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110TH CONGRESS
1st Session

HOUSE OF REPRESENTATIVES

REPT. 110–284
Part 1

CHILDREN'S HEALTH AND MEDICARE PROTECTION ACT OF 2007

R E P O R T

OF THE

COMMITTEE ON WAYS AND MEANS

TOGETHER WITH

DISSENTING VIEWS

[TO ACCOMPANY H.R. 3162]

Filed on AUGUST 1 (legislative day, JULY 31), 2007.—Ordered to be printed

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110TH CONGRESS 1st Session } HOUSE OF REPRESENTATIVES { REPT. 110–284 Part 1

CHILDREN'S HEALTH AND MEDICARE PROTECTION ACT OF 2007

Filed on AUGUST 1 (legislative day, JULY 31), 2007.—Ordered to be printed

Mr. RANGEL, from the Committee on Ways and Means, submitted the following

R E P O R T

together with

DISSENTING VIEWS

[To accompany H.R. 3162]

[Including cost estimate of the Congressional Budget Office]

The Committee on Ways and Means, to whom was referred the bill (H.R. 3162) to amend titles XVIII, XIX, and XXI of the Social Security Act to extend and improve the children's health insurance program, to improve beneficiary protections under the Medicare, Medicaid, and the CHIP program, and for other purposes, having considered the same, report favorably thereon with an amendment and recommend that the bill as amended do pass.

C O N T E N T S

	Page
I. Introduction	121
A. Purpose and Summary	121
B. Background and Need for Legislation	121
C. Legislative History	124
II. Explanation of Provisions	127
A. Title II—Medicare Beneficiary Improvements	127
B. Title III—Physician's Service Payment Reform	158
C. Title IV—Medicare Advantage Reforms	178
D. Title V—Provisions Relating to Medicare Part A	200
E. Title VI—Other Provisions Relating to Medicare Part B	215
F. Title VII—Provisions Relating to Medicare Parts A and B	244
G. Title IX—Miscellaneous	249
H. Title X—Revenues	264
III. Votes of the Committee	271
IV. Budget Effects of the Bill	284
V. Other Matters Required to be Discussed Under House Rules	298

VI. Changes in Existing Law Made by the Bill, as Reported 299
VII. Views 553

The amendment is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

(b) TABLE OF CONTENTS.—The table of contents of 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 II—MEDICARE BENEFICIARY IMPROVEMENTS

Subtitle A—Improvements in Benefits

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

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

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

Subtitle C—Part D Beneficiary Improvements

Sec. 221. Including costs incurred by AIDS drug assistance programs and Indian Health Service in providing prescription drugs toward the annual out of pocket threshold under Part D.
Sec. 222. Permitting mid-year changes in enrollment for formulary changes adversely impact an enrollee.
Sec. 223. Removal of exclusion of benzodiazepines from required coverage under the Medicare prescription drug program.
Sec. 224. Permitting updating drug compendia under part D using part B update process.

Sec. 225. Codification of special protections for six protected drug classifications.
Sec. 226. Elimination of Medicare part D late enrollment penalties paid by low-income subsidy-eligible individuals.
Sec. 227. Special enrollment period for subsidy eligible individuals.

Subtitle D—Reducing Health Disparities

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

TITLE III—PHYSICIANS' SERVICE PAYMENT REFORM

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

TITLE IV—MEDICARE ADVANTAGE REFORMS

Subtitle A—Payment Reform

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

Subtitle B—Beneficiary Protections

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

Subtitle C—Quality and Other Provisions

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

Subtitle D—Extension of Authorities

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

TITLE V—PROVISIONS RELATING TO MEDICARE PART A

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

TITLE VI—OTHER PROVISIONS RELATING TO MEDICARE PART B

Subtitle A—Payment and Coverage Improvements

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

Subtitle B—Extension of Medicare Rural Access Protections

Sec. 621. 2-year extension of floor on medicare work geographic adjustment.
Sec. 622. 2-year extension of special treatment of certain physician pathology services under Medicare.
Sec. 623. 2-year extension of medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas.

Sec. 624. 2-year extension of Medicare incentive payment program for physician scarcity areas.
Sec. 625. 2-year extension of medicare increase payments for ground ambulance services in rural areas.
Sec. 626. Extending hold harmless for small rural hospitals under the HOPD prospective payment system.

Subtitle C—End Stage Renal Disease Program

Sec. 631. Chronic kidney disease demonstration projects.
Sec. 632. Medicare coverage of kidney disease patient education services.
Sec. 633. Required training for patient care dialysis technicians.
Sec. 634. MedPAC report on treatment modalities for patients with kidney failure.
Sec. 635. Adjustment for erythropoietin stimulating agents (ESAs).
Sec. 636. Site neutral composite rate.
Sec. 637. Development of ESRD bundling system and quality incentive payments.
Sec. 638. MedPAC report on ESRD bundling system.
Sec. 639. OIG study and report on erythropoietin.

Subtitle D—Miscellaneous

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

TITLE VII—PROVISIONS RELATING TO MEDICARE PARTS A AND B

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

TITLE VIII—MEDICAID

Subtitle A—Protecting Existing Coverage

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

Subtitle B—Payments

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

Subtitle C—Miscellaneous

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

TITLE IX—MISCELLANEOUS

Sec. 901. Medicare Payment Advisory Commission status.
Sec. 902. Repeal of trigger provision.
Sec. 903. Repeal of comparative cost adjustment (CCA) program.
Sec. 904. Comparative effectiveness research.
Sec. 905. Implementation of Health information technology (IT) under Medicare.
Sec. 906. Development, reporting, and use of health care measures.
Sec. 907. Improvements to the Medigap program.
Sec. 908. Implementation funding.

TITLE X—REVENUES

Sec. 1001. Increase in rate of excise taxes on tobacco products and cigarette papers and tubes.
Sec. 1002. Exemption for emergency medical services transportation.

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—

(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 section 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 enrolled under the State plan under this title (including children receiving health care coverage through funds under this title pur-

suant to a waiver under section 1115) during such fiscal year exceeds its target average number of such enrollees (as determined under subparagraph (B)) for that fiscal year, the allotment under this section for the State for the subsequent fiscal year (or, pursuant to subparagraph (F), for the fiscal year involved) shall be increased by the product of—

"(i) the amount by which such average monthly caseload exceeds such target number of enrollees; and

"(ii) the projected per capita expenditures under the State child health plan (as determined under subparagraph (C) for the original fiscal year involved), multiplied by the enhanced FMAP (as defined in section 2105(b)) for the State and fiscal year involved

"(B) TARGET AVERAGE NUMBER OF CHILD ENROLLEES.—In this subsection, the target average number of child enrollees for a State—

"(i) for fiscal year 2008 is equal to the monthly average unduplicated number of children enrolled in the State child health plan under this title (including such children receiving health care coverage through funds under this title pursuant to a waiver under section 1115) 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 target average number of child enrollees for the State for the previous fiscal year increased by the population growth for children in that State for the year ending on June 30 before the beginning of the fiscal year (as estimated by the Bureau of the Census) plus 1 percentage point.

"(C) PROJECTED PER CAPITA EXPENDITURES.—For purposes of subparagraph (A)(ii), the projected per capita expenditures under a State child health plan—

"(i) for fiscal year 2008 is equal to the average per capita expenditures (including both State and Federal financial participation) under such plan for the targeted low-income children counted in the average monthly caseload for purposes of this paragraph during fiscal year 2007, increased by the annual percentage increase in the per capita amount of National Health Expenditures (as estimated by the Secretary) for 2008; or

"(ii) for a subsequent fiscal year is equal to the projected per capita expenditures under such plan for the previous fiscal year (as determined under clause (i) or this clause) increased by the annual percentage increase in the per capita amount of National Health Expenditures (as estimated by the Secretary) for the year in which such subsequent fiscal year ends.

"(D) AVAILABILITY.—Notwithstanding subsection (e), an increase in allotment under this paragraph shall only be available for expenditure during the fiscal year in which it is provided.

"(E) NO REDISTRIBUTION OF PERFORMANCE-BASED SHORTFALL ADJUSTMENT.—In no case shall any increase in allotment under this paragraph for a State be subject to redistribution to other States.

"(F) INTERIM ALLOTMENT ADJUSTMENT.—The Secretary shall develop a process to administer the performance-based shortfall adjustment in a manner so it is applied to (and before the end of) the fiscal year (rather than the subsequent fiscal year) involved for a State that the Secretary estimates will be in shortfall and will exceed its enrollment target for that fiscal year.

"(G) PERIODIC AUDITING.—The Comptroller General of the United States shall periodically audit the accuracy of data used in the computation of allotment adjustments under this paragraph. Based on such audits, the Comptroller General shall make such recommendations to the Congress and the Secretary as the Comptroller General deems appropriate.

"(4) CONTINUED REPORTING.—For purposes of paragraph (3) and subsection (f), the State shall submit to the Secretary the State's projected Federal expenditures, even if the amount of such expenditures exceeds the total amount of allotments available to the State in such fiscal year.".

SEC. 102. 2-YEAR INITIAL AVAILABILITY OF CHIP ALLOTMENTS.

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

"(e) AVAILABILITY OF AMOUNTS ALLOTTED.—

"(1) IN GENERAL.—Except as provided in paragraph (2) and subsection (i)(3)(D), amounts allotted to a State pursuant to this section—

"(A) for each of fiscal years 1998 through 2007, shall remain available for expenditure by the State through the end of the second succeeding fiscal year; and

"(B) for fiscal year 2008 and each fiscal year thereafter, shall remain available for expenditure by the State through the end of the succeeding fiscal year.

"(2) AVAILABILITY OF AMOUNTS REDISTRIBUTED.—Amounts redistributed to a State under subsection (f) shall be available for expenditure by the State through the end of the fiscal year in which they are redistributed, except that funds so redistributed 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.

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

"(i) FOR ABOVE BASELINE MEDICAID CHILD ENROLLMENT COSTS.—

"(I) FIRST TIER ABOVE BASELINE MEDICAID ENROLLEES.—An amount equal to the number of first tier above baseline child enrollees (as determined under subparagraph (C)(i)) under title XIX for the State and fiscal year multiplied by 35 percent of the projected per capita State Medicaid expenditures (as determined under subparagraph (D)(i)) for the State and fiscal year under title XIX.

"(II) SECOND TIER ABOVE BASELINE MEDICAID ENROLLEES .—An amount equal to the number of second tier above baseline child enrollees (as determined under subparagraph (C)(ii)) under title XIX for the State and fiscal year multiplied by 90 percent of the projected per capita State Medicaid expenditures (as determined under subparagraph (D)(i)) for the State and fiscal year under title XIX.

"(ii) FOR ABOVE BASELINE CHIP ENROLLMENT COSTS.—

"(I) FIRST TIER ABOVE BASELINE CHIP ENROLLEES.—An amount equal to the number of first tier above baseline child enrollees under this title (as determined under subparagraph (C)(i)) for the State and fiscal year multiplied by 5 percent of the projected per capita State CHIP expenditures (as determined under subparagraph (D)(ii)) for the State and fiscal year under this title.

"(II) SECOND TIER ABOVE BASELINE CHIP ENROLLEES.—An amount equal to the number of second tier above baseline child enrollees under this title (as determined under subparagraph (C)(ii)) for the State and fiscal year multiplied by 75 percent of the projected per capita State CHIP expenditures (as determined under subparagraph (D)(ii)) for the State and fiscal year under this title.

"(C) NUMBER OF FIRST AND SECOND TIER ABOVE BASELINE CHILD ENROLLEES; BASELINE NUMBER OF CHILD ENROLLEES.—For purposes of this paragraph:

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

"(I) the monthly average unduplicated number of qualifying children (as defined in subparagraph (E)) enrolled during the fiscal year under the State child health plan under this title or under the State plan under title XIX, respectively; exceeds

"(II) the baseline number of enrollees described in clause (iii) for the State and fiscal year under this title or title XIX, respectively;

but not to exceed 3 percent (in the case of title XIX) or 7.5 percent (in the case of this title) of the baseline number of enrollees described in subclause (II).

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

"(I) the monthly average unduplicated number of qualifying children (as defined in subparagraph (E)) enrolled during the fiscal year under this title or under title XIX, respectively, as described in clause (i)(I); exceeds

"(II) the sum of the baseline number of child enrollees described in clause (iii) for the State and fiscal year under this title or title XIX, respectively, as described in clause (i)(II), and the maximum number of 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 June 30 before the beginning of the fiscal year (as estimated by the Bureau of the Census) plus 1 percentage point.

"(D) PROJECTED PER CAPITA STATE EXPENDITURES.—For purposes of subparagraph (B)—

"(i) PROJECTED PER CAPITA STATE MEDICAID EXPENDITURES.—The projected per capita State Medicaid expenditures for a State and fiscal year under title XIX is equal to the average per capita expenditures (including both State and Federal financial participation) for children under the State plan under such title, including under waivers but not including such children eligible for assistance by virtue of the receipt of benefits under title XVI, for the most recent fiscal year for which actual data are available (as determined by the Secretary), increased (for each subsequent fiscal year up to and including the fiscal year involved) by the annual percentage increase in per capita amount of National Health Expenditures (as estimated by the Secretary) for the calendar year in which the respective subsequent fiscal year ends and multiplied by a State matching percentage equal to 100 percent minus the Federal medical assistance percentage (as defined in section 1905(b)) for the fiscal year involved.

"(ii) PROJECTED PER CAPITA STATE CHIP EXPENDITURES.—The projected per capita State CHIP expenditures for a State and fiscal year under this title is equal to the average per capita expenditures (including both State and Federal financial participation) for children under the State child health plan under this title, including under waivers, for the most recent fiscal year for which actual data are available (as determined by the Secretary), increased (for each subsequent fiscal year up to and including the fiscal year involved) by the annual percentage increase in per capita amount of National Health Expenditures (as estimated by the Secretary) for the calendar year in which the 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 eligibility for a full 12 months for all children described in section 1902(e)(12) under title XIX under 19 years of age, as well as applying such policy under its State child health plan under this title.

"(B) LIBERALIZATION OF ASSET REQUIREMENTS.—The State meets the requirement specified in either of the following clauses:

"(i) ELIMINATION OF ASSET TEST.—The State does not apply any asset or resource test for eligibility for children under title XIX or this title.

"(ii) ADMINISTRATIVE VERIFICATION OF ASSETS.—The State—

"(I) permits a parent or caretaker relative who is applying on behalf of a child for medical assistance under title XIX or child health assistance under this title to declare and certify by signature under penalty of perjury information relating to family assets for purposes of determining and redetermining financial eligibility; and

"(II) takes steps to verify assets through means other than by requiring documentation from parents and applicants except in individual cases of discrepancies or where otherwise justified.

"(C) ELIMINATION OF IN-PERSON INTERVIEW REQUIREMENT.—The State does not require an application of a child for medical assistance under title XIX (or for child health assistance under this title), including an application for renewal of such assistance, to be made in person nor does the State require a face-to-face interview, unless there are discrepancies or individual circumstances justifying an in-person application or face-to-face interview.

"(D) USE OF JOINT APPLICATION FOR MEDICAID AND CHIP.—The application form and supplemental forms (if any) and information verification process is the same for purposes of establishing and renewing eligibility for children for medical assistance under title XIX and child health assistance under this title.

"(E) AUTOMATIC RENEWAL (USE OF ADMINISTRATIVE RENEWAL).—

"(i) IN GENERAL.—The State provides, in the case of renewal of a child's eligibility for medical assistance under title XIX or child health assistance under this title, a pre-printed form completed by the State based on the information available to the State and notice to the parent or caretaker relative of the child that eligibility of the child will be renewed and continued based on such information unless the State is provided other information. Nothing in this clause shall be construed as preventing a State from verifying, through electronic and other means, the information so provided.

"(ii) SATISFACTION THROUGH DEMONSTRATED USE OF EX PARTE PROCESS.—A State shall be treated as satisfying the requirement of clause (i) if renewal of eligibility of children under title XIX or this title is determined without any requirement for an in-person interview, unless sufficient information is not in the State's possession and cannot be acquired from other sources (including other State agencies) without the participation of the applicant or the applicant's parent or caretaker relative.

"(F) PRESUMPTIVE ELIGIBILITY FOR CHILDREN.—The State is implementing section 1920A under title XIX as well as, pursuant to section 2107(e)(1), under this title .

"(G) EXPRESS LANE.—The State is implementing the option described in section 1902(e)(13) under title XIX as well as, pursuant to section 2107(e)(1), under this title.".

SEC. 112. STATE OPTION TO RELY ON FINDINGS FROM AN EXPRESS LANE AGENCY TO CONDUCT SIMPLIFIED ELIGIBILITY DETERMINATIONS.

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

"(13) EXPRESS LANE OPTION.—

"(A) IN GENERAL.—

"(i) OPTION TO USE A FINDING FROM AN EXPRESS LANE AGENCY.—At the option of the State, the State plan may provide that in determining eligibility under this title for a child (as defined in subparagraph (F)), the State may rely on a finding made within a reasonable period (as determined by the State) from an Express Lane agency (as defined in subparagraph (E)) when it determines whether a child satisfies one or more components of eligibility for medical assistance under this title. The State may rely on a finding from an Express Lane agency notwithstanding sections 1902(a)(46)(B), 1903(x), and 1137(d) and any differences in budget unit, disregard, deeming or other methodology, if the following requirements are met:

"(I) PROHIBITION ON DETERMINING CHILDREN INELIGIBLE FOR COVERAGE.—If a finding from an Express Lane agency would result in a determination that a child does not satisfy an eligibility requirement for medical assistance under this title and for child health assistance under title XXI, the State shall determine eligibility for assistance using its regular procedures.

"(II) NOTICE REQUIREMENT.—For any child who is found eligible for medical assistance under the State plan under this title or child health assistance under title 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—

"(i) to limit or prohibit a State from taking any actions otherwise permitted under this title or title XXI in determining eligibility for or enrolling children into medical assistance under this title or child health assistance under title XXI; or

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

"(C) OPTIONS FOR SATISFYING THE SCREEN AND ENROLL REQUIREMENT.—

"(i) IN GENERAL.—With respect to a child whose eligibility for medical assistance under this title or for child health assistance under title XXI has been evaluated by a State agency using an income finding from an Express Lane agency, a State may carry out its duties under subparagraphs (A) and (B) of section 2102(b)(3) (relating to screen and enroll) in accordance with either clause (ii) or clause (iii).

"(ii) ESTABLISHING A SCREENING THRESHOLD.—

"(I) IN GENERAL.—Under this clause, the State establishes a screening threshold set as a percentage of the Federal poverty level that exceeds the highest income threshold applicable under this title to the child by a minimum of 30 percentage points or, at State option, a higher number of percentage points that reflects the value (as determined by the State and described in the State plan) of any differences between income methodologies used by the program administered by the Express Lane agency and the methodologies used by the State in determining eligibility for medical assistance under this title.

"(II) CHILDREN WITH INCOME NOT ABOVE THRESHOLD.—If the income of a child does not exceed the screening threshold, the child is deemed to satisfy the income eligibility criteria for medical assistance under this title regardless of whether such child would otherwise satisfy such criteria.

"(III) CHILDREN WITH INCOME ABOVE THRESHOLD.—If the income of a child exceeds the screening threshold, the 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 differences in cost-sharing requirements and covered benefits.

"(iii) TEMPORARY ENROLLMENT IN CHIP PENDING SCREEN AND ENROLL.—

"(I) IN GENERAL.—Under this clause, a State enrolls a child in child health assistance under title XXI for a temporary period if the child appears eligible for such assistance based on an income finding by an Express Lane agency.

"(II) DETERMINATION OF ELIGIBILITY.—During such temporary enrollment period, the State shall determine the child's eligibility for child health assistance under title XXI or for medical assistance under this title in accordance with this clause.

"(III) PROMPT FOLLOW UP.—In making such a determination, the State shall take prompt action to determine whether the child should be enrolled in medical assistance under this title or child health assist-

ance under title XXI pursuant to subparagraphs (A) and (B) of section 2102(b)(3) (relating to screen and enroll).

"(IV) REQUIREMENT FOR SIMPLIFIED DETERMINATION.—In making such a determination, the State shall use procedures that, to the maximum feasible extent, reduce the burden imposed on the individual of such determination. Such procedures may not require the child's parent, guardian, or custodial relative to provide or verify information that already has been provided to the State agency by an Express Lane agency or another source of information unless the State agency has reason to believe the information is erroneous.

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

"(D) OPTION FOR AUTOMATIC ENROLLMENT.—

"(i) IN GENERAL.—At its option, a State may initiate an evaluation of an individual's eligibility 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.

"(E) EXPRESS LANE AGENCY DEFINED.—In this paragraph, the term 'express lane agency' means an agency that meets the following requirements:

"(i) The agency determines eligibility for assistance under the Food Stamp Act of 1977, the Richard B. Russell National School Lunch Act, the Child Nutrition Act of 1966, or the Child Care and Development Block Grant Act of 1990.

"(ii) The agency notifies the child (or a parent, caretaker relative, or guardian on the behalf of the child)—

"(I) of the information which shall be disclosed;

"(II) that the information will be used by the State solely for purposes of determining eligibility for and for providing medical assistance under this title or child health assistance under title XXI; and

"(III) that the child, or parent, caretaker relative, or guardian, may elect to not have the information disclosed for such purposes.

"(iii) The agency and the State agency are subject to an interagency agreement limiting the disclosure and use of such information to such purposes.

"(iv) The agency is determined by the State agency to be capable of making the determinations described in this paragraph and is identified in the State plan under this title or title XXI.

For purposes of this subparagraph, the term 'State agency' refers to the agency determining eligibility for medical assistance under this title or child health assistance under title XXI.

"(F) CHILD DEFINED.—For purposes of this paragraph, the term 'child' means an individual under 19 years of age, or, at the option of a State, such higher age, not to exceed 21 years of age, as the State may elect.".

(b) CHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)) is amended by redesignating subparagraphs (B), (C), and (D) as subparagraphs (E), (H), and (I), respectively, and by inserting after subparagraph (A) the following new subparagraph:

"(C) Section 1902(e)(13) (relating to the State option to rely on findings from an Express Lane agency to help evaluate a child's eligibility for medical assistance).".

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

"(dd) ELECTRONIC TRANSMISSION OF INFORMATION.—If the State agency determining eligibility for medical assistance under this title or child health assistance under title XXI verifies an element of eligibility based on information from an Express Lane Agency (as defined in subsection (e)(13)(F)), or from another public agency, then the applicant's signature under penalty of perjury shall not be required as to such element. Any signature requirement for an application for medical assistance may be satisfied through an electronic signature, as defined in section 1710(1) of the Government Paperwork Elimination Act (44 U.S.C. 3504 note). The requirements of subparagraphs (A) and (B) of section 1137(d)(2) may be met through evidence in digital or electronic form.".

(d) AUTHORIZATION OF INFORMATION DISCLOSURE.—

(1) IN GENERAL.—Title XIX of the Social Security Act is amended—

(A) by redesignating section 1939 as section 1940; and

(B) by inserting after section 1938 the following new section:

"SEC. 1939. AUTHORIZATION TO RECEIVE PERTINENT INFORMATION.

"(a) IN GENERAL.—Notwithstanding any other provision of law, a Federal or State agency or private entity in possession of the sources of data potentially pertinent to eligibility determinations under this title (including eligibility files maintained by Express Lane agencies described in section 1902(e)(13)(F), information described in paragraph (2) or (3) of section 1137(a), vital records information about births in any State, and information described in sections 453(i) and 1902(a)(25)(I)) is authorized to convey such data or information to the State agency administering the State plan under this title, to the extent such conveyance meets the requirements of subsection (b).

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

"(1) The individual whose circumstances are described in the data or information (or such individual's parent, guardian, caretaker relative, or authorized representative) has either provided advance consent to disclosure or has not objected to disclosure after receiving advance notice of disclosure and a reasonable opportunity to object.

"(2) Such data or information are used solely for the purposes of—

"(A) identifying individuals who are eligible or potentially eligible for medical assistance under this title and enrolling or attempting to enroll such individuals in the State plan; and

"(B) verifying the eligibility of individuals for medical assistance under the State plan.

"(3) An interagency or other agreement, consistent with standards developed by the Secretary—

"(A) prevents the unauthorized use, disclosure, or modification of such data and otherwise meets applicable Federal requirements safeguarding privacy and data security; and

"(B) requires the State agency administering the State plan to use the data and information obtained under this section to seek to enroll individuals in the plan.

"(c) CRIMINAL PENALTY.—A private entity described in the subsection (a) that publishes, discloses, or makes known in any manner, or to any extent not authorized by Federal law, any information obtained under this section 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:

"(J) 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.

SEC. 114. ENCOURAGING CULTURALLY APPROPRIATE ENROLLMENT AND RETENTION PRACTICES.

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

"(E) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to translation or interpretation services in connection with the enrollment and retention under this title of children of families for whom English is not the primary language; plus".

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

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

(2) IN FEDERAL EVALUATION.—Section 2108(c)(3)(B) of such Act (42 U.S.C. 1397hh(c)(3)(B)) is amended by inserting "(such as through community health workers and others)" 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 (C) the following new subparagraph:

"(D) 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 described in subparagraph (B) of such subsection)" after "75 percent".

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

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

(1) IN GENERAL.—Section 1937(a)(1) of the Social Security Act (42 U.S.C. 1396u–7(a)(1)) is amended—

(A) in subparagraph (A)—

(i) in the matter before clause (i), by striking "Notwithstanding any other provision of this title" and inserting "Subject to subparagraph (E)"; and

(ii) by striking "enrollment in coverage that provides" and all that follows and inserting "benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2).";

(B) by striking subparagraph (C) and inserting 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 services 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 amended by inserting before the period at the end the following: "if the health benefits coverage is at least equivalent to the benefits coverage in a benchmark benefit package described in subsection (b)".

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

(b) REQUIREMENT FOR MOST POPULAR FAMILY COVERAGE FOR STATE EMPLOYEE COVERAGE BENCHMARK.—

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

(2) MEDICAID.—Section 1937(b)(1)(B) of such Act is amended by inserting "and that has been selected most frequently, by employees seeking dependent coverage, among such plans that provide such dependent coverage, in either of the previous 2 plan years" before the period at the end.

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

SEC. 123. PREMIUM GRACE PERIOD.

(a) IN GENERAL.—Section 2103(e)(3) of the Social Security Act (42 U.S.C. 1397cc(e)(3)) is amended by adding at the end the following new subparagraph:

"(C) PREMIUM GRACE PERIOD.—The State child health plan—

"(i) shall afford individuals enrolled under the plan a grace period of at least 30 days from the beginning of a new coverage period to make premium payments before the individual's coverage under the plan may be terminated; and

"(ii) shall provide to such an individual, not later than 7 days after the first day of such grace period, notice—

"(I) that failure to make a premium payment within the grace period will result in termination of coverage under the State child health 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.—

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

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

(C) Section 1905(a) of such Act (42 U.S.C. 1396d(a)) is amended, in clause (i), by inserting "or under such higher age as the State has elected under subsection (l)(1)(D)" after "as the State may choose".

(D) Section 1920A(b)(1) of such Act (42 U.S.C. 1396r–1a(b)(1)) is amended by inserting "or under such higher age as the State has elected under section 1902(l)(1)(D)" after "19 years of age".

(E) Section 1928(h)(1) of such Act (42 U.S.C. 1396s(h)(1)) is amended by striking "18 years of age or younger" and inserting "under 19 years of age or under such higher age as the State has elected under section 1902(l)(1)(D)".

(F) Section 1932(a)(2)(A) of such Act (42 U.S.C. 1396u–2(a)(2)(A)) is amended by inserting "(or under such higher age as the State has elected under section 1902(l)(1)(D))" after "19 years of age".

(b) TITLE XXI.—Section 2110(c)(1) of such Act (42 U.S.C. 1397jj(c)(1)) is amended by inserting "(or, at the option of the State and subject to section 131(d) of the Children's Health and Medicare Protection Act of 2007, under such higher age as the State has elected under section 1902(l)(1)(D))" after "19 years of age".

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

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

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

(2) for 2011, 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 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 otherwise eligible for such assistance, within either or both of the following eligibility categories:

"(i) PREGNANT WOMEN.—Women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

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

"(B) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of medical assistance to such category and the cost of such assistance shall not be considered as an unreimbursed cost.".

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

"(F) Section 1903(v)(4)(A) (relating to optional coverage of certain categories of lawfully 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.

"(G) 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 enrollment cap or other numerical limitation on enrollment, any waiting list, any procedures designed to delay the consideration of applications for enrollment, or similar limitation with respect to enrollment.

"(b) DEFINITIONS.—For purposes of this title:

"(1) ASSISTANCE FOR PREGNANT WOMEN.—The term 'assistance for pregnant women' has the meaning given the term child health assistance in section 2110(a) as if any reference to targeted low-income children were a reference to targeted low-income pregnant women.

"(2) TARGETED LOW-INCOME PREGNANT WOMAN.—The term 'targeted low-income pregnant woman' means a woman—

"(A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends;

"(B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (a)(1)(A)) of the poverty level applicable to a family of the size involved, but does not exceed the income eligibility level established 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).

"(4) In applying section 2102(b)(3)(B), any reference to children found through screening to be eligible for medical assistance under the State medicaid plan under title XIX is deemed a reference to pregnant women.

"(5) There shall be no exclusion of benefits for services described in subsection (b)(1) based on any preexisting condition and no waiting period (including any waiting period imposed to carry out section 2102(b)(3)(C)) shall apply.

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

"(7) In applying section 2104(i)—

"(A) in the case of a State which did not provide for coverage for pregnant women under this title (under a waiver or otherwise) during fiscal year 2007, the allotment amount otherwise computed for the first fiscal year in which the State elects to provide coverage under this section shall be increased by an amount (determined by the Secretary) equal to the enhanced FMAP of the expenditures under this title for such coverage, based upon projected enrollment and per capita costs of such enrollment; and

"(B) in the case of a State which provided for coverage of pregnant women under this title for the previous fiscal year—

"(i) in applying paragraph (2)(B) of such section, there shall also be taken into account (in an appropriate proportion) the percentage increase in births in the State for the relevant period; and

"(ii) in applying paragraph (3), pregnant women (and per capita expenditures for such women) shall be accounted for separately from children, but shall be included in the total amount of any allotment adjustment under such paragraph.

"(d) AUTOMATIC ENROLLMENT FOR CHILDREN BORN TO WOMEN RECEIVING ASSISTANCE FOR PREGNANT WOMEN.—If a child is born to a targeted low-income pregnant woman who was receiving assistance for pregnant women under this section on the date of the child's birth, the child shall be deemed to have applied for child health assistance under the State child health plan and to have been found eligible for such assistance under such plan or to have applied for medical assistance under title XIX and to have been found eligible for such assistance under such title on the date of such birth, based on the mother's reported income as of the time of her enrollment under this section and applicable income eligibility levels under this title and title XIX, and to remain eligible for such assistance until the child attains 1 year of age. During the period in which a child is deemed under the preceding sentence to be eligible for child health or medical assistance, the assistance for pregnant women or medical assistance eligibility identification number of the mother shall also serve as the identification number of the child, and all claims shall be submitted and paid under such number (unless the State issues a separate identification number for the child before such period expires).".

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

"(I) Sections 1920 and 1920A (relating to presumptive eligibility for pregnant women and children).".

(b) AMENDMENTS TO MEDICAID.—

(1) ELIGIBILITY OF A NEWBORN.—Section 1902(e)(4) of the Social Security Act (42 U.S.C. 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—

"(A) review Federal and State payment policies of the Medicaid program established under this title (in this section referred to as 'Medicaid') and the State Children's Health Insurance Program established under title XXI (in this section referred to as 'CHIP'), including topics described in paragraph (2);

"(B) review access to, and affordability of, coverage and services for enrollees under Medicaid and CHIP;

"(C) make recommendations to Congress concerning such policies;

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

"(E) by not later than June 1 of each year, submit to Congress a report containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

"(2) SPECIFIC TOPICS TO BE REVIEWED.—Specifically, the Commission shall review the following:

"(A) The factors affecting expenditures for services in different sectors (such as physician, hospital and other sectors), payment methodologies, and their relationship to access and quality of care for Medicaid and CHIP beneficiaries.

"(B) The impact of Federal and State Medicaid and CHIP payment policies on access to services (including dental services) for children (including children with disabilities) and other Medicaid and CHIP populations.

"(C) The impact of Federal and State Medicaid and CHIP policies on reducing health disparities, including geographic disparities and disparities among minority populations.

"(D) The overall financial stability of the health care safety net, including Federally-qualified health centers, rural health centers, school-based clinics, disproportionate share hospitals, public hospitals, providers and grantees under section 2612(a)(5) of the Public Health Service Act (popularly known as the Ryan White CARE Act), and other providers that have a patient base which includes a disproportionate number of uninsured or low-income individuals and the impact of CHIP and Medicaid policies on such stability.

"(E) The relation (if any) between payment rates for providers and improvement in care for children as measured under the children's health quality measurement program established under section 151 of the Children's Health and Medicare Protection Act of 2007.

