1).

TITLE O—PROVISIONS RELATING TO MEDICARE PARTS A AND B

SEC. 701. HOME HEALTH PAYMENT UPDATE FOR 2008.

Section 1895(b)(3)(B)(ii) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)(ii)) is amended—

(1) in subclause (IV) at the end, by striking ''and'';

(2) by redesignating subclause (V) as subclause (VII); and

(3) by inserting after subclause (IV) the following new subclauses:

"(V) 2007, subject to clause (v), the home health market basket percentage increase;

"(VI) 2008, subject to clause (v), 0 percent; and".

SEC. 702. 2-YEAR EXTENSION OF TEMPORARY MEDICARE PAYMENT INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

Section 421 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2283; 42 U.S.C. 1395fff note), as amended by section 5201(b) of the Deficit Reduction Act of 2005, is amended—

(1) in the heading, by striking "**ONE-YEAR**" and inserting "**TEMPORARY**"; and

(2) in subsection (a), by striking "and episodes and visits beginning on or after January 1, 2006, and before January 1, 2007" and inserting "episodes and visits beginning on or after January 1, 2006, and before January 1, 2007, and episodes and

1 visits beginning on or after January 1, 2008, and
2 before January 1, 2010''.

3 **SEC. 703. EXTENSION OF MEDICARE SECONDARY PAYER**
4 **FOR BENEFICIARIES WITH END STAGE**
5 **RENAL DISEASE FOR LARGE GROUP PLANS.**

6 (a) IN GENERAL.—Section 1862(b)(1)(C) of the So-
7 cial Security Act (42 U.S.C. 1395y(b)(1)(C)) is amend-
8 ed—

9 (1) by redesignating clauses (i) and (ii) as sub-
10 clauses (I) and (II), respectively, and indenting ac-
11 cordingly;

12 (2) by amending the text preceding subclause
13 (I), as so redesignated, to read as follows:

14 ''(C) INDIVIDUALS WITH END STAGE
15 RENAL DISEASE.—

16 ''(i) IN GENERAL.—A group health
17 plan (as defined in subparagraph (A)(v))—
18 '';

19 (3) in the matter following subclause (II), as so
20 redesignated—

21 (A) by striking ''clause (i)'' and inserting
22 ''subclause (I)'';

23 (B) by striking ''clause (ii)'' and inserting
24 ''subclause (II)''; and

1 (C) by striking ''clauses (i) and (ii)'' and
2 inserting ''subclauses (I) and (II)''; and
3 (D) in the last sentence, by striking ''Ef-
4 fective for items'' and inserting ''Subject to
5 clause (ii), effective for items''; and
6 (4) by adding at the end the following new
7 clause:
8 ''(ii) SPECIAL RULE FOR LARGE
9 GROUP PLANS.—In applying clause (i) to
10 a large group health plan (as defined in
11 subparagraph (B)(iii)). effective for items
12 and services furnished on or after January
13 1, 2008, (with respect to periods beginning
14 on or after the date that is 30 months
15 prior to January 1, 2008), subclauses (I)
16 and (II) of such clause shall be applied by
17 substituting '42-month' for '12-month'
18 each place it appears.''.

19 **SEC. 704. PLAN FOR MEDICARE PAYMENT ADJUSTMENTS**
20 **FOR NEVER EVENTS.**

21 (a) IN GENERAL.—The Secretary of Health and
22 Human Services (in this section referred to as the ''Sec-
23 retary'') shall develop a plan (in this section referred to
24 as the ''never events plan'') to implement, beginning in
25 fiscal year 2010, a policy to reduce or eliminate payments

1 under title XVIII of the Social Security Act for never
2 events.
3 (b) NEVER EVENT DEFINED.—For purposes of this
4 section, the term ''never event'' means an event involving
5 the delivery of (or failure to deliver) physicians' services,
6 inpatient or outpatient hospital services, or facility serv-
7 ices furnished in an ambulatory surgical facility in which
8 there is an error in medical care that is clearly identifiable,
9 usually preventable, and serious in consequences to pa-
10 tients, and that indicates a deficiency in the safety and
11 process controls of the services furnished with respect to
12 the physician, hospital, or ambulatory surgical center in-
13 volved.
14 (c) PLAN DETAILS.—
15 (1) DEFINING NEVER EVENTS.—With respect
16 to criteria for identifying never events under the
17 never events plan, the Secretary should consider
18 whether the event meets the following characteris-
19 tics:
20 (A) CLEARLY IDENTIFIABLE.—The event
21 is clearly identifiable and measurable and fea-
22 sible to include in a reporting system for never
23 events.
24 (B) USUALLY PREVENTABLE.—The event
25 is usually preventable taking into consideration

1 that, because of the complexity of medical care,
2 certain medical events are not always avoidable.
3 (C) SERIOUS.—The event is serious and
4 could result in death or loss of a body part, dis-
5 ability, or more than transient loss of a body
6 function.
7 (D) DEFICIENCY IN SAFETY AND PROCESS
8 CONTROLS.—The event is indicative of a prob-
9 lem in safety systems and process controls used
10 by the physician, hospital, or ambulatory sur-
11 gical center involved and is indicative of the re-
12 liability of the quality of services provided by
13 the physician, hospital, or ambulatory surgical
14 center, respectively.
15 (2) IDENTIFICATION AND PAYMENT ISSUES.—
16 With respect to policies under the never events plan
17 for identifying and reducing (or eliminating) pay-
18 ment for never events, the Secretary shall consider—
19 (A) mechanisms used by hospitals and
20 physicians in reporting and coding of services
21 that would reliably identify never events; and
22 (B) modifications in billing and payment
23 mechanisms that would enable the Secretary to
24 efficiently and accurately reduce or eliminate
25 payments for never events.

1 (3) PRIORITIES.—Under the never events plan
2 the Secretary shall identify priorities regarding the
3 services to focus on and, among those, the never
4 events for which payments should be reduced or
5 eliminated.
6 (4) CONSULTATION.—In developing the never
7 events plan, the Secretary shall consult with affected
8 parties that are relevant to payment reductions in
9 response to never events.
10 (d) CONGRESSIONAL REPORT.—By not later than
11 June 1, 2008, the Secretary shall submit a report to Con-
12 gress on the never events plan developed under this sub-
13 section and shall include in the report recommendations
14 on specific methods for implementation of the plan on a
15 timely basis.
16 **SEC. 705. REINSTATEMENT OF RESIDENCY SLOTS.**
17 (a) IN GENERAL.—Section 1886(h) of the Social Se-
18 curity Act (42 U.S.C. 1395ww(h)) is amended—
19 (1) in paragraph (4)(H), by adding at the end
20 the following new clause
21 ''(v) INCREASE IN RESIDENT LIMIT
22 DUE TO CLOSURE OF OTHER HOSPITALS.—
23 If one or more hospitals with approved
24 medical residency training programs, which
25 are located within the same metropolitan

1 division of the core based statistical area
2 as of January 1, 2000, closed, the Sec-
3 retary shall increase by not more than 10
4 (subject to the limitation set forth in the
5 last sentence of this clause) the otherwise
6 applicable resident limit under subpara-
7 graph (F) for each hospital within the
8 same metropolitan division of the core
9 based statistical area that meets all the fol-
10 lowing 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 pro-
19 vider number and a resident limit as
20 of January 1, 2000, and remained
21 open as of October 1, 2007.
22 ''(IV) The hospital did not re-
23 ceive an increase in its resident limit
24 under paragraph (7)(B).

In no event may the resident limit for any hospital be increased above 50 through application of this clause.''; and

(2) in paragraph (7)—

(A) by redesignating subparagraph (D) as subparagraph (E); and

(B) by inserting after subparagraph (C) the following new subparagraph:

''(D) ADJUSTMENT BASED ON SETTLED COST REPORT.—In the case of a hospital with a dual accredited osteopathic and allopathic family practice program for which—

''(i) the otherwise applicable resident limit was reduced under subparagraph (A)(i)(I); and

''(ii) such reduction was based on a reference resident level that was determined using a cost report and where a revised or corrected notice of program reimbursement was issued between September 1, 2006 and September 15, 2006, whether as a result of an appeal or otherwise, and the reference resident level under such settled cost report is higher than the level

used for the reduction under subparagraph (A)(i)(I);

the Secretary shall apply subparagraph (A)(i)(I) using the higher resident reference level and make any necessary adjustments to such reduction. Any such necessary adjustments shall be effective for portions of cost reporting periods occurring on or after July 1, 2005.''.

(b) EFFECTIVE DATES.—The amendment made by paragraph (1) shall be effective for cost reporting periods beginning on or after October 1, 2007, and the amendments made by paragraph (2) shall take effect as if included in the enactment of section 422 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173).

TITLE P—MEDICAID

Subtitle A—Protecting Existing Coverage

SEC. 801. MODERNIZING TRANSITIONAL MEDICAID.

(a) TWO-YEAR EXTENSION.—

(1) IN GENERAL.—Sections 1902(e)(1)(B) and 1925(f) of the Social Security Act (42 U.S.C. 1396a(e)(1)(B), 1396r–6(f)) are each amended by striking ''September 30, 2003'' and inserting ''September 30, 2009''.

1 (2) EFFECTIVE DATE.—The amendments made
2 by this subsection shall take effect on October 1,
3 2007.
4 (b) STATE OPTION OF INITIAL 12-MONTH ELIGI-
5 BILITY.—Section 1925 of the Social Security Act (42
6 U.S.C. 1396r–6) is amended—
7 (1) in subsection (a)(1), by inserting ''but sub-
8 ject to paragraph (5)'' after ''Notwithstanding any
9 other provision of this title'';
10 (2) by adding at the end of subsection (a) the
11 following:
12 ''(5) OPTION OF 12-MONTH INITIAL ELIGIBILITY
13 PERIOD.—A State may elect to treat any reference
14 in this subsection to a 6-month period (or 6 months)
15 as a reference to a 12-month period (or 12 months).
16 In the case of such an election, subsection (b) shall
17 not apply.''; and
18 (3) in subsection (b)(1), by inserting ''but sub-
19 ject to subsection (a)(5)'' after ''Notwithstanding
20 any other provision of this title''.
21 (c) REMOVAL OF REQUIREMENT FOR PREVIOUS RE-
22 CEIPT OF MEDICAL ASSISTANCE.—Section 1925(a)(1) of
23 such Act (42 U.S.C. 1396r–6(a)(1)), as amended by sub-
24 section (b)(1), is further amended—

1 (1) by inserting ''subparagraph (B) and'' before
2 ''paragraph (5)'';
3 (2) by redesignating the matter after ''Re-
4 quirement.—'' as a subparagraph (A) with the
5 heading ''In general.—'' and with the same inden-
6 tation as subparagraph (B) (as added by paragraph
7 (3)); and
8 (3) by adding at the end the following:
9 ''(B) State option to waive require-
10 ment for 3 months before receipt of
11 medical assistance.—A State may, at its op-
12 tion, elect also to apply subparagraph (A) in
13 the case of a family that was receiving such aid
14 for fewer than three months or that had applied
15 for and was eligible for such aid for fewer than
16 3 months during the 6 immediately preceding
17 months described in such subparagraph.''.
18 (d) CMS Report on Enrollment and Participa-
19 tion Rates Under TMA.—Section 1925 of such Act (42
20 U.S.C. 1396r-6), as amended by this section, is further
21 amended by adding at the end the following new sub-
22 section:
23 ''(g) Collection and Reporting of Participa-
24 tion Information.—