"(F) The affordability, cost effectiveness, and accessibility of services needed by special populations under Medicaid and CHIP as compared with private-sector coverage.

"(G) The extent to which the operation of Medicaid and CHIP ensures access, comparable to access under employer-sponsored or other private health insurance coverage (or in the case of federally-qualified health center services (as defined in section 1905(l)(2)) and rural health clinic services (as defined in section 1905(l)(1)), access comparable to the access to such services under title XIX), for targeted low-income children.

"(H) The effect of demonstrations under section 1115, benchmark coverage under section 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.

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

SEC. 142. MODEL OF INTERSTATE COORDINATED ENROLLMENT AND COVERAGE PROCESS.

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

(b) REPORT TO CONGRESS.—After development of such model process, the Comptroller General shall submit to Congress a report describing additional steps or authority needed to make further improvements to coordinate the enrollment, retention, and coverage under CHIP and Medicaid of children described in subsection (a).

SEC. 143. MEDICAID CITIZENSHIP DOCUMENTATION REQUIREMENTS.

(a) STATE OPTION TO REQUIRE CHILDREN TO PRESENT SATISFACTORY DOCUMENTARY EVIDENCE OF PROOF OF CITIZENSHIP OR NATIONALITY FOR PURPOSES OF ELIGIBILITY FOR MEDICAID; REQUIREMENT FOR AUDITING.—

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

(A) in subsection (a)(46)—

(i) by inserting "(A)" after "(46)"; and

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

"(B) at the option of the State, require that, with respect to a child under 21 years of age (other than an individual described in section 1903(x)(2)) who declares to be a citizen or national of the United States for purposes of establishing initial eligibility for medical assistance under this title (or, at State option, for purposes of renewing or redetermining such eligibility to the extent that such satisfactory documentary evidence of citizenship or nationality has not yet been presented), there is presented satisfactory documentary evidence of citizenship or nationality of the individual (using criteria determined by the State, which shall be no more restrictive than the documentation specified in section 1903(x)(3)); and

"(C) comply with the auditing requirements of section 1903(x)(4);"; and

(B) in subsection (b)(3), by inserting "or any citizenship documentation requirement for a child under 21 years of age that is more restrictive than what a State may provide under section 1903(x)" before the period at the end.

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

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

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

"(C) If the erroneous error rate described in subparagraph (A)—

"(i) exceeds 3 percent, the State shall—

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

"(II) shall develop a corrective action plan; and

"(III) shall conduct another audit the following fiscal year, after the corrective action plan is implemented; or

"(ii) does not exceed 3 percent, the State is not required to conduct another audit under subparagraph (A) until the third fiscal year succeeding the fiscal year for which the audit was conducted.";

(3) ELIMINATION OF DENIAL OF PAYMENTS FOR CHILDREN.—Section 1903(i)(22) of such Act (42 U.S.C. 1396b(i)(22)) is amended by inserting "(other than a child under the age of 21)" after "for an individual".

(b) CLARIFICATION OF RULES FOR CHILDREN BORN IN THE UNITED STATES TO MOTHERS ELIGIBLE FOR MEDICAID.—Section 1903(x)(2) of such Act (42 U.S.C. 1396b(x)(2)) is amended—

(1) in subparagraph (C), by striking "or" at the end;

(2) by redesignating subparagraph (D) as subparagraph (E); and

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

"(D) pursuant to the application of section 1902(e)(4) (and, in the case of an individual who is eligible for medical assistance on such basis, the individual shall be deemed to have provided satisfactory documentary evidence of citizenship or nationality and shall not be required to provide further documentary evidence on any date that occurs during or after the period in which the individual is eligible for medical assistance on such basis; or".

(c) DOCUMENTATION FOR NATIVE AMERICANS.—Section 1903(x)(3)(B) of such Act is amended—

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

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

"(v) For an individual who is a member of, or enrolled in or affiliated with, a federally-recognized Indian tribe, a document issued by such tribe evidencing such membership, enrollment, or affiliation with the tribe (such as a tribal enrollment card or certificate of degree of Indian blood), and, only with respect to those federally-recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, such other forms of documentation (including tribal documentation, if appropriate) as the Secretary, after consulting with such tribes, determines to be satisfactory documentary evidence of citizenship or nationality for purposes of satisfying the requirement of this subparagraph.".

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

"(5) In the case of an individual declaring to be a citizen or national of the United States with respect to whom a State requires the presentation of satisfactory documentary evidence of citizenship or nationality under section 1902(a)(46)(B), the individual shall be provided at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality under this subsection as is provided under clauses (i) and (ii) of section 1137(d)(4)(A) to an individual for the submittal to the State of evidence indicating a satisfactory immigration status and shall not be denied medical assistance on the basis of failure to provide such documentation until the individual has had such an opportunity.".

(e) EFFECTIVE DATE.—

(1) RETROACTIVE APPLICATION.—The amendments made by this section shall take effect as if included in the enactment of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 4).

(2) RESTORATION OF ELIGIBILITY.—In the case of an individual who, during the period that began on July 1, 2006, and ends on the date of the enactment of this Act, was determined to be ineligible for medical assistance under a State Medicaid program solely as a result of the application of subsections (i)(22) and (x) of section 1903 of the Social Security Act (as in effect during such period), but who would have been determined eligible for such assistance if such subsections, as amended by this section, had applied to the individual, a State may deem the individual to be eligible for such assistance as of the date that the individual was determined to be ineligible for such medical assistance on such basis.

SEC. 144. ACCESS TO DENTAL CARE FOR CHILDREN.

(a) DENTAL EDUCATION FOR PARENTS OF NEWBORNS.—The Secretary of Health and Human Services shall develop and implement, through entities that fund or provide perinatal care services to targeted low-income children under a State child health plan under title XXI of the Social Security Act, a program to deliver oral health educational materials that inform new parents about risks for, and preven-

tion of, early childhood caries and the need for a dental visit within their newborn's first year of life.

(b) PROVISION OF DENTAL SERVICES THROUGH FQHCS.—

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

(A) by striking "and" at the end of paragraph (69);

(B) by striking the period at the end of paragraph (70) and inserting "; and"; and

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

"(71) provide that the State will not prevent a Federally-qualified health center from entering into contractual relationships with private practice dental providers in the provision of Federally-qualified health center services.".

(2) CHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397g(e)(1)), as amended by section 112(b), is amended by inserting after subparagraph (A) the following new subparagraph:

"(B) Section 1902(a)(71) (relating to limiting FQHC contracting for provision of dental services).".

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

(c) REPORTING INFORMATION ON DENTAL HEALTH.—

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

(2) CHIP.—Section 2108 of such Act (42 U.S.C. 1397hh) is amended by adding at the end the following new subsection:

"(e) INFORMATION ON DENTAL CARE FOR CHILDREN.—

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

"(A) The number of enrolled children by age grouping used for reporting purposes under 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) ESTABLISHMENT OF PROGRAM TO DEVELOP QUALITY MEASURES FOR CHILDREN'S HEALTH.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish a child health care quality measurement program (in this subsection referred to as the "children's health quality measurement program") to develop and implement—

(A) pediatric quality measures on children's health care that may be used by public and private health care purchasers (and a system for reporting such measures); and

(B) measures of overall program performance that may be used by public and private health care purchasers.

The Secretary shall publish, not later than September 30, 2009, the recommended measures under the program for application under the amendments made by subsection (b) for years beginning with 2010.

(2) MEASURES.—

(A) SCOPE.—The measures developed under the children's health quality measurement program shall—

(i) provide comprehensive information with respect to the provision and outcomes of health care for young children, school age children, and older children.

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

(iii) be designed to ensure that the data required for such measures is collected and reported in a standard format that permits comparison at a State, plan, and provider level, and between insured and uninsured children;

(iv) take into account existing measures of child health quality and be periodically updated;

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

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

(vii) increase the portfolio of evidence-based pediatric quality measures available to public and private purchasers, providers, and consumers.

(B) SPECIFIC MEASURES.—Such measures shall include measures relating to at least the following aspects of health care for children:

(i) The proportion of insured (and uninsured) children who receive age-appropriate preventive health and dental care (including age appropriate immunizations) at each stage of child health development.

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

(iii) The effectiveness of early health care interventions for children whose assessments indicate the presence or risk of physical or mental conditions that could adversely affect growth and development.

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

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

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

In carrying out clause (vi), the Secretary shall develop quality measures and best practices relating to cystic fibrosis.

(C) REPORTING METHODOLOGY FOR ANALYSIS BY PEDIATRIC CHARACTERISTICS.—The children's health quality measurement program shall describe with specificity such measures and the process by which such measures will be reported in a manner that permits analysis based on each of the following pediatric characteristics:

(i) Age.

(ii) Gender.

(iii) Race.

(iv) Ethnicity.

(v) Primary language of the child's parents (or caretaker relative).

(vi) Disability or chronic condition (including cystic fibrosis).

(vii) Geographic location.

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

(D) PEDIATRIC QUALITY MEASURE.—In this subsection, the term "pediatric quality measure" means a measurement of clinical care that assesses one or more aspects of pediatric health care quality (in various settings) including the structure of the clinical care system, the process and outcome of care, or patient experience in such care.

(3) CONSULTATION IN DEVELOPING QUALITY MEASURES FOR CHILDREN'S HEALTH SERVICES.—In developing and implementing the children's health quality measurement program, the Secretary shall consult with—

(A) States;

(B) pediatric hospitals, pediatricians, and other primary and specialized pediatric health care professionals (including members of the allied health professions) who specialize in the care and treatment of children, particularly children with special physical, mental, and developmental health care needs;

(C) dental professionals;

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

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

(F) national organizations and individuals with expertise in pediatric health quality performance measurement; and

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

(4) USE OF GRANTS AND CONTRACTS.—In carrying out the children's health quality measurement program, the Secretary may award grants and contracts to develop, test, validate, update, and disseminate quality measures under the program.

(5) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to States to establish for the reporting of quality measures under titles XIX and XXI of the Social Security Act in accordance with the children's health quality measurement program.

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

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

(2) information on health care quality for children contained in external quality review reports required under section 1932(c)(2) of such Act (42 U.S.C. 1396u–2) or produced by States that administer separate plans under title XXI of such Act.

(c) REPORTS TO CONGRESS ON PROGRAM PERFORMANCE.—Not later than January 1, 2010, and every 2 years thereafter, the Secretary shall report to Congress on—

(1) the quality of health care for children enrolled under title XIX and XXI of the Social Security Act under the children's health quality measurement program; and

(2) patterns of health care utilization with respect to the measures specified in subsection (a)(2)(B) among children by the pediatric characteristics listed in subsection (a)(2)(C).

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

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

"(3) COMPLIANCE WITH MANAGED CARE REQUIREMENTS.—The State child health plan shall provide for the application of subsections (a)(4), (a)(5), (b), (c), (d), and (e) of section 1932 (relating to requirements for managed care) to coverage, State agencies, enrollment brokers, managed care entities, and managed care organizations under this title in the same manner as such subsections apply to coverage and such entities and organizations under title XIX.".

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

SEC. 153. UPDATED FEDERAL EVALUATION OF CHIP.

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

"(5) SUBSEQUENT EVALUATION USING UPDATED INFORMATION.—

"(A) IN GENERAL.—The Secretary, directly or through contracts or interagency agreements, shall conduct an independent subsequent evaluation of 10 States with approved child health plans.

"(B) SELECTION OF STATES AND MATTERS INCLUDED.—Paragraphs (2) and (3) shall apply to such subsequent evaluation in the same manner as such provisions apply to the evaluation conducted under paragraph (1).

"(C) SUBMISSION TO CONGRESS.—Not later than December 31, 2010, the Secretary shall submit to Congress the results of the evaluation conducted under this paragraph.

"(D) FUNDING.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $10,000,000 for fiscal year 2009 for the purpose of conducting the evaluation authorized under this paragraph. Amounts appropriated under this subparagraph shall remain available for expenditure through fiscal year 2011." .

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

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

"(d) ACCESS TO RECORDS FOR IG AND GAO AUDITS AND EVALUATIONS.—For the purpose of evaluating and auditing the program established under this title, the Secretary, the Office of Inspector General, and the Comptroller General shall have access to any books, accounts, records, correspondence, and other documents that are related to the expenditure of Federal funds under this title and that are in the possession, custody, or control of States receiving Federal funds under this title or political subdivisions thereof, or any grantee or contractor of such States or political subdivisions.".

SEC. 155. REFERENCES TO TITLE XXI.

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

SEC. 156. RELIANCE ON LAW; EXCEPTION FOR STATE LEGISLATION.

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

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

(2) Federal financial participation for medical assistance or child health assistance furnished under title XIX or XXI, respectively, of the Social Security Act on or after such date by a State in good faith reliance on such amendments before the date of promulgation of final regulations, if any, to carry out such amendments (or before the date of guidance, if any, regarding the implementation of such amendments) shall not be denied on the basis of the State's failure to comply with such regulations or guidance.

(b) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX or State child health plan under XXI of the Social Security Act, which the Secretary 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 II—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;

(B) in subparagraph (AA), by adding "and" after the semicolon at the end; and

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

"(BB) additional preventive services (described in subsection (ccc)(1)(M));"; and

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

"Preventive Services

"(ccc)(1) The term 'preventive services' means the following:

"(A) Prostate cancer screening tests (as defined in subsection (oo)).

"(B) Colorectal cancer screening tests (as defined in subsection (pp)).

"(C) Diabetes outpatient self-management training services (as defined in subsection (qq)).

"(D) Screening for glaucoma for certain individuals (as described in subsection (s)(2)(U)).

"(E) Medical nutrition therapy services for certain individuals (as described in subsection (s)(2)(V)).

"(F) An initial preventive physical examination (as defined in subsection (ww)).

"(G) Cardiovascular screening blood tests (as defined in subsection (xx)(1)).

"(H) Diabetes screening tests (as defined in subsection described in subsection (s)(2)(Y)).

"(I) Ultrasound screening for abdominal aortic aneurysm for certain individuals (as described in described in subsection (s)(2)(AA)).

"(J) Pneumococcal and influenza vaccine and their administration (as described in subsection (s)(10)(A)).

"(K) Hepatitis B vaccine and its administration for certain individuals (as described in subsection (s)(10)(B)).

"(L) Screening mammography (as defined in subsection (jj)).

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

"(N) Bone mass measurement (as defined in subsection (rr)).

"(O) Additional preventive services (as determined under paragraph (2)).

"(2)(A) The term 'additional preventive services' means items and services, including mental health services, not described in subparagraphs (A) through (N) of paragraph (1) that the Secretary determines to be reasonable and necessary for the prevention or early detection of an illness or disability.

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

"(i) take into account evidence-based recommendations by the United States Preventive Services Task Force and other appropriate organizations; and

"(ii) use the process for making national coverage determinations (as defined in section 1869(f)(1)(B)) under this title.".

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

(1) IN GENERAL.—

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

(i) in clause (T), by striking "80 percent" and inserting "100 percent"; and

(ii) by striking "and" before "(V)"; and

(iii) by inserting before the semicolon at the end the following: ", and (W) with respect to additional preventive services (as defined in section 1861(ccc)(2)) and other preventive services for which a payment rate is not otherwise established under this section, the amount paid shall be 100 percent of the lesser of the actual charge for the services or the

amount determined under a fee schedule established by the Secretary for purposes of this clause".

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

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

"(ii) NO COINSURANCE.—In the case of a beneficiary who receives services described in clause (i), there shall be no coinsurance applied."; and.

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

"(ii) NO COINSURANCE.—In the case of a beneficiary who receives services described in clause (i), there shall be no coinsurance applied.".

(2) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by striking "screening mammography (as defined in section 1861(jj)) and diagnostic mammography" and inserting "diagnostic mammography and preventive services (as defined in section 1861(ccc)(1))".

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

(i) in subparagraph (F), by striking "and" after the semicolon at the end;

(ii) in subparagraph (G)(ii), by adding "and"at the end; and

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

"(H) with respect to additional preventive services (as defined in section 1861(ccc)(2)) furnished by an outpatient department of a hospital, the amount determined under paragraph (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) of the Social Security Act (42 U.S.C. 1395l(b)), as amended by section 201(b), is amended by adding at the end the following new sentence: "Clause (1) of the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code applied, of the establishment of a diagnosis as a result of the test, or of the removal of tissue or other matter or other procedure that is performed in connection with and as a result of the screening test.".

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

SEC. 203. PARITY FOR MENTAL HEALTH COINSURANCE.

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

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)".

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

SEC. 212. MAKING QI PROGRAM PERMANENT AND EXPANDING ELIGIBILITY.

(a) MAKING PROGRAM PERMANENT.—

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

(A) by striking "sections 1933 and" and by inserting "section"; and

(B) by striking "(but only for" and all that follows through "September 2007)".

(2) ELIMINATION OF FUNDING LIMITATION.—

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

(i) in subsection (a), by striking "who are selected to receive such assistance under subsection (b)"

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

(iii) in subsection (d), by striking "furnished in a State" and all that follows and inserting "the Federal medical assistance 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).".

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

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

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

"(c) ASSISTANCE WITH MEDICARE SAVINGS PROGRAM AND LOW-INCOME SUBSIDY PROGRAM APPLICATIONS.—

"(1) DISTRIBUTION OF APPLICATIONS TO APPLICANTS FOR MEDICARE.—In the case of each individual applying for hospital insurance benefits under section 226 or 226A, the Commissioner shall provide the following:

"(A) Information describing the low-income subsidy program under section 1860D–14 and the medicare savings program under title XIX.

"(B) An application for enrollment under such low-income subsidy program as well as an application form (developed under section 1905(p)(5)) for medical assistance for medicare cost-sharing under title XIX.

"(C) Information on how the individual may obtain assistance in completing such applications, including information on how the individual may contact the State health insurance assistance program (SHIP) for the State in which the individual is located.

The Commissioner shall make such application forms available at local offices of the Social Security Administration.

"(2) TRAINING PERSONNEL IN ASSISTING IN COMPLETING APPLICATIONS.—The Commissioner shall provide training to those employees of the Social Security Administration who are involved in receiving applications for benefits described in paragraph (1) in assisting applicants in completing a medicare savings program application described in paragraph (1). Such employees who are so trained shall provide such assistance upon request.

"(3) TRANSMITTAL OF COMPLETED APPLICATION.—If such an employee assists in completing such an application, the employee, with the consent of the applicant, shall transmit the completed application to the appropriate State medicaid agency for processing.

"(4) COORDINATION WITH OUTREACH.—The Commissioner shall coordinate outreach activities under this subsection with outreach activities conducted by States in connection with the low-income subsidy program and the medicare savings program.".

(e) MEDICAID AGENCY CONSIDERATION OF APPLICATIONS.—Section 1935(a) of such Act (42 U.S.C. 1396u–5(a)) is amended by adding at the end the following new paragraph:

"(4) CONSIDERATION OF MSP APPLICATIONS.—The State shall accept medicare savings program applications transmitted under section 1144(c)(3) and act on such applications in the same manner and deadlines as if they had been submitted directly by the applicant.".

(f) TRANSLATION OF MODEL FORM.—Section 1905(p)(5)(A) of the Social Security Act (42 U.S.C. 1396d(p)(5)(A)) is amended by adding at the end the following: "The Secretary shall provide for the translation of such application form into at least the 10 languages (other than English) that are most often used by individuals applying for hospital insurance benefits under section 226 or 226A and shall make the translated forms available to the States and to the Commissioner of Social Security.".

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

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

"(21) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF PROVIDING LOW-INCOME SUBSIDIES UNDER MEDICARE.—

"(A) RETURN INFORMATION FROM INTERNAL REVENUE SERVICE TO SOCIAL SECURITY ADMINISTRATION.—The Secretary, upon written request from the Commissioner of Social Security, shall disclose to the officers and employees of the Social Security Administration with respect to any individual identified by the 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 (17)" each place it appears and inserting "(17), or (21)".

(3) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Secretary of the Treasury, after consultation with the Commissioner of Social Security, shall submit a written report to Congress regarding the use of disclosures made under section 6103(l)(21) of the Internal Revenue Code of 1986, as added by this subsection, in identifying individuals eligible for the low-income subsidies under section 1860D–14 of the Social Security Act.

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

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

SEC. 214. ELIMINATING APPLICATION OF ESTATE RECOVERY.

(a) IN GENERAL.—Section 1917(b)(1)(B)(ii) of the Social Security Act (42 U.S.C. 1396p(b)(1)(B)(ii)) is amended by inserting "(but not including medical assistance for medicare cost-sharing or for benefits described in section 1902(a)(10)(E))" before the period at the end.

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

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

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

(1) by striking "INSTITUTIONALIZED INDIVIDUALS.—In" and inserting "ELIMINATION OF COST-SHARING FOR CERTAIN FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

"(I) INSTITUTIONALIZED INDIVIDUALS.—In"; and

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

"(II) CERTAIN OTHER INDIVIDUALS.—In the case of an individual who is a full-benefit dual eligible individual and with respect to whom there has been a determination that but for the provision of home and community based care (whether under section 1915 or under a waiver under section 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 coinsurance 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 apply to determinations of eligibility for months beginning with January 2009.

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

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

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

"(iv) OVERALL LIMITATION ON COST-SHARING.—In the case of all such individuals, a limitation on aggregate cost-sharing under this part for a year not to exceed 2.5 percent of income."; and

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

"(F) OVERALL LIMITATION ON COST-SHARING.—A limitation on aggregate cost-sharing under this part for a year not to exceed 2.5 percent of income.".

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

SEC. 218. INTELLIGENT ASSIGNMENT IN ENROLLMENT.

(a) IN GENERAL.—Section 1860D–1(b)(1) of the Social Security Act (42 U.S.C. 1395w–101(b)(1)) is amended—

(1) in the second sentence of subparagraph (C), by inserting ", subject to subparagraph (D)," before "on a random basis"; and

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

"(D) INTELLIGENT ASSIGNMENT.—In the case of any auto-enrollment under subparagraph (C), no part D eligible individual described in such subparagraph shall be enrolled in a prescription drug plan which does not meet the following requirements:

"(i) FORMULARY.—The plan has a formulary that covers at least—

"(I) 95 percent of the 100 most commonly prescribed non-duplicative generic covered part D drugs for the population of individuals entitled to benefits under part A or enrolled under part B; and

"(II) 95 percent of the 100 most commonly prescribed non-duplicative brand name covered part D drugs for such population.

"(ii) PHARMACY NETWORK.—The plan has a network of pharmacies that substantially exceeds the minimum requirements for prescription drug plans in the State and that provides access in areas where lower income individuals reside.

"(iii) QUALITY.—

"(I) IN GENERAL.—Subject to subclause (I), the plan has an above average score on quality ratings of the Secretary of prescription drug plans under this part.

"(II) EXCEPTION.—Subclause (I) shall not apply to a plan that is a new plan (as defined by the Secretary), with respect to the plan year involved.

"(iv) LOW COST.—The total cost under this title of providing prescription drug coverage under the plan consistent with the previous clauses of this subparagraph is among the lowest 25th percentile of prescription drug plans under this part in the State.

In the case that no plan meets the requirements under clauses (i) through (iv), the Secretary shall implement this subparagraph to the greatest extent possible with the goal of protecting beneficiary access to drugs without increasing the cost relative to the enrollment process under subparagraph (C) as in existence before the date of the enactment of this subparagraph.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect for enrollments effected on or after November 15, 2009.

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.

(a) IN GENERAL.—Section 1860D–2(b)(4)(C) of the Social Security Act (42 U.S.C. 1395w–102(b)(4)(C)) is amended—

(1) in clause (i), by striking "and" at the end;

(2) in clause (ii)—

(A) by striking "such costs shall be treated as incurred only if" and inserting "subject to clause (iii), such costs shall be treated as incurred only if";

(B) by striking ", under section 1860D–14, or under a State Pharmaceutical Assistance Program"; and

(C) by striking the period at the end and inserting "; and"; and

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

"(iii) such costs shall be treated as incurred and shall not be considered to be reimbursed under clause (ii) if such costs are borne or paid—

"(I) under section 1860D–14;

"(II) under a State Pharmaceutical Assistance Program;

"(III) by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act); or

"(IV) under an AIDS Drug Assistance Program under part B of title XXVI of the Public Health Service Act.".

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

SEC. 222. PERMITTING MID-YEAR CHANGES IN ENROLLMENT FOR FORMULARY CHANGES ADVERSELY IMPACT AN ENROLLEE.

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

"(F) CHANGE IN FORMULARY RESULTING IN INCREASE IN COST-SHARING.—

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

"(ii) EXCEPTION.—Clause (i) shall not apply in the case that a drug is removed from the formulary of a plan because 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:

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

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

(a) IN GENERAL.—Section 1860D–4(b)(3) of the Social Security Act (42 U.S.C. 1395w–104(b)(3)) is amended—

(1) in subparagraph (C)(i), by inserting ", except as provided in subparagraph (G)," after "although"; and

(2) by inserting after subparagraph (F) the following new subparagraph:

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

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

"(I) Anticonvulsants.

"(II) Antineoplastics.

"(III) Antiretrovirals.

"(IV) Antidepressants.

"(V) Antipsychotics.

"(VI) Immunosuppresessants.

"(ii) USE OF UTILIZATION MANAGEMENT TOOLS.—A PDP sponsor of a prescription drug plan may use prior authorization or step therapy for the initiation of medications within one of the classifications specified in clause (i) but only when approved by the Secretary, except that such prior authorization or step therapy may not be used in the case of antiretrovirals and in the case of individuals who already are stabilized on a drug treatment regimen.".

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

SEC. 226. ELIMINATION OF MEDICARE PART D LATE ENROLLMENT PENALTIES PAID BY LOW-INCOME SUBSIDY-ELIGIBLE INDIVIDUALS.

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

"(ii) 100 percent of any late enrollment penalties imposed under section 1860D–13(b) for such individual.".

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

(1) by inserting "equal to (i) an amount" after "premium subsidy";

(2) by striking "paragraph (1)(A)" and inserting "clause (i) of paragraph (1)(A)"; and

(3) by adding at the end before the period the following: ", plus (ii) 100 percent of the amount described in clause (ii) of such paragraph for such individual".

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

SEC. 227. SPECIAL ENROLLMENT PERIOD FOR SUBSIDY ELIGIBLE INDIVIDUALS.

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

"(G) ELIGIBILITY FOR LOW-INCOME SUBSIDY.—

"(i) IN GENERAL.—In the case of an applicable subsidy eligible individual (as defined in clause (ii)), the special enrollment period described in clause (iii).

"(ii) APPLICABLE SUBSIDY ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this subparagraph, the term 'applicable subsidy eligible individual' means a part D eligible individual who is determined under subparagraph (B) of section 1860D–14(a)(3) to be a subsidy eligible in-

dividual (as defined in subparagraph (A) of such section), and includes such an individual who was enrolled in a prescription drug plan or an MA–PD plan on the date of such determination.

"(iii) SPECIAL ENROLLMENT PERIOD DESCRIBED.—The special enrollment period described in this clause, with respect to an applicable subsidy eligible individual, is the 90-day period beginning on the date the individual receives notification that such individual has been determined under section 1860D–14(a)(3)(B) to be a subsidy eligible individual (as so defined).".

(b) AUTOMATIC ENROLLMENT PROCESS FOR CERTAIN SUBSIDY ELIGIBLE INDIVIDUALS.—Section 1860D–1(b)(1) of the Social Security Act (42 U.S.C. 1395w–101(b)(1)), as amended by section 218(a)(2), is further amended by adding at the end the following new subparagraph:

"(E) SPECIAL RULE FOR SUBSIDY ELIGIBLE INDIVIDUALS.—The process established under subparagraph (A) shall include, in the case of an applicable subsidy eligible individual (as defined in clause (ii) of paragraph (3)(F)) who fails to enroll in a prescription drug plan or an MA–PD plan during the special enrollment period described in clause (iii) of such paragraph applicable to such individual, a process for the facilitated enrollment of the individual in the prescription drug plan or MA–PD plan that is most appropriate for such individual (as determined by the Secretary). Nothing in the previous sentence shall prevent an individual described in such sentence from declining 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;

(ii) using the standards developed under subsection (e) for the collection of language data;

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

(iv) where practicable, through self-reporting;

(B) with respect to the collection of the data described in subparagraph (A) for applicants and recipients who are minors or otherwise legally incapacitated, require that—

(i) such data be collected from the parent or legal guardian of such an applicant or recipient; and

(ii) the preferred language of the parent or legal guardian of such an applicant or recipient be collected;

(C) systematically analyze at least annually such data using the smallest appropriate units of analysis feasible to detect racial and ethnic disparities in health and health care and when appropriate, for men and women separately;

(D) report the results of analysis annually to the Director of the Office for Civil Rights, the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate, and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives; and

(E) ensure that the provision of assistance to an applicant or recipient of assistance is not denied or otherwise adversely affected because of the failure of the applicant or recipient to provide race, ethnicity, and primary language data.

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

(A) to permit the use of information collected under this subsection in a manner that would adversely affect any individual providing any such information; and

(B) to require health care providers to collect data.

(b) PROTECTION OF DATA.—The Secretary shall ensure (through the promulgation of regulations or otherwise) that all data collected pursuant to subsection (a) is protected—

(1) under the same privacy protections as the Secretary applies to other health data under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033) relating to the privacy of individually identifiable health information and other protections; and

(2) from all inappropriate internal use by any entity that collects, stores, or receives the data, including use of such data in determinations of eligibility (or continued eligibility) in health plans, and from other inappropriate uses, as defined by the Secretary.

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

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

(2) expand awareness that data collection, analysis, and reporting by race, ethnicity, and primary language is legal and necessary to assure equity and non-discrimination in the quality of health care services;

(3) ensure that future patient record systems have data code sets for racial, ethnic, and primary language identifiers and that such identifiers can be retrieved from clinical records, including records transmitted electronically;

(4) improve health and health care data collection and analysis for more population groups if such groups can be aggregated into the minimum race and ethnicity categories;

(5) provide researchers with greater access to racial, ethnic, and primary language data, subject to privacy and confidentiality regulations; and

(6) safeguard and prevent the misuse of data collected under subsection (a).

(d) COMPLIANCE WITH STANDARDS.—Data collected under subsection (a) shall be obtained, maintained, and presented (including for reporting purposes and at a minimum) in accordance with the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity.

(e) LANGUAGE COLLECTION STANDARDS.—Not later than 1 year after the date of enactment of this Act, the Director of the Office of Minority Health, in consultation with the Office for Civil Rights of the Department of Health and Human Services, shall develop and disseminate Standards for the Classification of Federal Data on Preferred Written and Spoken Language.

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

(1) IN GENERAL.—The Secretary may, either directly or through grant or contract, provide technical assistance to enable a health care provider or plan operating under the Medicare program to comply with the requirements of this section.

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

(A) enhance or upgrade computer technology that will facilitate racial, ethnic, and primary language data collection and analysis;

(B) improve methods for health data collection and analysis including additional population groups beyond the Office of Management and Budget categories if such groups can be aggregated into the minimum race and ethnicity categories;

(C) develop mechanisms for submitting collected data subject to existing privacy and confidentiality regulations; and

(D) develop educational programs to raise awareness that data collection and reporting by race, ethnicity, and preferred language are legal and essential for eliminating health and health care disparities.

(g) ANALYSIS OF RACIAL AND ETHNIC DATA.—The Secretary, acting through the Director of the Agency for Health Care Research and Quality and in coordination with the Administrator of the Centers for Medicare & Medicaid Services, shall—

(1) identify appropriate quality assurance mechanisms to monitor for health disparities under the Medicare program;

(2) specify the clinical, diagnostic, or therapeutic measures which should be monitored;

(3) develop new quality measures relating to racial and ethnic disparities in health and health care;

(4) identify the level at which data analysis should be conducted; and

(5) share data with external organizations for research and quality improvement purposes, in compliance with applicable Federal privacy laws.

(h) REPORT.—Not later than 2 years after the date of enactment of this Act, and biennially thereafter, the Secretary shall submit to the appropriate committees of Congress a report on the effectiveness of data collection, analysis, and reporting on race, ethnicity, and primary language under the programs administered through title XVIII of the Social Security Act. The report shall evaluate the progress made with respect to the plan under subsection (c) or subsequent revisions thereto.

(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2008 through 2012.

SEC. 232. ENSURING EFFECTIVE COMMUNICATION IN MEDICARE.

(a) ENSURING EFFECTIVE COMMUNICATION BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(1) STUDY ON MEDICARE PAYMENTS FOR LANGUAGE SERVICES.—The Secretary of Health and Human Services shall conduct a study that examines ways that Medicare should develop payment systems for language services using the results of the demonstration program conducted under section 233.

(2) ANALYSES.—The study shall include an analysis of each of the following:

(A) How to develop and structure appropriate payment systems for language services for all Medicare service providers.

(B) The feasibility of adopting a payment methodology for on-site interpreters, including interpreters who work as independent contractors and interpreters who work for agencies that provide on-site interpretation, pursuant to which such interpreters could directly bill Medicare for services provided in support of physician office services for an LEP Medicare patient.

(C) The feasibility of Medicare contracting directly with agencies that provide off-site interpretation including telephonic and video interpretation pursuant to which such contractors could directly bill Medicare for the services provided in support of physician office services for an LEP Medicare patient.

(D) The feasibility of modifying the existing Medicare resource-based relative value scale (RBRVS) by using adjustments (such as multipliers or add-ons) when a patient is LEP.

(E) How each of options described in a previous paragraph would be funded and how such funding would affect physician payments, a physician's practice, and beneficiary cost-sharing.

(3) VARIATION IN PAYMENT SYSTEM DESCRIBED.—The payment systems described in subsection (b) may allow variations based upon types of service providers, available delivery methods, and costs for providing language services including such factors as—

(A) the type of language services provided (such as provision of health care or health care related services directly in a non-English language by a bilingual provider or use of an interpreter);

(B) type of interpretation services provided (such as in-person, telephonic, video interpretation);

(C) the methods and costs of providing language services (including the costs of providing language services with internal staff or through contract with external independent contractors and/or agencies);

(D) providing services for languages not frequently encountered in the United States; and

(E) providing services in rural areas.

(4) REPORT.—The Secretary shall submit a report on the study conducted under subsection (a) to appropriate committees of Congress not later than 1 year after the expiration of the demonstration program conducted under section 3.

(b) HEALTH PLANS.—Section 1857(g)(1) of the Social Security Act (42 U.S.C. 1395w–27(g)(1)) is amended—

(1) by striking "or" at the end of subparagraph (F);

(2) by adding "or" at the end of subparagraph (G); and

(3) by inserting after subparagraph (G) the following new subparagraph:

"(H) fails substantially to provide language services to limited English proficient beneficiaries enrolled in the plan that are required under law;".

SEC. 233. DEMONSTRATION TO PROMOTE ACCESS FOR MEDICARE BENEFICIARIES WITH LIMITED ENGLISH PROFICIENCY BY PROVIDING REIMBURSEMENT FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES.

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

(b) ELIGIBILITY; PRIORITY.—

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

(A) be—

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

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

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

(iv) a PDP sponsor of a prescription drug plan under part D of such title; and

(B) prepare and submit to the Secretary an application, at such time, in such manner, and accompanied by such additional information as the Secretary may require.

(2) PRIORITY.—

(A) DISTRIBUTION.—To the extent feasible, in awarding grants under this section, the Secretary shall award—

(i) 6 grants to providers of services described in paragraph (1)(A)(i);

(ii) 6 grants to service providers described in paragraph (1)(A)(ii);

(iii) 6 grants to organizations described in paragraph (1)(A)(iii); and

(iv) 6 grants to sponsors described in paragraph (1)(A)(iv).

(B) FOR COMMUNITY ORGANIZATIONS.—The Secretary shall give priority to applicants that have developed partnerships with community organizations or with agencies with experience in language access.

(C) VARIATION IN GRANTEES.—The Secretary 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 percent of the grant funds to pay for administrative costs associated with the provision of competent language services and for reporting required under subsection (E).

(2) ORGANIZATIONS.—Grantees that are part C organizations or PDP sponsors must ensure that their network providers receive at least 50 percent of the grant funds to pay for the provision of competent language services to Medicare beneficiaries who are limited English proficient, including physicians and pharmacies.

(3) DETERMINATION OF PAYMENTS FOR LANGUAGE SERVICES.—Payments to grantees shall be calculated based on the estimated numbers of LEP Medicare beneficiaries in a grantee's service area utilizing—

(A) data on the numbers of limited English proficient individuals who speak English less than "very well" from the most recently available data from the Bureau of the Census or other State-based study the Secretary determines likely to yield accurate data regarding the number of LEP individuals served by the grantee; or

(B) the grantee's own data if the grantee routinely collects data on Medicare beneficiaries' primary language in a manner determined by the Sec-

retary to yield accurate data and such data shows greater numbers of LEP individuals than the data listed in subparagraph (A).

(4) LIMITATIONS.—

(A) REPORTING.—Payments shall only be provided under this section to grantees that report their costs of providing language services as required under subsection (e). If a grantee fails to provide the reports under such section for the first year of a grant, the Secretary may terminate the grant and solicit applications from new grantees to participate in the subsequent two years of the demonstration program.

(B) TYPE OF SERVICES.—

(i) IN GENERAL.—Subject to clause (ii), payments shall be provided under this section only to grantees that utilize competent bilingual staff or competent interpreter or translation services which—

(I) if the grantee operates in a State that has statewide health care interpreter standards, meet the State standards currently in effect; or

(II) if the grantee operates in a State that does not have statewide health care interpreter standards, utilizes competent interpreters who follow the National Council on Interpreting in Health Care's Code of Ethics and Standards of Practice.

(ii) EXEMPTIONS.—The requirements of clause (i) shall not apply—

(I) in the case of a Medicare beneficiary who is limited English proficient (who has been informed in the beneficiary's primary language of the availability of free interpreter and translation services) and who requests the use of family, friends, or other persons untrained in interpretation or translation and the grantee documents the request in the beneficiary's record; and

(II) in the case of a medical emergency where the delay directly associated with obtaining a competent interpreter or translation services would jeopardize the health of the patient.

Nothing in clause (ii)(II) shall be construed to exempt an emergency rooms or similar entities that regularly provide health care services in medical emergencies from having in place systems to provide competent interpreter and translation services without undue delay.

(d) ASSURANCES.—Grantees under this section shall—

(1) ensure that appropriate clinical and support staff receive ongoing education and training in linguistically appropriate service delivery; ensure the linguistic competence of bilingual providers;

(2) offer and provide appropriate language services at no additional charge to each patient with limited English proficiency at all points of contact, in a timely manner during all hours of operation;

(3) notify Medicare beneficiaries of their right to receive language services in their primary language;

(4) post signage in the languages of the commonly encountered group or groups present in the service area of the organization; and

(5) ensure that—

(A) primary language data are collected for recipients of language services; and

(B) consistent with the privacy protections provided under the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), if the recipient of language services is a minor or is incapacitated, the primary language of the parent or legal guardian is collected and utilized.

(e) REPORTING REQUIREMENTS.—Grantees under this section shall provide the Secretary with reports at the conclusion of the each year of a grant under this section. each report shall include at least the following information:

(1) The number of Medicare beneficiaries to whom language services are provided.

(2) The languages of those Medicare beneficiaries.

(3) The types of language services provided (such as provision of services directly in non-English language by a bilingual health care provider or use of an interpreter).

(4) Type of interpretation (such as in-person, telephonic, or video interpretation).

(5) The methods of providing language services (such as staff or contract with external independent contractors or agencies).

(6) The length of time for each interpretation encounter.

(7) The costs of providing language services (which may be actual or estimated, as determined by the Secretary).

(f) NO COST SHARING.—LEP Beneficiaries shall not have to pay cost-sharing or co-pays for language services provided through this demonstration program.

(g) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the demonstration program under this section and shall submit to the appropriate committees of Congress a report not later than 1 year after the completion of the program. The report shall include the following:

(1) An analysis of the patient outcomes and costs of furnishing care to the LEP Medicare beneficiaries participating in the project as compared to such outcomes and costs for limited English proficient Medicare beneficiaries not participating.

(2) The effect of delivering culturally and linguistically appropriate services on beneficiary access to care, utilization of services, efficiency and cost-effectiveness of health care delivery, patient satisfaction, and select health outcomes.

(3) Recommendations regarding the extension of such project to the entire Medicare program.

(h) GENERAL PROVISIONS.—Nothing in this section shall be construed to limit otherwise existing obligations of recipients of Federal financial assistance under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000(d) et seq.) or any other statute.

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $10,000,000 for each fiscal year of the demonstration.

SEC. 234. DEMONSTRATION TO IMPROVE CARE TO PREVIOUSLY UNINSURED.

(a) ESTABLISHMENT.—Within one year after the date of enactment of this Act, the Secretary shall establish a demonstration project to determine the greatest needs and most effective methods of outreach to medicare beneficiaries who were previously uninsured.

(b) SCOPE.—The demonstration shall be in no fewer than 10 sites, and shall include state health insurance assistance programs, community health centers, community-based organizations, community health workers, and other service providers under parts A, B, and C of title XVIII of the Social Security Act. Grantees that are plans operating under part C shall document that enrollees who were previously uninsured receive the "Welcome to Medicare" physical exam.

(c) DURATION.—The Secretary shall conduct the demonstration project for a period of 2 years.

(d) REPORT AND EVALUATION.—The Secretary shall conduct an evaluation of the demonstration and not later than 1 year after the completion of the project shall submit to Congress a report including the following:

(1) An analysis of the effectiveness of outreach activities targeting beneficiaries who were previously uninsured, such as revising outreach and enrollment materials (including the potential for use of video information), providing one-on-one counseling, working with community health workers, and amending the Medicare and You handbook.

(2) The effect of such outreach on beneficiary access to care, utilization of services, efficiency and cost-effectiveness of health care delivery, patient satisfaction, and select health outcomes.

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.

(a) REPORT.—Not later than two years after the date of the enactment of this Act, the Inspector General of the Department of Health and Human Services shall prepare and publish a report on—

(1) the extent to which Medicare providers and plans are complying with the Office for Civil Rights' Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons and the Office of Minority Health's Culturally and Linguistically Appropriate Services Standards in health care; and

(2) a description of the costs associated with or savings related to the provision of language services.

Such report shall include recommendations on improving compliance with CLAS Standards and recommendations on improving enforcement of CLAS Standards.

(b) IMPLEMENTATION.—Not later than one year after the date of publication of the report under subsection (a), the Department of Health and Human Services shall implement changes responsive to any deficiencies identified in the report.

SEC. 236. IOM REPORT ON IMPACT OF LANGUAGE ACCESS SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall seek to enter into an arrangement with the Institute of Medicine under which the Institute will prepare and publish, not later than 3 years after the date of the enactment of

this Act, a report on the impact of language access services on the health and health care of limited English proficient populations.

(b) CONTENTS.—Such report shall include—

(1) recommendations on the development and implementation of policies and practices by health care organizations and providers for limited English proficient patient populations;

(2) a description of the effect of providing language access services on quality of health care and access to care and reduced medical error; and

(3) a description of the costs associated with or savings related to provision of language access services.

SEC. 237. DEFINITIONS.

In this subtitle:

(1) BILINGUAL.—The term "bilingual" with respect to an individual means a person who has sufficient degree of proficiency in two languages and can ensure effective communication can occur in both languages.

(2) COMPETENT INTERPRETER SERVICES.—The term "competent interpreter services" means a trans-language rendition of a spoken message in which the interpreter comprehends the source language and can speak comprehensively in the target language to convey the meaning intended in the source language. The interpreter knows health and health-related terminology and provides accurate interpretations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source message.

(3) COMPETENT TRANSLATION SERVICES.—The term "competent translation services" means a trans-language rendition of a written document in which the translator comprehends the source language and can write comprehensively in the target language to convey the meaning intended in the source language. The translator knows health and health-related terminology and provides accurate translations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source document.

(4) EFFECTIVE COMMUNICATION.—The term "effective communication" means an exchange of information between the provider of health care or health care-related services and the limited English proficient recipient of such services that enables limited English proficient individuals to access, understand, and benefit from health care or health care-related services.

(5) INTERPRETING/INTERPRETATION.—The terms "interpreting" and "interpretation" mean the transmission of a spoken message from one language into another, faithfully, accurately, and objectively.

(6) HEALTH CARE SERVICES.—The term "health care services" means services that address physical as well as mental health conditions in all care settings.

(7) HEALTH CARE-RELATED SERVICES.—The term "health care-related services" means human or social services programs or activities that provide access, referrals or links to health care.

(8) LANGUAGE ACCESS.—The term "language access" means the provision of language services to an LEP individual designed to enhance that individual's access to, understanding of or benefit from health care or health care-related services.

(9) LANGUAGE SERVICES.—The term "language services" means provision of health care services directly in a non-English language, interpretation, translation, and non-English signage.

(10) LIMITED ENGLISH PROFICIENT.—The term "limited English proficient" or "LEP" with respect to an individual means an individual who speaks a primary language other than English and who cannot speak, read, write or understand the English language at a level that permits the individual to effectively communicate with clinical or nonclinical staff at an entity providing health care or health care related services.

(11) MEDICARE PROGRAM.—The term "Medicare program" means the programs under parts A through D of title XVIII of the Social Security Act.

(12) SERVICE PROVIDER.—The term "service provider" includes all suppliers, providers of services, or entities under contract to provide coverage, items or services under any part of title XVIII of the Social Security Act.

TITLE III—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 the recommendations of the United States Preventive Services Task Force).

"(B) Evaluation and management services not described in subparagraph (A).

"(C) Imaging services (as defined in subsection (b)(4)(B)) and diagnostic tests (other than clinical diagnostic laboratory tests) not described in subparagraph (A).

"(D) Procedures that are subject (under regulations promulgated to carry out this section) to a 10-day or 90-day global period (in this paragraph referred to as 'major procedures'), except that the Secretary may reclassify as minor procedures under subparagraph (F) any procedures that would otherwise be included in this category if the Secretary determines that such procedures are not major procedures.

"(E) Anesthesia services that are paid on the basis of the separate conversion factor for anesthesia services determined under subsection (d)(1)(D).

"(F) Minor procedures and any other physicians' services that are not described in a preceding subparagraph.".

(b) ESTABLISHMENT OF SEPARATE CONVERSION FACTORS FOR EACH SERVICE CATEGORY.—Subsection (d)(1) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(1) in subparagraph (A)—

(A) by designating the sentence beginning "The conversion factor" as clause (i) with the heading "APPLICATION OF SINGLE CONVERSION FACTOR.—" and with appropriate indentation;

(B) by striking "The conversion factor" and inserting "Subject to clause (ii), the conversion factor"; and

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

"(ii) APPLICATION OF MULTIPLE CONVERSION FACTORS BEGINNING WITH 2008.—

"(I) IN GENERAL.—In applying clause (i) for years beginning with 2008, separate conversion factors shall be established for each service category of physicians' services (as defined in subsection (j)(5)) and any reference in this section to a conversion factor for such years shall be deemed to be a reference to the conversion factor for each of such categories.

"(II) INITIAL CONVERSION FACTORS; SPECIAL RULE FOR ANESTHESIA SERVICES.—Such factors for 2008 shall be based upon the single conversion factor for 2007 multiplied by the update established under paragraph (8) for such category for 2008. In the case of the service category described in subsection (j)(5)(F) (relating to anesthesia services), the conversion factor for 2008 shall be based on the separate conversion factor specified in subparagraph (D) for 2007 multiplied by the update established under paragraph (8) for such category for 2008.

"(III) UPDATING OF CONVERSION FACTORS.—Such factor for a service category for a subsequent year shall be based upon the conversion factor for such category for the previous year and adjusted by the update established for such category under paragraph (8) for the year involved."; and

(2) in subparagraph (D), by inserting "(before 2008)" after "for a year".

(c) ESTABLISHING UPDATES FOR CONVERSION FACTORS FOR SERVICE CATEGORIES.—Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) is amended—

(1) in paragraph (4)(B), by striking "and (6)" and inserting ", (6), and (8)";

(2) in paragraph (4)(C)(iii), by striking "The allowed" and inserting "Subject to paragraph (8)(B), the allowed";

(3) in paragraph (4)(D), by striking "The update" and inserting "Subject to paragraph (8)(E), the update"; and

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

"(8) UPDATES FOR SERVICE CATEGORIES BEGINNING WITH 2008.—

"(A) IN GENERAL.—In applying paragraph (4) for a year beginning with 2008, the following rules apply:

"(i) APPLICATION OF SEPARATE UPDATE ADJUSTMENTS FOR EACH SERVICE CATEGORY.—Pursuant to paragraph (1)(A)(ii)(I), the update shall be made to the conversion factor for each service category (as defined in subsection (j)(5)) based upon an update adjustment factor for the respective category and year and the update adjustment factor shall be computed, for a year, separately for each service category.

"(ii) COMPUTATION OF ALLOWED AND ACTUAL EXPENDITURES BASED ON SERVICE CATEGORIES.—In computing the prior year adjustment component and the cumulative adjustment component under clauses (i) and (ii) of paragraph (4)(B), the following rules apply:

"(I) APPLICATION BASED ON SERVICE CATEGORIES.—The allowed expenditures and actual expenditures shall be the allowed and actual expenditures for the service category, as determined under subparagraph (B).

"(II) LIMITATION TO PHYSICIAN FEE-SCHEDULE SERVICES.—Actual expenditures shall only take into account expenditures for services furnished under the physician fee schedule.

"(III) APPLICATION OF CATEGORY SPECIFIC TARGET GROWTH RATE.—The growth rate applied under clause (ii)(II) of such paragraph shall be the target growth rate for the service category involved under subsection (f)(5).

"(IV) ALLOCATION OF CUMULATIVE OVERHANG.—There shall be substituted for the difference described in subparagraph (B)(ii)(I) of such paragraph the amount described in subparagraph (C)(i) for the service category involved.

"(B) DETERMINATION OF ALLOWED EXPENDITURES.—In applying paragraph (4) for a year beginning with 2008, notwithstanding subparagraph (C)(iii) of such paragraph, the allowed expenditures for a service category for a year is an amount computed by the Secretary as follows:

"(i) FOR 2008.—For 2008:

"(I) TOTAL 2007 ALLOWED EXPENDITURES.—Compute the total allowed expenditures for services furnished under the physician fee schedule under such paragraph for 2007.

"(II) INCREASE BY GROWTH RATE.—Increase the total under subclause (I) by the target growth rate for such category under subsection (f) for 2008.

"(III) ALLOCATION TO SERVICE CATEGORY.—Multiply the increased total under subclause (II) by the overhang allocation factor for the service category (as defined in subparagraph (C)(iii)).

"(ii) FOR SUBSEQUENT YEARS.—For a subsequent year, take the amount of allowed expenditures for such category for the preceding year (under clause (i) or this clause) and increase it by the target growth rate determined under subsection (f) for such category and year.

"(C) COMPUTATION AND APPLICATION OF CUMULATIVE OVERHANG AMONG CATEGORIES.—

"(i) IN GENERAL.—For purposes of applying paragraph (4)(B)(ii)(II) under clause (ii)(IV), the amount described in this clause for a year (beginning with 2008) is the sum of the following:

"(I) PRE-2008 CUMULATIVE OVERHANG.—The amount of the pre-2008 cumulative excess spending (as defined in clause (ii)) multiplied by the overhang allocation factor for the service category (under clause (iii)).

"(II) POST-2007 CUMULATIVE AMOUNTS.—For a year beginning with 2009, the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services (as determined under paragraph (4)(C)) in the service category from January 1, 2008, through the end of the prior year and 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 computing the sustainable growth rate except for the following:

"(A) The reference in paragraphs (2)(A) and (2)(D) to 'all physicians' services' is deemed a reference to the physicians' services included in such category but shall not take into account items and services included in physicians' services through the operation of paragraph (4)(A).

"(B) The factor described in paragraph (2)(C) for the service category described in subsection (j)(5)(A) shall be increased by 0.03.

"(C) A national coverage determination (as defined in section 1869(f)(1)(B)) shall be treated as a change in regulation described in paragraph (2)(D).".

(2) USE OF TARGET GROWTH RATES.—Section 1848 of such Act is further amended—

(A) in subsection (d)—

(i) in paragraph (1)(E)(ii), by inserting "or target" after "sustainable"; and

(ii) in paragraph (4)(B)(ii)(II), by inserting "or target" after "sustainable"; and

(B) in subsection (f)—

(i) in the heading by inserting "; TARGET GROWTH RATE" after "SUSTAINABLE GROWTH RATE"

(ii) in paragraph (1)—

(I) by striking "and" at the end of subparagraph (A);

(II) in subparagraph (B), by inserting "before 2008" after "each succeeding year" and by striking the period at the end and inserting "; and"; and

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

"(C) November 1 of each succeeding year the target growth rate for such succeeding year and each of the 2 preceding years."; and

(iii) in paragraph (2), in the matter before subparagraph (A), by inserting after "beginning with 2000" the following: "and ending with 2007" .

(e) REPORTS ON EXPENDITURES FOR PART B DRUGS AND CLINICAL DIAGNOSTIC LABORATORY TESTS.—

(1) REPORTING REQUIREMENT.—The Secretary of Health and Human Services shall include information in the annual physician fee schedule proposed rule on the change in the annual rate of growth of actual expenditures for clinical diagnostic laboratory tests or drugs, biologicals, and radiopharmaceuticals for which payment is made under part B of title XVIII of the Social Security Act.

(2) RECOMMENDATIONS.—The report submitted under paragraph (1) shall include an analysis of the reasons for such excess expenditures and recommendations for addressing them in the future.

SEC. 302. IMPROVING ACCURACY OF RELATIVE VALUES UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

(a) USE OF EXPERT PANEL TO IDENTIFY MISVALUED PHYSICIANS' SERVICES.—Section 1848(c) of the Social Security Act (42 U.S.C. 1395w(c)) is amended by adding at the end the following new paragraph:

"(7) USE OF EXPERT PANEL TO IDENTIFY MISVALUED PHYSICIANS' SERVICES.—

"(A) IN GENERAL.—The Secretary shall establish an expert panel (in this paragraph referred to as the 'expert panel')—

"(i) to identify, through data analysis, physicians' services for which the relative value under this subsection is potentially misvalued, particularly those services for which such relative value may be overvalued;

"(ii) to assess whether those misvalued services warrant review using existing processes (referred to in paragraph (2)(J)(ii)) for the consideration of coding changes; and

"(iii) to advise the Secretary concerning the exercise of authority under clauses (ii)(III) and (vi) of paragraph (2)(B).

"(B) COMPOSITION OF PANEL.—The expert panel shall be appointed by the Secretary and composed of—

"(i) members with expertise in medical economics and technology diffusion;

"(ii) members with clinical expertise;

"(iii) physicians, particularly physicians (such as a physician employed by the Veterans Administration or a physician who has a full time faculty appointment at a medical school) who are not directly affected by changes in the physician fee schedule under this section;

"(iv) carrier medical directors; and

"(v) representatives of private payor health plans.

"(C) APPOINTMENT CONSIDERATIONS.—In appointing members to the expert panel, the Secretary shall assure racial and ethnic diversity on the panel and may consider appointing a liaison from organizations with experience in the consideration of coding changes to the panel.".

(b) EXAMINATION OF SERVICES WITH SUBSTANTIAL CHANGES.—Such section is further amended by adding at the end the following new paragraph:

"(8) EXAMINATION OF SERVICES WITH SUBSTANTIAL CHANGES.—The Secretary, in consultation with the expert panel under paragraph (7), shall—

"(A) conduct a five-year review of physicians' services in conjunction with the RUC 5-year review, particularly for services that have experienced substantial changes in length of stay, site of service, volume, practice expense, or other factors that may indicate changes in physician work;

"(B) identify new services to determine if they are likely to experience a reduction in relative value over time and forward a list of the services so identified for such five-year review; and

"(C) for physicians' services that are otherwise unreviewed under the process the Secretary has established, periodically review a sample of relative value units within different types of services to assess the accuracy of the relative values contained in the Medicare physician fee schedule.".

(c) AUTHORITY TO REDUCE WORK COMPONENT FOR SERVICES WITH ACCELERATED VOLUME GROWTH.—

(1) IN GENERAL.—Paragraph (2)(B) of such section is amended—

(A) in clause (v), by adding at the end the following new subclause:

"(III) REDUCTIONS IN WORK VALUE UNITS FOR SERVICES WITH ACCELERATED VOLUME GROWTH.—Effective January 1, 2009, reduced expenditures attributable to clause (vi).."; and

(B) by adding at the end the following new clauses:

"(vi) AUTHORIZING REDUCTION IN WORK VALUE UNITS FOR SERVICES WITH ACCELERATED VOLUME GROWTH.—The Secretary may provide (without using existing processes the Secretary has established for review of relative value) for a reduction in the work value units for a particular physician's service if the annual rate of growth in the expenditures for such service for which payment is made under this part for individuals for 2006 or a subsequent year exceeds the average annual rate of growth in expenditures of all physicians' services for which payment is made under this part by more than 10 percentage points for such year.

"(vii) CONSULTATION WITH EXPERT PANEL AND BASED ON CLINICAL EVIDENCE.—The Secretary shall exercise authority under clauses (ii)(III) and (vi) in consultation with the expert panel established under paragraph (7) and shall take into account clinical evidence supporting or refuting the merits of such accelerated growth.".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply with respect to payment for services furnished on or after January 1, 2009.

(d) ADJUSTMENT AUTHORITY FOR EFFICIENCY GAINS FOR NEW PROCEDURES.—Paragraph (2)(B)(ii) of such section is amended by adding at the end the following new subclause:

"(III) ADJUSTMENT AUTHORITY FOR EFFICIENCY GAINS FOR NEW PROCEDURES.—In carrying out subclauses (I) and (II), the Secretary may apply a methodology, based on supporting evidence, under which there is imposed a reduction over a period of years in specified relative value units in the case of a new (or newer) procedure to take into account inherent efficiencies that are typically or likely to be gained during the period of initial increased application of the procedure.".

SEC. 303. FEEDBACK MECHANISM ON PRACTICE PATTERNS.

By not later than July 1, 2008, the Secretary of Health and Human Services shall develop and implement a mechanism to measure resource use on a per capita and an episode basis in order to provide confidential feedback to physicians in the Medicare program on how their practice patterns compare to physicians generally, both in the same locality as well as nationally. Such feedback shall not be subject to disclosure under section 552 of title 5, United States Code). The Secretary shall consider extending such mechanism to other suppliers as necessary.

SEC. 304. PAYMENTS FOR EFFICIENT AREAS.

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

"(v) INCENTIVE PAYMENTS FOR EFFICIENT AREAS.—

"(1) IN GENERAL.—In the case of services furnished under the physician fee schedule under section 1848 on or after January 1, 2009, and before January 1, 2011, by a supplier that is paid under such fee schedule in an efficient area (as identified under paragraph (2)), in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid an amount equal to 5 percent of the payment amount for the services under this part.

"(2) IDENTIFICATION OF EFFICIENT AREAS.—

"(A) IN GENERAL.—Based upon available data, the Secretary shall identify those counties or equivalent areas in the United States in the lowest fifth percentile of utilization based on per capita spending for services provided in 2007 under this part and part A.

"(B) IDENTIFICATION OF COUNTIES WHERE SERVICE IS FURNISHED..—For purposes of paying the additional amount specified in paragraph (1), if the Secretary uses the 5-digit postal ZIP Code where the service is furnished, the dominant county of the postal ZIP Code (as determined by the United States Postal Service, or otherwise) shall be used to determine whether the postal ZIP Code is in a county described in subparagraph (A).

"(C) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting—

"(i) the identification of a county or other area under subparagraph (A); or

"(ii) the assignment of a postal ZIP Code to a county or other area under subparagraph (B).

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

SEC. 305. RECOMMENDATIONS ON REFINING THE PHYSICIAN FEE SCHEDULE.

(a) RECOMMENDATIONS ON CONSOLIDATED CODING FOR SERVICES COMMONLY PERFORMED TOGETHER.—Not later than December 31, 2008, the Comptroller General of the United States shall—

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

(2) submit to Congress a report on such analysis and include in the report recommendations on whether an adjustment should be made to the relative value units for such combined code.

(b) RECOMMENDATIONS ON INCREASED USE OF BUNDLED PAYMENTS.—Not later than December 31, 2008, the Comptroller General of the United States shall—

(1) complete an analysis of those procedures under the Medicare physician fee schedule for which no global payment methodology is applied but for which a "bundled" payment methodology would be appropriate; and

(2) submit to Congress a report on such analysis and include in the report recommendations on increasing the use of "bundled" payment methodology under such schedule.

(c) MEDICARE PHYSICIAN FEE SCHEDULE.—In this section, the term "Medicare physician fee schedule" means the fee schedule established under section 1848 of the Social Security Act (42 U.S.C. 1395w4).

SEC. 306. IMPROVED AND EXPANDED MEDICAL HOME DEMONSTRATION PROJECT.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall establish under title XVIII of the Social Security Act an expanded medical home demonstration project (in this section referred to as the "expanded project") under this section. The expanded project supersedes the project that was initiated under section 204 of the Medicare Improvement and Extension Act of 2006 (division B of Public Law 109–432). The purpose of the expanded project is—

(1) to guide the redesign of the health care delivery system to provide accessible, continuous, comprehensive, and coordinated, care to Medicare beneficiaries; and

(2) to provide care management fees to personal physicians delivering continuous and comprehensive care in qualified medical homes.

(b) NATURE AND SCOPE OF PROJECT.—

(1) DURATION; SCOPE.—The expanded project shall operate during a period of three years, beginning not later than October 1, 2009, and shall include a nationally representative sample of physicians serving urban, rural, and underserved areas throughout the United States.

(2) ENCOURAGING PARTICIPATION OF SMALL PHYSICIAN PRACTICES.—

(A) IN GENERAL.—The expanded project shall be designed to include the participation of physicians in practices with fewer than four full-time equivalent physicians, as well as physicians in larger practices particularly in rural and underserved areas.

(B) TECHNICAL ASSISTANCE.—In order to facilitate the participation under the expanded project of physicians in such practices, the Secretary shall make available additional technical assistance to such practices during the first year of the expanded project.

(3) SELECTION OF HOMES TO PARTICIPATE.—The Secretary shall select up to 500 medical homes to participate in the expanded project and shall give priority to—

(A) the selection of up to 100 HIT-enhanced medical homes; and

(B) the selection of other medical homes that serve communities whose populations are at higher risk for health disparities,

(4) BENEFICIARY PARTICIPATION.—The Secretary shall establish a process for any Medicare beneficiary who is served by a medical home participating in the expanded project to elect to participate in the project. Each beneficiary who elects to so participate shall be eligible—

(A) for enhanced medical home services under the project with no cost sharing for the additional services; and

(B) for a reduction of up to 50 percent in the coinsurance for services furnished under the physician fee schedule under section 1848 of the Social Security Act by the medical home.

The Secretary shall develop standard recruitment materials and election processes for Medicare beneficiaries who are electing to participate in the expanded project.

(c) STANDARDS FOR MEDICAL HOMES, HIT-ENHANCED MEDICAL HOMES.—

(1) STANDARD SETTING AND CERTIFICATION PROCESS.—The Secretary shall establish a process for selection of a qualified standard setting and certification organization—

(A) to establish standards, consistent with this section, for medical practices to qualify as medical homes or as HIT-enhanced medical homes; and

(B) to provide for the review and certification of medical practices as meeting such standards.

(2) BASIC STANDARDS FOR MEDICAL HOMES.—For purposes of this subsection, the term "medical home" means a physician-directed practice that has been certified, under paragraph (1), as meeting the following standards:

(A) ACCESS AND COMMUNICATION WITH PATIENTS.—The practice applies standards for access to care and communication with participating beneficiaries.

(B) MANAGING PATIENT INFORMATION AND USING INFORMATION IN MANAGEMENT TO SUPPORT PATIENT CARE.—The practice has readily accessible, clinically useful information on participating beneficiaries that enables the practice to treat such beneficiaries comprehensively and systematically.

(C) MANAGING AND COORDINATING CARE ACCORDING TO INDIVIDUAL NEEDS.—The practice maintains continuous relationships with participating beneficiaries by implementing evidence-based guidelines and applying them to the identified needs of individual beneficiaries over time and with the intensity needed by such beneficiaries.

(D) PROVIDING ONGOING ASSISTANCE AND ENCOURAGEMENT IN PATIENT SELF-MANAGEMENT.—The practice—

(i) collaborates with participating beneficiaries to pursue their goals for optimal achievable health; and

(ii) assesses patient-specific barriers to communication and conducts activities to support patient self-management.

(E) RESOURCES TO MANAGE CARE.—The practice has in place the resources and processes necessary to achieve improvements in the management and coordination of care for participating beneficiaries.

(F) MONITORING PERFORMANCE.—The practice monitors its clinical process and performance (including outcome measures) in meeting the applicable standards under this subsection and provides information in a form and manner specified by the Secretary with respect to such process and performance.

(3) ADDITIONAL STANDARDS FOR HIT-ENHANCED MEDICAL HOME.—For purposes of this subsection, the term "HIT-enhanced medical home" means a medical home that has been certified, under paragraph (1), as using a health information technology system that includes at least the following elements:

(A) ELECTRONIC HEALTH RECORD (EHR).—The system uses, for participating beneficiaries, an electronic health record that meets the following standards:

(i) IN GENERAL.—The record—

(I) has the capability of interoperability with secure data acquisition from health information technology systems of other health care providers in the area served by the home; or

(II) the capability to securely acquire clinical data delivered by such other health care providers to a secure common data source.

(ii) The record protects the privacy and security of health information.

(iii) The record has the capability to acquire, manage, and display all the types of clinical information commonly relevant to services furnished by the medical home, such as complete medical records, radiographic image retrieval, and clinical laboratory information.