1 "(1) COLLECTION OF INFORMATION FROM
2 STATES.—Each State shall collect and submit to the
3 Secretary (and make publicly available), in a format
4 specified by the Secretary, information on average
5 monthly enrollment and average monthly participa-
6 tion rates for adults and children under this section
7 and of the number and percentage of children who
8 become ineligible for medical assistance under this
9 section whose medical assistance is continued under
10 another eligibility category or who are enrolled under
11 the State's child health plan under title XXI. Such
12 information shall be submitted at the same time and
13 frequency in which other enrollment information
14 under this title is submitted to the Secretary.
15 "(2) ANNUAL REPORTS TO CONGRESS.—Using
16 the information submitted under paragraph (1), the
17 Secretary shall submit to Congress annual reports
18 concerning enrollment and participation rates de-
19 scribed in such paragraph.".
20 (e) EFFECTIVE DATE.—The amendments made by
21 subsections (b) through (d) shall take effect on the date
22 of the enactment of this Act.
23 **SEC. 802. FAMILY PLANNING SERVICES.**
24 (a) COVERAGE AS OPTIONAL CATEGORICALLY
25 NEEDY GROUP.—

1 (1) IN GENERAL.—Section 1902(a)(10)(A)(ii)
2 of the Social Security Act (42 U.S.C.
3 1396a(a)(10)(A)(ii)) is amended—
4 (A) in subclause (XVIII), by striking ''or''
5 at the end;
6 (B) in subclause (XIX), by adding ''or'' at
7 the end; and
8 (C) by adding at the end the following new
9 subclause:
10 ''(XX) who are described in subsection (ee) (re-
11 lating to individuals who meet certain income stand-
12 ards);''.
13 (2) GROUP DESCRIBED.—Section 1902 of the
14 Social Security Act (42 U.S.C. 1396a), as amended
15 by section 112(c), is amended by adding at the end
16 the following new subsection:
17 ''(ee)(1) Individuals described in this subsection are
18 individuals
19 ''(A) whose income does not exceed an in-
20 come eligibility level established by the State
21 that does not exceed the highest income eligi-
22 bility level established under the State plan
23 under this title (or under its State child health
24 plan under title XXI) for pregnant women; and
25 ''(B) who are not pregnant.

1 ''(2) At the option of a State, individuals de-
2 scribed in this subsection may include individuals
3 who are determined to meet the eligibility require-
4 ments referred to in paragraph (1) under the terms,
5 conditions, and procedures applicable to making eli-
6 gibility determinations for medical assistance under
7 this title under a waiver to provide the benefits de-
8 scribed in clause (XV) of the matter following sub-
9 paragraph (G) of section 1902(a)(10) granted to the
10 State under section 1115 as of January 1, 2007.''.
11 (3) LIMITATION ON BENEFITS.—Section
12 1902(a)(10) of the Social Security Act (42 U.S.C.
13 1396a(a)(10)) is amended in the matter following
14 subparagraph (G)—
15 (A) by striking ''and (XIV)'' and inserting
16 ''(XIV)''; and
17 (B) by inserting '', and (XV) the medical
18 assistance made available to an individual de-
19 scribed in subsection (ee) shall be limited to
20 family planning services and supplies described
21 in section 1905(a)(4)(C) including medical di-
22 agnosis or treatment services that are provided
23 pursuant to a family planning service in a fam-
24 ily planning setting provided during the period

in which such an individual is eligible;'' after ''cervical cancer''.

(4) CONFORMING AMENDMENTS.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

(A) in clause (xii), by striking ''or'' at the end;

(B) in clause (xii), by adding ''or'' at the end; and

(C) by inserting after clause (xiii) the following:

''(xiv) individuals described in section 1902(ee),''.

(b) PRESUMPTIVE ELIGIBILITY.—

(1) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1920B the following:

''PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING SERVICES

''SEC. 1920C. (a) STATE OPTION.— State plan approved under section 1902 may provide for making medical assistance available to an individual described in section 1902(ee) (relating to individuals who meet certain income eligibility standard) during a presumptive eligibility period. In the case of an individual described in section

1 1902(ee), such medical assistance shall be limited to fam-
2 ily planning services and supplies described in
3 1905(a)(4)(C) and, at the State's option, medical diag-
4 nosis or treatment services that are provided in conjunc-
5 tion with a family planning service in a family planning
6 setting provided during the period in which such an indi-
7 vidual is eligible.

8 "(b) DEFINITIONS.—For purposes of this section:

9 "(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The
10 term 'presumptive eligibility period' means, with re-
11 spect to an individual described in subsection (a),
12 the period that—

13 "(A) begins with the date on which a
14 qualified entity determines, on the basis of pre-
15 liminary information, that the individual is de-
16 scribed in section 1902(ee); and

17 "(B) ends with (and includes) the earlier
18 of—

19 "(i) the day on which a determination
20 is made with respect to the eligibility of
21 such individual for services under the State
22 plan; or

23 "(ii) in the case of such an individual
24 who does not file an application by the last
25 day of the month following the month dur-

1 ing which the entity makes the determina-
2 tion referred to in subparagraph (A), such
3 last day.
4 ''(2) QUALIFIED ENTITY.—
5 ''(A) IN GENERAL.—Subject to subpara-
6 graph (B), the term 'qualified entity' means
7 any entity that—
8 ''(i) is eligible for payments under a
9 State plan approved under this title; and
10 ''(ii) is determined by the State agen-
11 cy to be capable of making determinations
12 of the type described in paragraph (1)(A).
13 ''(B) RULE OF CONSTRUCTION.—Nothing
14 in this paragraph shall be construed as pre-
15 venting a State from limiting the classes of en-
16 tities that may become qualified entities in
17 order to prevent fraud and abuse.
18 ''(c) ADMINISTRATION.—
19 ''(1) IN GENERAL.—The State agency shall pro-
20 vide qualified entities with—
21 ''(A) such forms as are necessary for an
22 application to be made by an individual de-
23 scribed in subsection (a) for medical assistance
24 under the State plan; and

1 "(B) information on how to assist such in-
2 dividuals in completing and filing such forms.
3 "(2) NOTIFICATION REQUIREMENTS.—A quali-
4 fied entity that determines under subsection
5 (b)(1)(A) that an individual described in subsection
6 (a) is presumptively eligible for medical assistance
7 under a State plan shall—
8 "(A) notify the State agency of the deter-
9 mination within 5 working days after the date
10 on which determination is made; and
11 "(B) inform such individual at the time
12 the determination is made that an application
13 for medical assistance is required to be made by
14 not later than the last day of the month fol-
15 lowing the month during which the determina-
16 tion is made.
17 "(3) APPLICATION FOR MEDICAL ASSIST-
18 ANCE.—In the case of an individual described in
19 subsection (a) who is determined by a qualified enti-
20 ty to be presumptively eligible for medical assistance
21 under a State plan, the individual shall apply for
22 medical assistance by not later than the last day of
23 the month following the month during which the de-
24 termination is made.

1 "(d) PAYMENT.—Notwithstanding any other provi-
2 sion of this title, medical assistance that—
3 "(1) is furnished to an individual described in
4 subsection (a)—
5 "(A) during a presumptive eligibility pe-
6 riod;
7 "(B) by a entity that is eligible for pay-
8 ments under the State plan; and
9 "(2) is included in the care and services covered
10 by the State plan, shall be treated as medical assist-
11 ance provided by such plan for purposes of clause
12 (4) of the first sentence of section 1905(b).".
13 (2) CONFORMING AMENDMENTS.—
14 (A) Section 1902(a)(47) of the Social Se-
15 curity Act (42 U.S.C. 1396a(a)(47)) is amend-
16 ed by inserting before the semicolon at the end
17 the following: "and provide for making medical
18 assistance available to individuals described in
19 subsection (a) of section 1920C during a pre-
20 sumptive eligibility period in accordance with
21 such section.".
22 (B) Section 1903(u)(1)(D)(v) of such Act
23 (42 U.S.C. 1396b(u)(1)(D)(v)) is amended—
24 (i) by striking "or for" and inserting
25 ", for"; and

(ii) by inserting before the period the following: ", or for medical assistance provided to an individual described in subsection (a) of section 1920C during a presumptive eligibility period under such section".

(e) CLARIFICATION OF COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Section 1937(b) of the Social Security Act (42 U.S.C. 1396u-7(b)) is amended by adding at the end the following:

"(5) COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark-equivalent coverage under this section unless such coverage includes for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.".

(f) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2007.

1 **SEC. 803. AUTHORITY TO CONTINUE PROVIDING ADULT**
2 **DAY HEALTH SERVICES APPROVED UNDER A**
3 **STATE MEDICAID PLAN.**

4 (a) IN GENERAL.—During the period described in
5 subsection (b), the Secretary of Health and Human Serv-
6 ices shall not—

7 (1) withhold, suspend, disallow, or otherwise
8 deny Federal financial participation under section
9 1903(a) of the Social Security Act (42 U.S.C.
10 1396b(a)) for the provision of adult day health care
11 services, day activity and health services, or adult
12 medical day care services, as defined under a State
13 Medicaid plan approved during or before 1994, dur-
14 ing such period if such services are provided con-
15 sistent with such definition and the requirements of
16 such plan; or

17 (2) withdraw Federal approval of any such
18 State plan or part thereof regarding the provision of
19 such services (by regulation or otherwise).

20 (b) PERIOD DESCRIBED.—The period described in
21 this subsection is the period that begins on November 3,
22 2005, and ends on March 1, 2009.

SEC. 804. STATE OPTION TO PROTECT COMMUNITY SPOUSES OF INDIVIDUALS WITH DISABILITIES.

Section 1924(h)(1)(A) of the Social Security Act (42 U.S.C. 1396r-5(h)(1)(A)) is amended by striking ''is described in section 1902(a)(10)(A)(ii)(VI)'' and inserting ''is being provided medical assistance for home and community-based services under subsection (c), (d), (e), (i), or (j) of section 1915 or pursuant to section 1115''.

SEC. 805. COUNTY MEDICAID HEALTH INSURING ORGANIZATIONS .

(a) IN GENERAL.—Section 9517(c)(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1396b note), as added by section 4734 of the Omnibus Budget Reconciliation Act of 1990 and as amended by section 704 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, is amended—

(1) in subparagraph (A), by inserting '', in the case of any health insuring organization described in such subparagraph that is operated by a public entity established by Ventura County, and in the case of any health insuring organization described in such subparagraph that is operated by a public entity established by Merced County'' after ''described in subparagraph (B)''; and

(2) in subparagraph (C), by striking ''14 percent'' and inserting ''16 percent''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

Subtitle B—Payments

SEC. 811. PAYMENTS FOR PUERTO RICO AND TERRITORIES.

(a) PAYMENT CEILING.—Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended—

(1) in paragraph (2), by striking ''paragraph (3)'' and inserting ''paragraphs (3) and (4)''; and

(2) by adding at the end the following new paragraph:

''(4) FISCAL YEARS 2009 THROUGH 2012 FOR CERTAIN INSULAR AREAS.—The amounts otherwise determined under this subsection for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for fiscal years 2009 through 2012 shall be increased by the following amounts:

''(A) PUERTO RICO.—For Puerto Rico, $250,000,000 for fiscal year 2009, $350,000,000 for fiscal year 2010, $500,000,000 for fiscal year 2011, and $600,000,000 for fiscal year 2012.

1 "(B) VIRGIN ISLANDS.—For the Virgin Is-
2 lands, $5,000,000 for each of fiscal years 2009
3 through 2012.
4 "(C) GUAM .—For Guam, $5,000,000 for
5 each of fiscal years 2009 through 2012.
6 "(D) NORTHERN MARIANA ISLANDS.—For
7 the Northern Mariana Islands, $4,000,000 for
8 each of fiscal years 2009 through 2012.
9 "(E) AMERICAN SAMOA.—For American
10 Samoa, $4,000,000 for each of fiscal years
11 2009 through 2012.
12 Such amounts shall not be taken into account in ap-
13 plying paragraph (2) for fiscal years 2009 through
14 2012 but shall be taken into account in applying
15 such paragraph for fiscal year 2013 and subsequent
16 fiscal years.".
17 (b) REMOVAL OF FEDERAL MATCHING PAYMENTS
18 FOR IMPROVING DATA REPORTING SYSTEMS FROM THE
19 OVERALL LIMIT ON PAYMENTS TO TERRITORIES UNDER
20 TITLE XIX.—Such section is further amended by adding
21 at the end the following new paragraph:
22 "(5) EXCLUSION OF CERTAIN EXPENDITURES
23 FROM PAYMENT LIMITS.— With respect to fiscal
24 year 2008 and each fiscal year thereafter, if Puerto
25 Rico, the Virgin Islands, Guam, the Northern Mar-

1 iana Islands, or American Samoa qualify for a pay-
2 ment under subparagraph (A)(i) or (B) of section
3 1903(a)(3) for a calendar quarter of such fiscal year
4 with respect to expenditures for improvements in
5 data reporting systems described in such subpara-
6 graph, the limitation on expenditures under title
7 XIX for such commonwealth or territory otherwise
8 determined under subsection (f) and this subsection
9 for such fiscal year shall be determined without re-
10 gard to payment for such expenditures.''.

11 **SEC. 812. MEDICAID DRUG REBATE.**

12 (a) BRAND.—Paragraph (1)(B)(i) of section 1927(c)
13 of the Social Security Act (42 U.S.C. 1396r-8(c)) is
14 amended—

15 (1) by striking ''and'' at the end of subclause
16 (IV);

17 (2) in subclause (V)—

18 (A) by inserting ''and before January 1,
19 2008,'' after ''December 31, 1995''; and

20 (B) by striking the period at the end and
21 inserting ''; and''; and

22 (3) by adding at the end the following new sub-
23 clause:

24 ''(VI) after December 31, 2007,
25 is 20.1 percent.''.

1 (b) PBMs to Best Price Definition.—
2 (1) In general.—Section 1927(c)(1)(C)(ii)(I)
3 of the Social Security Act (42 U.S.C. 1396r-
4 8(c)(1)(C)(ii)(I)) is amended—
5 (A) by striking ''and'' before ''rebates'';
6 and
7 (B) by inserting before the semicolon at
8 the end the following: '', and rebates, discounts,
9 and other price concessions to pharmaceutical
10 benefit managers (PBMs)''.
11 (2) Effective date.—The amendments made
12 by paragraph (1) shall apply to calendar quarters
13 beginning on or after January 1, 2008.

14 **SEC. 813. ADJUSTMENT IN COMPUTATION OF MEDICAID**
15 **FMAP TO DISREGARD AN EXTRAORDINARY**
16 **EMPLOYER PENSION CONTRIBUTION.**

17 (a) In General.—Only for purposes of computing
18 the Federal medical assistance percentage under section
19 1905(b) of the Social Security Act (42 U.S.C. 1396d(b))
20 for a State for a fiscal year (beginning with fiscal year
21 2006), any significantly disproportionate employer pension
22 contribution described in subsection (b) shall be dis-
23 regarded in computing the per capita income of such
24 State, but shall not be disregarded in computing the per

1 capita income for the continental United States (and Alas-
2 ka) and Hawaii.

3 (b) SIGNIFICANTLY DISPROPORTIONATE EMPLOYER
4 PENSION CONTRIBUTION.—For purposes of subsection
5 (a), a significantly disproportionate employer pension con-
6 tribution described in this subsection with respect to a
7 State for a fiscal year is an employer contribution towards
8 pensions that is allocated to such State for a period if the
9 aggregate amount so allocated exceeds 25 percent of the
10 total increase in personal income in that State for the pe-
11 riod involved.

12 **SEC. 814. MORATORIUM ON CERTAIN PAYMENT RESTRIC-**
13 **TIONS.**

14 Notwithstanding any other provision of law, the Sec-
15 retary of Health and Human Services shall not, prior to
16 the date that is 1 year after the date of enactment of this
17 Act, take any action (through promulgation of regulation,
18 issuance of regulatory guidance, use of federal payment
19 audit procedures, or other administrative action, policy, or
20 practice, including a Medical Assistance Manual trans-
21 mittal or letter to State Medicaid directors) to restrict cov-
22 erage or payment under title XIX of the Social Security
23 Act for rehabilitation services, or school-based administra-
24 tion, transportation, or medical services if such restric-

1 tions are more restrictive in any aspect than those applied
2 to such coverage or payment as of July 1, 2007.

3 **SEC. 815. TENNESSEE DSH.**

4 The DSH allotments for Tennessee for each fiscal
5 year beginning with fiscal year 2008 under subsection
6 (f)(3) of section 1923 of the Social Security Act (42
7 U.S.C. 13961396r-4) are deemed to be $30,000,000. The
8 Secretary of Health and Human Services may impose a
9 limitation on the total amount of payments made to hos-
10 pitals under the TennCare Section 1115 waiver only to
11 the extent that such limitation is necessary to ensure that
12 a hospital does not receive payment in excess of the
13 amounts described in subsection (f) of such section or as
14 necessary to ensure that the waiver remains budget neu-
15 tral.

16 **SEC. 816. CLARIFICATION TREATMENT OF REGIONAL MED-**
17 **ICAL CENTER.**

18 (a) IN GENERAL.—Nothing in section 1903(w) of the
19 Social Security Act (42 U.S.C. 1396b(w)) shall be con-
20 strued by the Secretary of Health and Human Services
21 as prohibiting a State's use of funds as the non-Federal
22 share of expenditures under title XIX of such Act where
23 such funds are transferred from or certified by a publicly-
24 owned regional medical center located in another State
25 and described in subsection (b), so long as the Secretary

1 determines that such use of funds is proper and in the
2 interest of the program under title XIX.
3 (b) CENTER DESCRIBED.—A center described in this
4 subsection is a publicly-owned regional medical center
5 that—
6 (1) provides level 1 trauma and burn care serv-
7 ices;
8 (2) provides level 3 neonatal care services;
9 (3) is obligated to serve all patients, regardless
10 of ability to pay;
11 (4) is located within a Standard Metropolitan
12 Statistical Area (SMSA) that includes at least 3
13 States;
14 (5) provides services as a tertiary care provider
15 for patients residing within a 125-mile radius; and
16 (6) meets the criteria for a disproportionate
17 share hospital under section 1923 of such Act (42
18 U.S.C. 1396r-4) in at least one State other than the
19 State in which the center is located.

20 **Subtitle C—Miscellaneous**

21 **SEC. 821. DEMONSTRATION PROJECT FOR EMPLOYER BUY-**
22 **IN.**

23 Title XXI of the Social Security Act, as amended by
24 section 115(a)(1), is further amended by adding at the
25 end the following new section:

1 **"SEC. 2112. DEMONSTRATION PROJECT FOR EMPLOYER**
2 **BUY-IN.**
3 "(a) AUTHORITY.—
4 "(1) IN GENERAL.—The Secretary shall estab-
5 lish a demonstration project under which up to 10
6 States (each referred to in this section as a 'partici-
7 pating State') that meets the conditions of para-
8 graph (2) may provide, under its State child health
9 plan (notwithstanding section 2102(b)(3)(C)) for a
10 period of 5 years, for child health assistance in rela-
11 tion to family coverage described in subsection (d)
12 for children who would be targeted low-income chil-
13 dren but for coverage as beneficiaries under a group
14 health plan as the children of participants by virtue
15 of a qualifying employer's contribution under sub-
16 section (b)(2). :
17 "(2) CONDITIONS.—The conditions described in
18 this paragraph for a State are as follows:
19 "(A) NO WAITING LISTS.—The State does
20 not impose any waiting list, enrollment cap, or
21 similar limitation on enrollment of targeted low-
22 income children under the State child health
23 plan.
24 "(B) ELIGIBILITY OF ALL CHILDREN
25 UNDER 200 PERCENT OF POVERTY LINE.—The
26 State is applying an income eligibility level

1 under section 2110(b)(1)(B)(ii)(I) that is at
2 least 200 percent of the poverty line.
3 ''(3) QUALIFYING EMPLOYER DEFINED.—In
4 this section, the term 'qualifying employer' means an
5 employer that has a majority of its workforce com-
6 posed of full-time workers with family incomes rea-
7 sonably estimated by the employer (based on wage
8 information available to the employer) at or below
9 200 percent of the poverty line. In applying the pre-
10 vious sentence, two part-time workers shall be treat-
11 ed as a single full-time worker.
12 ''(b) FUNDING.—A demonstration project under this
13 section in a participating State shall be funded, with re-
14 spect to assistance provided to children described in sub-
15 section (a)(1), consistent with the following:
16 ''(1) LIMITED FAMILY CONTRIBUTION.—The
17 family involved shall be responsible for providing
18 payment towards the premium for such assistance of
19 such amount as the State may specify, except that
20 the limitations on cost-sharing (including premiums)
21 under paragraphs (2) and (3) of section 2103(e)
22 shall apply to all cost-sharing of such family under
23 this section.
24 ''(2) MINIMUM EMPLOYER CONTRIBUTION.—
25 The qualifying employer involved shall be responsible

1 for providing payment to the State child health plan
2 in the State of at least 50 percent of the portion of
3 the cost (as determined by the State) of the family
4 coverage in which the employer is enrolling the fam-
5 ily that exceeds the amount of the family contribu-
6 tion under paragraph (1) applied towards such cov-
7 erage.

8 ''(3) LIMITATION ON FEDERAL FINANCIAL PAR-
9 TICIPATION.—In no case shall the Federal financial
10 participation under section 2105 with respect to a
11 demonstration project under this section be made for
12 any portion of the costs of family coverage described
13 in subsection (d) (including the costs of administra-
14 tion of such coverage) that are not attributable to
15 children described in subsection (a)(1).

16 ''(c) UNIFORM ELIGIBILITY RULES.—In providing
17 assistance under a demonstration project under this sec-
18 tion—

19 ''(1) a State shall establish uniform rules of eli-
20 gibility for families to participate; and

21 ''(2) a State shall not permit a qualifying em-
22 ployer to select, within those families that meet such
23 eligibility rules, which families may participate.