(iv) The record is integrated with decision support capacities that facilitate the use of evidence-based medicine and clinical decision support tools to guide decision-making at the point-of-care based on patient-specific factors.

(B) E-PRESCRIBING.—The system supports e-prescribing and computerized physician order entry.

(C) OUTCOME MEASUREMENT.—The system supports the secure, confidential provision of clinical process and outcome measures approved by the National Quality Forum to the Secretary for use in confidential manner for provider feedback and peer review and for outcomes and clinical effectiveness research.

(D) PATIENT EDUCATION CAPABILITY.—The system actively facilitates participating beneficiaries engaging in the management of their own health through education and support systems and tools for shared decision-making.

(E) SUPPORT OF BASIC STANDARDS.—The elements of such system, such as the electronic health record, email communications, patient registries, and clinical-decision support tools, are integrated in a manner to better achieve the basic standards specified in paragraph (2) for a medical home.

(4) USE OF DATA.—The Secretary shall use the data submitted under paragraph (1)(F) in a confidential manner for feedback and peer review for medical homes and for outcomes and clinical effectiveness research. After the first two years of the expanded project, these data may be used for adjustment in the monthly medical home care management fee under subsection (d)(2)(E).

(d) MONTHLY MEDICAL HOME CARE MANAGEMENT FEE.—

(1) IN GENERAL.—Under the expanded project, the Secretary shall provide for payment to the personal physician of each participating beneficiary of a monthly medical home care management fee.

(2) AMOUNT OF PAYMENT.—In determining the amount of such fee, the Secretary shall consider the following:

(A) OPERATING EXPENSES.—The additional practice expenses for the delivery of services through a medical home, taking into account the additional expenses for an HIT-enhanced medical home. Such expenses include costs associated with—

(i) structural expenses, such as equipment, maintenance, and training costs;

(ii) enhanced access and communication functions;

(iii) population management and registry functions;

(iv) patient medical data and referral tracking functions;

(v) provision of evidence-based care;

(vi) implementation and maintenance of health information technology;

(vii) reporting on performance and improvement conditions; and

(viii) patient education and patient decision support, including print and electronic patient education materials.

(B) ADDED VALUE SERVICES.—The value of additional physician work, such as augmented care plan oversight, expanded e-mail and telephonic consultations, extended patient medical data review (including data stored and transmitted electronically), and physician supervision of enhanced self management education, and expanded follow-up accomplished by non-physician personnel, in a medical home that is not adequately taken into account in the establishment of the physician fee schedule under section 1848 of the Social Security Act.

(C) RISK ADJUSTMENT.—The development of an appropriate risk adjustment mechanism to account for the varying costs of medical homes based upon characteristics of participating beneficiaries.

(D) HIT ADJUSTMENT.—Variation of the fee based on the extensiveness of use of the health information technology in the medical home.

(E) PERFORMANCE-BASED.—After the first two years of the expanded project, an adjustment of the fee based on performance of the medical home in achieving quality or outcomes standards.

(3) PERSONAL PHYSICIAN DEFINED.—For purposes of this subsection, the term "personal physician" means, with respect to a participating Medicare beneficiary, a physician (as defined in section 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 medical home care management fees under subsection (d), reductions in coinsurance for participating beneficiaries under subsection (b)(4)(B), and funds for the design, implementation, and evaluation of the expanded project.

(B) MONITORING EXPENDITURES; EARLY TERMINATION.—The Secretary shall monitor the expenditures under the expanded project and may terminate the project early in order that expenditures not exceed the amount of funding provided for the project under subparagraph (A).

(f) EVALUATIONS AND REPORTS.—.

(1) ANNUAL INTERIM EVALUATIONS AND REPORTS.—For each year of the expanded project, the Secretary shall provide for an evaluation of the project and shall submit to Congress, by a date specified by the Secretary, a report on the project and on the evaluation of the project for each such year.

(2) FINAL EVALUATION AND REPORT.—The Secretary shall provide for an evaluation of the expanded project and shall submit to Congress, not later than 18 months after the date of completion of the project, a report on the project and on the evaluation of the project.

SEC. 307. REPEAL OF PHYSICIAN ASSISTANCE AND QUALITY INITIATIVE FUND.

Subsection (l) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is repealed.

SEC. 308. ADJUSTMENT TO MEDICARE PAYMENT LOCALITIES.

Section 1848(e) of the Social Security Act (42 U.S.C.1395w–4(e)) is amended by adding at the end the following new paragraph:

"(6) FEE SCHEDULE GEOGRAPHIC AREAS.—

"(A) IN GENERAL.—

"(i) REVISION.—Subject to clause (ii), for services furnished on or after January 1, 2008, the Secretary shall revise the fee schedule areas used for payment under this section applicable to the State of California using the county-based geographic adjustment factor as specified in option 3 (table 9) in the proposed rule for the 2008 physician fee schedule published at 72 Fed. Reg. 38,122 (July 12, 2007).

"(ii) TRANSITION.—For services furnished during the period beginning January 1, 2008, and ending December 31, 2010, after calculating the work, practice expense, and malpractice geographic indices described in clauses (i), (ii), and (iii) of paragraph (1)(A) that would otherwise apply, the Secretary shall increase any such geographic index for any county in California that is lower than the geographic index used for payment for services under this section as of December 31, 2007, in such county to such geographic index level.

"(B) SUBSEQUENT REVISIONS.—

"(i) TIMING.—Not later than January 1, 2011, the Secretary shall review and make revisions to fee schedule areas in all States for which more than one fee schedule area is used for payment of services under this section. The Secretary may revise fee schedule areas in States in which a single fee schedule area is used for payment for services under this section using the same methodology applied in the previous sentence.

"(ii) LINK WITH GEOGRAPHIC INDEX DATA REVISION.—The revision described in clause (i) shall be made effective concurrently with the application of the periodic review of geographic adjustment factors required under paragraph (1)(C) for 2011 and subsequent periods.".

SEC. 309. PAYMENT FOR IMAGING SERVICES.

(a) PAYMENT UNDER PART B OF THE MEDICARE PROGRAM FOR DIAGNOSTIC IMAGING SERVICES FURNISHED IN FACILITIES CONDITIONED ON ACCREDITATION OF FACILITIES.—

(1) SPECIAL PAYMENT RULE.—

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

(i) in the heading, by striking "RULE" and inserting "RULES";

(ii) in subparagraph (A), by striking "IN GENERAL" and inserting "LIMITATION"; and

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

"(C) PAYMENT ONLY FOR SERVICES PROVIDED IN ACCREDITED FACILITIES.—

"(i) IN GENERAL.—In the case of imaging services that are diagnostic imaging services described in clause (ii), the payment amount for the technical component and the professional component of the services established for a year under the fee schedule described in paragraph (1) shall each be zero, unless the services are furnished at a diagnostic imaging services facility that meets the certificate requirement described in section 354(b)(1) of the Public Health Service Act, as applied under subsection (m). The previous sentence shall not apply with respect to the technical component if the imaging equipment meets certification standards and the professional component of a diagnostic imaging service that is furnished by a physician.

"(ii) DIAGNOSTIC IMAGING SERVICES.—For purposes of clause (i) and subsection (m), the term 'diagnostic imaging services' means all imaging modalities, including diagnostic magnetic resonance imaging ('MRI'), computed tomography ('CT'), positron emission tomography ('PET'), nuclear medicine procedures, x-rays, sonograms, ultrasounds, echocardiograms, and such emerging diagnostic imaging technologies as specified by the Secretary.".

(B) EFFECTIVE DATE.—

(i) IN GENERAL.—Subject to clause (ii), the amendments made by subparagraph (A) shall apply to diagnostic imaging services furnished on or after January 1, 2010.

(ii) EXTENSION FOR ULTRASOUND SERVICES.—The amendments made by subparagraph (A) shall apply to diagnostic imaging services that are ultrasound services on or after January 1, 2012.

(2) CERTIFICATION OF FACILITIES THAT FURNISH DIAGNOSTIC IMAGING SERVICES.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new subsection:

"(m) CERTIFICATION OF FACILITIES THAT FURNISH DIAGNOSTIC IMAGING SERVICES.—

"(1) IN GENERAL.—For purposes of subsection (b)(4)(C)(i), except as provided under paragraphs (2) through (8), the provisions of section 354 of the Public Health Service Act (as in effect as of June 1, 2007), relating to the certification of mammography facilities, shall apply, with respect to the provision of diagnostic imaging services (as defined in subsection (b)(4)(C)(ii)) and to a diagnostic imaging services facility defined in paragraph (8) (and to the process of accrediting such facilities) in the same manner that such provisions apply, with respect to the provision of mammograms and to a facility defined in subsection (a)(3) of such section (and to the process of accrediting such mammography facilities).

"(2) TERMINOLOGY AND REFERENCES.—For purposes of applying section 354 of the Public Health Service Act under paragraph (1)—

"(A) any reference to 'mammography', or 'breast imaging' is deemed a reference to 'diagnostic imaging services (as defined in section 1848(b)(4)(C)(ii) of the Social Security Act)';

"(B) any reference to a mammogram or film is deemed a reference to an image, as defined in paragraph (8);

"(C) any reference to 'mammography facility' or to a 'facility' under such section 354 is deemed a reference to a diagnostic imaging services facility, as defined in paragraph (8);

"(D) any reference to radiological equipment used to image the breast is deemed a reference to medical imaging equipment used to provide diagnostic imaging services;

"(E) any reference to radiological procedures or radiological is deemed a reference to medical imaging services, as defined in paragraph (8) or medical imaging, respectively;

"(F) any reference to an inspection (as defined in subsection (a)(4) of such section) or inspector is deemed a reference to an audit (as defined in paragraph (8)) or auditor, respectively;

"(G) any reference to a medical physicist (as described in subsection (f)(1)(E) of such section) is deemed to include a reference to a magnetic resonance scientist or the appropriate qualified expert as determined by the accrediting body;

"(H) in applying subsection (d)(1)(A)(i) of such section, the reference to 'type of each x-ray machine, image receptor, and processor' is deemed a reference to 'type of imaging equipment';

"(I) in applying subsection (d)(1)(B) of such section, the reference that 'the person or agent submits to the Secretary' is deemed a reference that 'the person or agent submits to the Secretary, through the appropriate accreditation body';

"(J) in applying subsection (d)(1)(B)(i) of such section, the reference to standards established by the Secretary is deemed a reference to standards established by an accreditation body and approved by the Secretary;

"(K) in applying subsection (e) of such section, relating to an accreditation body—

"(i) in paragraph (1)(A), the reference to 'may' is deemed a reference to 'shall';

"(ii) in paragraph (1)(B)(i)(II), the reference to 'a random sample of clinical images from such facilities' is deemed a reference to 'a statis-

tically significant random sample of clinical images from a statistically significant random sample of facilities';

"(iii) in paragraph (3)(A) of such section—

"(I) the reference to 'paragraph (1)(B)' in such subsection is deemed to be a reference to 'paragraph (1)(B) and subsection (f)'; and

"(II) the reference to the 'Secretary' is deemed a reference to 'an accreditation body, with the approval of the Secretary'; and

"(iv) in paragraph (6)(B), the reference to the Committee on Labor and Human Resources of the Senate is deemed to be the Committee on Finance of the Senate and the reference to the Committee on Energy and Commerce of the House of Representatives is deemed to include a reference to the Committee on Ways and Means of the House of Representatives;

"(L) in applying subsection (f), relating to quality standards—

"(i) each reference to standards established by the Secretary is deemed a reference to standards established by an accreditation body involved and approved by the Secretary under subsection (d)(1)(B)(i) of such section;

"(ii) in paragraph (1)(A), the reference to 'radiation dose' is deemed a reference to 'radiation dose, as appropriate';

"(iii) in paragraph (1)(B), the reference to 'radiological standards' is deemed a reference to 'medical imaging standards, as appropriate';

"(iv) in paragraphs (1)(D)(ii) and (1)(E)(iii), the reference to 'the Secretary' is deemed a reference to 'an accreditation body with the approval of the Secretary';

"(v) in each of subclauses (III) and (IV) of paragraph (1)(G)(ii), each reference to 'patient' is deemed a reference to 'patient, if requested by the patient'; and

"(M) in applying subsection (g), relating to inspections—

"(i) each reference to the 'Secretary or State or local agency acting on behalf of the Secretary' is deemed to include a reference to an accreditation body involved;

"(ii) in the first sentence of paragraph (1)(F), the reference to 'annual inspections required under this paragraph' is deemed a reference to 'the audits carried out in facilities at least every three years from the date of initial accreditation under this paragraph'; and

"(iii) in the second sentence of paragraph (1)(F), the reference to 'inspections carried out under this paragraph' is deemed a reference to 'audits conducted under this paragraph during the previous year'.

"(3) DATES AND PERIODS.—For purposes of paragraph (1), in applying section 354 of the Public Health Service Act, the following applies:

"(A) IN GENERAL.—Except as provided in subparagraph (B)—

"(i) any reference to 'October 1, 1994' shall be deemed a reference to 'January 1, 2010';

"(ii) the reference to 'the date of the enactment of this section' in each of subsections (e)(1)(D) and (f)(1)(E)(iii) is deemed to be a reference to 'the date of the enactment of the Children's Health and Medicare Protection Act of 2007';

"(iii) the reference to 'annually' in subsection (g)(1)(E) is deemed a reference to 'every three years';

"(iv) the reference to 'October 1, 1996' in subsection (l) is deemed to be a reference to 'January 1, 2011';

"(v) the reference to 'October 1, 1999' in subsection (n)(3)(H) is deemed to be a reference to 'January 1, 2012'; and

"(vi) the reference to 'October 1, 1993' in the matter following paragraph (3)(J) of subsection (n) is deemed to be a reference 'January 1, 2010'.

"(B) ULTRASOUND SERVICES.—With respect to diagnostic imaging services that are ultrasounds—

"(i) any reference to 'October 1, 1994' shall be deemed a reference to 'January 1, 2012';

"(ii) the reference to 'the date of the enactment of this section' in subsection (f)(1)(E)(iii) is deemed to be a reference to '7 years after the date of the enactment of the Children's Health and Medicare Protection Act of 2007';

"(iii) the reference to 'October 1, 1996' in subsection (l) is deemed to be a reference to 'January 1, 2013';

"(4) PROVISIONS NOT APPLICABLE.—For purposes of paragraph (1), in applying section 354 of the Public Health Service Act, the following provision shall not apply:

"(A) Subsections (e) and (f) of such section, in so far as the respective subsection imposes any requirement for a physician to be certified, accredited, or otherwise meet requirements, with respect to the provision of any diagnostic imaging services, as a condition of payment under subsection (b)(4)(C)(i), with respect to the professional or technical component, for such service.

"(B) Subsection (e)(1)(B)(iv) of such section, insofar as it applies to a facility with respect to the provision of ultrasounds.

"(C) Subsection (e)(1)(B)(v).

"(D) Subsection (f)(1)(H) of such section, relating to standards for special techniques for mammograms of patients with breast implants.

"(E) Subsection (g)(6) of such section, relating to an inspection demonstration program.

"(F) Subsection (n)(3)(G) of such section, relating to the national advisory committee.

"(G) Subsection (p) of such section, relating to breast cancer screening surveillance research grants.

"(H) Paragraphs (1)(B) and (2) of subsection (r) of such section, related to funding.

"(5) ACCREDITATION BODIES.—For purposes of paragraph (1), in applying section 354(e)(1) of the Public Health Service, the following shall apply:

"(A) APPROVAL OF TWO ACCREDITATION BODIES FOR EACH TREATMENT MODALITY.—In the case that there is more than one accreditation body for a treatment modality that qualifies for approval under this subsection, the Secretary shall approve at least two accreditation bodies for such treatment modality.

"(B) ADDITIONAL ACCREDITATION BODY STANDARDS.—In addition to the standards described in subparagraph (B) of such section for accreditation bodies, the Secretary shall establish standards that require—

"(i) the timely integration of new technology by accreditation bodies for purposes of accrediting facilities under this subsection; and

"(ii) the accreditation body involved to evaluate the annual medical physicist survey (or annual medical survey of another appropriate qualified expert chosen by the accreditation body) of a facility upon onsite review of such facility.

"(6) ADDITIONAL QUALITY STANDARDS.—For purposes of paragraph (1), in applying subsection (f)(1) of section 354 of the Public Health Service—

"(A) the quality standards under such subsection shall, with respect to a facility include—

"(i) standards for qualifications of medical personnel who are not physicians and who perform diagnostic imaging services at the facility that require such personnel to ensure that individuals, prior to performing medical imaging, demonstrate compliance with the standards established under subsection (a) through successful completion of certification by a nationally recognized professional organization, licensure, completion of an examination, pertinent coursework or degree program, verified pertinent experience, or through other ways determined appropriate by an accreditation body (with the approval of the Secretary, or through some combination thereof);

"(ii) standards requiring the facility to maintain records of the credentials of physicians and other medical personnel described in clause (i);

"(iii) standards for qualifications and responsibilities of medical directors and other personnel with supervising roles at the facility;

"(iv) standards that require the facility has procedures to ensure the safety of patients of the facility; and

"(v) standards for the establishment of a quality control program at the facility to be implemented as described in subparagraph (E) of such subsection;

"(B) the quality standards described in subparagraph (B) of such subsection shall be deemed to include standards that require the establishment and maintenance of a quality assurance and quality control program at each facility that is adequate and appropriate to ensure the reliability, clarity, and accuracy of the technical quality of diagnostic images produced at such facilities; and

"(C) the quality standard described in subparagraph (C) of such subsection, relating to a requirement for personnel who perform specified services, shall include in such requirement that such personnel must meet continuing medical education standards as specified by an accreditation body (with the approval of the Secretary) and update such standards at least once every three years.

"(7) ADDITIONAL REQUIREMENTS.—Notwithstanding any provision of section 354 of the Public Health Service Act, the following shall apply to the accreditation process under this subsection for purposes of subsection (b)(4)(C)(i):

"(A) Any diagnostic imaging services facility accredited before January 1, 2010 (or January 1, 2012 in the case of ultrasounds), by an accrediting body approved by the Secretary shall be deemed a facility accredited by an approved accreditation body for purposes of such subsection as of such date if the facility submits to the Secretary proof of such accreditation by transmittal of the certificate of accreditation, including by electronic means.

"(B) The Secretary may require the accreditation under this subsection of an emerging technology used in the provision of a diagnostic imaging service as a condition of payment under subsection (b)(4)(C)(i) for such service at such time as the Secretary determines there is sufficient empirical and scientific information to properly carry out the accreditation process for such technology.

"(8) DEFINITIONS.—For purposes of this subsection:

"(A) AUDIT.—The term 'audit' means an onsite evaluation, with respect to a diagnostic imaging services facility, by the Secretary, State or local agency on behalf of the Secretary, or accreditation body approved under this subsection that includes the following:

"(i) Equipment verification.

"(ii) Evaluation of policies and procedures for compliance with accreditation requirements.

"(iii) Evaluation of personnel qualifications and credentialing.

"(iv) Evaluation of the technical quality of images.

"(v) Evaluation of patient reports.

"(vi) Evaluation of peer-review mechanisms and other quality assurance activities.

"(vii) Evaluation of quality control procedures, results, and follow-up actions.

"(viii) Evaluation of medical physicists (or other appropriate professionals chosen by the accreditation body) and magnetic resonance scientist surveys.

"(ix) Evaluation of consumer complaint mechanisms.

"(x) Provision of recommendations for improvement based on findings with respect to clauses (i) through (ix).

"(B) DIAGNOSTIC IMAGING SERVICES FACILITY.—The term 'diagnostic imaging services facility' has the meaning given the term 'facility' in section 354(a)(3) of the Public Health Service Act (42 U.S.C. 263b(a)(3)) subject to the reference changes specified in paragraph (2), but does not include any facility that does not furnish diagnostic imaging services for which payment may be made under this section.

"(C) IMAGE.—The term 'image' means the portrayal of internal structures of the human body for the purpose of detecting and determining the presence or extent of disease or injury and may be produced through various techniques or modalities, including radiant energy or ionizing radiation and ultrasound and magnetic resonance. Such term does not include image guided procedures.

"(D) MEDICAL IMAGING SERVICE.—The term 'medical imaging service' means a service that involves the science of an image.".

(b) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—Section 1848 of the Social Security Act (42 U.S.C. 1395w) is amended—

(1) in subsection (b)(4)—

(A) in subparagraph (B), by striking "subparagraph (A)" and inserting "this paragraph"; and

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

"(D) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—In computing the number of practice expense relative value units under subsection (c)(2)(C)(ii) with respect to imaging services described in subparagraph (B), the Secretary shall adjust such number of units so it reflects a 75 percent (rather than 50 percent) presumed rate of utilization of imaging equipment."; and

(2) in subsection (c)(2)(B)(v)(II), by inserting "AND OTHER PROVISIONS" after "OPD PAYMENT CAP"

(c) ADJUSTMENT IN TECHNICAL COMPONENT "DISCOUNT" ON SINGLE-SESSION IMAGING TO CONSECUTIVE BODY PARTS.—Section 1848(b)(4) of such Act is further amended by adding at the end the following new subparagraph:

"(E) ADJUSTMENT IN TECHNICAL COMPONENT DISCOUNT ON SINGLE-SESSION IMAGING INVOLVING CONSECUTIVE BODY PARTS.—The Secretary shall increase the reduction in expenditures attributable to the multiple procedure payment reduction applicable to the technical component for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (42 CFR 405, et al.) from 25 percent to 50 percent.".

(d) ADJUSTMENT IN ASSUMED INTEREST RATE FOR CAPITAL PURCHASES.—Section 1848(b)(4) of such Act is further amended by adding at the end the following new subparagraph:

"(F) ADJUSTMENT IN ASSUMED INTEREST RATE FOR CAPITAL PURCHASES.—In computing the practice expense component for imaging services under this section, the Secretary shall change the interest rate assumption for capital purchases of imaging devices to reflect the prevailing rate in the market, but in no case higher than 11 percent.".

(e) DISALLOWANCE OF GLOBAL BILLING.—Effective for claims filed for imaging services (as defined in subsection (b)(4)(B) of section 1848 of the Social Security Act) furnished on or after the first day of the first month that begins more than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall not accept (or pay) a claim under such section unless the claim is made separately for each component 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. REDUCING FREQUENCY OF MEETINGS OF THE PRACTICING PHYSICIANS ADVISORY COUNCIL.

Section 1868(a)(2) of the Social Security Act (42 U.S.C. 1395ee(a)(2)) is amended by striking "once during each calendar quarter" and inserting "once each year (and at such other times as the Secretary may specify)".

TITLE IV—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

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

"(l) DETERMINATION OF BLENDED BENCHMARK AMOUNT.—

"(1) IN GENERAL.—For purposes of subsection (j), subject to paragraphs (2) and (3), the term 'blended benchmark amount' means for an area—

"(A) for 2009 the sum of—

"(i) 2/3 of the applicable amount (as defined in subsection (k)(1)) for the area and year; and

"(ii) 1/3 of the amount specified in subsection (c)(1)(D)(i) for the area and year;

"(B) for 2010 the sum of—

"(i) 1/3 of the applicable amount for the area and year; and

"(ii) 2/3 of the amount specified in subsection (c)(1)(D)(i) for the area and year; and

"(C) for a subsequent year the amount specified in subsection (c)(1)(D)(i) for the area and year.

"(2) FEE-FOR-SERVICE PAYMENT FLOOR.—In no case shall the blended benchmark amount for an area and year be less than the amount specified in subsection (c)(1)(D)(i) for the area and year.

"(3) EXCEPTION FOR PACE PLANS.—This subsection shall not apply to payments to a PACE program under section 1894.".

(b) PHASE IN OF PAYMENT BASED ON IME COSTS.—

(1) IN GENERAL.—Section 1853(c)(1)(D)(i) of such Act (42 U.S.C. 1395w–23(c)(1)(D)(i)) is amended by inserting "and costs attributable to payments under section 1886(d)(5)(B)" after "1886(h)".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to the capitation rate for years beginning with 2009.

(c) LIMITATION ON PLAN ENROLLMENT IN CASES OF EXCESS BIDS FOR 2009 AND 2010.—

(1) IN GENERAL.—In the case of a Medicare Part C organization that offers a Medicare Part C plan in the 50 States or the District of Columbia for which—

(A) bid amount described in paragraph (2) for a Medicare Part C plan for 2009 or 2010, exceeds

(B) the percent specified in paragraph (4) of the fee-for-service amount described in paragraph (3),

the Medicare Part C plan may not enroll any new enrollees in the plan during the annual, coordinated election period (under section 1851(e)(3)(B) of such Act (42 U.S.C. 1395w–21(e)(3)(B)) for the year or during the year (if the enrollment becomes effective during the year).

(2) BID AMOUNT FOR PART A AND B SERVICES.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the bid amount described in this paragraph is the unadjusted Medicare Part C statutory non-drug monthly bid amount (as defined in section 1854(b)(2)(E) of the Social Security Act (42 U.S.C. 1395w–24(b)(2)(E)).

(B) TREATMENT OF MSA PLANS.—In the case of an MSA plan (as defined in section 1859(b)(3) of the Social Security Act, 42 U.S.C. 1935w–28(b)(3)), the bid amount described in this paragraph is the amount described in section 1854(a)(3)(A) of such Act (42 U.S.C. 1395w–24(a)(3)(A)).

(3) FEE-FOR-SERVICE AMOUNT DESCRIBED.—

(A) IN GENERAL.—Subject to subparagraph (B), the fee-for-service amount described in this paragraph for an Medicare Part C local area is the amount described in section 1853(c)(1)(D)(i) of the Social Security Act (42 U.S.C. 1395w–23) for such area.

(B) TREATMENT OF MULTI-COUNTY PLANS.—In the case of an MA plan the service area for which covers more than one Medicare Part C local area, the fee-for-service amount described in this paragraph is the amount described in section 1853(c)(1)(D)(i) of the Social Security Act for each such area served, weighted for each such area by the proportion of the enrollment of the plan that resides in the county (as determined based on amounts posted by the Administrator of the Centers for Medicare & Medicaid Services in the April bid notice for the year involved).

(4) PERCENTAGE PHASE DOWN.—For purposes of paragraph (1), the percentage specified in this paragraph—

(A) for 2009 is 106 percent; and

(B) for 2010 is 103 percent.

(5) EXEMPTION OF AGE-INS.—For purposes of paragraph (1), the term "new enrollee" with respect to a Medicare Part C plan offered by a Medicare Part C organization, does not include an individual who was enrolled in a plan offered by the organization in the month immediately before the month in which the individual was eligible to enroll in such a Medicare Part C plan offered by the organization.

(d) ANNUAL REBASING OF FEE-FOR-SERVICE RATES.—Section 1853(c)(1)(D)(ii) of the Social Security Act (42 U.S.C. 1395w–23(c)(1)(D)(ii)) is amended—

(1) by inserting "(before 2009)" after "for subsequent years"; and

(2) by inserting before the period at the end the following: "and for each year beginning with 2009".

(e) REPEAL OF PPO STABILIZATION FUND.—Section 1858 of the Social Security Act (42 U.S.C. 1395) is amended—

(1) by striking subsection (e); and

(2) in subsection (f)(1), by striking "subject to 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 and brokers in selling plans, including defining and prohibiting cold calls, unsolicited door-to-door sales, cross-selling, and co-branding.

"(B) SPECIAL CONSIDERATIONS.—The model regulations shall specifically address the marketing—

"(i) of plans to full benefit dual-eligible individuals and qualified medicare beneficiaries;

"(ii) of plans to populations with limited English proficiency;

"(iii) of plans to beneficiaries in senior living facilities; and

"(iv) of plans at educational events.

"(3) ENROLLMENT GUIDELINES.—

"(A) IN GENERAL.—The model regulations shall address the disclosures Medicare private plans, agents, and brokers must make when enrolling beneficiaries, and a process—

"(i) for affirmative beneficiary sign off before enrollment in a plan; and

"(ii) in the case of Medicare Part C plans, for plans to conduct a beneficiary call-back to confirm beneficiary sign off and enrollment.

"(B) SPECIFIC CONSIDERATIONS.—The model regulations shall specially address beneficiary understanding of the Medicare plan through required disclosure (or beneficiary verification) of each of the following:

"(i) The type of Medicare private plan involved.

"(ii) Attributes of the plan, including premiums, cost sharing, formularies (if applicable), benefits, and provider access limitations in the plan.

"(iii) Comparative quality of the plan.

"(iv) The fact that plan attributes may change annually.

"(4) APPOINTMENT, CERTIFICATION AND TRAINING OF AGENTS AND BROKERS.—The model regulations shall establish procedures and requirements for appointment, certification (and periodic recertification), and training of agents and brokers that market or sell Medicare private plans consistent with existing State appointment and certification procedures and with this paragraph.

"(5) AGENT AND BROKER COMMISSIONS.—

"(A) IN GENERAL.—The model regulations shall establish standards for fair and appropriate commissions for agents and brokers consistent with this paragraph.

"(B) LIMITATION ON TYPES OF COMMISSION.—The model regulations shall specifically prohibit the following:

"(i) Differential commissions—

"(I) for Medicare Part C plans based on the type of Medicare private plan; or

"(II) prescription drug plans under part D based on the type of prescription drug plan.

"(ii) Commissions in the first year that are more than 200 percent of subsequent year commissions.

"(iii) The payment of extra bonuses or incentives (such as trips, gifts, and other non-commission cash payments).

"(C) AGENT DISCLOSURE.—In developing the model regulations, the NAIC shall consider requiring agents and brokers to disclose commissions to a beneficiary upon request of the beneficiary before enrollment.

"(D) PREVENTION OF FRAUD.—The model regulations shall consider the opportunity for fraud and abuse and beneficiary steering in setting standards under this paragraph and shall provide for the ability of State commissioners to investigate commission structures.

"(6) MARKET CONDUCT.—

"(A) IN GENERAL.—The model regulations shall establish standards for the market conduct of organizations offering Medicare private plans, and of

agents and brokers selling such plans, and for State review of plan market conduct.

"(B) MATTERS TO BE INCLUDED.—Such standards shall include standards for—

"(i) timely payment of claims;

"(ii) beneficiary complaint reporting and disclosure; and

"(iii) State reporting of market conduct violations and sanctions.

"(7) IMPLEMENTATION.—

"(A) PUBLICATION OF NAIC MODEL REGULATIONS.—If the model regulations are submitted on a timely basis under paragraph (1)—

"(i) the Secretary shall publish them in the Federal Register upon receipt and request public comment on the issue of whether such regulations are consistent with the requirements established in this subsection for such regulations;

"(ii) not later than 6 months after the date of such publication, the Secretary shall determine whether such regulations are so consistent with such requirements and shall publish notice of such determination in the Federal Register; and

"(iii) if the Secretary makes the determination under clause (ii) that such regulations are consistent with such requirements, in the notice published under clause (ii) the Secretary shall publish notice of adoption of such model regulations as constituting the marketing and enrollment standards adopted under this subsection to be applied under this title; and

"(iv) if the Secretary makes the determination under such clause that such regulations are not consistent with such requirements, the procedures of clauses (ii) and (iii) of subparagraph (B) shall apply (in relation to the notice published under clause (ii)), in the same manner as such clauses would apply in the case of publication of a notice under subparagraph (B)(i).

"(B) NO MODEL REGULATIONS.—If the model regulations are not submitted on a timely basis under paragraph (1)—

"(i) the Secretary shall publish notice of such fact in the Federal Register;

"(ii) not later than 6 months after the date of publication of such notice, the Secretary shall propose regulations that provide for marketing and enrollment standards that incorporate the requirements of this subsection for the model regulations and request public comments on such proposed regulations; and

"(iii) not later than 6 months after the date of publication of such proposed regulations, the Secretary shall publish final regulations that shall constitute the marketing and enrollment standards adopted under this subsection to be applied under this title.

"(C) REFERENCES TO MARKETING AND ENROLLMENT STANDARDS.—In this title, a reference to marketing and enrollment standards adopted under this subsection is deemed a reference to the regulations constituting such standards adopted under subparagraph (A) or (B), as the case may be.

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

"(i) In the case of components that relate predominantly to operations in relation to Medicare private plans, the effective date shall be for plan years beginning on or after such date (not later than 1 year after the date of promulgation of the standards) as the Secretary specifies.

"(ii) In the case of other components, the effective date shall be such date, not later than 1 year after the date of promulgation of the standards, as the Secretary specifies.

"(E) CONSULTATION.—In promulgating marketing and enrollment standards under this paragraph, the NAIC or Secretary shall consult with a working group composed of representatives of issuers of Medicare private plans, consumer groups, medicare beneficiaries, State Health Insurance Assistance Programs, and other qualified individuals. Such representatives shall be selected in a manner so as to assure balanced representation among the interested groups.

"(8) ENFORCEMENT.—

"(A) IN GENERAL.—Any Medicare private plan that violates marketing and enrollment standards is subject to sanctions under section 1857(g).