24 ''(d) TERMS AND CONDITIONS.—The family coverage
25 offered to families of qualifying employers under a dem-

1 onstration project under this section in a State shall be
2 the same as the coverage and benefits provided under the
3 State child health plan in the State for targeted low-in-
4 come children with the highest family income level per-
5 mitted.''.

6 **SEC. 822. DIABETES GRANTS.**

7 Section 2104 of the Social Security Act (42 U.C.C
8 1397dd), as amended by section 101, is further amend-
9 ed—

10 (1) in subsection (a)(11), by inserting before
11 the period at the end the following: ''plus for fiscal
12 year 2009 the total of the amount specified in sub-
13 section (j)''; and

14 (2) by adding at the end the following new sub-
15 section:

16 ''(j) FUNDING FOR DIABETES GRANTS.—From the
17 amounts appropriated under subsection (a)(11), for fiscal
18 year 2009 from the amounts—

19 ''(1) $150,000,000 is hereby transferred and
20 made available in such fiscal year for grants under
21 section 330B of the Public Health Service Act; and

22 ''(2) $150,000,000 is hereby transferred and
23 made available in such fiscal year for grants under
24 section 330C of such Act.''.

SEC. 823. TECHNICAL CORRECTION.

(a) CORRECTION OF REFERENCE TO CHILDREN IN FOSTER CARE RECEIVING CHILD WELFARE SERVICES.—Section 1937(a)(2)(B)(viii) of the Social Security Act (42 U.S.C. 1396u-7(a)(2)(B) is amended by striking ''aid or assistance is made available under part B of title IV to children in foster care'' and inserting ''child welfare services are made available under part B of title IV on the basis of being a child in foster care''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the amendment made by section 6044(a) of the Deficit Reduction Act of 2005.

TITLE Q—MISCELLANEOUS

SEC. 901. MEDICARE PAYMENT ADVISORY COMMISSION STATUS.

Section 1805(a) of the Social Security Act (42 U.S.C. 1395b-6(a)) is amended by inserting ''as an agency of Congress'' after ''established''.

SEC. 902. REPEAL OF TRIGGER PROVISION.

Subtitle A of title VIII of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) is repealed and the provisions of law amended by such subtitle are restored as if such subtitle had never been enacted.

1 **SEC. 903. REPEAL OF COMPARATIVE COST ADJUSTMENT**
2 **(CCA) PROGRAM.**
3 Section 1860C–1 of the Social Security Act (42
4 U.S.C. 1395w-29), as added by section 241(a) of the
5 Medicare Prescription Drug, Improvement, and Mod-
6 ernization Act of 2003 (Public Law 108–173), is repealed.
7 **SEC. 904. COMPARATIVE EFFECTIVENESS RESEARCH.**
8 (a) IN GENERAL.—Part A of title XVIII of the Social
9 Security Act is amended by adding at the end the fol-
10 lowing new section:
11 ''COMPARATIVE EFFECTIVENESS RESEARCH
12 ''SEC. 1822. (a) CENTER FOR COMPARATIVE EFFEC-
13 TIVENESS RESEARCH ESTABLISHED.—
14 ''(1) IN GENERAL.—The Secretary shall estab-
15 lish within the Agency of Healthcare Research and
16 Quality a Center for Comparative Effectiveness Re-
17 search (in this section referred to as the 'Center') to
18 conduct, support, and synthesize research (including
19 research conducted or supported under section 1013
20 of the Medicare Prescription Drug, Improvement,
21 and Modernization Act of 2003) with respect to the
22 outcomes, effectiveness, and appropriateness of
23 health care services and procedures in order to iden-
24 tify the manner in which diseases, disorders, and
25 other health conditions can most effectively and ap-

1 propriately be prevented, diagnosed, treated, and
2 managed clinically.
3 "(2) DUTIES.—The Center shall—
4 "(A) conduct, support, and synthesize re-
5 search relevant to the comparative clinical effec-
6 tiveness of the full spectrum of health care
7 treatments, including pharmaceuticals, medical
8 devices, medical and surgical procedures, and
9 other medical interventions;
10 "(B) conduct and support systematic re-
11 views of clinical research, including original re-
12 search conducted subsequent to the date of the
13 enactment of this section;
14 "(C) use methodologies such as random-
15 ized controlled clinical trials as well as other
16 various types of clinical research, such as obser-
17 vational studies;
18 "(D) submit to the Comparative Effective-
19 ness Research Commission, the Secretary, and
20 Congress appropriate relevant reports described
21 in subsection (d)(2);
22 "(E) encourage, as appropriate, the devel-
23 opment and use of clinical registries and the de-
24 velopment of clinical effectiveness research data
25 networks from electronic health records, post

1 marketing drug and medical device surveillance
2 efforts, and other forms of electronic health
3 data; and
4 "(F) not later than 180 days after the
5 date of the enactment of this section, develop
6 methodological standards to be used when con-
7 ducting studies of comparative clinical effective-
8 ness and value (and procedures for use of such
9 standards) in order to help ensure accurate and
10 effective comparisons and update such stand-
11 ards at least biennially.
12 "(b) OVERSIGHT BY COMPARATIVE EFFECTIVENESS
13 RESEARCH COMMISSION.—
14 "(1) IN GENERAL.—The Secretary shall estab-
15 lish an independent Comparative Effectiveness Re-
16 search Commission (in this section referred to as the
17 'Commission') to oversee and evaluate the activities
18 carried out by the Center under subsection (a) to en-
19 sure such activities result in highly credible research
20 and information resulting from such research.
21 "(2) DUTIES.—The Commission shall—
22 "(A) determine national priorities for re-
23 search described in subsection (a) and in mak-
24 ing such determinations consult with patients
25 and health care providers and payers;

1 "(B) monitor the appropriateness of use of
2 the CERTF described in subsection (f) with re-
3 spect to the timely production of comparative
4 effectiveness research determined to be a na-
5 tional priority under subparagraph (A);
6 "(C) identify highly credible research
7 methods and standards of evidence for such re-
8 search to be considered by the Center;
9 "(D) review and approve the methodo-
10 logical standards (and updates to such stand-
11 ards) developed by the Center under subsection
12 (a)(2)(F);
13 "(E) enter into an arrangement under
14 which the Institute of Medicine of the National
15 Academy of Sciences shall conduct an evalua-
16 tion and report on standards of evidence for
17 such research;
18 "(F) support forums to increase stake-
19 holder awareness and permit stakeholder feed-
20 back on the efforts of the Agency of Healthcare
21 Research and Quality to advance methods and
22 standards that promote highly credible re-
23 search;
24 "(G) make recommendations for public
25 data access policies of the Center that would

1 allow for access of such data by the public while
2 ensuring the information produced from re-
3 search involved is timely and credible;
4 ''(H) appoint a clinical perspective advisory
5 panel for each research priority determined
6 under subparagraph (A), which shall frame the
7 specific research inquiry to be examined with
8 respect to such priority to ensure that the infor-
9 mation 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 pri-
13 ority for periodic reviews of previous compara-
14 tive effectiveness research and studies con-
15 ducted by the Center under subsection (a);
16 ''(J) routinely review processes of the Cen-
17 ter with respect to such research to confirm
18 that the information produced by such research
19 is objective, credible, consistent with standards
20 of evidence established under this section, and
21 developed through a transparent process that
22 includes consultations with appropriate stake-
23 holders;
24 ''(K) at least annually, provide guidance or
25 recommendations to health care providers and

1 consumers for the use of information on the
2 comparative effectiveness of health care services
3 by consumers, providers (as defined for pur-
4 poses of regulations promulgated under section
5 264(c) of the Health Insurance Portability and
6 Accountability Act of 1996) and public and pri-
7 vate purchasers;
8 ''(L) make recommendations for a strategy
9 to disseminate the findings of research con-
10 ducted and supported under this section that
11 enables clinicians to improve performance, con-
12 sumers to make more informed health care de-
13 cisions, and payers to set medical policies that
14 improve quality and value;
15 ''(M) provide for the public disclosure of
16 relevant reports described in subsection (d)(2);
17 and
18 ''(N) submit to Congress an annual report
19 on the progress of the Center in achieving na-
20 tional priorities determined under subparagraph
21 (A) for the provision of credible comparative ef-
22 fectiveness information produced from such re-
23 search to all interested parties.
24 ''(3) COMPOSITION OF COMMISSION.—

1 "(A) IN GENERAL.—The members of the
2 Commission shall consist of—
3 "(i) the Director of the Agency for
4 Healthcare Research and Quality;
5 "(ii) the Chief Medical Officer of the
6 Centers for Medicare & Medicaid
7 Services; and
8 "(iii) up to 15 additional members
9 who shall represent broad constituencies of
10 stakeholders including clinicians, patients,
11 researchers, third-party payers, consumers
12 of Federal and State beneficiary programs.
13 .
14 "(B) QUALIFICATIONS.—
15 "(i) DIVERSE REPRESENTATION OF
16 PERSPECTIVES.—The members of the
17 Commission shall represent a broad range
18 of perspectives and shall collectively have
19 experience in the following areas:
20 "(I) Epidemiology.
21 "(II) Health services research.
22 "(III) Bioethics.
23 "(IV) Decision sciences.
24 "(V) Economics.

1 "(ii) DIVERSE REPRESENTATION OF
2 HEALTH CARE COMMUNITY.—At least one
3 member shall represent each of the fol-
4 lowing health care communities:
5 "(I) Consumers.
6 "(II) Practicing physicians, in-
7 cluding surgeons.
8 "(III) Employers.
9 "(IV) Public payers.
10 "(V) Insurance plans.
11 "(VI) Clinical researchers who
12 conduct research on behalf of pharma-
13 ceutical or device manufacturers.
14 "(4) APPOINTMENT.—The Comptroller General
15 of the United States, in consultation with the chairs
16 of the committees of jurisdiction of the House of
17 Representatives and the Senate, shall appoint the
18 members of the Commission.
19 "(5) CHAIRMAN; VICE CHAIRMAN.—The Comp-
20 troller General of the United States shall designate
21 a member of the Commission, at the time of ap-
22 pointment of the member, as Chairman and a mem-
23 ber as Vice Chairman for that term of appointment,
24 except that in the case of vacancy of the Chairman-
25 ship or Vice Chairmanship, the Comptroller General

may designate another member for the remainder of that member's term.

"(6) TERMS.—

"(A) IN GENERAL.—Except as provided in subparagraph (B), each member of the Commission shall be appointed for a term of 4 years.

"(B) TERMS OF INITIAL APPOINTEES.—Of the members first appointed—

"(i) 10 shall be appointed for a term of 4 years; and

"(ii) 9 shall be appointed for a term of 3 years.

"(7) COORDINATION.—To enhance effectiveness and coordination, the Comptroller General is encouraged, to the greatest extent possible, to seek coordination between the Commission and the National Advisory Council of the Agency for Healthcare Research and Quality.

"(8) CONFLICTS OF INTEREST.—In appointing the members of the Commission or a clinical perspective advisory panel described in paragraph (2)(H), the Comptroller General of the United States or the Commission, respectively, shall take into consideration any financial conflicts of interest.

1 "(9) COMPENSATION.—While serving on the
2 business of the Commission (including traveltime), a
3 member of the Commission shall be entitled to com-
4 pensation at the per diem equivalent of the rate pro-
5 vided for level IV of the Executive Schedule under
6 section 5315 of title 5, United States Code; and
7 while so serving away from home and the member's
8 regular place of business, a member may be allowed
9 travel expenses, as authorized by the Director of the
10 Commission.

11 "(10) AVAILABILITY OF REPORTS.—The Com-
12 mission shall transmit to the Secretary a copy of
13 each report submitted under this subsection and
14 shall make such reports available to the public.

15 "(11) DIRECTOR AND STAFF; EXPERTS AND
16 CONSULTANTS.—Subject to such review as the Sec-
17 retary, in consultation with the Comptroller General
18 deems necessary to assure the efficient administra-
19 tion of the Commission, the Commission may—

20 "(A) employ and fix the compensation of
21 an Executive Director (subject to the approval
22 of the Secretary, in consultation with the
23 Comptroller General) and such other personnel
24 as may be necessary to carry out its duties
25 (without regard to the provisions of title 5,

1 United States Code, governing appointments in
2 the competitive service);
3 ''(B) seek such assistance and support as
4 may be required in the performance of its du-
5 ties from appropriate Federal departments and
6 agencies;
7 ''(C) enter into contracts or make other ar-
8 rangements, as may be necessary for the con-
9 duct of the work of the Commission (without
10 regard to section 3709 of the Revised Statutes
11 (41 U.S.C. 5));
12 ''(D) make advance, progress, and other
13 payments which relate to the work of the Com-
14 mission;
15 ''(E) provide transportation and subsist-
16 ence for persons serving without compensation;
17 and
18 ''(F) prescribe such rules and regulations
19 as it deems necessary with respect to the inter-
20 nal organization and operation of the Commis-
21 sion.
22 ''(12) POWERS.—
23 ''(A) OBTAINING OFFICIAL DATA.—The
24 Commission may secure directly from any de-
25 partment or agency of the United States infor-

1 mation necessary to enable it to carry out this
2 section. Upon request of the Executive Director,
3 the head of that department or agency shall
4 furnish that information to the Commission on
5 an agreed upon schedule.
6 ''(B) DATA COLLECTION.—In order to
7 carry out its functions, the Commission shall—
8 ''(i) utilize existing information, both
9 published and unpublished, where possible,
10 collected and assessed either by its own
11 staff or under other arrangements made in
12 accordance with this section,
13 ''(ii) carry out, or award grants or
14 contracts for, original research and experi-
15 mentation, where existing information is
16 inadequate, and
17 ''(iii) adopt procedures allowing any
18 interested party to submit information for
19 the Commission's use in making reports
20 and recommendations.
21 ''(C) ACCESS OF GAO TO INFORMATION.—
22 The Comptroller General shall have unrestricted
23 access to all deliberations, records, and non-
24 proprietary data of the Commission, imme-
25 diately upon request.

1 "(D) PERIODIC AUDIT.—The Commission
2 shall be subject to periodic audit by the Comp-
3 troller General.
4 "(c) RESEARCH REQUIREMENTS.—Any research con-
5 ducted, supported, or synthesized under this section shall
6 meet the following requirements:
7 "(1) ENSURING TRANSPARENCY, CREDIBILITY,
8 AND ACCESS.—
9 "(A) The establishment of the agenda and
10 conduct of the research shall be insulated from
11 inappropriate political or stakeholder influence.
12 "(B) Methods of conducting such research
13 shall be scientifically based.
14 "(C) All aspects of the prioritization of re-
15 search, conduct of the research, and develop-
16 ment of conclusions based on the research shall
17 be transparent to all stakeholders.
18 "(D) The process and methods for con-
19 ducting such research shall be publicly docu-
20 mented and available to all stakeholders.
21 "(E) Throughout the process of such re-
22 search, the Center shall provide opportunities
23 for all stakeholders involved to review and pro-
24 vide comment on the methods and findings of
25 such research.

1 "(2) USE OF CLINICAL PERSPECTIVE ADVISORY
2 PANELS.—The research shall meet a national re-
3 search priority determined under subsection
4 (b)(2)(A) and shall examine the specific research in-
5 quiry framed by the clinical perspective advisory
6 panel for the national research priority.
7 "(3) STAKEHOLDER INPUT.—The priorities of
8 the research, the research, and the dissemination of
9 the research shall involve the consultation of pa-
10 tients, health care providers, and health care con-
11 sumer representatives through transparent mecha-
12 nisms recommended by the Commission.
13 "(d) PUBLIC ACCESS TO COMPARATIVE EFFECTIVE-
14 NESS INFORMATION.—
15 "(1) IN GENERAL.—Not later than 90 days
16 after receipt by the Center or Commission, as appli-
17 cable, of a relevant report described in paragraph
18 (2) made by the Center, Commission, or clinical per-
19 spective advisory panel under this section, appro-
20 priate information contained in such report shall be
21 posted on the official public Internet site of the Cen-
22 ter and of the Commission, as applicable.
23 "(2) RELEVANT REPORTS DESCRIBED.—For
24 purposes of this section, a relevant report is each of

1 the following submitted by a grantee or contractor
2 of the Center:
3 ''(A) An interim progress report.
4 ''(B) A draft final comparative effective-
5 ness review.
6 ''(C) A final progress report on new re-
7 search submitted for publication by a peer re-
8 view journal.
9 ''(D) Stakeholder comments.
10 ''(E) A final report.
11 ''(3) ACCESS BY CONGRESS AND THE COMMIS-
12 SION TO THE CENTER'S INFORMATION.—Congress
13 and the Commission shall each have unrestricted ac-
14 cess to all deliberations, records, and nonproprietary
15 data of the Center, immediately upon request.
16 ''(e) DISSEMINATION AND INCORPORATION OF COM-
17 PARATIVE EFFECTIVENESS INFORMATION.—
18 ''(1) DISSEMINATION.—The Center shall pro-
19 vide for the dissemination of appropriate findings
20 produced by research supported, conducted, or syn-
21 thesized under this section to health care providers,
22 patients, vendors of health information technology
23 focused on clinical decision support, appropriate pro-
24 fessional associations, and Federal and private
25 health plans.

1 "(2) INCORPORATION.—The Center shall assist
2 users of health information technology focused on
3 clinical decision support to promote the timely incor-
4 poration of the findings described in paragraph (1)
5 into clinical practices and to promote the ease of use
6 of such incorporation.
7 "(f) REPORTS TO CONGRESS.—
8 "(1) ANNUAL REPORTS.—Beginning not later
9 than one year after the date of the enactment of this
10 section, the Director of the Agency of Healthcare
11 Research and Quality and the Commission shall sub-
12 mit to Congress an annual report on the activities
13 of the Center and the Commission, as well as the re-
14 search, conducted under this section.
15 "(2) RECOMMENDATION FOR FAIR SHARE PER
16 CAPITA AMOUNT FOR ALL-PAYER FINANCING.—Be-
17 ginning not later than December 31, 2009, the Sec-
18 retary shall submit to Congress an annual rec-
19 ommendation for a fair share per capita amount de-
20 scribed in subsection (c)(1) of section 9511 of the
21 Internal Revenue Code of 1986 for purposes of
22 funding the CERTF under such section.
23 "(3) ANALYSIS AND REVIEW.—Not later than
24 December 31, 2011, the Secretary, in consultation
25 with the Commission, shall submit to Congress a re-

1 port on all activities conducted or supported under
2 this section as of such date. Such report shall in-
3 clude an evaluation of the return on investment re-
4 sulting from such activities, the overall costs of such
5 activities, and an analysis of the backlog of any re-
6 search proposals approved by the Commission but
7 not funded. Such report shall also address whether
8 Congress should expand the responsibilities of the
9 Center and of the Commission to include studies of
10 the effectiveness of various aspects of the health care
11 delivery system, including health plans and delivery
12 models, such as health plan features, benefit designs
13 and performance, and the ways in which health serv-
14 ices are organized, managed, and delivered.
15 ''(g) COORDINATING COUNCIL FOR HEALTH SERV-
16 ICES RESEARCH.—
17 ''(1) ESTABLISHMENT.—The Secretary shall es-
18 tablish a permanent council (in this section referred
19 to as the 'Council') for the purpose of—
20 ''(A) assisting the offices and agencies of
21 the Department of Health and Human Services,
22 the Department of Veterans Affairs, the De-
23 partment of Defense, and any other Federal de-
24 partment or agency to coordinate the conduct
25 or support of health services research; and

1 "(B) advising the President and Congress
2 on—
3 "(i) the national health services re-
4 search agenda;
5 "(ii) strategies with respect to infra-
6 structure needs of health services research;
7 and
8 "(iii) appropriate organizational ex-
9 penditures in health services research by
10 relevant Federal departments and agen-
11 cies.
12 "(2) MEMBERSHIP.—
13 "(A) NUMBER AND APPOINTMENT.—The
14 Council shall be composed of 20 members. One
15 member shall be the Director of the Agency for
16 Healthcare Research and Quality. The Director
17 shall appoint the other members not later than
18 30 days after the enactment of this Act.
19 "(B) TERMS.—
20 "(i) IN GENERAL.—Except as pro-
21 vided in clause (ii), each member of the
22 Council shall be appointed for a term of 4
23 years.

1 "(ii) TERMS OF INITIAL AP-
2 POINTEES.—Of the members first ap-
3 pointed—
4 "(I) 8 shall be appointed for a
5 term of 4 years; and
6 "(II) 7 shall be appointed for a
7 term of 3 years.
8 "(iii) VACANCIES.—Any vacancies
9 shall not affect the power and duties of the
10 Council and shall be filled in the same
11 manner as the original appointment.
12 "(C) QUALIFICATIONS.—
13 "(i) IN GENERAL.—The members of
14 the Council shall include one senior official
15 from each of the following agencies:
16 "(I) The Veterans Health Ad-
17 ministration.
18 "(II) The Department of Defense
19 Military Health Care System.
20 "(III) The Centers for Disease
21 Control and Prevention.
22 "(IV) The National Center for
23 Health Statistics.
24 "(V) The National Institutes of
25 Health.