"(B) STATE RESPONSIBILITIES.—Nothing in this subsection or section 1857(g) shall prohibit States from imposing sanctions against Medicare private plans, agents, or brokers for violations of the marketing and enrollment standards adopted under section 1852(m). States shall have the sole authority to regulate agents and brokers.

"(9) MEDICARE PRIVATE PLAN DEFINED.—In this subsection, the term 'Medicare private plan' means a Medicare Part C plan and a prescription drug plan under part D.".

(b) EXPANSION OF EXCEPTION TO PREEMPTION OF STATE ROLE.—

(1) IN GENERAL.—Section 1856(b)(3) of the Social Security Act (42 U.S.C. 1395w–26(b)(3)) is amended by striking "(other than State licensing laws or State laws relating to plan solvency)" and inserting "(other than State laws relating to licensing or plan solvency and State laws or regulations adopting the marketing and enrollment standards adopted under section 1852(m))".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to plans offered on or after July 1, 2008.

(c) APPLICATION TO PRESCRIPTION DRUG PLANS.—

(1) IN GENERAL.—Section 1860D–1 of such Act is amended by adding at the end the following new subsection:

"(d) APPLICATION OF MARKETING AND ENROLLMENT STANDARDS.—The marketing and enrollment standards adopted under section 1852(m) shall apply to prescription drug plans (and sponsors of such plans) in the same manner as they apply to Medicare Part C plans and organizations offering such plans.".

(2) REFERENCE TO CURRENT LAW PROVISIONS.—The amendment made by subsection (a) and (b) apply, pursuant to section 1860D–1(b)(1)(B)(ii) of the Social Security Act (42 U.S.C. 1395w–101(b)(1)(B)(ii)), to prescription drug plans under part D of title XVIII of such Act.

(d) CONTRACT REQUIREMENT TO MEET MARKETING AND ADVERTISING STANDARDS.—

(1) IN GENERAL.—Section 1857(d) of the Social Security Act (42 U.S.C. 1395w–27(d)), as amended by subsection (b)(1), is further amended by adding at the end the following new paragraph:

"(7) MARKETING AND ADVERTISING STANDARDS.—The contract shall require the organization to meet all standards adopted under section 1852(m) (including those enforced by the State involved pursuant to section 1856(b)(3)) relating to marketing and advertising conduct.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to contracts for plan years beginning on or after January 1, 2011.

(e) APPLICATION OF SANCTIONS.—

(1) APPLICATION TO VIOLATION OF MARKETING AND ENROLLMENT STANDARDS.—Section 1857(g)(1) of such Act (42 U.S.C. 1395w–27(g)(1)), as amended by the preceding provisions of this Act, is further amended—

(A) by striking "and" at the end of subparagraph (G);

(B) by adding "and" at the end of subparagraph (H); and

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

"(I) violates marketing and enrollment standards adopted under section 1852(m);".

(2) ENHANCED CIVIL MONEY SANCTIONS.—Such section is further amended—

(A) in paragraph (2)(A), by striking "$25,000", "$100,000", and "$15,000" and inserting "$50,000", "$200,000", and "$30,000", respectively; and

(B) in subparagraphs (A), (B), and (D) of paragraph (3), by striking "$25,000", "$10,000", and "$100,000", respectively, and inserting "$50,000", "$20,000", and "$200,000", respectively.

(3) EFFECTIVE DATE.—The amendments made by paragraph (2) shall apply to violations occurring on or after the date of the enactment of this Act.

(f) DISCLOSURE OF MARKET AND ADVERTISING CONTRACT VIOLATIONS AND IMPOSED SANCTIONS.—Section 1857 of such Act is amended by adding at the end the following new subsection

"(j) DISCLOSURE OF MARKET AND ADVERTISING CONTRACT VIOLATIONS AND IMPOSED SANCTIONS.—For years beginning with 2009, the Secretary shall post on its public website for the Medicare program an annual report that—

"(1) lists each MA organization for which the Secretary made during the year a determination under subsection (c)(2) the basis of which is described in paragraph (1)(E); and

"(2) that describes any applicable sanctions under subsection (g) applied to such organization pursuant to such determination.".

(g) STANDARD DEFINITIONS OF BENEFITS AND FORMATS FOR USE IN MARKETING MATERIALS.—Section 1851(h) of such Act (42 U.S.C. 1395w–21(h)) is amended by adding at the end the following new paragraph:

"(6) STANDARD DEFINITIONS OF BENEFITS AND FORMATS FOR USE IN MARKETING MATERIALS.—

"(A) IN GENERAL.—Not later than January 1, 2010, the Secretary, in consultation with the National Association of Insurance Commissioners and a working group of the type described in section 1852(m)(7)(E), shall develop standard descriptions and definitions for benefits under this title for use in marketing material distributed by Medicare Part C organizations and formats for including such descriptions in such marketing material.

"(B) REQUIRED USE OF STANDARD DEFINITIONS.—For plan years beginning on or after January 1, 2011, the Secretary shall disapprove the distribution of marketing material under paragraph (1)(B) if such marketing material does not use, without modification, the applicable descriptions and formats specified under subparagraph (A).".

(h) SUPPORT FOR STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPS).—Section 1857(e)(2) of the Social Security Act (42 U.S.C. 1395w–27(e)(2)) is amended—

(1) in subparagraph (B), by adding at the end the following: "Of the amounts so collected, no less than $55,000,000 for fiscal year 2009, $65,000,000 for fiscal year 2010, $75,000,000 for fiscal year 2011, and $85,000,000 for fiscal year 2012 and each succeeding fiscal year shall be used to support Medicare Part C and Part D counseling and assistance provided by State Health Insurance Assistance Programs.";

(2) in subparagraph (C)—

(A) by striking "and" after "$100,000,000,";

(B) by striking "an amount equal to $200,000,000" and inserting "and ending with fiscal year 2008 an amount equal to $200,000,000, for fiscal year 2009 an amount equal to $255,000,000, for fiscal year 2010 an amount equal to $265,000,000, for fiscal year 2011 an amount equal to $275,000,000, and for fiscal year 2012 and each succeeding fiscal year an amount equal to $285,000,000"; and

(C) by adding at the end the following: "The amounts in excess of $200,000,000 in any fiscal year shall be used to support State Health Insurance Assistance Programs under subparagraph (B) and the remaining amount used to support activities related to enrollment and dissemination of information."; and

(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 subclause:

"(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:

"(ii) PERMITTING USE OF FLAT COPAYMENT OR PER DIEM RATE.—Nothing in clause (i) shall be construed as prohibiting a Medicare part C plan from using a flat copayment or per diem rate, in lieu of the cost-sharing that would be imposed under part A or B, so long as the amount of the cost-sharing imposed does not exceed the amount of the cost-sharing that would be imposed under the respective part if the individual were not enrolled in a plan under this part.".

(b) LIMITATION FOR DUAL ELIGIBLES AND QUALIFIED MEDICARE BENEFICIARIES.—Section 1852(a) of such Act is amended by adding at the end the following new paragraph:

"(7) LIMITATION ON COST-SHARING FOR DUAL ELIGIBLES AND QUALIFIED MEDICARE BENEFICIARIES.—In the case of a individual who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)) or a qualified medicare beneficiary (as defined in section 1905(p)(1)) who is enrolled in a Medicare Part C plan, the plan may not impose cost-sharing that exceeds the amount of cost-

sharing that would be permitted with respect to the individual under this title and title XIX if the individual were not enrolled with such plan.".

(c) EFFECTIVE DATES.—

(1) The amendments made by subsection (a) shall apply to plan years beginning on or after January 1, 2009.

(2) The amendments made by subsection (b) shall apply to plan years beginning on or after January 1, 2008.

SEC. 413. MA PLAN ENROLLMENT MODIFICATIONS.

(a) IMPROVED PLAN ENROLLMENT, DISENROLLMENT, AND CHANGE OF ENROLLMENT.—

(1) CONTINUOUS OPEN ENROLLMENT FOR FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS AND QUALIFIED MEDICARE BENEFICIARIES (QMB).—Section 1851(e)(2)(D) of the Social Security Act (42 U.S.C. 1395w–21(e)(2)(D)) is amended—

(A) in the heading, by inserting", FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS, AND QUALIFIED MEDICARE BENEFICIARIES" after "INSTITUTIONALIZED INDIVIDUALS"; and

(B) in the matter before clause (i), by inserting ", a full-benefit dual eligible individual (as defined in section 1935(c)(6)), or a qualified 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 (F); 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);

"(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; or".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of the enactment of this Act.

(b) ACCESS TO MEDIGAP COVERAGE FOR INDIVIDUALS WHO LEAVE MA PLANS.—

(1) IN GENERAL.—Section 1882(s)(3) of the Social Security Act (42 U.S.C. 1395ss(s)(3)) is amended—

(A) in each of clauses (v)(III) and (vi) of subparagraph (B), by striking "12 months" and inserting "24 months"; and

(B) in each of subclauses (I) and (II) of subparagraph (F)(i), by striking "12 months" and inserting "24 months".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to terminations of enrollments in MA plans occurring on or after the date of the enactment of this Act.

(c) IMPROVED ENROLLMENT POLICIES.—

(1) NO AUTO-ENROLLMENT OF MEDICAID BENEFICIARIES.—

(A) IN GENERAL.—Section 1851(e) of such Act (42 U.S.C. 1395w–21(e)) is amended by adding at the end the following new paragraph:

"(7) NO AUTO-ENROLLMENT OF MEDICAID BENEFICIARIES.—In no case may the Secretary provide for the enrollment in a MA plan of a Medicare Advantage eligible individual who is eligible to receive medical assistance under title XIX as a full-benefit dual eligible individual or a qualified medicare beneficiary, without the affirmative application of such individual (or authorized representative of the individual) to be enrolled in such plan.".

(B) NO APPLICATION TO PRESCRIPTION DRUG PLANS.—Section 1860D–1(b)(1)(B)(iii) of such Act (42 U.S.C. 1395w–101(b)(1)(B)(iii)) is amended—

(i) by striking "paragraph (2) and" and by inserting "paragraph (2),"; and

(ii) by inserting ", and paragraph (7)," after "paragraph (4)".

(C) EFFECTIVE DATE.—The amendments made by this paragraph shall apply to enrollments that are effective on or after the date of the enactment of this Act.

SEC. 414. INFORMATION FOR BENEFICIARIES ON MA PLAN ADMINISTRATIVE COSTS.

(a) DISCLOSURE OF MEDICAL LOSS RATIOS AND OTHER EXPENSE DATA.—Section 1851 of the Social Security Act (42 U.S.C. 1395w–21) is amended by adding at the end the following new subsection:

"(j) PUBLICATION OF MEDICAL LOSS RATIOS AND OTHER COST-RELATED INFORMATION.—

"(1) IN GENERAL.—The Secretary shall publish, not later than October 1 of each year (beginning with 2009), for each Medicare Part C plan contract, the following:

"(A) The medical loss ratio of the plan in the previous year.

"(B) The per enrollee payment under this part to the plan, as adjusted to reflect a risk score (based on factors described in section 1853(a)(1)(C)(i)) of 1.0.

"(C) The average risk score (as so based).

"(2) SUBMISSION OF DATA.—

"(A) IN GENERAL.—Each Medicare Part C organization shall submit to the Secretary, in a form and manner specified by the Secretary, data necessary for the Secretary to publish the information described in paragraph (1) on a timely basis, including the information described in paragraph (3).

"(B) DATA FOR 2008 AND 2009.—The data submitted under subparagraph (A) for 2008 and for 2009 shall be consistent in content with the data reported as part of the Medicare Part C plan bid in June 2007 for 2008.

"(C) MEDICAL LOSS RATIO DATA.—The data to be submitted under subparagraph (A) relating to medical loss ratio for a year—

"(i) shall be submitted not later than June 1 of the following year; and

"(ii) beginning with 2010, shall be submitted based on the standardized elements and definitions developed under paragraph (4).

"(D) AUDITED DATA.—Data submitted under this paragraph shall be data that has been audited by an independent third party auditor.

"(3) MLR INFORMATION.—The information described in this paragraph with respect to a Medicare Part C plan for a year is as follows:

"(A) The costs for the plan in the previous year for each of the following:

"(i) Total medical expenses, separately indicated for benefits for the original medicare fee-for-service program option and for supplemental benefits.

"(ii) Non-medical expenses, shown separately for each of the following categories of expenses:

"(I) Marketing and sales.

"(II) Direct administration.

"(III) Indirect administration.

"(IV) Net cost of private reinsurance.

"(B) Gain or loss margin.

"(C) Total revenue requirement, computed as the total of medical and nonmedical expenses and gain or loss margin, multiplied by the gain or loss margin.

"(D) Percent of revenue ratio, computed as the total revenue requirement expressed as a percentage of revenue.

"(4) DEVELOPMENT OF DATA REPORTING STANDARDS.—

"(A) IN GENERAL.—The Secretary shall develop and implement standardized data elements and definitions for reporting under this subsection, for contract years beginning with 2010, of data necessary for the calculation of the medical loss ratio for Medicare Part C plans. Not later than December 31, 2008, the Secretary shall publish a report describing the elements and definitions so developed.

"(B) CONSULTATION.—The Secretary shall consult with representatives of Medicare Part C organizations, experts on health plan accounting systems, and representatives of the National Association of Insurance Commissioners, in the development of such data elements and definitions

"(5) MEDICAL LOSS RATIO DEFINED.—For purposes of this part, the term 'medical loss ratio' means, with respect to an MA plan for a year, the ratio of—

"(A) the aggregate benefits (excluding nonmedical expenses described in paragraph (3)(A)(ii)) paid under the plan for the year, to

"(B) the aggregate amount of premiums (including basic and supplemental beneficiary premiums) and payments made under sections 1853 and 1860D–15) collected for the plan and year.

Such ratio shall be computed without regard to whether the benefits or premiums are for required or supplemental benefits under the plan.".

(b) AUDIT OF ADMINISTRATIVE COSTS AND COMPLIANCE WITH THE FEDERAL ACQUISITION REGULATION.—

(1) IN GENERAL.—Section 1857(d)(2)(B) of such Act (42 U.S.C. 1395w–27(d)(2)(B)) is amended—

(A) by striking "or (ii)" and inserting "(ii)"; and

(B) by inserting before the period at the end the following: ", or (iii) to compliance with the requirements of subsection (e)(4) and the extent to which administrative costs comply with the applicable requirements for such costs under the Federal Acquisition Regulation".

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply for contract years beginning after the date of the enactment of this Act.

(c) MINIMUM MEDICAL LOSS RATIO.—Section 1857(e) of the Social Security Act (42 U.S.C. 1395w–27(e)) is amended by adding at the end the following new paragraph:

"(4) REQUIREMENT FOR MINIMUM MEDICAL LOSS RATIO.—If the Secretary determines for a contract year (beginning with 2010) that an MA plan has failed to have a medical loss ratio (as defined in section 1851(j)(4)) of at least .85—

"(A) for that contract year, the Secretary shall reduce the blended benchmark amount under subsection (l) for the second succeeding contract year by the numer of percentage points by which such loss ratio was less than 85 percent;

"(B) for 3 consecutive contract years, the Secretary shall not permit the enrollment of new enrollees under the plan for coverage during the second succeeding contract year; and

"(C) the Secretary shall terminate the plan contract if the plan fails to have such a medical loss ratio for 5 consecutive contract years.".

(d) INFORMATION ON MEDICARE PART C PLAN ENROLLMENT AND SERVICES.—Section 1851 of such Act, as amended by subsection (a), is further amended by adding at the end the following new subsection:

"(k) PUBLICATION OF ENROLLMENT AND OTHER INFORMATION.—

"(1) MONTHLY PUBLICATION OF PLAN-SPECIFIC ENROLLMENT DATA.—The Secretary shall publish (on the public website of the Centers for Medicare & Medicaid Services or otherwise) not later than 30 days after the end of each month (beginning with January 2008) on the actual enrollment in each Medicare Part C plan by contract and by county.

"(2) AVAILABILITY OF OTHER INFORMATION.—The Secretary shall make publicly available data and other information in a format that may be readily used for analysis of the Medicare Part C program under this part and will contribute to the understanding of the organization and operation of such program.".

(e) MEDPAC REPORT ON VARYING MINIMUM MEDICAL LOSS RATIOS.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study of the need and feasibility ofproviding for different minimum medical loss ratios for different types of Medicare Part C plans, including coordinated care plans, group model plans, coordinated care independent practice association plans, preferred provider organization plans, and private fee-for-services plans.

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, submit to Congress a report on the study conducted under paragraph (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 Medicare Part C plans that are preferred provider organization plans for that year.

"(ii) APPLICATION OF SAME MEASURES AS COORDINATED CARE PLANS BEGINNING IN CONTRACT YEAR 2010.—For a contract year beginning with 2010, a 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 such contract year Medicare Part C plans described in section 1851(a)(2)(A)(i) for contract year such contract year.".

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

(b) EMPLOYER PLANS.—

(1) IN GENERAL.—The first sentence of paragraph (2) of section 1857(i) of such Act (42 U.S.C. 1395w–27(i)) is amended by inserting before the period at the end the following: ", but only if 90 percent of the Medicare part C eligible individuals enrolled under such plan reside in a county in which the Medicare Part C organization offers a Medicare Part C local plan".

(2) LIMITATION ON APPLICATION OF WAIVER AUTHORITY.—Paragraphs (1) and (2) of such section are each amended by inserting "that were in effect before the date of the enactment of the Children's Health and Medicare Protection Act of 2007" after "waive or modify requirements".

(3) EFFECTIVE DATES.—The amendment made by paragraph (1) shall apply for plan years beginning on or after January 1, 2009, and the amendments made by paragraph (2) shall take effect on the date of the enactment of this Act.

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

(a) NEW QUALITY REPORTING MEASURES.—

(1) IN GENERAL.—Section 1852(e)(3) of the Social Security Act (42 U.S.C. 1395w–22(e)(3)), as amended by section 421(a)(2), is amended—

(A) in subparagraph (B)—

(i) in clause (i), by striking "The Secretary" and inserting "Subject to subparagraph (D), the Secretary"; and

(ii) in clause (ii), by striking "subclause (iii)" and inserting "clause (iii) and subparagraph (C)" ; and

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

"(D) ADDITIONAL QUALITY REPORTING MEASURES.—

"(i) IN GENERAL.—The Secretary shall develop by October 1, 2009, quality measures for Medicare Part C plans that measure disparities in the amount and quality of health services provided to racial and ethnic minorities.

"(ii) DATA TO MEASURE RACIAL AND ETHNIC DISPARITIES IN THE AMOUNT AND QUALITY OF CARE PROVIDED TO ENROLLEES.—The Secretary shall provide for Medicare Part C organizations to submit data under this paragraph, including data similar to those submitted for other quality measures, that permits analysis of disparities among racial and ethnic minorities in health services, quality of care, and health status among Medicare Part C plan enrollees for use in submitting the reports under paragraph (5).".

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to reporting of quality measures for plan years beginning on or after January 1, 2010.

(b) BIENNIAL REPORT ON RACIAL AND ETHNIC MINORITIES.—Section 1852(e) of such Act (42 U.S.C. 1395w∓22(e)) is amended by adding at the end the following new paragraph:

"(5) REPORT TO CONGRESS.—

"(A) IN GENERAL.—Not later than 2 years after the date of the enactment of this paragraph, and biennially thereafter, the Secretary shall submit to Congress a report regarding how quality assurance programs conducted under this subsection measure and report on disparities in the amount and quality of health care services furnished to racial and ethnic minorities.

"(B) CONTENTS OF REPORT.—Each such report shall include the following:

"(i) A description of the means by which such programs focus on such racial and ethnic minorities.

"(ii) An evaluation of the impact of such programs on eliminating health disparities and on improving health outcomes, continuity and coordination of care, management of chronic conditions, and consumer satisfaction.

"(iii) Recommendations on ways to reduce clinical outcome disparities among racial and ethnic minorities.

"(iv) Data for each MA plan from HEDIS and other source reporting the disparities in the amount and quality of health services furnished to racial and ethnic minorities.".

SEC. 423. STRENGTHENING AUDIT AUTHORITY.

(a) FOR PART C PAYMENTS RISK ADJUSTMENT.—Section 1857(d)(1) of the Social Security Act (42 U.S.C. 1395w–27(d)(1)) is amended by inserting after "section 1858(c))" the following: ", and data submitted with respect to risk adjustment under section 1853(a)(3)".

(b) ENFORCEMENT OF AUDITS AND DEFICIENCIES.—

(1) IN GENERAL.—Section 1857(e) of such Act is amended by adding at the end the following new paragraph:

"(5) ENFORCEMENT OF AUDITS AND DEFICIENCIES.—

"(A) INFORMATION IN CONTRACT.—The Secretary shall require that each contract with a Medicare Part C organization under this section shall include terms that inform the organization of the provisions in subsection (d).

"(B) ENFORCEMENT AUTHORITY.—The Secretary is authorized, in connection with conducting audits and other activities under subsection (d), to take such actions, including pursuit of financial recoveries, necessary to address deficiencies identified in such audits or other activities.".

(2) APPLICATION UNDER PART D.—For provision applying the amendment made by paragraph (1) to prescription drug plans under part D, see section 1860D–12(b)(3)(D) of the Social Security Act.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect the date of the enactment of this Act and shall apply to audits and activities conducted for contract years beginning on or after January 1, 2009.

SEC. 424. IMPROVING RISK ADJUSTMENT FOR MA PAYMENTS.

(a) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report that evaluates the adequacy of the Medicare Advantage risk adjustment system under section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395–23(a)(1)(C)).

(b) PARTICULARS.—The report under subsection (a) shall include an evaluation of at least the following:

(1) The need and feasibility of improving the adequacy of the risk adjustment system in predicting costs for beneficiaries with co-morbid conditions and associated cognitive impairments.

(2) The need and feasibility of including further gradations of diseases and conditions (such as the degree of severity of congestive heart failure).

(3) The feasibility of measuring difference in coding over time between Medicare part C plans and the medicare traditional fee-for-service program and, to the extent this difference exists, the options for addressing it.

(4) The feasibility and value of including part D and other drug utilization data in the risk adjustment model.

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

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

(1) in subparagraph (A)(i), by striking "115 percent" and inserting "100 percent"; and

(2) in subparagraph (C)(i), by striking "including any liability for balance billing consistent with this subsection)".

(b) REVIEW OF BID INFORMATION.—Section 1854(a)(6)(B) of such Act (42 U.S.C. 1395w–24(a)(6)(B)) is amended—

(1) in clause (i), by striking "clauses (iii) and (iv)" and inserting "clause (iii)"; and

(2) by striking clause (iv).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to contract years beginning with 2009.

SEC. 426. RENAMING OF MEDICARE ADVANTAGE PROGRAM.

(a) IN GENERAL.—The program under part C of title XVIII of the Social Security Act is henceforth to be known as the "Medicare Part C program".

(b) CHANGE IN REFERENCES.—

(1) AMENDING SOCIAL SECURITY ACT.—The Social Security Act is amended by striking "Medicare Advantage", "MA", and "Medicare+Choice" and inserting "Medicare Part C" each place it appears, with the appropriate, respective typographic 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—

"(i) that serves special needs individuals (as defined in subparagraph (B));

"(ii) as of January 1, 2009, either—

"(I) at least 90 percent of the enrollees in which are described in subparagraph (B)(i), as determined under regulations in effect as of July 1, 2007; or

"(II) at least 90 percent of the enrollees in which are described in subparagraph (B)(ii) and are full-benefit dual eligible individuals (as defined in section 1935(c)(6)) or qualified medicare beneficiaries (as defined in section 1905(p)(1)); and

"(iii) as of January 1, 2009, meets the applicable requirements of paragraph (2) or (3) of subsection (f), as the case may be.";

(B) in subsection (b)(6)(B)(iii), by inserting "only for contract years beginning before January 1, 2009," after "(iii)"; and

(C) in subsection (f)—

(i) by amending the heading to read as follows: "REQUIREMENTS FOR ENROLLMENT IN PART C PLANS FOR SPECIAL NEEDS BENEFICIARIES";

(ii) by designating the sentence beginning "In the case of" as paragraph (1) with the heading "REQUIREMENTS FOR ENROLLMENT.—" and with appropriate indentation; and

(iii) by adding at the end the following new paragraphs:

"(2) ADDITIONAL REQUIREMENTS FOR INSTITUTIONAL SNPS.—In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(A)(ii)(I), the applicable requirements of this subsection are as follows:

"(A) The plan has an agreement with the State that includes provisions regarding cooperation on the coordination of care for such individuals. Such agreement shall include a description of the manner that the State Medicaid program under title XIX will pay for the costs of services for individuals eligible under such title for medical assistance for acute care and long-term care services.

"(B) The plan has a contract with long-term care facilities and other providers in the area sufficient to provide care for enrollees described in subsection (b)(6)(B)(i).

"(C) The plan reports to the Secretary information on additional quality measures specified by the Secretary under section 1852(e)(3)(D)(iv)(I) for such plans.

"(3) ADDITIONAL REQUIREMENTS FOR DUAL SNPS.—In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(A)(ii)(II), the applicable requirements of this subsection are as follows:

"(A) The plan has an agreement with the State Medicaid agency that—

"(i) includes provisions regarding cooperation on the coordination of the financing of care for such individuals;

"(ii) includes a description of the manner that the State Medicaid program under title XIX will pay for the costs of cost-sharing and supplemental services for individuals enrolled in the plan eligible under such title for medical assistance for acute and long-term care services; and

"(iii) effective January 1, 2011, provides for capitation payments to cover costs of supplemental benefits for individuals described in subsection (b)(6)(A)(ii)(II).

"(B) The out-of-pocket costs for services under parts A and B that are charged to enrollees may not exceed the out-of-pocket costs for same services permitted for such individuals under title XIX.

"(C) The plan reports to the Secretary information on additional quality measures specified by the Secretary under section 1852(e)(3)(D)(iv)(II) for such plans.".

(2) QUALITY STANDARDS AND QUALITY REPORTING.—Section 1852(e)(3) of such Act (42 U.S.C. 1395w–22(e)(3) is amended—

(A) in subparagraph (A)(i), by adding at the end the following: "In the case of a specialized Medicare Part C plan for special needs individuals described in paragraph (2) or (3) of section 1859(f), the organization shall provide for the reporting on quality measures developed for the plan under subparagraph (D)(iii)."; and

(B) in subparagraph (D), as added by section 422(a)(1), by adding at the end the following new clause:

"(iii) SPECIFICATION OF ADDITIONAL QUALITY MEASUREMENTS FOR SPECIALIZED PART C PLANS.—For implementation for plan years beginning not later than January 1, 2010, the Secretary shall develop new quality measures appropriate to meeting the needs of—

"(I) beneficiaries enrolled in specialized Medicare Part C plans for special needs individuals (described in section 1859(b)(6)(A)(ii)(I)) that serve predominantly individuals who are dual-eligible individuals eligible for medical assistance under title XIX by measuring the special needs for care of individuals who are both Medicare and Medicaid beneficiaries; and

"(II) beneficiaries enrolled in specialized Medicare Part C plans for special needs individuals (described in section 1859(b)(6)(A)(ii)(II)) that serve predominantly institutionalized individuals by measuring the special needs for care of individuals who are a resident in long-term care institution.".

(3) EFFECTIVE DATE; GRANDFATHER.—The amendments made by paragraph (1) shall take effect for enrollments occurring on or after January 1, 2009, and shall not apply—

(A) to plans with a contract with a State Medicaid agency to operate an integrated Medicaid-Medicare program, that had been approved by Centers for Medicare & Medicaid Services on January 1, 2004; and

(B) to plans that are operational as of the date of the enactment of this Act as approved Medicare demonstration projects and that provide services predominantly to individuals with end-stage renal disease.

(4) TRANSITION FOR NON-QUALIFYING SNPS.—

(A) RESTRICTIONS IN 2008 FOR CHRONIC CARE SNPS.—In the case of a specialized MA plan for special needs individuals (as defined in section 1859(b)(6)(A) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(A)) that, as of December 31, 2007, is not described in either subclause (I) or subclause (II) of clause (ii) of such section, as amended by paragraph (1), then as of January 1, 2008—

(i) the plan may not be offered unless it was offered before such date;

(ii) no new members may be enrolled with the plan; and

(iii) there may be no expansion of the service area of such plan.

(B) TRANSITION OF ENROLLEES.—The Secretary of Health and Human Services shall provide for an orderly transition of those specialized MA plans for special needs individuals (as defined in section 1859(b)(6)(A) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(A)), as of the date of the enactment of this Act), and their enrollees, that no longer qualify as such plans under such section, as amended by this subsection.

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

(a) EXTENSION FOR 3 YEARS OF PERIOD REASONABLE COST PLANS CAN REMAIN IN THE MARKET.—Section 1876(h)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)(ii)) is amended, in the matter preceding subclause (I), by striking "January 1, 2008" and inserting "January 1, 2011".

(b) APPLICATION OF CERTAIN MEDICARE ADVANTAGE REQUIREMENTS TO COST CONTRACTS EXTENDED OR RENEWED AFTER ENACTMENT.—Section 1876(h) of such Act (42 U.S.C. 1395mm(h)), as amended by subsection (a), is amended—

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

(2) by inserting after paragraph (4) the following new paragraph:

"(5)(A) Any reasonable cost reimbursement contract with an eligible organization under this subsection that is extended or renewed on or after the date of enactment of the Children's Health and Medicare Protection Act of 2007 shall provide that the provisions of the Medicare Part C program described in subparagraph (B) shall apply to such organization and such contract in a substantially similar manner as such provisions apply to Medicare Part C organizations and Medicare Part C plans under part C.

"(B) The provisions described in this subparagraph are as follows:

"(i) Section 1851(h) (relating to the approval of marketing material and application forms).

"(ii) Section 1852(e) (relating to the requirement of having an ongoing quality improvement program and treatment of accreditation in the same manner as such provisions apply to Medicare Part C local plans that are preferred provider organization plans).

"(iii) Section 1852(f) (relating to grievance mechanisms).

"(iv) Section 1852(g) (relating to coverage determinations, reconsiderations, and appeals).

"(v) Section 1852(j)(4) (relating to limitations on physician incentive plans).

"(vi) Section 1854(c) (relating to the requirement of uniform premiums among individuals enrolled in the plan).

"(vii) Section 1854(g) (relating to restrictions on imposition of premium taxes with respect to payments to organizations).

"(viii) Section 1856(b)(3) (relating to relation to State laws).

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

TITLE V—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".

SEC. 502. PAYMENT FOR INPATIENT REHABILITATION FACILITY (IRF) SERVICES.

(a) PAYMENT UPDATE.—

(1) IN GENERAL.—Section 1886(j)(3)(C) of the Social Security Act (42 U.S.C. 1395ww(j)(3)(C)) is amended by adding at the end the following: "The increase factor to be applied under this subparagraph for fiscal year 2008 shall be 1 percent."

(2) DELAYED EFFECTIVE DATE.—The amendment made by paragraph (1) shall not apply to payment units occurring before January 1, 2008.

(b) INPATIENT REHABILITATION FACILITY CLASSIFICATION CRITERIA.—

(1) IN GENERAL.—Section 5005 of the Deficit Reduction Act of 2005 (Public Law 109–171) is amended—

(A) in subsection (a), by striking "apply the applicable percent specified in subsection (b)" and inserting "require a compliance rate that is no greater than the 60 percent compliance rate that became effective for cost reporting periods beginning on or after July 1, 2006,"; and

(B) by amending subsection (b) to read as follows:

"(b) CONTINUED USE OF COMORBIDITIES.—For portions of cost reporting periods occurring on or after the date of the enactment of the Children's Health and Medicare Protection Act of 2007, the Secretary shall include patients with comorbidities as described in section 412.23(b)(2)(i) of title 42, Code of Federal Regulations (as in ef-

fect as of January 1, 2007), in the inpatient population that counts towards the percent specified in subsection (a).".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1)(A) shall apply to portions of cost reporting periods beginning on or after the date of the enactment of this Act.

(c) PAYMENT FOR CERTAIN MEDICAL CONDITIONS TREATED IN INPATIENT REHABILITATION FACILITIES.—

(1) IN GENERAL.—Section 1886(j) of the Social Security Act (42 U.S.C. 1395ww(j)) is amended—

(A) by redesignating paragraph (7) as paragraph (8);

(B) by inserting after paragraph (6) the following new paragraph:

"(7) SPECIAL PAYMENT RULE FOR CERTAIN MEDICAL CONDITIONS.—

"(A) IN GENERAL.—Subject to subparagraph (H), in the case of discharges occurring on or after October 1, 2008, in lieu of the standardized payment amount (as determined pursuant to the preceding provisions of this subsection) that would otherwise be applicable under this subsection, the Secretary shall substitute, for payment units with respect to an applicable medical condition (as defined in subparagraph (G)(i)) that is treated in an inpatient rehabilitation facility, the modified standardized payment amount determined under subparagraph (B).

"(B) MODIFIED STANDARDIZED PAYMENT AMOUNT.—The modified standardized payment amount for an applicable medical condition shall be based on the amount determined under subparagraph (C) for such condition, as adjusted under subparagraphs (D), (E), and (F).

"(C) AMOUNT DETERMINED.—

"(i) IN GENERAL.—The amount determined under this subparagraph for an applicable medical condition shall be based on the sum of the following:

"(I) An amount equal to the average per stay skilled nursing facility payment rate for the applicable medical condition (as determined under clause (ii)).

"(II) An amount equal to 25 percent of the difference between the overhead costs (as defined in subparagraph (G)(ii)) component of the average inpatient rehabilitation facility per stay payment amount for the applicable medical condition (as determined under the preceding paragraphs of this subsection) and the overhead costs component of the average per stay skilled nursing facility payment rate for such condition (as determined under clause (ii)).

"(III) An amount equal to 33 percent of the difference between the patient care costs (as defined in subparagraph (G)(iii)) component of the average inpatient rehabilitation facility per stay payment amount for the applicable medical condition (as determined under the preceding paragraphs of this subsection) and the patient care costs component of the average per stay skilled nursing facility payment rate for such condition (as determined under clause (ii)).

"(ii) DETERMINATION OF AVERAGE PER STAY SKILLED NURSING FACILITY PAYMENT RATE.—For purposes of clause (i), the Secretary shall convert skilled nursing facility payment rates for applicable medical conditions, as determined under section 1888(e), to average per stay skilled nursing facility payment rates for each such condition.

"(D) ADJUSTMENTS.—The Secretary shall adjust the amount determined under subparagraph (C) for an applicable medical condition using the adjustments to the prospective payment rates for inpatient rehabilitation facilities described in paragraphs (2), (3), (4), and (6).

"(E) UPDATE FOR INFLATION.—Except in the case of a fiscal year for which the Secretary rebases the amounts determined under subparagraph (C) for applicable medical conditions pursuant to subparagraph (F), the Secretary shall annually update the amounts determined under subparagraph (C) for each applicable medical condition by the increase factor for inpatient rehabilitation facilities (as described in paragraph (3)(C)).

"(F) REBASING.—The Secretary shall periodically (but in no case less than once every 5 years) rebase the amounts determined under subparagraph (C) for applicable medical conditions using the methodology described in such subparagraph and the most recent and complete cost report and claims data available.

"(G) DEFINITIONS.—In this paragraph:

"(i) APPLICABLE MEDICAL CONDITION.—The term 'applicable medical condition' means—

"(I) unilateral knee replacement;
"(II) unilateral hip replacement; and
"(III) unilateral hip fracture.

"(ii) OVERHEAD COSTS.—The term 'overhead costs' means those Medicare-allowable costs that are contained in the General Service cost centers of the Medicare cost reports for inpatient rehabilitation facilities and for skilled nursing facilities, respectively, as determined by the Secretary.

"(iii) PATIENT CARE COSTS.—The term 'patient care costs' means total Medicare-allowable costs minus overhead costs.

"(H) SUNSET.—The provisions of this paragraph shall cease to apply as of the date the Secretary implements an integrated, site-neutral payment methodology under this title for post-acute care."; and

(C) in paragraph (8), as redesignated by paragraph (1)—

(i) in subparagraph (C), by striking "and" at the end;

(ii) in subparagraph (D), by striking the period at the end and inserting ", and"; and

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

"(E) modified standardized payment amounts under paragraph (7).".

(2) SPECIAL RULE FOR DISCHARGES OCCURRING IN THE SECOND HALF OF FISCAL YEAR 2008.—

(A) IN GENERAL.—In the case of discharges from an inpatient rehabilitation facility occurring during the period beginning on April 1, 2008, and ending on September 30, 2008, for applicable medical conditions (as defined in paragraph (7)(G)(i) of section 1886(j) of the Social Security Act (42 U.S.C. 1395ww(j)), as inserted by paragraph (1)(B), in lieu of the standardized payment amount determined pursuant to such section, the standardized payment amount shall be $9,507 for unilateral knee replacement, $10,398 for unilateral hip replacement, and $10,958 for unilateral hip fracture. Such amounts are the amounts that are estimated would be determined under paragraph (7)(C) of such section 1886(j) for such conditions if such paragraph applied for such period. Such standardized payment amounts shall be multiplied by the relative weights for each case-mix group and tier, as published in the final rule of the Secretary of Health and Human Services for inpatient rehabilitation facility services prospective payment for fiscal year 2008, to obtain the applicable payment amounts for each such condition for each case-mix group and tier.

(B) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement this subsection by program instruction or otherwise. Paragraph (8)(E) of such section 1886(j) of the Social Security Act, as added by paragraph (1)(C), shall apply for purposes of this subsection in the same manner as such paragraph applies for purposes of paragraph (7) of such section 1886(j).

(d) RECOMMENDATIONS FOR CLASSIFYING INPATIENT REHABILITATION HOSPITALS AND UNITS.—

(1) REPORT TO CONGRESS.—Not later than 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with physicians (including geriatricians and physiatrists), administrators of inpatient rehabilitation, acute care hospitals, skilled nursing facilities, and other settings providing rehabilitation services, Medicare beneficiaries, trade organizations representing inpatient rehabilitation hospitals and units and skilled nursing facilities, and the Medicare Payment Advisory Commission, shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that includes—

(A) an examination of Medicare beneficiaries' access to medically necessary rehabilitation services;

(B) alternatives or refinements to the 75 percent rule policy for determining exclusion criteria for inpatient rehabilitation hospital and unit designation under the Medicare program, including determining clinical appropriateness of inpatient rehabilitation hospital and unit admissions and alternative criteria which would consider a patient's functional status, diagnosis, co-morbidities, and other relevant factors; and

(C) an examination that identifies any condition for which individuals are commonly admitted to inpatient rehabilitation hospitals that is not included as a condition described in section 412.23(b)(2)(iii) of title 42, Code of Federal Regulations, to determine the appropriate setting of care, and any variation in patient outcomes and costs, across settings of care, for treatment of such conditions.

For the purposes of this subsection, the term "75 percent rule" means the requirement of section 412.23(b)(2) of title 42, Code of Federal Regulations, that 75 percent of the patients of a rehabilitation hospital or converted rehabilitation unit are in 1 or more of 13 listed treatment categories.

(2) CONSIDERATIONS.—In developing the report described in paragraph (1), the Secretary shall include the following:

(A) The potential effect of the 75 percent rule on access to rehabilitation care by Medicare beneficiaries for the treatment of a condition, whether or not such condition is described in section 412.23(b)(2)(iii) of title 42, Code of Federal Regulations.

(B) An analysis of the effectiveness of rehabilitation care for the treatment of conditions, whether or not such conditions are described in section 412.23(b)(2)(iii) of title 42, Code of Federal Regulations, available to Medicare beneficiaries in various health care settings, taking into account variation in patient outcomes and costs across different settings of care, and which may include whether the Medicare program and Medicare beneficiaries may 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 discharges for the hospital shall be the same as the base rate for discharges for the hospital occurring during the previous rate year.".

(2) DELAYED EFFECTIVE DATE.—Subsection (m)(2) of section 1886 of the Social Security Act, as added by paragraph (1), shall not apply to discharges occurring on or after July 1, 2007, and before January 1, 2008.

(b) PAYMENT FOR LONG-TERM CARE HOSPITAL SERVICES; PATIENT AND FACILITY CRITERIA.—

(1) DEFINITION OF LONG-TERM CARE HOSPITAL.—

(A) DEFINITION.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 201(a)(2), is amended by adding at the end the following new subsection:

"Long-Term Care Hospital

"(ddd) The term 'long-term care hospital' means an institution which—

"(1) is primarily engaged in providing inpatient services, by or under the supervision of a physician, to Medicare beneficiaries whose medically complex conditions require a long hospital stay and programs of care provided by a long-term care hospital;

"(2) has an average inpatient length of stay (as determined by the Secretary) for Medicare beneficiaries of greater than 25 days, or as otherwise defined in section 1886(d)(1)(B)(iv);

"(3) satisfies the requirements of subsection (e);

"(4) meets the following facility criteria:

"(A) the institution has a patient review process, documented in the patient medical record, that screens patients prior to admission for appropriateness of admission to a long-term care hospital, validates within 48 hours of admission that patients meet admission criteria for long-term care hospitals, regularly evaluates patients throughout their stay for continuation of care in a long-term care hospital, and assesses the available discharge options when patients no longer meet such continued stay criteria;

"(B) the institution has active physician involvement with patients during their treatment through an organized medical staff, physician-directed treatment with physician on-site availability on a daily basis to review patient 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(n).".

(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 level of severity, as defined by the Secretary, and who are assigned to one or more of the following major diagnostic categories:

"(A) Circulatory diagnoses.

"(B) Digestive, endocrine, and metabolic diagnoses.

"(C) Infection disease diagnoses.

"(D) Neurological diagnoses.

"(E) Renal diagnoses.

"(F) Respiratory diagnoses.

"(G) Skin diagnoses.

"(H) Other major diagnostic categories as selected by the Secretary.

"(2) MAJOR DIAGNOSTIC CATEGORY DEFINED.—In paragraph (1), the term 'major diagnostic category' means the medical categories formed by dividing all possible principle diagnosis into mutually exclusive diagnosis areas which are referred to in 67 Federal Register 49985 (August 1, 2002).".

(C) ESTABLISHMENT OF REHABILITATION UNITS WITHIN CERTAIN LONG-TERM CARE HOSPITALS.—If the Secretary of Health and Human Services does not include rehabilitation services within a major diagnostic category under section 1886(n)(2) of the Social Security Act, as added by subparagraph (B), the Secretary shall approve for purposes of title XVIII of such Act distinct part inpatient rehabilitation hospital units in long-term care hospitals consistent with the following:

(i) A hospital that, on or before October 1, 2004, was classified by the Secretary as a long-term care hospital, as described in section 1886(d)(1)(B)(iv)(I) of such Act (42 U.S.C. 1395ww(d)(1)(V)(iv)(I)), and was accredited by the Commission on Accreditation of Rehabilitation Facilities, may establish a hospital rehabilitation unit that is a distinct part of the long-term care hospital, if the distinct part meets the requirements (including conditions of participation) that would otherwise apply to a distinct-part rehabilitation unit if the distinct part were established by a subsection (d) hospital in accordance with the matter following clause (v) of section 1886(d)(1)(B) of such Act, including any regulations adopted by the Secretary in accordance with this section, except that the one-year waiting period described in section 412.30(c) of title 42, Code of Federal Regulations, applicable to the conversion of hospital beds into a distinct-part rehabilitation unit shall not apply to such units.

(ii) Services provided in inpatient rehabilitation units established under clause (i) shall not be reimbursed as long-term care hospital services under section 1886 of such Act and shall be subject to payment policies established by the Secretary to reimburse services provided by inpatient hospital rehabilitation units.

(D) EFFECTIVE DATE.—The amendments made by subparagraphs (A) and (B), and the provisions of subparagraph (C), shall apply to discharges occurring on or after January 1, 2008.

(2) IMPLEMENTATION OF FACILITY AND PATIENT CRITERIA.—

(A) REPORT.—No later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall submit to the appropriate committees of Congress a report containing recommendations regarding the promulgation of the national long-term care hospital facility and patient criteria for application under paragraphs (4) and (5) of section 1861(ccc) and section 1886(n)

of the Social Security Act, as added by subparagraphs (A) and (B), respectively, of paragraph (1). In the report, the Secretary shall consider recommendations contained in a report to Congress by the Medicare Payment Advisory Commission in June 2004 for long-term care hospital-specific facility and patient criteria to ensure that patients admitted to long-term care hospitals are medically complex and appropriate to receive long-term care hospital services.

(B) IMPLEMENTATION.—No later than 1 year after the date of submittal of the report under subparagraph (A), the Secretary shall, after rulemaking, implement the national long-term care hospital facility and patient criteria referred to in such subparagraph. Such long-term care hospital facility and patient criteria shall be used to screen patients in determining the medical necessity and appropriateness of a Medicare beneficiary's admission to, continued stay at, and discharge from, long-term care hospitals under the Medicare program and shall take into account the medical judgment of the patient's physician, as provided for under sections 1814(a)(3) and 1835(a)(2)(B) of the Social Security Act (42 U.S.C. 1395f(a)(3), 1395n(a)(2)(B)).

(3) EXPANDED REVIEW OF MEDICAL NECESSITY.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall provide, under contracts with one or more appropriate fiscal intermediaries or medicare administrative contractors under section 1874A(a)(4)(G) of the Social Security Act (42 U.S.C. 1395kk(a)(4)(G)), for reviews of the medical necessity of admissions to long-term care hospitals (described in section 1886(d)(1)(B)(iv) of such Act) and continued stay at such hospitals, of individuals entitled to, or enrolled for, benefits under part A of title XVIII of such Act on a hospital-specific basis consistent with this paragraph. Such reviews shall be made for discharges occurring on or after October 1, 2007.

(B) REVIEW METHODOLOGY.—The medical necessity reviews under paragraph (A) shall be conducted for each such long-term care hospital on an annual basis in accordance with rules (including a sample methodology) specified by the Secretary. Such sample methodology shall—

(i) provide for a statistically valid and representative sample of admissions of such individuals sufficient to provide results at a 95 percent confidence interval; and

(ii) guarantee that at least 75 percent of overpayments received by long-term care hospitals for medically unnecessary admissions and continued stays of individuals in long-term care hospitals will be identified and recovered and that related days of care will not be counted toward the length of stay requirement contained in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)).

(C) CONTINUATION OF REVIEWS.—Under contracts under this paragraph, the Secretary shall establish a denial rate with respect to such reviews that, if exceeded, could require further review of the medical necessity of admissions and continued stay in the hospital involved.

(D) TERMINATION OF REQUIRED REVIEWS.—

(i) IN GENERAL.—Subject to clause (iii), the previous provisions of this subsection shall cease to apply as of the date specified in clause (ii).

(ii) DATE SPECIFIED.—The date specified in this clause is the later of January 1, 2013, or the date of implementation of national long-term care hospital facility and patient criteria under section paragraph (2)(B).

(iii) CONTINUATION.—As of the date specified in clause (ii), the Secretary shall determine whether to continue to guarantee, through continued medical review and sampling under this paragraph, recovery of at least 75 percent of overpayments received by long-term care hospitals due to medically unnecessary admissions and continued stays.

(E) FUNDING.—The costs to fiscal intermediaries or medicare administrative contractors conducting the medical necessity reviews under subparagraph (A) shall be funded from the aggregate overpayments recouped by the Secretary of Health and Human Services from long-term care hospitals due to medically unnecessary admissions and continued stays. The Secretary may use an amount not in excess of 40 percent of the overpayments recouped under this paragraph to compensate the fiscal intermediaries or Medicare administrative contractors for the costs of services performed.

(4) LIMITED, QUALIFIED MORATORIUM OF LONG-TERM CARE HOSPITALS.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall impose a temporary moratorium on the certification of new long-term care hospitals (and satellite facilities), and new long-term care hospital and satellite facil-

ity beds, for purposes of the Medicare program under title XVIII of the Social Security Act. The moratorium shall terminate at the end of the 4-year period beginning on the date of the enactment of this Act.

(B) EXCEPTIONS.—

(i) IN GENERAL.—The moratorium under subparagraph (A) shall not apply as follows:

(I) To a long-term care hospital, satellite facility, or additional beds under development as of the date of the enactment of this Act.

(II) To an existing long-term care hospital that requests to increase its number of long-term care hospital beds, if the Secretary determines there is a need at the long-term care hospital for additional beds to accommodate—

(aa) infectious disease issues for isolation of patients;

(bb) bedside dialysis services;

(cc) single-sex accommodation issues;

(dd) behavioral issues; or

(ee) any requirements of State or local law.

(III) To an existing long-term care hospital that requests an increase in beds because of the closure of a long-term care hospital or significant decrease in the number of long-term 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 the enactment of this Act, at least 10 percent of the estimated cost of the project (or, if less, $2,500,000).

(III) A certificate of need has been approved in a State where one is required or other necessary approvals from appropriate State agencies have been received for the operation of the hospital.

(IV) The hospital documents that, within 3 months after the date of the enactment of this Act, it is within a 6-month long-term care hospital demonstration period required by section 412.23(e)(1)–(3) of title 42, Code of Federal Regulations, to demonstrate that it has a greater than 25 day average length of stay.

(5) NO APPLICATION OF 25 PERCENT PATIENT THRESHOLD PAYMENT ADJUSTMENT TO FREESTANDING AND GRANDFATHERED LTCHS.—The Secretary shall not apply, during the 5-year period beginning on the date of the enactment of this Act, section 412.536 of title 42, Code of Federal Regulations, or any similar provision, to freestanding long-term care hospitals and the Secretary shall not apply such section or section 412.534 of title 42, Code of Federal Regulations, or any similar provisions, to a long-term care hospital identified by section 4417(a) of the Balanced Budget Act of 1997 (Public Law 105–33). A long-term care hospital identified by such section 4417(a) shall be deemed to be a freestanding long-term care hospital for the purpose of this section. Section 412.536 of title 42, Code of Federal Regulations, shall be void and of no effect.

(6) PAYMENT FOR HOSPITALS-WITHIN-HOSPITALS.—

(A) IN GENERAL.—Payments to an applicable long-term care hospital or satellite facility which is located in a rural area or which is co-located with an urban single or MSA dominant hospital under paragraphs (d)(1), (e)(1), and (e)(4) of section 412.534 of title 42, Code of Federal Regulations, shall not be subject to any payment adjustment under such section if no more than 75 percent of the hospital's Medicare discharges (other than discharges described in paragraphs (d)(2) or (e)(3) of such section) are admitted from a co-located hospital.

(B) CO-LOCATED LONG-TERM CARE HOSPITALS AND SATELLITE FACILITIES.—

(i) IN GENERAL.—Payment to an applicable long-term care hospital or satellite facility which is co-located with another hospital shall not be

subject to any payment adjustment under section 412.534 of title 42, Code of Federal Regulations, if no more than 50 percent of the hospital's Medicare discharges (other than discharges described in section 412.534(c)(3) of such title) are admitted from a co-located hospital.

(ii) APPLICABLE LONG-TERM CARE HOSPITAL OR SATELLITE FACILITY DEFINED.—In this paragraph, the term "applicable long-term care hospital or satellite facility" means a hospital or satellite facility that is subject to the transition rules under section 412.534(g) of title 42, Code of Federal Regulations.

(C) EFFECTIVE DATE.—Subparagraphs (A) and (B) shall apply to discharges occurring on or after October 1, 2007, and before October 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)—

(i) in subclause (I), by striking "(iv)(I)" and inserting "(iv)" and by striking "or" at the end; and

(ii) in subclause (II)—

(I) by striking ", or" at the end and inserting a semicolon; and

(II) by redesignating such subclause as clause (vi) and by moving it to immediately follow clause (v); and

(B) in clause (v), by striking the semicolon at the end and inserting ", or".

(2) CONFORMING PAYMENT REFERENCES.—Subsection (b) of such section is amended—

(A) in paragraph (2)(E)(ii), by adding at the end the following new subclause:

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

(B) in paragraph (3)(F)(iii), by adding at the end the following new subclause:

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

(C) in paragraphs (3)(G)(ii), (3)(H)(i), and (3)(H)(ii)(I), by inserting "or (vi)" after "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 and which is classified under clause (vi) of such section after such date of enactment, payments under section 1886 of such Act for cost reporting periods beginning after the date of the enactment of this Act shall be based upon payment rates in effect for the cost reporting period for such hospital beginning during fiscal year 2001, increased for each succeeding cost reporting period (beginning before the date of the enactment of this Act) by the applicable percentage increase under section 1886(b)(3)(B)(ii) of such Act.

(5) CLARIFICATION OF TREATMENT OF SATELLITE FACILITIES AND REMOTE LOCATIONS.—A long-stay cancer hospital described in section 1886(d)(1)(B)(vi) of the Social Security Act, as designated under paragraph (1), shall include satellites

or remote site locations for such hospital established before or after the date of the enactment of this Act if the provider-based requirements under section 413.65 of title 42, Code of Federal Regulations, applicable certification requirements under title XVIII of the Social Security, and such other applicable State licensure and certificate of need requirements are met with respect to such satellites or remote site 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) in 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 reporting periods beginning before October 1, 1999, that is within a class of hospital described in clause (iii) (other than subclause (IV), relating to long-term care hospitals, and that requests the Secretary (in a form and manner specified by the Secretary) to effect a rebasing under this clause for the hospital, the Secretary may compute the target amount for the hospital's 12-month cost reporting period beginning during fiscal year 2008 as an amount equal to the average described in clause (ii) but determined as if any reference in such clause to 'the date of the enactment of this subparagraph' were a reference to 'the date of the enactment of this clause'.".

(b) ADDITIONAL CANCER HOSPITAL PROVISIONS.—

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

(A) in subparagraph (B)(v)—

(i) by striking "or" at the end of subclause (II); and

(ii) by adding at the end the following:

"(IV) a hospital that is a nonprofit corporation, the sole member of which is affiliated with a university that has been the recipient of a cancer center support grant from the National Cancer Institute of the National Institutes of Health, and which sole member (or its predecessors or such university) was recognized as a comprehensive cancer center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, if the hospital's articles of incorporation specify that at least 50 percent of its total discharges have a principal finding of neoplastic disease (as defined in subparagraph (E)) and if, of December 31, 2005, the hospital was licensed for less than 150 acute care beds, or

"(V) a hospital (aa) that the Secretary has determined to be, at any time on or before December 31, 2011, a hospital involved extensively in treatment for, or research on, cancer, (bb) that is (as of the date of such determination) a freestanding facility, (cc) for which the hospital's predecessor provider entity was University Hospitals of Cleveland with medicare provider number 36–0137;"; and

(B) in subparagraph (B), by inserting after clause (vi), as redesignated by section 503(c)(1)(A)(ii)(II), the following new clause:

"(vii) a hospital that—

"(I) is located in a State which ranks (according to the National Cancer Institute's statistics published in May of 2005) among the top ten States in the incidence of non-Hodgkins lymphoma, ovarian cancer, thyroid cancer, and cervical cancer and among the top ten States with the highest death rate for breast cancer and uterine cancer;

"(II) is located in a State that as of December 31, 2006, had only one center under section 414 of the Public Health Service Act that has been designated by the National Cancer Institute as a comprehensive center cur-

rently serving all 21 counties in the most densely populated State in the nation (U.S. Census estimate for 2005: 8,717,925 persons; 1,134.5 persons per square mile), serving more than 70,000 patient visits annually;

"(III) as of December 31, 2006, served as the teaching and clinical care, research and training hospital for the Center described in subclause (II), providing significant financial and operational support to such Center;

"(IV) as of December 31, 2006, served as a core and essential element in such Center which conducts more than 130 clinical trial activities, national cooperative group studies, investigator-initiated and peer review studies and has received as of 2005 at least $93,000,000 in research grant awards;

"(V) as of December 31, 2006, can demonstrate that it has been a unique and an integral component of such Center since such Center's inception;

"(VI) as of December 31, 2006, includes dedicated patient care units organized primarily for the treatment of and research on cancer with approximately 125 beds, 75 percent of which are dedicated to cancer patients, and contains a radiation oncology department as well as specialized emergency services for oncology patients;

"(VII) as of December 31, 2004, is identified as the focus of the Center's inpatient activities in the Center's application as a NCI-designated comprehensive cancer center and shares the NCI comprehensive cancer designation with the Center; and

"(VIII) as of December 31, 2006, has been recognized with a certificate of approval with commendation by the American College of Surgeons Commission on Cancer;"; and

(D) in subparagraph (E)—

(i) by striking "subclauses (II) and (III)" and inserting "subclauses (II), (III), and (IV)"; and

(ii) by inserting "and subparagraph (B)(vi)" after "subparagraph (B)(v)".

(2) EFFECTIVE DATES; PAYMENTS.—

(A) APPLICATION TO COST REPORTING PERIODS.—

(i) Any classification by reason of section 1886(d)(1)(B)(vi) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(vi)), as inserted by paragraph (1), shall apply to cost reporting periods beginning on or after January 1, 2006.

(ii) The provisions of section 1886(d)(1)(B)(v)(IV) of the Social Security Act, as added by paragraph (1), shall take effect on January 1, 2008.

(B) BASE TARGET AMOUNT.—Notwithstanding subsection (b)(3)(E) of section 1886 of the Social Security Act (42 U.S.C. 1395ww), in the case of a hospital described in subsection (d)(1)(B)(vi) of such section, as inserted by paragraph (1)—

(i) the hospital shall be permitted to resubmit the 2006 Medicare 2552 cost report incorporating a cancer hospital sub-provider number and to apply the Medicare ratio-of-cost-to-charge settlement methodology for outpatient cancer services; and

(ii) the hospital's target amount under subsection (b)(3)(E)(i) of such section for the first cost reporting period beginning on or after January 1, 2006, shall be the allowable operating costs of inpatient hospital services (referred to in subclause (I) of such subsection) for such first cost reporting period.

(C) DEADLINE FOR PAYMENTS.—Any payments owed to a hospital as a result of this subsection for periods occurring before the date of the enactment of this Act shall be made expeditiously, but in no event later than 1 year after such date of enactment.

(3) APPLICATION TO CERTAIN HOSPITALS.—

(A) INAPPLICABILITY OF CERTAIN REQUIREMENTS.—The provisions of section 412.22(e) of title 42, Code of Federal Regulations, shall not apply to a hospital described in section 1886(d)(1)(B)(v)(V) of the Social Security Act, as added by paragraph (1).

(B) APPLICATION TO COST REPORTING PERIODS.—If the Secretary makes a determination that a hospital is described in section 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 de-

scribed 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 shall be applicable to such first cost reporting period, that the hospital intends to have total discharges during such first cost reporting period of which 50 percent or more have a principal finding of neoplastic disease.

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

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

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

(3) Payment adequacy for cancer discharges under the Medicare inpatient hospital prospective 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" at the end;

(2) by redesignating subclause (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 ac-

creditation 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.

(2) For purposes of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), the amendments made by this section shall not effect the accreditation of a hospital by the Joint Commission on Accreditation of Healthcare Organizations, or under accreditation or comparable approval standards found to be essentially equivalent to accreditation or approval standards of the Joint Commission on Accreditation of Healthcare Organizations, for the period of time applicable under such accreditation.

SEC. 508. TREATMENT OF MEDICARE HOSPITAL RECLASSIFICATIONS.

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

(1) IN GENERAL.—Section 106(a) of the Medicare Improvements and Extension Act of 2006 (division B of Public Law 109–432) is amended by striking "September 30, 2007" and inserting "September 30, 2009".

(2) SPECIAL EXCEPTION RECLASSIFICATIONS.—The Secretary of Health and Human Services shall extend for discharges occurring through September 30, 2009, the special exception reclassification made under the authority of section 1886(d)(5)(I)(i) of 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) by redesignating clause (v) as clause (vi); and

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

"(v) Notwithstanding the previous provisions of this subparagraph, in the case that the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10) results in the redesignation of a rural hospital that is classified as a rural referral center under paragraph (5)(C) and sole community hospital under paragraph (5)(D)(iii) and that has at least 250 beds to an urban area that is in a non-location State, for which the combined average hourly wage of all hospitals located in such area is less than the combined average hourly wage of all hospitals located in the rural area of such State, and which was not reclassified under section 508 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the wage index applicable to

such hospital may not be less than the area wage index otherwise applicable to a hospital located in the rural area in the non-location State (or, if the non-location State has no rural area, the minimum wage index that the Secretary establishes for such State). For purposes of this clause, the term 'non-location State' means, with respect to a hospital, a State other than the State in which the hospital is located.".

(d) APPLICATION OF FLOOR ON AREA WAGE INDEX IN CASE OF RECLASSIFIED HOSPITALS.—

(1) IN GENERAL.—Section 4410 of the Balanced Budget Act of 1997 (Public Law 105–33) is amended by adding at the end the following new subsection:

"(d) APPLICATION TO RECLASSIFIED HOSPITALS.—In the case of a hospital that is reclassified based on wages under paragraph (8) or (10) of section 1886(d) of the Social Security Act into an area the area wage index for which is increased under subsection (a), such increased area wage index shall also apply to such hospital.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to payments for discharges occurring on or after October 1, 2008.

(e) OTHER HOSPITAL RECLASSIFICATION PROVISIONS.—Notwithstanding any other provision of law—

(1) In the case of a subsection (d) hospital (as defined for purposes of section 1886 of the Social Security Act (42 U.S.C. 1395ww)) located in Putnam County, Tennessee with respect to which a reclassification of its wage index for purposes of such section would (but for this subsection) expire on September 30, 2007, such reclassification of such hospital shall be extended through September 30, 2008.

(2) For purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), the Secretary of Health and Human Services shall classify any hospital located in Orange County, New York that was reclassified under the authority of section 508 of the the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Public Law 108–173) as being located in the New York-White Plains-Wayne, NY-NJ Core Based Statistical Area. Any reclassification under this subsection shall be treated as a reclassification under section 1886(d)(8) of such Act.

(3) For purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), the large urban area of New York, New York is deemed to include hospitals, required by State law enacted prior to June 30, 2007, to join under a single unified governance structure if—

(A) such hospitals are located in a city with a population of no less than 20,000 and no than 30,000; and

(B) such hospitals are less than ¾ miles apart.

(4) For purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) the large urban area of Buffalo-Niagara Falls, New York is deemed to include Chautauqua County, New York. Notwithstanding paragraph (6), in no case shall there be a reduction in the hospital wage index for Erie County, New York, or any adjoining county, as a result of the application of this section (other than as a result of a general reduction required to carry out paragraph (8)(D) of that section).

(5) For purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) a hospital shall be reclassified into the New York-White Plains-Wayne, New York-New Jersey core based statistical area (CBSA code 35644) if the hospital is a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) that—

(A) is licensed by the State in which it is located as a specialty hospital;

(B) specializes in the treatment of cardiac, vascular, and pulmonary diseases;

(C) provides at least 100 beds; and

(D) is located in Burlington County, New Jersey.

(6)(A) Any hospital described in subparagraph (B) shall be treated as located in the core based statistical area described in subparagraph (C) for purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)).

(B) A hospital described in this subparagraph is any hospital that—

(i) is located in a core based statistical area (CBSA) that—

(I) had a population (as reported in the decennial census for the year 2000) of at least 500,000, but not more than 750,000;

(II) had a population (as reported in such census) that was at least 10,000 below the population for the area as reported in the previous decennial census; and

(III) has as of January 1, 2006, at least 5, and no more than 7, subsection (d) hospitals; and

(ii) demonstrates that its average hourly wage amount (as determined consistent with section 1886(d)(10)(D)(vi) of the Social Security Act is not less than 96 percent of such average hourly wage amount rate for all subsection (d) hospitals located in same core base statistical area of the hospital.

(C) The area described in this subparagraph, with respect to a hospital described in subparagraph (B), is the core based statistical area that—

(i) is within the same State as, and is adjacent to, the core based statistical area in which the hospital is located; and

(ii) has an average hourly wage amount (described in subparagraph (B)(ii)) that is closest to (but does not exceed) such average hourly wage amount of the hospital.

(7) For purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), the large urban area of Hartford, Connecticut is deemed to include Albany, Schenectady, and Rensselaer Counties, New York.

(8) For purposes of the previous provisions of this subsection (other than paragraph (1))—

(A) any reclassification effected under such provisions shall be treated as a decision of the 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 care services to residents in the area of the hospital.

"(B) CRITERIA DESCRIBED.—A hospital meets the criteria described in this subparagraph if the hospital

"(i) has been granted an exception by the State to an otherwise applicable statutory restriction on hospital construction or licensing prior to the date of enactment of this subparagraph; and

"(ii) is located on property which the State has approved for conveyance to a county within the State prior to such date of enactment.".

(2) Section 1820(c)(2)(B)(i)(I) of the Social Security Act (42 U.S.C. 1395i–4(c)(2)(B)(i)(I)) is amended by striking "or," and inserting "or, in the case of a hospital that is located in the county seat of Butler, Alabama, a 32-mile drive, or,".

(b) EFFECTIVE DATE.—The amendment made by subsection (a)(2) shall apply to cost reporting periods beginning on or after the date of the enactment of this Act.

TITLE VI—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 oc-

cupational 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 'outpatient physical therapy services' in subsection (p), except that in applying such subsection—

"(A) 'speech-language pathology' shall be substituted for 'physical therapy' each place it appears; and

"(B) 'speech-language pathologist' shall be substituted for 'physical therapist' each place it appears.".

(b) CONFORMING AMENDMENTS.—

(1) Section 1832(a)(2)(C) of the Social Security Act (42 U.S.C. 1395k(a)(2)(C)) is amended—

(A) by striking "and outpatient" and inserting ", outpatient"; and

(B) by inserting before the semicolon at the end the following: ", and outpatient speech-language pathology services (other than services to which the second sentence of section 1861(p) applies through the application of section 1861(ll)(2))".

(2) Subparagraphs (A) and (B) of section 1833(a)(8) of such Act (42 U.S.C. 1395l(a)(8)) are each amended by striking "(which includes outpatient speech-language pathology services)" and inserting ", outpatient speech-language pathology 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".