1 "(VI) The Center for Medicare
2 & Medicaid Services.
3 "(VII) The Federal Employees
4 Health Benefits Program.
5 "(ii) NATIONAL, PHILANTHROPIC
6 FOUNDATIONS.—The members of the
7 Council shall include 4 senior leaders from
8 major national, philanthropic foundations
9 that fund and use health services research.
10 "(iii) STAKEHOLDERS.—The remain-
11 ing members of the Council shall be rep-
12 resentatives of other stakeholders in health
13 services research, including private pur-
14 chasers, health plans, hospitals and other
15 health facilities, and health consumer
16 groups.
17 "(3) ANNUAL REPORT.—The Council shall sub-
18 mit to Congress an annual report on the progress of
19 the implementation of the national health services
20 research agenda.
21 "(h) FUNDING OF COMPARATIVE EFFECTIVENESS
22 RESEARCH.—For fiscal year 2008 and each subsequent
23 fiscal year, amounts in the Comparative Effectiveness Re-
24 search Trust Fund (referred to in this section as the
25 'CERTF') under section 9511 of the Internal Revenue

1 Code of 1986 shall be available to the Secretary to carry
2 out this section.''.
3 (b) COMPARATIVE EFFECTIVENESS RESEARCH
4 TRUST FUND; FINANCING FOR TRUST FUND.—
5 (1) ESTABLISHMENT OF TRUST FUND.—
6 (A) IN GENERAL.—Subchapter A of chap-
7 ter 98 of the Internal Revenue Code of 1986
8 (relating to trust fund code) is amended by
9 adding at the end the following new section:
10 **''SEC. 9511. HEALTH CARE COMPARATIVE EFFECTIVENESS**
11 **RESEARCH TRUST FUND.**
12 ''(a) CREATION OF TRUST FUND.—There is estab-
13 lished in the Treasury of the United States a trust fund
14 to be known as the 'Health Care Comparative Effective-
15 ness Research Trust Fund' (hereinafter in this section re-
16 ferred to as the 'CERTF'), consisting of such amounts
17 as may be appropriated or credited to such Trust Fund
18 as provided in this section and section 9602(b).
19 ''(b) TRANSFERS TO FUND.—There are hereby ap-
20 propriated to the Trust Fund the following:
21 ''(1) For fiscal year 2008, $90,000,000.
22 ''(2) For fiscal year 2009, $100,000,000.
23 ''(3) For fiscal year 2010, $110,000,000.
24 ''(4) For each fiscal year beginning with fiscal
25 year 2011—

1 "(A) an amount equivalent to the net reve-
2 nues received in the Treasury from the fees im-
3 posed under subchapter B of chapter 34 (relat-
4 ing to fees on health insurance and self-insured
5 plans) for such fiscal year; and
6 "(B) subject to subsection (c)(2), amounts
7 determined by the Secretary of Health and
8 Human Services to be equivalent to the fair
9 share per capita amount computed under sub-
10 section (c)(1) for the fiscal year multiplied by
11 the average number of individuals entitled to
12 benefits under part A, or enrolled under part B,
13 of title XVIII of the Social Security Act during
14 such fiscal year.
15 The amounts appropriated under paragraphs (1), (2), (3),
16 and (4)(B) shall be transferred from the Federal Hospital
17 Insurance Trust Fund and from the Federal Supple-
18 mentary Medical Insurance Trust Fund (established
19 under section 1841 of such Act), and from the Medicare
20 Prescription Drug Account within such Trust Fund, in
21 proportion (as estimated by the Secretary) to the total ex-
22 penditures during such fiscal year that are made under
23 title XVIII of such Act from the respective trust fund or
24 account.
25 "(c) FAIR SHARE PER CAPITA AMOUNT.—

1 "(1) COMPUTATION.—
2 "(A) IN GENERAL.—Subject to subpara-
3 graph (B), the fair share per capita amount
4 under this paragraph for a fiscal year (begin-
5 ning with fiscal year 2011) is an amount com-
6 puted by the Secretary of Health and Human
7 Services for such fiscal year that, when applied
8 under this section and subchapter B of chapter
9 34 of the Internal Revenue Code of 1986, will
10 result in revenues to the CERTF of
11 $375,000,000 for the fiscal year.
12 "(B) ALTERNATIVE COMPUTATION.—
13 "(i) IN GENERAL.—If the Secretary is
14 unable to compute the fair share per capita
15 amount under subparagraph (A) for a fis-
16 cal year, the fair share per capita amount
17 under this paragraph for the fiscal year
18 shall be the default amount determined
19 under clause (ii) for the fiscal year.
20 "(ii) DEFAULT AMOUNT.—The default
21 amount under this clause for—
22 "(I) fiscal year 2011 is equal to
23 $2; or
24 "(II) a subsequent year is equal
25 to the default amount under this

1 clause for the preceeding fiscal year
2 increased by the annual percentage in-
3 crease in the medical care component
4 of the consumer price index (United
5 States city average) for the 12-month
6 period ending with April of the pre-
7 ceding fiscal year.
8 Any amount determined under subclause
9 (II) shall be rounded to the nearest penny.
10 "(2) LIMITATION ON MEDICARE FUNDING.—In
11 no case shall the amount transferred under sub-
12 section (b)(4)(B) for any fiscal year exceed
13 $90,000,000.
14 "(d) EXPENDITURES FROM FUND.—
15 "(1) IN GENERAL.—Subject to paragraph (2),
16 amounts in the CERTF are available to the Sec-
17 retary of Health and Human Services for carrying
18 out section 1822 of the Social Security Act.
19 "(2) ALLOCATION FOR COMMISSION.—Not less
20 than the following amounts in the CERTF for a fis-
21 cal year shall be available to carry out the activities
22 of the Comparative Effectiveness Research Commis-
23 sion established under section 1822(b) of the Social
24 Security Act for such fiscal year:
25 "(A) For fiscal year 2008, $7,000,000.

1 "(B) For fiscal year 2009, $9,000,000.
2 "(C) For each fiscal year beginning with
3 2010, $10,000,000.
4 Nothing in this paragraph shall be construed as pre-
5 venting additional amounts in the CERTF from
6 being made available to the Comparative Effective-
7 ness Research Commission for such activities.
8 "(e) NET REVENUES.—For purposes of this section,
9 the term 'net revenues' means the amount estimated by
10 the Secretary based on the excess of—
11 "(1) the fees received in the Treasury under
12 subchapter B of chapter 34, over
13 "(2) the decrease in the tax imposed by chapter
14 1 resulting from the fees imposed by such sub-
15 chapter.".
16 (B) CLERICAL AMENDMENT.—The table of
17 sections for such subchapter A is amended by
18 adding at the end thereof the following new
19 item:

"Sec. 9511. Health Care Comparative Effectiveness Research Trust Fund".

20 (2) FINANCING FOR FUND FROM FEES ON IN-
21 SURED AND SELF-INSURED HEALTH PLANS.—
22 (A) GENERAL RULE.—Chapter 34 of the
23 Internal Revenue Code of 1986 is amended by
24 adding at the end the following new subchapter:

1 **"Subchapter B—Insured and Self-Insured**
2 **Health Plans**

"Sec. 4375. Health insurance.
"Sec. 4376. Self-insured health plans
"Sec. 4377. Definitions and special rules

3 **"SEC. 4375. HEALTH INSURANCE.**

4 "(a) IMPOSITION OF FEE.—There is hereby imposed
5 on each specified health insurance policy for each policy
6 year a fee equal to the fair share per capita amount deter-
7 mined under section 9511(c)(1) multiplied by the average
8 number of lives covered under the policy.

9 "(b) LIABILITY FOR FEE.—The fee imposed by sub-
10 section (a) shall be paid by the issuer of the policy.

11 "(c) SPECIFIED HEALTH INSURANCE POLICY.—For
12 purposes of this section—

13 "(1) IN GENERAL.—Except as otherwise pro-
14 vided in this section, the term 'specified health in-
15 surance policy' means any accident or health insur-
16 ance policy issued with respect to individuals resid-
17 ing in the United States.

18 "(2) EXEMPTION OF CERTAIN POLICIES.—The
19 term 'specified health insurance policy' does not in-
20 clude any insurance policy if substantially all of the
21 coverage provided under such policy relates to—

22 "(A) liabilities incurred under workers'
23 compensation laws,

24 "(B) tort liabilities,

1 "(C) liabilities relating to ownership or use
2 of property,
3 "(D) credit insurance,
4 "(E) medicare supplemental coverage, or
5 "(F) such other similar liabilities as the
6 Secretary may specify by regulations.
7 "(3) TREATMENT OF PREPAID HEALTH COV-
8 ERAGE ARRANGEMENTS.—
9 "(A) IN GENERAL.—In the case of any ar-
10 rangement described in subparagraph (B)—
11 "(i) such arrangement shall be treated
12 as a specified health insurance policy, and
13 "(ii) the person referred to in such
14 subparagraph shall be treated as the
15 issuer.
16 "(B) DESCRIPTION OF ARRANGEMENTS.—
17 An arrangement is described in this subpara-
18 graph if under such arrangement fixed pay-
19 ments or premiums are received as consider-
20 ation for any person's agreement to provide or
21 arrange for the provision of accident or health
22 coverage to residents of the United States, re-
23 gardless of how such coverage is provided or ar-
24 ranged to be provided.

1 **"SEC. 4376. SELF-INSURED HEALTH PLANS.**

2 "(a) IMPOSITION OF FEE.—In the case of any appli-
3 cable self-insured health plan for each plan year, there is
4 hereby imposed a fee equal to the fair share per capita
5 amount determined under section 9511(c)(1) multiplied by
6 the average number of lives covered under the plan.

7 "(b) LIABILITY FOR FEE.—

8 "(1) IN GENERAL.—The fee imposed by sub-
9 section (a) shall be paid by the plan sponsor.

10 "(2) PLAN SPONSOR.—For purposes of para-
11 graph (1) the term 'plan sponsor' means—

12 "(A) the employer in the case of a plan es-
13 tablished or maintained by a single employer,

14 "(B) the employee organization in the case
15 of a plan established or maintained by an em-
16 ployee organization,

17 "(C) in the case of—

18 "(i) a plan established or maintained
19 by 2 or more employers or jointly by 1 or
20 more employers and 1 or more employee
21 organizations,

22 "(ii) a multiple employer welfare ar-
23 rangement, or

24 "(iii) a voluntary employees' bene-
25 ficiary association described in section
26 501(c)(9),

the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, or

"(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

"(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term 'applicable self-insured health plan' means any plan for providing accident or health coverage if—

"(1) any portion of such coverage is provided other than through an insurance policy, and

"(2) such plan is established or maintained—

"(A) by one or more employers for the benefit of their employees or former employees,

"(B) by one or more employee organizations for the benefit of their members or former members,

"(C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees,

"(D) by a voluntary employees' beneficiary association described in section 501(c)(9),

1 "(E) by any organization described in sec-
2 tion 501(c)(6), or
3 "(F) in the case of a plan not described in
4 the preceding subparagraphs, by a multiple em-
5 ployer welfare arrangement (as defined in sec-
6 tion 3(40) of Employee Retirement Income Se-
7 curity Act of 1974), a rural electric cooperative
8 (as defined in section 3(40)(B)(iv) of such Act),
9 or a rural telephone cooperative association (as
10 defined in section 3(40)(B)(v) of such Act).

11 **"SEC. 4377. DEFINITIONS AND SPECIAL RULES.**

12 "(a) DEFINITIONS.—For purposes of this sub-
13 chapter—
14 "(1) ACCIDENT AND HEALTH COVERAGE.—The
15 term 'accident and health coverage' means any cov-
16 erage which, if provided by an insurance policy,
17 would cause such policy to be a specified health in-
18 surance policy (as defined in section 4375(c)).
19 "(2) INSURANCE POLICY.—The term 'insurance
20 policy' means any policy or other instrument where-
21 by a contract of insurance is issued, renewed, or ex-
22 tended.
23 "(3) UNITED STATES.—The term 'United
24 States' includes any possession of the United States.
25 "(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

1 "(1) IN GENERAL.—For purposes of this sub-
2 chapter—
3 "(A) the term 'person' includes any gov-
4 ernmental entity, and
5 "(B) notwithstanding any other law or rule
6 of law, governmental entities shall not be ex-
7 empt from the fees imposed by this subchapter
8 except as provided in paragraph (2).
9 "(2) TREATMENT OF EXEMPT GOVERNMENTAL
10 PROGRAMS.—In the case of an exempt governmental
11 program, no fee shall be imposed under section 4375
12 or section 4376 on any covered life under such pro-
13 gram.
14 "(3) EXEMPT GOVERNMENTAL PROGRAM DE-
15 FINED.—For purposes of this subchapter, the term
16 'exempt governmental program' means—
17 "(A) any insurance program established
18 under title XVIII of the Social Security Act,
19 "(B) the medical assistance program es-
20 tablished by title XIX or XXI of the Social Se-
21 curity Act,
22 "(C) any program established by Federal
23 law for providing medical care (other than
24 through insurance policies) to individuals (or

1 the spouses and dependents thereof) by reason
2 of such individuals being—
3 ''(i) members of the Armed Forces of
4 the United States, or
5 ''(ii) veterans, and
6 ''(D) any program established by Federal
7 law for providing medical care (other than
8 through insurance policies) to members of In-
9 dian tribes (as defined in section 4(d) of the In-
10 dian Health Care Improvement Act).
11 ''(c) TREATMENT AS TAX.—For purposes of subtitle
12 F, the fees imposed by this subchapter shall be treated
13 as if they were taxes.
14 ''(d) NO COVER OVER TO POSSESSIONS.—Notwith-
15 standing any other provision of law, no amount collected
16 under this subchapter shall be covered over to any posses-
17 sion of the United States.''
18 (B) CLERICAL AMENDMENT.—Chapter 34
19 of such Code is amended by striking the chap-
20 ter heading and inserting the following:
21 **''CHAPTER 34—TAXES ON CERTAIN**
22 **INSURANCE POLICIES**

''SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

''SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

1 **"Subchapter A—Policies Issued By Foreign**
2 **Insurers".**
3 (C) EFFECTIVE DATE.—The amendments
4 made by this subsection shall apply with respect
5 to policies and plans for portions of policy or
6 plan years beginning on or after October 1,
7 2010.

8 **SEC. 905. IMPLEMENTATION OF HEALTH INFORMATION**
9 **TECHNOLOGY (IT) UNDER MEDICARE.**

10 (a) IN GENERAL.—Not later than January 1, 2010,
11 the Secretary of Health and Human Services shall submit
12 to Congress a report that includes—
13 (1) a plan to develop and implement a health
14 information technology (health IT) system for all
15 health care providers under the Medicare program
16 that meets the specifications described in subsection
17 (b); and
18 (2) an analysis of the impact, feasibility, and
19 costs associated with the use of health information
20 technology in medically underserved communities.
21 (b) PLAN SPECIFICATION.—The specifications de-
22 scribed in this subsection, with respect to a health infor-
23 mation technology system described in subsection (a), are
24 the following:

1 (1) The system protects the privacy and secu-
2 rity of individually identifiable health information.
3 (2) The system maintains and provides per-
4 mitted access to health information in an electronic
5 format (such as through computerized patient
6 records or a clinical data repository).
7 (3) The system utilizes interface software that
8 allows for interoperability.
9 (4) The system includes clinical decision sup-
10 port.
11 (5) The system incorporates e-prescribing and
12 computerized physician order entry.
13 (6) The system incorporates patient tracking
14 and reminders.
15 (7) The system utilizes technology that is open
16 source (if available) or technology that has been de-
17 veloped by the government.
18 The report shall include an analysis of the financial and
19 administrative resources necessary to develop such system
20 and recommendations regarding the level of subsidies
21 needed for all such health care providers to adopt the sys-
22 tem.

1 **SEC. 906. DEVELOPMENT, REPORTING, AND USE OF**
2 **HEALTH CARE MEASURES.**

3 (a) IN GENERAL.—Part E of title XVIII of the Social
4 Security Act (42 U.S.C. 1395x et seq.) is amended by in-
5 serting after section 1889 the following:

6 ''DEVELOPMENT, REPORTING, AND USE OF HEALTH CARE
7 MEASURES

8 ''SEC. 1890. (a) FOSTERING DEVELOPMENT OF
9 HEALTH CARE MEASURES.—The Secretary shall des-
10 ignate, and have in effect an arrangement with, a single
11 organization (such as the National Quality Forum) that
12 meets the requirements described in subsection (c), under
13 which such organization provides the Secretary with ad-
14 vice on, and recommendations with respect to, the key ele-
15 ments and priorities of a national system for establishing
16 health care measures. The arrangement shall be effective
17 beginning no sooner than January 1, 2008, and no later
18 than September 30, 2008.

19 ''(b) DUTIES.—The duties of the organization des-
20 ignated under subsection (a) (in this title referred to as
21 the 'designated organization') shall, in accordance with
22 subsection (d), include—

23 ''(1) establishing and managing an integrated
24 national strategy and process for setting priorities
25 and goals in establishing health care measures;

1 "(2) coordinating the development and speci-
2 fications of such measures;
3 "(3) establishing standards for the development
4 and testing of such measures;
5 "(4) endorsing national consensus health care
6 measures; and
7 "(5) advancing the use of electronic health
8 records for automating the collection, aggregation,
9 and transmission of measurement information.
10 "(c) REQUIREMENTS DESCRIBED.—For purposes of
11 subsection (a), the requirements described in this sub-
12 section, with respect to an organization, are the following:
13 "(1) PRIVATE NONPROFIT.—The organization
14 is a private nonprofit entity governed by a board and
15 an individual designated as president and chief exec-
16 utive officer.
17 "(2) BOARD MEMBERSHIP.—The members of
18 the board of the organization include representatives
19 of—
20 "(A) health care providers or groups rep-
21 resenting such providers;
22 "(B) health plans or groups representing
23 health plans;
24 "(C) groups representing health care con-
25 sumers;

1 "(D) health care purchasers and employers
2 or groups representing such purchasers or em-
3 ployers; and
4 "(E) health care practitioners or groups
5 representing practitioners.
6 "(3) OTHER MEMBERSHIP REQUIREMENTS.—
7 The membership of the organization is representa-
8 tive of individuals with experience with—
9 "(A) urban health care issues;
10 "(B) safety net health care issues;
11 "(C) rural and frontier health care issues;
12 and
13 "(D) health care quality and safety issues.
14 "(4) OPEN AND TRANSPARENT.—With respect
15 to matters related to the arrangement described in
16 subsection (a), the organization conducts its busi-
17 ness in an open and transparent manner and pro-
18 vides the opportunity for public comment.
19 "(5) VOLUNTARY CONSENSUS STANDARDS SET-
20 TING ORGANIZATION.—The organization operates as
21 a voluntary consensus standards setting organization
22 as defined for purposes of section 12(d) of the Na-
23 tional Technology Transfer and Advancement Act of
24 1995 (Public Law 104–113) and Office of Manage-

1 ment and Budget Revised Circular A–119 (published
2 in the Federal Register on February 10, 1998).
3 "(6) EXPERIENCE.—The organization has at
4 least 7 years experience in establishing national con-
5 sensus standards.
6 "(d) REQUIREMENTS FOR EFFECTIVENESS MEAS-
7 URES.—In carrying out its duties under subsection (b),
8 the designated organization shall ensure the following:
9 "(1) MEASURES.—The designated organization
10 shall ensure that the measures established or en-
11 dorsed under subsection (b) are evidence-based, reli-
12 able, and valid; and include—
13 "(A) measures of clinical processes and
14 outcomes, patient experience, efficiency, and eq-
15 uity;
16 "(B) measures to assess effectiveness,
17 timeliness, patient self-management, patient
18 centeredness, and safety; and
19 "(C) measures of under use and over use.
20 "(2) PRIORITIES.—
21 "(A) IN GENERAL.—The designated orga-
22 nization shall ensure that priority is given to es-
23 tablishing and endorsing—

1 ''(i) measures with the greatest poten-
2 tial impact for improving the effectiveness
3 and efficiency of health care;
4 ''(ii) measures that may be rapidly
5 implemented by group health plans, health
6 insurance issuers, physicians, hospitals,
7 nursing homes, long-term care providers,
8 and other providers;
9 ''(iii) measures which may inform
10 health care decisions made by consumers
11 and patients; and
12 ''(iv) measures that apply to multiple
13 services furnished by different providers
14 during an episode of care.
15 ''(B) ANNUAL REPORT ON PRIORITIES;
16 SECRETARIAL PUBLICATION AND COMMENT.—
17 ''(i) ANNUAL REPORT.—The des-
18 ignated organization shall issue and submit
19 to the Secretary a report by March 31 of
20 each year (beginning with 2009) on the or-
21 ganization's recommendations for priorities
22 and goals in establishing and endorsing
23 health care measures under this section
24 over the next five years.

1 "(ii) SECRETARIAL REVIEW AND COM-
2 MENT.—After receipt of the report under
3 clause (i) for a year, the Secretary shall
4 publish the report in the Federal Register,
5 including any comments of the Secretary
6 on the priorities and goals set forth in the
7 report.
8 "(3) RISK ADJUSTMENT.—The designated orga-
9 nization, in consultation with health care measure
10 developers and other stakeholders, shall establish
11 procedures to assure that health care measures es-
12 tablished and endorsed under this section account
13 for differences in patient health status, patient char-
14 acteristics, and geographic location, as appropriate.
15 "(4) MAINTENANCE.—The designated organiza-
16 tion, in consultation with owners and developers of
17 health care measures, shall require the owners or de-
18 velopers of such measures to update and enhance
19 such measures, including the development of more
20 accurate and precise specifications, and retire exist-
21 ing outdated measures. Such updating shall occur
22 not more often than once during each 12-month pe-
23 riod, except in the case of emergent circumstances
24 requiring a more immediate update to a measure.

1 "(e) USE OF HEALTH CARE MEASURES; REPORT-
2 ING.—
3 "(1) USE OF MEASURES.—For purposes of ac-
4 tivities authorized or required under this title, the
5 Secretary shall select from health care measures—
6 "(A) recommended by multi-stakeholder
7 groups; and
8 "(B) endorsed by the designated organiza-
9 tion under subsection (b)(4).
10 "(2) REPORTING.—The Secretary shall imple-
11 ment procedures, consistent with generally accepted
12 standards, to enable the Department of Health and
13 Human Services to accept the electronic submission
14 of data for purposes of—
15 "(A) effectiveness measurement using the
16 health care measures developed pursuant to this
17 section; and
18 "(B) reporting to the Secretary measures
19 used to make value-based payments under this
20 title.
21 "(f) CONTRACTS.—The Secretary, acting through the
22 Agency for Healthcare Research and Quality, may con-
23 tract with organizations to support the development and
24 testing of health care measures meeting the standards es-
25 tablished by the designated organization.

1 "(g) DISSEMINATION OF INFORMATION.—In order to
2 make comparative effectiveness information available to
3 health care consumers, health professionals, public health
4 officials, oversight organizations, researchers, and other
5 appropriate individuals and entities, the Secretary shall
6 work with multi-stakeholder groups to provide for the dis-
7 semination of effectiveness information developed pursu-
8 ant to this title.