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

(d) CONSTRUCTION.—Nothing in this section shall be construed to affect existing regulations and policies of the Centers for Medicare & Medicaid Services that require physician oversight of care as a condition of payment for speech-language pathology services under part B of the medicare program.

SEC. 603. INCREASED REIMBURSEMENT RATE FOR CERTIFIED NURSE-MIDWIVES.

(a) IN GENERAL.—Section 1833(a)(1)(K) of the Social Security Act (42 U.S.C.1395l(a)(1)(K)) is amended by striking "(but in no event" and all that follows through "performed by a physician)".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after April 1, 2008.

SEC. 604. ADJUSTMENT IN OUTPATIENT HOSPITAL FEE SCHEDULE INCREASE FACTOR.

The first sentence of section 1833(t)(3)(C)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(3)(C)(iv)) is amended by inserting before the period at the end the following: "and reduced by 0.25 percentage point for such 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 services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation".

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

SEC. 607. COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES.

(a) COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES.—

(1) COVERAGE OF SERVICES.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by section 201(a)(1), is amended—

(A) in subparagraph (AA), by striking "and" at the end;

(B) in subparagraph (BB), by adding "and" at the end; and

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

"(CC) marriage and family therapist services (as defined in subsection (eee));".

(2) DEFINITION.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by sections 201(a)(2) and 503(b)(1), is amended by adding at the end the following new subsection:

"Marriage and Family Therapist Services

"(eee)(1) The term 'marriage and family therapist services' means services performed by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses, which the marriage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed, provided such services are covered under this title, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

"(2) The term 'marriage and family therapist' means an individual who—

"(A) possesses a master's or doctoral degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law;

"(B) after obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and

"(C) is licensed or certified as a marriage and family therapist in the State in which marriage and 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)), as amended by section 201(b)(1), is amended—

(i) by striking "and" before "(W)"; and

(ii) by inserting before the semicolon at the end the following: ", and (X) with respect to marriage and family therapist services under section 1861(s)(2)(CC), 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 patient confidentiality, develop criteria with respect to payment for marriage and family therapist services for which payment may be made directly to the marriage and family therapist under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) under which such a therapist must agree to consult with a patient's attending or primary care physician in accordance with such criteria.

(5) EXCLUSION OF MARRIAGE AND FAMILY THERAPIST SERVICES FROM SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)), is amended by inserting "marriage and family therapist services (as defined in subsection (eee)(1))," after "qualified psychologist services,".

(6) COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES PROVIDED IN RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking "or by a clinical social worker (as defined in subsection (hh)(1))," and inserting ", by a clinical social worker (as defined in subsection (hh)(1)), or by a marriage and family therapist (as defined in subsection (eee)(2)),".

(7) INCLUSION OF MARRIAGE AND FAMILY THERAPISTS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clause:

"(vii) A marriage and family therapist (as defined in section 1861(eee)(2)).".

(b) COVERAGE OF MENTAL HEALTH COUNSELOR SERVICES.—

(1) COVERAGE OF SERVICES.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by subsection (a)(1), is further amended—

(A) in subparagraph (BB), by striking "and" at the end;

(B) in subparagraph (CC), by inserting "and" at the end; and

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

"(DD) mental health counselor services (as defined in subsection (fff)(2));".

(2) DEFINITION.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by sections 201(a)(2) and 503(b)(1) and subsection (a)(2), is amended by adding at the end the following new subsection:

"Mental Health Counselor; Mental Health Counselor Services

"(fff)(1) The term 'mental health counselor' means an individual who—

"(A) possesses a master's or doctor's degree which qualifies the individual for licensure or certification for the practice of mental health counseling in the State in which the services are performed;

"(B) after obtaining such a degree has performed at least 2 years of supervised mental health counselor practice; and

"(C) is licensed or certified as a mental health counselor or professional counselor by the State in which the services are performed.

"(2) The term 'mental health counselor services' means services performed by a mental health counselor (as defined in paragraph (1)) for the diagnosis and treatment of mental illnesses which the mental health counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are performed, provided such services are covered under this title, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.".

(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)), as amended by subsection (a)(3), is further amended by adding at the end the following new clause:

"(vi) mental health counselor 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)), as amended by subsection (a)(4), is further amended—

(i) by striking "and" before "(X)"; and

(ii) by inserting before the semicolon at the end the following: ", and (Y) with respect to mental health counselor services under section 1861(s)(2)(DD), 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 patient confidentiality, develop criteria with respect to payment for mental health counselor services for which payment may be made directly to the mental health counselor under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) under which such a counselor must agree to consult with a patient's attending or primary care physician in accordance with such criteria.

(5) EXCLUSION OF MENTAL HEALTH COUNSELOR SERVICES FROM SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)), as amended by subsection (a)(5), is amended by inserting "mental health counselor services (as defined in section 1861(ddd)(2))," after "marriage and family therapist services (as defined in subsection (eee)(1)),".

(6) COVERAGE OF MENTAL HEALTH COUNSELOR SERVICES PROVIDED IN RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)), as amended by subsection (a)(6), is amended by striking "or by a marriage and family therapist (as defined in subsection (eee)(2))," and inserting "by a marriage and family therapist (as defined in subsection (eee)(2)), or a mental health counselor (as defined in subsection (fff)(1)),".

(7) INCLUSION OF MENTAL HEALTH COUNSELORS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)), as amended by subsection (a)(7), is amended by adding at the end the following new clause:

"(viii) A mental health counselor (as defined in section 1861(fff)(1)).".

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

SEC. 608. RENTAL AND PURCHASE OF POWER-DRIVEN WHEELCHAIRS.

(a) IN GENERAL.—Section 1834(a)(7) of the Social Security Act (42 U.S.C. 1395m(a)(7)) is amended—

(1) in subparagraph (A)—

(A) in 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 '18 months' is deemed a reference to '36 months'.".

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (3), the amendments made by subsection (a) shall apply to oxygen equipment furnished on or after January 1, 2008.

(2) TRANSITION.—In the case of an individual receiving oxygen equipment on December 31, 2007, for which payment is made under section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)), the 18-month period described in paragraph (5)(F)(i) of such section, as amended by subsection (a), shall begin on January 1, 2008, but in no case shall the rental period for such equipment exceed 36 months.

(3) 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.

(c) STUDY AND REPORT.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study to examine the service component and the equipment component of the provision of oxygen to Medicare beneficiaries. The study shall assess—

(A) the type of services provided and variation across suppliers in providing such services;

(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 and Human Services shall increase the amount otherwise payable for applicable services by 5 percent.

(b) DEFINITIONS.—For purposes of subsection (a):

(1) APPLICABLE PERIOD.—The term "applicable period" means the period beginning on January 1, 2008, and ending on December 31 of the year before the effective date of the first review after January 1, 2008, of work relative value units conducted under section 1848(c)(2)(B)(i) of the Social Security Act.

(2) APPLICABLE SERVICES.—The term "applicable services" means procedure codes for services—

(A) in the categories of psychiatric therapeutic procedures furnished in office or other outpatient facility settings, or inpatient hospital, partial hospital or residential care facility settings; and

(B) which cover insight oriented, behavior modifying, or supportive psychotherapy and interactive psychotherapy services in the Healthcare Common Procedure Coding System established by the Secretary of Health and Human Services under section 1848(c)(5) of 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) CONTINUOUS OPEN ENROLLMENT; AUTOMATIC REENROLLMENT WITHOUT NEED FOR REAPPLICATION.—Subsection (a)(1)(A) of section 1847B of the Social Security Act (42 U.S.C. 1395w–3b) is amended—

(A) in clause (ii), by striking "annually" and inserting "on an ongoing basis";

(B) in clause (iii), by striking "an annual selection" and inserting "a selection (which may be changed on an annual basis)" ; and

(C) by adding at the end the following: "An election and selection described in clauses (ii) and (iii) shall continue to be effective without the need for any periodic reelection or reapplication or selection.".

(2) PERMITTING VENDER TO DELIVER DRUGS TO SITE OF ADMINISTRATION.—Subsection (b)(4)(E) of such section is amended—

(A) by striking "or" at the end of clause (i);

(B) by striking the period at the end of clause (ii) and inserting "; or"; and

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

"(iii) prevent a contractor from delivering drugs and biologicals to the site in which the drugs or biologicals will be administered.".

(3) PHYSICIAN OUTREACH AND EDUCATION.—Subsection (a)(1) of such section is amended by adding at the end the following new subparagraph:

"(E) PHYSICIAN OUTREACH AND EDUCATION.—The Secretary shall conduct a program of outreach to education physicians concerning the program and the ongoing opportunity of physicians to elect to obtain drugs and biologicals under the program.".

(4) REBIDDING OF CONTRACTS.—The Secretary of Health and Human Services shall provide for the rebidding of contracts under section 1847B(c) of the Social Security Act (42 U.S.C. 1395w–3b(c)) only for periods on or after the expiration of the contract in effect under such section as of the date of the enactment of this Act.

(c) TREATMENT OF CERTAIN DRUGS.—Section 1847A(b) of the Social Security Act (42 U.S.C. 1395w–3a(b)) is amended—

(1) in paragraph (1), by inserting "paragraph (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".

(b) TRANSITION.—With respect to physicians' services furnished during 2008 and 2009, for purposes of subsection (a), the Secretary of Health and Human Services shall use the primary care scarcity areas and the specialty care scarcity areas (as identified in section 1833(u)(4)) that the Secretary was using under such subsection with respect to physicians' services furnished on December 31, 2007.

SEC. 625. 2-YEAR EXTENSION OF MEDICARE INCREASE PAYMENTS FOR GROUND AMBULANCE SERVICES IN RURAL AREAS.

Section 1834(l)(13) of the Social Security Act (42 U.S.C. 1395m(l)(13)) is amended—

(1) in subparagraph (A)—

(A) in the matter before clause (i), by striking "furnished on or after July 1, 2004, and before January 1, 2007,";

(B) in clause (i), by inserting "for services furnished on or after July 1, 2004, and before January 1, 2007, and on or after January 1, 2008, and before January 1, 2010," after "in such paragraph,"; and

(C) in clause (ii), by inserting "for services furnished on or after July 1, 2004, and before 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) SCOPE.—The Secretary shall select at least 3 States in which to conduct demonstration projects under this section. In selecting the States under this paragraph, the Secretary shall take into account the size of the population of

individuals with end-stage renal disease who are enrolled in part B of title XVIII of the Social Security Act and ensure the participation of individuals who reside in rural and urban areas.

(2) DURATION.—The demonstration projects under this section shall be conducted for a period that is not longer than 5 years and shall begin on January 1, 2009.

(c) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall conduct an evaluation of the demonstration projects conducted under this section.

(2) REPORT.—Not later than 12 months after the date on which the demonstration projects under this section are completed, the Secretary shall submit to Congress a report on the evaluation conducted under paragraph (1) together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

SEC. 632. MEDICARE COVERAGE OF KIDNEY DISEASE PATIENT EDUCATION SERVICES.

(a) COVERAGE OF KIDNEY DISEASE EDUCATION SERVICES.—

(1) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by sections 201(a)(1), 607(a)(1), and 607(b)(1), is amended—

(A) in subparagraph (CC), by striking "and" after the semicolon at the end;

(B) in subparagraph (DD), by adding "and" after the semicolon at the end; and

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

"(EE) kidney disease education services (as defined in subsection (ggg));".

(2) SERVICES DESCRIBED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by sections 201(a)(2), 503(b)(1), 607(a)(2), and 607(b)(2), is amended by adding at the end the following new subsection:

"Kidney Disease Education Services

"(ggg)(1) The term 'kidney disease education services' means educational services that are—

"(A) furnished to an individual with stage IV chronic kidney disease who, according to accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant;

"(B) furnished, upon the referral of the physician managing the individual's kidney condition, by a qualified person (as defined in paragraph (2)); and

"(C) designed—

"(i) to provide comprehensive information (consistent with the standards developed under paragraph (3)) regarding—

"(I) the management of comorbidities, including for purposes of delaying the need for dialysis;

"(II) the prevention of uremic complications; and

"(III) each option for renal replacement therapy (including hemodialysis and peritoneal dialysis at home and in-center as well as vascular access options and transplantation);

"(ii) to ensure that the individual has the opportunity to actively participate in the choice of therapy; and

"(iii) to be tailored to meet the needs of the individual involved.

"(2) The term 'qualified person' means a physician, physician assistant, nurse practitioner, or clinical nurse 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).

"(6) No individual shall be eligible to be provided more than 6 sessions of kidney disease education services under this title.".

(3) PAYMENT UNDER THE PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting "(2)(DD)," after "(2)(AA),".

(4) LIMITATION ON NUMBER OF SESSIONS.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)) is amended—

(A) in subparagraph (M), by striking "and" at the end;

(B) in subparagraph (N), by striking the semicolon at the end and inserting ", and"; and

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

"(O) in the case of kidney disease education services (as defined in section 1861(ggg)), which are furnished in excess of the number of sessions covered under such section;".

(5) GAO REPORT.—Not later than September 1, 2010, the Comptroller General of the United States shall submit to Congress a report on the following:

(A) The number of Medicare beneficiaries who are eligible to receive benefits for kidney disease education services (as defined in section 1861(ggg) of the Social Security Act, as added by paragraph (2)) under title XVIII of such Act and who receive such services.

(B) The extent to which there is a sufficient amount of physicians, physician assistants, nurse practitioners, and clinical nurse specialists to furnish kidney disease education services (as so defined) under such title and whether or not renal dialysis facilities (and appropriate employees of such facilities) should be included as an entity eligible under such section to furnish such services.

(C) Recommendations, if appropriate, for renal dialysis facilities (and appropriate employees of such facilities) to structure kidney disease education services (as so defined) in a manner that is objective and unbiased and that provides a range of options and alternative locations for renal replacement therapy and management of co-morbidities that may delay the need for dialysis.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2009.

SEC. 633. REQUIRED TRAINING FOR PATIENT CARE DIALYSIS TECHNICIANS.

Section 1881 of the Social Security Act (42 U.S.C. 1395rr) is amended by adding the following new subsection:

"(h)(1) Except as provided in paragraph (2), a provider of services or a renal dialysis facility may not use, for more than 12 months during 2009, or for any period beginning on January 1, 2010, any individual as a patient care dialysis technician unless the individual—

"(A) has completed a training program in the care and treatment of an individual with chronic kidney failure who is undergoing dialysis treatment; and

"(B) has been certified by a nationally recognized certification entity for dialysis technicians.

"(2)(A) A provider of services or a renal dialysis facility may permit an individual enrolled in a training program described in paragraph (1)(A) to serve as a patient care dialysis technician while they are so enrolled.

"(B) The requirements described in subparagraphs (A), (B), and (C) of paragraph (1) do not apply to an individual who has performed dialysis-related services for at least 5 years.

"(3) For purposes of paragraph (1), if, since the most recent completion by an individual of a training program described in paragraph (1)(A), there has been a period of 24 consecutive months during which the individual has not furnished dialysis-related services for monetary compensation, such individual shall be required to complete a new training program or become recertified as described in paragraph (1)(B).

"(4) A provider of services or a renal dialysis facility shall provide such regular performance review and regular in-service education as assures that individuals serving as patient care dialysis technicians for the provider or facility are competent to perform dialysis-related services.".

SEC. 634. MEDPAC REPORT ON TREATMENT MODALITIES FOR PATIENTS WITH KIDNEY FAILURE.

(a) EVALUATION.—

(1) IN GENERAL.—Not later than March 1, 2009, the Medicare Payment Advisory Commission (established under section 1805 of the Social Security Act) shall submit to the Secretary and Congress a report evaluating the barriers that exist to increasing the number of individuals with end-stage renal disease who

elect to receive home dialysis services under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) REPORT DETAILS.—The report shall include the following:

(A) A review of Medicare home dialysis demonstration projects initiated before the date of the enactment of this Act, and the results of such demonstration projects and recommendations for future Medicare home dialysis demonstration projects or Medicare program changes that will test models that can improve Medicare beneficiary access to home dialysis.

(B) A comparison of current Medicare home dialysis costs and payments with current in-center and hospital dialysis costs and payments.

(C) An analysis of the adequacy of Medicare reimbursement for patient training for home dialysis (including hemodialysis and peritoneal dialysis) and recommendations for ensuring appropriate payment for such home dialysis training.

(D) A catalogue and evaluation of the incentives and disincentives in the current reimbursement system that influence whether patients receive home dialysis services or other treatment modalities.

(E) An evaluation of patient education services and how such services impact the treatment choices made by patients.

(F) Recommendations for implementing incentives to encourage patients to elect to receive home dialysis services or other treatment modalities under the Medicare program

(3) SCOPE OF REVIEW.—In preparing the report under paragraph (1), the Medicare Payment Advisory Commission shall consider a variety of perspectives, including the perspectives of physicians, other health care professionals, hospitals, dialysis facilities, health plans, purchasers, and patients.

SEC. 635. ADJUSTMENT FOR ERYTHROPOIETIN STIMULATING AGENTS (ESAS).

(a) IN GENERAL.—Subsection (b)(13) of section 1881 of the Social Security Act (42 U.S.C. 1395rr) is amended—

(1) in subparagraph (A)(iii), by striking "For such drugs" and inserting "Subject to subparagraph (C), for such drugs"; and

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

"(C)(i) The payment amounts under this title for erythropoietin furnished during 2008 or 2009 to an individual with end stage renal disease by a large dialysis facility (as defined in subparagraph (D)) (whether to individuals in the facility or at home), in an amount equal to $8.75 per thousand units (rounded to the nearest 100 units) or, if less, 102 percent of the average sales price (as determined under section 1847A) for such drug or biological.

"(ii) The payment amounts under this title for darbepoetin alfa furnished during 2008 or 2009 to an individual with end stage renal disease by a large dialysis facility (as defined in clause (iii)) (whether to individuals in the facility or at home), in an amount equal to $2.92 per microgram or, if less, 102 percent of the average sales price (as determined under section 1847A) for such drug or biological.

"(iii) For purposes of this subparagraph, the term 'large dialysis facility' means a provider of services or renal dialysis facility that is owned or managed by a corporate entity that, as of July 24, 2007, owns or manages 300 or more such providers or facilities, and includes a successor to such a corporate entity.".

(b) NO IMPACT ON DRUG ADD-ON PAYMENT.—Nothing in the amendments made by subsection (a) shall be construed to affect the amount of any payment adjustment made under section 1881(b)(12)(B)(ii) of the Social Security Act (42 U.S.C. 1395rr(b)(12)(B)(ii)).

SEC. 636. SITE NEUTRAL COMPOSITE RATE.

Subsection (b)(12)(A) of section 1881 of the Social Security Act (42 U.S.C. 1395rr) is amended by adding at the end the following new sentence: "Under such system the payment rate for dialysis services furnished on or after January 1, 2008, by providers of such services for hospital-based facilities shall be the same as the payment rate (computed without regard to this sentence) for such services furnished by renal dialysis facilities that are not hospital-based, except that in applying the geographic index under subparagraph (D) to hospital-based facilities, the labor share shall be based on the labor share otherwise applied for such facilities.".

SEC. 637. DEVELOPMENT OF ESRD BUNDLING SYSTEM AND QUALITY INCENTIVE PAYMENTS.

(a) DEVELOPMENT OF ESRD BUNDLING SYSTEM.—Subsection (b) of section 1881 of the Social Security Act (42 U.S.C. 1395rr) is further amended—

(1) in paragraph (12)(A), by striking "In lieu of payment" and inserting "Subject to paragraph (14), in lieu of payment";

(2) in the second sentence of paragraph (12)(F)—

(A) by inserting "or paragraph (14)" after "this paragraph"; and

(B) by inserting "or under the system under paragraph (14)" after "subparagraph (B)";

(3) in paragraph (12)(H)—

(A) by inserting "or paragraph (14)" after "under this paragraph" the first place it appears; and

(B) by inserting before the period at the end the following: "or, under paragraph (14), the identification of renal dialysis services included in the bundled payment, the adjustment for outliers, the identification of facilities to which the phase-in may apply, and the determination of payment amounts under subparagraph (A) under such paragraph, and the application of paragraph (13)(C)(iii)";

(4) in paragraph (13)—

(A) in subparagraph (A), by striking "The payment amounts" and inserting "subject to paragraph (14), the payment amounts"; and

(B) in subparagraph (B)—

(i) in clause (i), by striking "(i)" after "(B)" and by inserting ", subject to paragraph (14)" before the period at the end; and

(ii) by striking clause (ii); and

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

"(14)(A) Subject to subparagraph (E), for services furnished on or after January 1, 2010, the Secretary shall implement a payment system under which a single payment is made under this title for renal dialysis services (as defined in subparagraph (B)) in lieu of any other payment (including a payment adjustment under paragraph (12)(B)(ii)) for such services and items furnished pursuant to paragraph (4). In implementing the system the Secretary shall ensure that the estimated total amount of payments under this title for 2010 for renal dialysis services shall equal 96 percent of the estimated amount of payments for such services, including payments under paragraph (12)(B)(ii), that would have been made if such system had not been implemented.

"(B) For purposes of this paragraph, the term 'renal dialysis services' includes—

"(i) items and services included in the composite rate for renal dialysis services as of December 31, 2009;

"(ii) erythropoietin stimulating agents furnished to individuals with end stage renal disease;

"(iii) other drugs and biologicals and diagnostic laboratory tests, that the Secretary identifies as commonly used in the treatment of such patients and for which payment was (before the application of this paragraph) made separately under this title, and any oral equivalent form of such drugs and biologicals or of drugs and biologicals described in clause (ii); and

"(iv) home dialysis training for which payment was (before the application of this paragraph) made separately under this section.

Such term does not include vaccines.

"(C) The system under this paragraph may provide for payment on the basis of services furnished during a week or month or such other appropriate unit of payment as the Secretary specifies.

"(D) Such system—

"(i) shall include a payment adjustment based on case mix that may take into account patient weight, body mass index, comorbidities, length of time on dialysis, age, race, ethnicity, and other appropriate factors;

"(ii) shall include a payment adjustment for high cost outliers due to unusual variations in the type or amount of medically necessary care, including variations in the amount of erythropoietin stimulating agents necessary for anemia management; and

"(iii) may include such other payment adjustments as the Secretary determines appropriate, such as a payment adjustment—

"(I) by a geographic index, such as the index referred to in paragraph (12)(D), as the Secretary determines to be appropriate;

"(II) for pediatric providers of services and renal dialysis facilities;

"(III) for low volume providers of services and renal dialysis facilities;

"(IV) for providers of services or renal dialysis facilities located in rural areas; and

"(V) for providers of services or renal dialysis facilities that are not large dialysis facilities.

"(E) The Secretary may provide for a phase-in of the payment system described in subparagraph (A) for services furnished by a provider of services or renal dialysis facility described in any of subclauses (II) through (V) of subparagraph (D)(iii), but such payment system shall be fully implemented for services furnished in the case of any such provider or facility on or after January 1, 2013.

"(F) The Secretary shall apply the annual increase that would otherwise apply under subparagraph (F) of paragraph (12) to payment amounts established under such paragraph (if this paragraph did not apply) in an appropriate manner under this paragraph.".

(b) PROHIBITION OF UNBUNDLING.—Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

(1) by striking "or" at the end of paragraph (21);

(2) by striking the period at the end of paragraph (22) and inserting "; or"; and

(3) by inserting after paragraph (22) the following new paragraph:

"(23) where such expenses are for renal dialysis services (as defined in subparagraph (B) of section 1881(b)(14)) for which payment is made under such section (other than under subparagraph (E) of such section) unless such payment is made under such section to a provider of services or a renal dialysis facility for such services.".

(c) QUALITY INCENTIVE PAYMENTS.—Section 1881 of such Act is amended by adding at the end the following new subsection:

"(i) QUALITY INCENTIVE PAYMENTS IN THE END-STAGE RENAL DISEASE PROGRAM.—

"(1) QUALITY INCENTIVE PAYMENTS FOR SERVICES FURNISHED IN 2008, 2009, AND 2010.—

"(A) IN GENERAL.—With respect to renal dialysis services furnished during a performance period (as defined in subparagraph (B)) by a provider of services or renal dialysis facility that the Secretary determines meets the applicable performance standard for the period under subparagraph (C) and reports on measures for 2009 and 2010 under subparagraph (D) for such services, in addition to the amount otherwise paid under this section, subject to subparagraph (G), there also shall be paid to the provider or facility an amount equal to the applicable percentage (specified in subparagraph (E) for the period) of the Secretary's estimate (based on claims submitted not later than two months after the end of the performance period) of the amount specified in subparagraph (F) for such period.

"(B) PERFORMANCE PERIOD.—In this paragraph, the term 'performance period' means each of the following:

"(i) The period beginning on July 1, 2008, and ending on December 31, 2008.

"(ii) 2009.

"(iii) 2010.

"(C) PERFORMANCE STANDARD.—

"(i) 2008.—For the performance period occurring in 2008, the applicable performance standards for a provider or facility under this subparagraph are—

"(I) 92 percent or more of individuals with end stage renal disease receiving erythopoetin stimulating agents who have an average hematocrit of 33.0 percent or more; and

"(II) less than a percentage, specified by the Secretary, of individuals with end stage renal disease receiving erythopoetin stimulating agents who have an average hematocrit of 39.0 percent or more.

"(ii) 2009 AND 2010.—For the 2009 and 2010 performance periods, the applicable performance standard for a provider or facility under this subparagraph is successful performance (relative to national average) on—

"(I) such measures of anemia management as the Secretary shall specify, including measures of hemoglobin levels or hematocrit levels for erythropoietin stimulating agents that are consistent with the labeling for dosage of erythropoietin stimulating agents approved by the Food and Drug Administration for treatment of anemia in patients with end stage renal disease, taking into account variations in hemoglobin ranges or hematocrit levels of patients; and

"(II) such other measures, relating to subjects described in subparagraph (D)(i), as the Secretary may specify.

"(D) REPORTING PERFORMANCE MEASURES.—The performance measures under this subparagraph to be reported shall include—

"(i) such measures as the Secretary specifies, before the beginning of the performance period involved and taking into account measures endorsed by the National Quality Forum, including, to the extent feasible measures on—

"(I) iron management;

"(II) dialysis adequacy; and

"(III) vascular access, including for maximizing the placement of arterial venous fistula; and

"(ii) to the extent feasible, such measure (or measures) of patient satisfaction as the Secretary shall specify.

The provider or facility submitting information on such measures shall attest to the completeness and accuracy of such information.

"(E) APPLICABLE PERCENTAGE.—The applicable percentage specified in this subparagraph for—

"(i) the performance period occurring in 2008, is 1.0 percent;

"(ii) the 2009 performance period, is 2.0 percent; and

"(iii) the 2010 performance period, is 3.0 percent.

In the case of any performance period which is less than an entire year, the applicable percentage specified in this subparagraph shall be multiplied by the ratio of the number of months in the year to the number of months in such performance period. In the case of 2010, the applicable percentage specified in this subparagraph shall be multiplied by the Secretary's estimate of the ratio of the aggregate payment amount described in subparagraph (F)(i) that would apply in 2010 if paragraph (14) did not apply, to the aggregate payment base under subparagraph (F)(ii) for 2010.

"(F) PAYMENT BASE.—The payment base described in this subparagraph for a provider or facility is—

"(i) for performance periods before 2010, the payment amount determined under paragraph (12) for services furnished by the provider or facility during the performance period, including the drug payment adjustment described in subparagraph (B)(ii) of such paragraph; and

"(ii) for the 2010 performance period is the amount determined under paragraph (14) for services furnished by the provider or facility during the period.

"(G) LIMITATION ON FUNDING.—

"(i) IN GENERAL.—If the Secretary determines that the total payments under this paragraph for a performance period is projected to exceed the dollar amount specified in clause (ii) for such period, the Secretary shall reduce, in a pro rata manner, the amount of such payments for each provider or facility for such period to eliminate any such projected excess for the period.

"(ii) DOLLAR AMOUNT.—The dollar amount specified in this clause—

"(I) for the performance period occurring in 2008, is $50,000,000;

"(II) for the 2009 performance period is $100,000,000; and

"(III) for the 2010 performance period is $150,000,000.

"(H) FORM OF PAYMENT.—The payment under this paragraph shall be in the form of a single consolidated payment.

"(2) QUALITY INCENTIVE PAYMENTS FOR FACILITIES AND PROVIDERS FOR 2011.—

"(A) INCREASED PAYMENT.—For 2011, in the case of a provider or facility that, for the performance period (as defined in subparagraph (B))—

"(i) meets (or exceeds) the performance standard for anemia management specified in paragraph (1)(C)(ii)(I);

"(ii) has substantially improved performance or exceeds a performance standard (as determined under subparagraph (E)); and

"(iii) reports measures specified in paragraph (1)(D),

with respect to renal dialysis services furnished by the provider or facility during the quality bonus payment period (as specified in subparagraph (C)) the payment amount otherwise made to such provider or facility under subsection (b)(14) shall be increased, subject to subparagraph (F), by the applicable percentage specified in subparagraph (D). Payment amounts under paragraph (1) shall not be counted for purposes of applying the previous sentence.

"(B) PERFORMANCE PERIOD.—In this paragraph, the term 'performance period' means a multi-month period specified by the Secretary.

"(C) QUALITY BONUS PAYMENT PERIOD.—In this paragraph, the term 'quality bonus payment period' means, with respect to a performance period, a multi-month period beginning on January 1, 2011, specified by the Secretary that begins at least 3 months (but not more than 9 months) after the end of the performance period.

"(D) APPLICABLE PERCENTAGE.—The applicable percentage specified in this subparagraph is a percentage, not to exceed the 4.0 percent, specified by the Secretary consistent with subparagraph (F). Such percentage may vary based on the level of performance and improvement. The applicable

percentage specified in this subparagraph shall be multiplied by the ratio applied under the third sentence of paragraph (1)(E) for 2010.

"(E) PERFORMANCE STANDARD.—Based on performance of a provider of services or a renal dialysis facility on performance measures described in paragraph (1)(D) for a performance period, the Secretary shall determine a composite score for such period.

"(F) LIMITATION ON FUNDING.—If the Secretary determines that the total amount to be paid under this paragraph for a quality bonus payment period is projected to exceed $200,000,000, the Secretary shall reduce, in a uniform manner, the applicable percentage otherwise applied under subparagraph (D) for services furnished during the period to eliminate any such projected excess.

"(3) APPLICATION.—

"(A) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement by program instruction or otherwise this subsection.

"(B) LIMITATIONS ON REVIEW.—

"(i) IN GENERAL.—There shall be no administrative or judicial review under section 1869 or 1878 or otherwise of—

"(I) the determination of performance measures and standards under this subsection;

"(II) the determination of successful reporting, including a determination of composite scores; and

"(III) the determination of the quality incentive payments made under this subsection.

"(ii) TREATMENT OF DETERMINATIONS.—A determination under this subparagraph shall not be treated as a determination for purposes of section 1869.

"(4) TECHNICAL ASSISTANCE.—The Secretary shall identify or establish an appropriately skilled group or organization, such as the ESRD Networks, to provide technical assistance to consistently low-performing facilities or providers that are in the bottom quintile.

"(5) PUBLIC REPORTING.—

"(A) ANNUAL NOTICE.—The Secretary shall provide an annual written notification to each individual who is receiving renal dialysis services from a provider of services or renal dialysis facility that—

"(i) informs such individual of the composite scores described in subparagraph (A) and other relevant quality measures with respect to providers of services or renal dialysis facilities in the local area;

"(ii) compares such scores and measures to the average local and national scores and measures; and

"(iii) provides information on how to access additional information on quality of such services furnished and options for alternative providers and facilities.

"(B) CERTIFICATES.—The Secretary shall provide certificates to facilities and providers who provide services to individuals with end-stage renal disease under this title to display in patient areas. The certificate shall indicate the composite score obtained by the facility or provider under the quality initiative.

"(C) WEB-BASED QUALITY LIST.—The Secretary shall establish a web-based list of facilities and providers who furnish renal dialysis services under this section that indicates their composite score of each provider and facility.

"(6) RECOMMENDATIONS FOR REPORTING AND QUALITY INCENTIVE INTITIATIVE FOR PHYSICIANS.—The Secretary shall develop recommendations for applying quality incentive payments under this subsection to physicians who receive the monthly capitated payment under this title. Such recommendations shall include the following:

"(A) Recommendations to include pediatric specific measures for physicians with at least 50 percent of their patients with end stage renal disease being individuals under 18 years of age.

"(B) Recommendations on how to structure quality incentive payments for physicians who demonstrate improvements in quality or who attain quality standards, as specified by the Secretary.

"(7) REPORTS.—

"(A) INITIAL REPORT.—Not later than January 1, 2013, the Secretary shall submit to Congress a report on the implementation of the bundled payment system under subsection (b)(14) and the quality initiative under this subsection. Such report shall include the following information:

"(i) A comparison of the aggregate payments under subsection (b)(14) for items and services to the cost of such items and services.