9 "(h) FUNDING.—For purposes of carrying out sub-
10 sections (a), (b), (c), and (d), including for expenses in-
11 curred for the arrangement under subsection (a) with the
12 designated organization, there is payable from the Federal
13 Hospital Insurance Trust Fund (established under section
14 1817) and the Federal Supplementary Medical Insurance
15 Trust Fund (established under section 1841)—

16 "(1) for fiscal year 2008, $15,000,000, multi-
17 plied by the ratio of the total number of months in
18 the year to the number of months (and portions of
19 months) of such year during which the arrangement
20 under subsection (a) is effective; and

21 "(2) for each of the fiscal years, 2009 through
22 2012, $15,000,000.".

23 **SEC. 907. IMPROVEMENTS TO THE MEDIGAP PROGRAM.**

24 (a) IMPLEMENTATION OF NAIC RECOMMENDA-
25 TIONS.—The Secretary of Health and Human Services

1 shall provide, under subsections (p)(1)(E) of section 1882
2 of the Social Security Act (42 U.S.C. 1395s), for imple-
3 mentation of the changes in the NAIC model law and reg-
4 ulations recommended by the National Association of In-
5 surance Commissioners in its Model #651 (''Model Regu-
6 lation to Implement the NAIC Medicare Supplement In-
7 surance Minimum Standards Model Act'') on March 11,
8 2007, as modified to reflect the changes made under this
9 Act. In carrying out the previous sentence, the benefit
10 packages classified as ''K'' and ''L'' shall be eliminated
11 and such NAIC recommendations shall be treated as hav-
12 ing been adopted by such Association as of January 1,
13 2008.

14 (b) REQUIRED OFFERING OF A RANGE OF POLI-
15 CIES.—

16 (1) IN GENERAL.—Subsection (o) of such sec-
17 tion is amended by adding at the end the following
18 new paragraph:

19 ''(4) In addition to the requirement of para-
20 graph (2), the issuer of the policy must make avail-
21 able to the individual at least medicare supplemental
22 policies with benefit packages classified as 'C' or
23 'F'.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to medicare supplemental policies issued on or after January 1, 2008.

(c) REMOVAL OF NEW BENEFIT PACKAGES.—Such section is further amended—

(1) in subsection (o)(1), by striking ''(p), (v), and (w)'' and inserting ''(p) and (v)'';

(2) in subsection (v)(3)(A)(i), by striking ''or a benefit package described in subparagraph (A) or (B) of subsection (w)(2)''; and

(3) in subsection (w)—

(A) by striking ''POLICIES'' and all that follows through ''The Secretary'' and inserting ''POLICIES.—The Secretary'';

(B) by striking the second sentence; and

(C) by striking paragraph (2) .

TITLE R—REVENUES

SEC. 1001. INCREASE IN RATE OF EXCISE TAXES ON TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES.

(a) SMALL CIGARETTES.—Paragraph (1) of section 5701(b) of the Internal Revenue Code of 1986 is amended by striking ''$19.50 per thousand ($17 per thousand on cigarettes removed during 2000 or 2001)'' and inserting ''$42 per thousand''.

1 (b) LARGE CIGARETTES.—Paragraph (2) of section
2 5701(b) of such Code is amended by striking ''$40.95 per
3 thousand ($35.70 per thousand on cigarettes removed
4 during 2000 or 2001)'' and inserting ''$88.20 per thou-
5 sand''.

6 (c) SMALL CIGARS.—Paragraph (1) of section
7 5701(a) of such Code is amended by striking ''$1.828
8 cents per thousand ($1.594 cents per thousand on cigars
9 removed during 2000 or 2001)'' and inserting ''$42 per
10 thousand''.

11 (d) LARGE CIGARS.—Paragraph (2) of section
12 5701(a) of such Code is amended—

13 (1) by striking ''20.719 percent (18.063 percent
14 on cigars removed during 2000 or 2001)'' and in-
15 serting ''44.63 percent'', and

16 (2) by striking ''$48.75 per thousand ($42.50
17 per thousand on cigars removed during 2000 or
18 2001)'' and inserting ''$1 per cigar''.

19 (e) CIGARETTE PAPERS.—Subsection (c) of section
20 5701 of such Code is amended by striking ''1.22 cents
21 (1.06 cents on cigarette papers removed during 2000 or
22 2001)'' and inserting ''2.63 cents''.

23 (f) CIGARETTE TUBES.—Subsection (d) of section
24 5701 of such Code is amended by striking ''2.44 cents

1 (2.13 cents on cigarette tubes removed during 2000 or
2 2001)'' and inserting ''5.26 cents''.
3 (g) SNUFF.—Paragraph (1) of section 5701(e) of
4 such Code is amended by striking ''58.5 cents (51 cents
5 on snuff removed during 2000 or 2001)'' and inserting
6 ''$1.26''.
7 (h) CHEWING TOBACCO.—Paragraph (2) of section
8 5701(e) of such Code is amended by striking ''19.5 cents
9 (17 cents on chewing tobacco removed during 2000 or
10 2001)'' and inserting ''42 cents''.
11 (i) PIPE TOBACCO.—Subsection (f) of section 5701
12 of such Code is amended by striking ''$1.0969 cents
13 (95.67 cents on pipe tobacco removed during 2000 or
14 2001)'' and inserting ''$2.36''.
15 (j) ROLL-YOUR-OWN TOBACCO.—
16 (1) IN GENERAL.—Subsection (g) of section
17 5701 of such Code is amended by striking ''$1.0969
18 cents (95.67 cents on roll-your-own tobacco removed
19 during 2000 or 2001)'' and inserting ''$7.4667''.
20 (2) INCLUSION OF CIGAR TOBACCO.—Sub-
21 section (o) of section 5702 of such Code is amended
22 by inserting ''or cigars, or for use as wrappers for
23 making cigars'' before the period at the end.

1 (k) EFFECTIVE DATE.—The amendments made by
2 this section shall apply to articles removed after December
3 31, 2007.
4 (l) FLOOR STOCKS TAXES.—
5 (1) IMPOSITION OF TAX.—On cigarettes manu-
6 factured in or imported into the United States which
7 are removed before January 1, 2008, and held on
8 such date for sale by any person, there is hereby im-
9 posed a tax in an amount equal to the excess of—
10 (A) the tax which would be imposed under
11 section 5701 of the Internal Revenue Code of
12 1986 on the article if the article had been re-
13 moved on such date, over
14 (B) the prior tax (if any) imposed under
15 section 5701 of such Code on such article.
16 (2) AUTHORITY TO EXEMPT CIGARETTES HELD
17 IN VENDING MACHINES.—To the extent provided in
18 regulations prescribed by the Secretary, no tax shall
19 be imposed by paragraph (1) on cigarettes held for
20 retail sale on January 1, 2008, by any person in any
21 vending machine. If the Secretary provides such a
22 benefit with respect to any person, the Secretary
23 may reduce the $500 amount in paragraph (3) with
24 respect to such person.

(3) CREDIT AGAINST TAX.—Each person shall be allowed as a credit against the taxes imposed by paragraph (1) an amount equal to $500. Such credit shall not exceed the amount of taxes imposed by paragraph (1) for which such person is liable.

(4) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) LIABILITY FOR TAX.—A person holding cigarettes on January 1, 2008, to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(C) TIME FOR PAYMENT.—The tax imposed by paragraph (1) shall be paid on or before April 14, 2008.

(5) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (48 Stat. 998, 19 U.S.C. 81a) and any other provision of law, any article which is located in a foreign trade zone on January 1, 2008, shall be subject to the tax imposed by paragraph (1) if—

1 (A) internal revenue taxes have been deter-
2 mined, or customs duties liquidated, with re-
3 spect to such article before such date pursuant
4 to a request made under the 1st proviso of sec-
5 tion 3(a) of such Act, or
6 (B) such article is held on such date under
7 the supervision of a customs officer pursuant to
8 the 2d proviso of such section 3(a).
9 (6) DEFINITIONS.—For purposes of this sub-
10 section—
11 (A) IN GENERAL.—Terms used in this sub-
12 section which are also used in section 5702 of
13 the Internal Revenue Code of 1986 shall have
14 the respective meanings such terms have in
15 such section.
16 (B) SECRETARY.—The term ''Secretary''
17 means the Secretary of the Treasury or the
18 Secretary's delegate.
19 (7) CONTROLLED GROUPS.—Rules similar to
20 the rules of section 5061(e)(3) of such Code shall
21 apply for purposes of this subsection.
22 (8) OTHER LAWS APPLICABLE.—All provisions
23 of law, including penalties, applicable with respect to
24 the taxes imposed by section 5701 of such Code
25 shall, insofar as applicable and not inconsistent with

the provisions of this subsection, apply to the floor stocks taxes imposed by paragraph (1), to the same extent as if such taxes were imposed by such section 5701. The Secretary may treat any person who bore the ultimate burden of the tax imposed by paragraph (1) as the person to whom a credit or refund under such provisions may be allowed or made.

SEC. 1002. EXEMPTION FOR EMERGENCY MEDICAL SERVICES TRANSPORTATION.

(a) IN GENERAL.—Subsection (l) of section 4041 of the Internal Revenue Code of 1986 is amended to read as follows:

"(l) EXEMPTION FOR CERTAIN USES.—

"(1) CERTAIN AIRCRAFT.—No tax shall be imposed under this section on any liquid sold for use in, or used in, a helicopter or a fixed-wing aircraft for purposes of providing transportation with respect to which the requirements of subsection (f) or (g) of section 4261 are met.

"(2) EMERGENCY MEDICAL SERVICES.—No tax shall be imposed under this section on any liquid sold for use in, or used in, any ambulance for purposes of providing transportation for emergency medical services. The preceding sentence shall not apply to any liquid used after December 31, 2012.".

1 (b) FUELS NOT USED FOR TAXABLE PURPOSES.—
2 Section 6427 of such Code is amended by inserting after
3 subsection (e) the following new subsection:
4 ''(f) USE TO PROVIDE EMERGENCY MEDICAL SERV-
5 ICES.—Except as provided in subsection (k), if any fuel
6 on which tax was imposed by section 4081 or 4041 is used
7 in an ambulance for a purpose described in section
8 4041(l)(2), the Secretary shall pay (without interest) to
9 the ultimate purchaser of such fuel an amount equal to
10 the aggregate amount of the tax imposed on such fuel.
11 The preceding sentence shall not apply to any liquid used
12 after December 31, 2012.''.
13 (c) TIME FOR FILING CLAIMS; PERIOD COVERED.—
14 Paragraphs (1) and (2)(A) of section 6427(i) of such Code
15 are each amended by inserting ''(f),'' after ''(d),''.
16 (d) CONFORMING AMENDMENT.—Section 6427(d) of
17 such Code is amended by striking ''4041(l)'' and inserting
18 ''4041(l)(1)''.
19 (e) EFFECTIVE DATE.—The amendments made by
20 this section shall apply to fuel used in transportation pro-
21 vided in quarters beginning after the date of the enact-
22 ment of this Act.