"(ii) The changes in utilization rates for erythropoietin stimulating agents.

"(iii) The mode of administering such agents, including information on the proportion of such individuals receiving such agents intravenously as compared to subcutaneously.

"(iv) The frequency of dialysis.

"(v) Other differences in practice patterns, such as the adoption of new technology, different modes of practice, and variations in use of drugs other than drugs described in clause (iii).

"(vi) The performance of facilities and providers under paragraph (2).

"(vii) Other recommendations for legislative and administrative actions determined appropriate by the Secretary.

"(B) SUBSEQUENT REPORT.—Not later than January 1, 2015, the Secretary shall submit to Congress a report that contains the information described in each of clauses (ii) through (vii) of subparagraph (A) and a comparison of the results of the payment system under subsection (b)(14) for renal dialysis services furnished during the 2-year period beginning on January 1, 2013, and the results of such payment system for such services furnished during the previous two-year period.".

SEC. 638. MEDPAC REPORT ON ESRD BUNDLING SYSTEM.

Not later than March 1, 2012, the Medicare Payment Advisory Commission (established under section 1805 of the Social Security Act) shall submit to Congress a report on the implementation of the payment system under section 1881(b)(14) of the Social Security Act (as added by section 7) for renal dialysis services and related services (defined in subparagraph (B) of such section). Such report shall include, with respect to such payment system for such services, an analysis of each of the following:

(1) An analysis of the overall adequacy of payment under such system for all such services.

(2) An analysis that compares the adequacy of payment under such system for services furnished by—

(A) a provider of services or renal dialysis facility that is described in section 1881(b)(13)(C)(iv) of the Social Security Act;

(B) a provider of services or renal dialysis facility not described in such section;

(C) a hospital-based facility;

(D) a freestanding renal dialysis facility;

(E) a renal dialysis facility located in an urban area; and

(F) a renal dialysis facility located in a rural area.

(3) An analysis of the financial status of providers of such services and renal dialysis facilities, including access to capital, return on equity, and return on capital.

(4) An analysis of the adequacy of payment under such method and the adequacy of the quality improvement payments under section 1881(i) of the Social Security Act in ensuring that payments for such services under the Medicare program are consistent with costs for such services.

(5) Recommendations, if appropriate, for modifications to such payment system.

SEC. 639. OIG STUDY AND REPORT ON ERYTHROPOIETIN.

(a) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct a study on the following:

(1) The dosing guidelines, standards, protocols, and alogorithms for erythropoietin stimulating agents recommended or used by providers of services and renal dialysis facilities that are described in section 1881(b)(13)(C)(iv) of the Social Security Act and providers and facilities that are not described in such section.

(2) The extent to which such guidelines, standards, protocols, and algorithms are consistent with the labeling of the Food and Drug Administration for such agents.

(3) The extent to which physicians sign standing orders for such agents that are consistent with such guidelines, standards, protocols, and algorithms recommended or used by the provider or facility involved.

(4) The extent to which the prescribing decisions of physicians, with respect to such agents, are independent of—

(A) such relevant guidelines, standards, 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

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

"(C) if the entity is a hospital, the hospital meets the requirements of paragraph (3)(D).";

(2) in subsection (d)(3)—

(A) in subparagraph (B), by striking "and" at the end;

(B) in subparagraph (C), by striking the period at the end and inserting "; and"; and

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

"(D) the hospital meets the requirements described in subsection (i)(1) not later than 18 months after the date of the enactment of this subparagraph."; and

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

"(i) REQUIREMENTS FOR HOSPITALS TO QUALIFY FOR HOSPITAL EXCEPTION TO OWNERSHIP OR INVESTMENT PROHIBITION.—

"(1) REQUIREMENTS DESCRIBED.—For purposes of paragraphs subsection (d)(3)(D), the requirements described in this paragraph for a hospital are as follows:

"(A) PROVIDER AGREEMENT.—The hospital had a provider agreement under section 1866 in effect on July 24, 2007.

"(B) PROHIBITION OF EXPANSION OF FACILITY CAPACITY.—The number of operating rooms and beds of the hospital at any time on or after the date of the enactment of this subsection are no greater than the number of operating rooms and beds as of such date.

"(C) PREVENTING CONFLICTS OF INTEREST.—

"(i) The hospital submits to the Secretary an annual report containing a detailed description of—

"(I) the identity of each physician owner and any other owners of the hospital; and

"(II) the nature and extent of all ownership interests in the hospital.

"(ii) The hospital has procedures in place to require that any referring physician owner discloses to the patient being referred, by a time that permits the patient to make a meaningful decision regarding the receipt of care, as determined by the Secretary—

"(I) the ownership interest of such referring physician in the hospital; and

"(II) if applicable, any such ownership interest of the treating physician.

"(iii) The hospital does not condition any physician ownership interests either directly or indirectly on the physician owner making or influencing referrals to the hospital or otherwise generating business for the hospital.

"(D) ENSURING BONA FIDE INVESTMENT.—

"(i) Physician owners in the aggregate do not own more than 40 percent of the total value of the investment interests held in the hospital or in an entity whose assets include the hospital.

"(ii) The investment interest of any individual physician owner does not exceed 2 percent of the total value of the investment interests held in the hospital or in an entity whose assets include the hospital.

"(iii) Any ownership or investment interests that the hospital offers to a physician owner are not offered on more favorable terms than the terms offered to a person who is not a physician owner.

"(iv) The hospital does not directly or indirectly provide loans or financing for any physician owner investments in the hospital.

"(v) The hospital does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any individual physician owner or group of physician owners that is related to acquiring any ownership interest in the hospital.

"(vi) Investment returns are distributed to investors in the hospital in an amount that is directly proportional to the investment of capital by the physician owner in the hospital.

"(vii) Physician owners do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other investors in the hospital or located near the premises of the hospital.

"(viii) The hospital does not offer a physician owner the opportunity to purchase or lease any property under the control of the hospital or any other investor in the hospital on more favorable terms than the terms offered to an individual who is not a physician owner.

"(E) PATIENT SAFETY.—

"(i) Insofar as the hospital admits a patient and does not have any physician available on the premises to provide services during all hours in which the hospital is providing services to such patient, before admitting the patient—

"(I) the hospital discloses such fact to a patient; and

"(II) following such disclosure, the hospital receives from the patient a signed acknowledgment that the patient understands such fact.

"(ii) The hospital has the capacity to—

"(I) provide assessment and initial treatment for patients; and

"(II) refer and transfer patients to hospitals with the capability to treat the needs of the patient involved.

"(2) PUBLICATION OF INFORMATION REPORTED.—The Secretary shall publish, and update on an annual basis, the information submitted by hospitals under paragraph (1)(C)(i) on the public Internet website of the Centers for Medicare & Medicaid Services.

"(3) COLLECTION OF OWNERSHIP AND INVESTMENT INFORMATION.—For purposes of clauses (i) and (ii) of paragraph (1)(D), the Secretary shall collect physician ownership and investment information for each hospital as it existed on the date of the enactment of this subsection.

"(4) PHYSICIAN OWNER DEFINED.—For purposes of this subsection, the term 'physician owner' 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 VII—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 visits beginning on or after January 1, 2008, and before January 1, 2010".

SEC. 703. EXTENSION OF MEDICARE SECONDARY PAYER FOR BENEFICIARIES WITH END STAGE RENAL DISEASE FOR LARGE GROUP PLANS.

(a) IN GENERAL.—Section 1862(b)(1)(C) of the Social Security Act (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) by redesignating clauses (i) and (ii) as subclauses (I) and (II), respectively, and indenting accordingly;

(2) by amending the text preceding subclause (I), as so redesignated, to read as follows:

"(C) INDIVIDUALS WITH END STAGE RENAL DISEASE.—

"(i) IN GENERAL.—A group health plan (as defined in subparagraph (A)(v))—";

(3) in the matter following subclause (II), as so redesignated—

(A) by striking "clause (i)" and inserting "subclause (I)";

(B) by striking "clause (ii)" and inserting "subclause (II)"; and

(C) by striking "clauses (i) and (ii)" and inserting "subclauses (I) and (II)"; and

(D) in the last sentence, by striking "Effective for items" and inserting "Subject to clause (ii), effective for items"; and

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

"(ii) SPECIAL RULE FOR LARGE GROUP PLANS.—In applying clause (i) to a large group health plan (as defined in subparagraph (B)(iii)). effective for items and services furnished on or after January 1, 2008, (with respect to periods beginning on or after the date that is 30 months prior to January 1, 2008), subclauses (I) and (II) of such clause shall be applied by substituting '42-month' for '12-month' each place it appears.".

SEC. 704. PLAN FOR MEDICARE PAYMENT ADJUSTMENTS FOR NEVER EVENTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the "Secretary") shall develop a plan (in this section referred to as the "never events plan") to implement, beginning in fiscal year 2010, a policy to reduce or eliminate payments under title XVIII of the Social Security Act for never events.

(b) NEVER EVENT DEFINED.—For purposes of this section, the term "never event" means an event involving the delivery of (or failure to deliver) physicians' services, inpatient or outpatient hospital services, or facility services furnished in an ambulatory surgical facility in which there is an error in medical care that is clearly identifiable, usually preventable, and serious in consequences to patients, and that indicates a deficiency in the safety and process controls of the services furnished with respect to the physician, hospital, or ambulatory surgical center involved.

(c) PLAN DETAILS.—

(1) DEFINING NEVER EVENTS.—With respect to criteria for identifying never events under the never events plan, the Secretary should consider whether the event meets the following characteristics:

(A) CLEARLY IDENTIFIABLE.—The event is clearly identifiable and measurable and feasible to include in a reporting system for never events.

(B) USUALLY PREVENTABLE.—The event is usually preventable taking into consideration that, because of the complexity of medical care, certain medical events are not always avoidable.

(C) SERIOUS.—The event is serious and could result in death or loss of a body part, disability, or more than transient loss of a body function.

(D) DEFICIENCY IN SAFETY AND PROCESS CONTROLS.—The event is indicative of a problem in safety systems and process controls used by the physi-

cian, hospital, or ambulatory surgical center involved and is indicative of the reliability of the quality of services provided by the physician, hospital, or ambulatory surgical center, respectively.

(2) IDENTIFICATION AND PAYMENT ISSUES.—With respect to policies under the never events plan for identifying and reducing (or eliminating) payment for never events, the Secretary shall consider—

(A) mechanisms used by hospitals and physicians in reporting and coding of services that would reliably identify never events; and

(B) modifications in billing and payment mechanisms that would enable the Secretary to efficiently and accurately reduce or eliminate payments for never events.

(3) PRIORITIES.—Under the never events plan the Secretary shall identify priorities regarding the services to focus on and, among those, the never events for which payments should be reduced or eliminated.

(4) CONSULTATION.—In developing the never events plan, the Secretary shall consult with affected parties that are relevant to payment reductions in response to never events.

(d) CONGRESSIONAL REPORT.—By not later than June 1, 2008, the Secretary shall submit a report to Congress on the never events plan developed under this subsection and shall include in the report recommendations on specific methods for implementation of the plan on a timely basis.

SEC. 705. REINSTATEMENT OF RESIDENCY SLOTS.

(a) IN GENERAL.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(H), by adding at the end the following new clause:

"(v) INCREASE IN RESIDENT LIMIT DUE TO CLOSURE OF OTHER HOSPITALS.—If one or more hospitals with approved medical residency training programs, which are located within the same metropolitan division of the core based statistical area as of January 1, 2001, closed, the Secretary shall increase by not more than 10 (subject to the limitation set forth in the last sentence of this clause) the otherwise applicable resident limit under subparagraph (F) for each hospital within the same metropolitan division of the core based statistical area that meets all the following criteria:

"(I) The hospital is described in subsection (d)(5)(F)(i).

"(II) The hospital instituted a medical residency training program in internal medicine that was accredited by the American Osteopathic Association on or after January 1, 2004.

"(III) The hospital had a provider number and a resident limit as of January 1, 2000, and remained open as of October 1, 2007.

"(IV) The hospital did not receive an increase in its resident limit under paragraph (7)(B).

In no event may the resident limit for any hospital be increased above 50 through application of this clause and in no event may the total of the residency positions added by this clause for all hospitals exceed 10."; 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 VIII—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".

(2) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on October 1, 2007.

(b) STATE OPTION OF INITIAL 12-MONTH ELIGIBILITY.—Section 1925 of the Social Security Act (42 U.S.C. 1396r–6) is amended—

(1) in subsection (a)(1), by inserting "but subject to paragraph (5)" after "Notwithstanding any other provision of this title";

(2) by adding at the end of subsection (a) the following:

"(5) OPTION OF 12-MONTH INITIAL ELIGIBILITY PERIOD.—A State may elect to treat any reference in this subsection to a 6-month period (or 6 months) as a reference to a 12-month period (or 12 months). In the case of such an election, subsection (b) shall not apply."; and

(3) in subsection (b)(1), by inserting "but subject to subsection (a)(5)" after "Notwithstanding any other provision of this title".

(c) REMOVAL OF REQUIREMENT FOR PREVIOUS RECEIPT OF MEDICAL ASSISTANCE.—Section 1925(a)(1) of such Act (42 U.S.C. 1396r–6(a)(1)), as amended by subsection (b)(1), is further amended—

(1) by inserting "subparagraph (B) and" before "paragraph (5)";

(2) by redesignating the matter after "REQUIREMENT.—" as a subparagraph (A) with the heading "IN GENERAL.—" and with the same indentation as subparagraph (B) (as added by paragraph (3)); and

(3) by adding at the end the following:

"(B) STATE OPTION TO WAIVE REQUIREMENT FOR 3 MONTHS BEFORE RECEIPT OF MEDICAL ASSISTANCE.—A State may, at its option, elect also to apply subparagraph (A) in the case of a family that was receiving such aid for fewer than three months or that had applied for and was eligible for such aid for fewer than 3 months during the 6 immediately preceding months described in such subparagraph.".

(d) CMS REPORT ON ENROLLMENT AND PARTICIPATION RATES UNDER TMA.—Section 1925 of such Act (42 U.S.C. 1396r–6), as amended by this section, is further amended by adding at the end the following new subsection:

"(g) COLLECTION AND REPORTING OF PARTICIPATION INFORMATION.—

"(1) COLLECTION OF INFORMATION FROM STATES.—Each State shall collect and submit to the Secretary (and make publicly available), in a format specified by the Secretary, information on average monthly enrollment and average monthly participation rates for adults and children under this section and of the number and percentage of children who become ineligible for medical assistance under this section whose medical assistance is continued under another eligibility category or who are enrolled under the State's child health plan under title XXI. Such information shall be submitted at the same time and frequency in which other enrollment information under this title is submitted to the Secretary.

"(2) ANNUAL REPORTS TO CONGRESS.—Using the information submitted under paragraph (1), the Secretary shall submit to Congress annual reports concerning enrollment and participation rates described in such paragraph.".

(e) EFFECTIVE DATE.—The amendments made by subsections (b) through (d) shall take effect on the date of the enactment of this Act.

SEC. 802. FAMILY PLANNING SERVICES.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(A) in subclause (XVIII), by striking "or" at the end;

(B) in subclause (XIX), by adding "or" at the end; and

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

"(XX) who are described in subsection (ee) (relating to individuals who meet certain income standards);".

(2) GROUP DESCRIBED.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by section 112(c), is amended by adding at the end the following new subsection:

"(ee)(1) Individuals described in this subsection are individuals—

"(A) whose income does not exceed an income eligibility level established by the State that does not exceed the highest income eligibility level established under the State plan under this title (or under its State child health plan under title XXI) for pregnant women; and

"(B) who are not pregnant.

"(2) At the option of a State, individuals described in this subsection may include individuals who are determined to meet the eligibility requirements referred to in paragraph (1) under the terms, conditions, and procedures applicable to making eligibility determinations for medical assistance under this title under a waiver to provide the benefits described in clause (XV) of the matter following subparagraph (G) of section 1902(a)(10) granted to the State under section 1115 as of January 1, 2007.".

(3) LIMITATION ON BENEFITS.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G)—

(A) by striking "and (XIV)" and inserting "(XIV)"; and

(B) by inserting ", and (XV) the medical assistance made available to an individual described in subsection (ee) shall be limited to family planning services and supplies described in section 1905(a)(4)(C) including medical diagnosis or treatment services that are provided pursuant to a family planning service in a family 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 (xiii), 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 1902(ee), such medical assistance shall be limited to family planning services and supplies described in 1905(a)(4)(C) and, at the State's option, medical diagnosis or treatment services that are provided in conjunction with a family planning service in a family planning setting provided during the period in which such an individual is eligible.

"(b) DEFINITIONS.—For purposes of this section:

"(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The term 'presumptive eligibility period' means, with respect to an individual described in subsection (a), the period that—

"(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(ee); and

"(B) ends with (and includes) the earlier of—

"(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

"(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

"(2) QUALIFIED ENTITY.—

"(A) IN GENERAL.—Subject to subparagraph (B), the term 'qualified entity' means any entity that—

"(i) is eligible for payments under a State plan approved under this title; and

"(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

"(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities in order to prevent fraud and abuse.

"(c) ADMINISTRATION.—

"(1) IN GENERAL.—The State agency shall provide qualified entities with—

"(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

"(B) information on how to assist such individuals in completing and filing such forms.

"(2) NOTIFICATION REQUIREMENTS.—A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

"(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

"(B) inform such individual at the time the determination is made that an application for medical assistance is required to be made by not later than the last day of the month following the month during which the determination is made.

"(3) APPLICATION FOR MEDICAL ASSISTANCE.—In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance by not later than the last day of the month following the month during which the determination is made.

"(d) PAYMENT.—Notwithstanding any other provision of this title, medical assistance that—

"(1) is furnished to an individual described in subsection (a)—

"(A) during a presumptive eligibility period;

"(B) by a entity that is eligible for payments under the State plan; and

"(2) is included in the care and services covered by the State plan, shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b).".

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)) is amended by inserting before the semicolon at the end the following: "and provide for making medical assistance available to individuals described in subsection (a) of section 1920C during a presumptive eligibility period in accordance with such section".

(B) Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)(v)) is amended—

(i) by striking "or for" and inserting "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.

SEC. 803. AUTHORITY TO CONTINUE PROVIDING ADULT DAY HEALTH SERVICES APPROVED UNDER A STATE MEDICAID PLAN.

(a) IN GENERAL.—During the period described in subsection (b), the Secretary of Health and Human Services shall not—

(1) withhold, suspend, disallow, or otherwise deny Federal financial participation under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) for the provision of adult day health care services, day activity and health services, or adult medical day care services, as defined under a State Medicaid plan approved during or before 1994, during such period if such services are provided consistent with such definition and the requirements of such plan; or

(2) withdraw Federal approval of any such State plan or part thereof regarding the provision of such services (by regulation or otherwise).

(b) PERIOD DESCRIBED.—The period described in this subsection is the period that begins on November 3, 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.

"(B) VIRGIN ISLANDS.—For the Virgin Islands, $5,000,000 for each of fiscal years 2009 through 2012.

"(C) GUAM.—For Guam, $5,000,000 for each of fiscal years 2009 through 2012.

"(D) NORTHERN MARIANA ISLANDS.—For the Northern Mariana Islands, $4,000,000 for each of fiscal years 2009 through 2012.

"(E) AMERICAN SAMOA.—For American Samoa, $4,000,000 for each of fiscal years 2009 through 2012.

Such amounts shall not be taken into account in applying paragraph (2) for fiscal years 2009 through 2012 but shall be taken into account in applying such paragraph for fiscal year 2013 and subsequent fiscal years.".

(b) REMOVAL OF FEDERAL MATCHING PAYMENTS FOR IMPROVING DATA REPORTING SYSTEMS FROM THE OVERALL LIMIT ON PAYMENTS TO TERRITORIES UNDER TITLE XIX.—Such section is further amended by adding at the end the following new paragraph:

"(5) EXCLUSION OF CERTAIN EXPENDITURES FROM PAYMENT LIMITS.—With respect to fiscal year 2008 and each fiscal year thereafter, if Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa qualify for a payment under subparagraph (A)(i) or (B) of section 1903(a)(3) for a calendar quarter of such fiscal year with respect to expenditures for improvements in data reporting systems described in such subparagraph, the limitation on expenditures under title XIX for such commonwealth or territory otherwise determined under subsection (f) and this subsection for such fiscal year shall be determined without regard to payment for such expenditures.".

SEC. 812. MEDICAID DRUG REBATE.

(a) BRAND.—Paragraph (1)(B)(i) of section 1927(c) of the Social Security Act (42 U.S.C. 1396r–8(c)) is amended—

(1) by striking "and" at the end of subclause (IV);

(2) in subclause (V)—

(A) by inserting "and before January 1, 2008," after "December 31, 1995,"; and

(B) by striking the period at the end and inserting "; and"; and

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

"(VI) after December 31, 2007, is 20.1 percent.".

(b) PBMs TO BEST PRICE DEFINITION.—

(1) IN GENERAL.—Section 1927(c)(1)(C)(ii)(I) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)(ii)(I)) is amended—

(A) by striking "and" before "rebates"; and

(B) by inserting before the semicolon at the end the following: ", and rebates, discounts, and other price concessions to pharmaceutical benefit managers (PBMs)".

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to calendar quarters beginning on or after January 1, 2008.

SEC. 813. ADJUSTMENT IN COMPUTATION OF MEDICAID FMAP TO DISREGARD AN EXTRAORDINARY EMPLOYER PENSION CONTRIBUTION.

(a) IN GENERAL.—Only for purposes of computing the Federal medical assistance percentage under section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) for a State for a fiscal year (beginning with fiscal year 2006), any significantly disproportionate employer pension contribution described in subsection (b) shall be disregarded in computing the per capita income of such State, but shall not be disregarded in computing the per capita income for the continental United States (and Alaska) and Hawaii.

(b) SIGNIFICANTLY DISPROPORTIONATE EMPLOYER PENSION CONTRIBUTION.—For purposes of subsection (a), a significantly disproportionate employer pension contribution described in this subsection with respect to a State for a fiscal year is an employer contribution towards pensions that is allocated to such State for a period if the aggregate amount so allocated exceeds 25 percent of the total increase in personal income in that State for the period involved.

SEC. 814. MORATORIUM ON CERTAIN PAYMENT RESTRICTIONS.

Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not, prior to the date that is 1 year after the date of enactment of this Act, take any action (through promulgation of regulation, issuance of regulatory guidance, use of federal payment audit procedures, or other administrative action, policy, or practice, including a Medical Assistance Manual transmittal or letter to State Medicaid directors) to restrict coverage or payment under title XIX of the Social Security Act for rehabilitation services, or school-based administration, transportation, or medical services if such restrictions are more restrictive in any aspect than those applied to such coverage or payment as of July 1, 2007.

SEC. 815. TENNESSEE DSH.

The DSH allotments for Tennessee for each fiscal year beginning with fiscal year 2008 under subsection (f)(3) of section 1923 of the Social Security Act (42 U.S.C. 13961396r–4) are deemed to be $30,000,000. The Secretary of Health and Human Services may impose a limitation on the total amount of payments made to hospitals under the TennCare Section 1115 waiver only to the extent that such limitation is necessary to ensure that a hospital does not receive payment in excess of the amounts described in subsection (f) of such section or as necessary to ensure that the waiver remains budget neutral.

SEC. 816. CLARIFICATION TREATMENT OF REGIONAL MEDICAL CENTER.

(a) IN GENERAL.—Nothing in section 1903(w) of the Social Security Act (42 U.S.C. 1396b(w)) shall be construed by the Secretary of Health and Human Services as prohibiting a State's use of funds as the non-Federal share of expenditures under title XIX of such Act where such funds are transferred from or certified by a publicly-owned regional medical center located in another State and described in subsection (b), so long as the Secretary determines that such use of funds is proper and in the interest of the program under title XIX.

(b) CENTER DESCRIBED.—A center described in this subsection is a publicly-owned regional medical center that—

(1) provides level 1 trauma and burn care services;

(2) provides level 3 neonatal care services;

(3) is obligated to serve all patients, regardless of ability to pay;

(4) is located within a Standard Metropolitan Statistical Area (SMSA) that includes at least 3 States;

(5) provides services as a tertiary care provider for patients residing within a 125-mile radius; and

(6) meets the criteria for a disproportionate share hospital under section 1923 of such Act (42 U.S.C. 1396r–4) in at least one State other than the State in which the center is located.

Subtitle C—Miscellaneous

SEC. 821. DEMONSTRATION PROJECT FOR EMPLOYER BUY-IN.

Title XXI of the Social Security Act, as amended by section 133(a)(1), is further amended by adding at the end the following new section:

"SEC. 2112. DEMONSTRATION PROJECT FOR EMPLOYER BUY-IN.

"(a) AUTHORITY.—

"(1) IN GENERAL.—The Secretary shall establish a demonstration project under which up to 10 States (each referred to in this section as a 'participating State') that meets the conditions of paragraph (2) may provide, under its State child health plan (notwithstanding section 2102(b)(3)(C)) for a period of 5 years, for child health assistance in relation to family coverage described in subsection (d) for children who would be targeted low-income children but for coverage as beneficiaries under a group health plan as the children of participants by virtue of a qualifying employer's contribution under subsection (b)(2).

"(2) CONDITIONS.—The conditions described in this paragraph for a State are as follows:

"(A) NO WAITING LISTS.—The State does not impose any waiting list, enrollment cap, or similar limitation on enrollment of targeted low-income children under the State child health plan.

"(B) ELIGIBILITY OF ALL CHILDREN UNDER 200 PERCENT OF POVERTY LINE.—The State is applying an income eligibility level under section 2110(b)(1)(B)(ii)(I) that is at least 200 percent of the poverty line.

"(3) QUALIFYING EMPLOYER DEFINED.—In this section, the term 'qualifying employer' means an employer that has a majority of its workforce composed of full-time workers with family incomes reasonably estimated by the employer (based on wage information available to the employer) at or below 200 percent of the poverty line. In applying the previous sentence, two part-time workers shall be treated as a single full-time worker.

"(b) FUNDING.—A demonstration project under this section in a participating State shall be funded, with respect to assistance provided to children described in subsection (a)(1), consistent with the following:

"(1) LIMITED FAMILY CONTRIBUTION.—The family involved shall be responsible for providing payment towards the premium for such assistance of such amount as the State may specify, except that the limitations on cost-sharing (including premiums) under paragraphs (2) and (3) of section 2103(e) shall apply to all cost-sharing of such family under this section.

"(2) MINIMUM EMPLOYER CONTRIBUTION.—The qualifying employer involved shall be responsible for providing payment to the State child health plan in the State of at least 50 percent of the portion of the cost (as determined by the State) of the family coverage in which the employer is enrolling the family that exceeds the amount of the family contribution under paragraph (1) applied towards such coverage.

"(3) LIMITATION ON FEDERAL FINANCIAL PARTICIPATION.—In no case shall the Federal financial participation under section 2105 with respect to a demonstration project under this section be made for any portion of the costs of family coverage described in subsection (d) (including the costs of administration of such coverage) that are not attributable to children described in subsection (a)(1).

"(c) UNIFORM ELIGIBILITY RULES.—In providing assistance under a demonstration project under this section—

"(1) a State shall establish uniform rules of eligibility for families to participate; and

"(2) a State shall not permit a qualifying employer to select, within those families that meet such eligibility rules, which families may participate.

"(d) TERMS AND CONDITIONS.—The family coverage offered to families of qualifying employers under a demonstration project under this section in a State shall be the same as the coverage and benefits provided under the State child health plan in the State for targeted low-income children with the highest family income level permitted.".

SEC. 822. DIABETES GRANTS.

Section 2104 of the Social Security Act (42 U.S.C 1397dd), as amended by section 101, is further amended—

(1) in subsection (a)(11), by inserting before the period at the end the following: "plus for fiscal year 2009 the total of the amount specified in subsection (j)"; and

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

"(j) FUNDING FOR DIABETES GRANTS.—From the amounts appropriated under subsection (a)(11), for fiscal year 2009 from the amounts—

"(1) $150,000,000 is hereby transferred and made available in such fiscal year for grants under section 330B of the Public Health Service Act; and

"(2) $150,000,000 is hereby transferred and made available in such fiscal year for grants under 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 IX—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.

SEC. 903. REPEAL OF COMPARATIVE COST ADJUSTMENT (CCA) PROGRAM.

Section 1860C–1 of the Social Security Act (42 U.S.C. 1395w–29), as added by section 241(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173), is repealed.

SEC. 904. COMPARATIVE EFFECTIVENESS RESEARCH.

(a) IN GENERAL.—Part A of title XVIII of the Social Security Act is amended by adding at the end the following new section:

"COMPARATIVE EFFECTIVENESS RESEARCH

"SEC. 1822. (a) CENTER FOR COMPARATIVE EFFECTIVENESS RESEARCH ESTABLISHED.—

"(1) IN GENERAL.—The Secretary shall establish within the Agency of Healthcare Research and Quality a Center for Comparative Effectiveness Research (in this section referred to as the 'Center') to conduct, support, and synthesize research (including research conducted or supported under section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically.

"(2) DUTIES.—The Center shall—

"(A) conduct, support, and synthesize research relevant to the comparative clinical effectiveness of the full spectrum of health care treatments, including pharmaceuticals, medical devices, medical and surgical procedures, and other medical interventions;

"(B) conduct and support systematic reviews of clinical research, including original research conducted subsequent to the date of the enactment of this section;

"(C) use methodologies such as randomized controlled clinical trials as well as other various types of clinical research, such as observational studies;

"(D) submit to the Comparative Effectiveness Research Commission, the Secretary, and Congress appropriate relevant reports described in subsection (d)(2);

"(E) encourage, as appropriate, the development and use of clinical registries and the development of clinical effectiveness research data networks from electronic health records, post marketing drug and medical device surveillance efforts, and other forms of electronic health data; and

"(F) not later than 180 days after the date of the enactment of this section, develop methodological standards to be used when conducting studies of comparative clinical effectiveness and value (and procedures for use of such standards) in order to help ensure accurate and effective comparisons and update such standards at least biennially.

"(b) OVERSIGHT BY COMPARATIVE EFFECTIVENESS RESEARCH COMMISSION.—

"(1) IN GENERAL.—The Secretary shall establish an independent Comparative Effectiveness Research Commission (in this section referred to as the 'Commission') to oversee and evaluate the activities carried out by the Center under subsection (a) to ensure such activities result in highly credible research and information resulting from such research.

"(2) DUTIES.—The Commission shall—

"(A) determine national priorities for research described in subsection (a) and in making such determinations consult with patients and health care providers and payers;

"(B) monitor the appropriateness of use of the CERTF described in subsection (f) with respect to the timely production of comparative effectiveness research determined to be a national priority under subparagraph (A);

"(C) identify highly credible research methods and standards of evidence for such research to be considered by the Center;

"(D) review and approve the methodological standards (and updates to such standards) developed by the Center under subsection (a)(2)(F);

"(E) enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences shall conduct an evaluation and report on standards of evidence for such research;

"(F) support forums to increase stakeholder awareness and permit stakeholder feedback on the efforts of the Agency of Healthcare Research and Quality to advance methods and standards that promote highly credible research;

"(G) make recommendations for public data access policies of the Center that would allow for access of such data by the public while ensuring the information produced from research involved is timely and credible;

"(H) appoint a clinical perspective advisory panel for each research priority determined under subparagraph (A), which shall frame the specific research inquiry to be examined with respect to such priority to ensure that the information produced from such research is clinically relevant to decisions made by clinicians and patients at the point of care;

"(I) make recommendations for the priority for periodic reviews of previous comparative effectiveness research and studies conducted by the Center under subsection (a);

"(J) routinely review processes of the Center with respect to such research to confirm that the information produced by such research is objective, credible, consistent with standards of evidence established under this section, and developed through a transparent process that includes consultations with appropriate stakeholders;

"(K) at least annually, provide guidance or recommendations to health care providers and consumers for the use of information on the comparative effectiveness of health care services by consumers, providers (as defined for purposes of regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996) and public and private purchasers;

"(L) make recommendations for a strategy to disseminate the findings of research conducted and supported under this section that enables clinicians to improve performance, consumers to make more informed health care decisions, and payers to set medical policies that improve quality and value;

"(M) provide for the public disclosure of relevant reports described in subsection (d)(2); and

"(N) submit to Congress an annual report on the progress of the Center in achieving national priorities determined under subparagraph (A) for the provision of credible comparative effectiveness information produced from such research to all interested parties.

"(3) COMPOSITION OF COMMISSION.—

"(A) IN GENERAL.—The members of the Commission shall consist of—

"(i) the Director of the Agency for Healthcare Research and Quality;

"(ii) the Chief Medical Officer of the Centers for Medicare & Medicaid Services; and

"(iii) up to 15 additional members who shall represent broad constituencies of stakeholders including clinicians, patients, researchers, third-party payers, consumers of Federal and State beneficiary programs.

"(B) QUALIFICATIONS.—

"(i) DIVERSE REPRESENTATION OF PERSPECTIVES.—The members of the Commission shall represent a broad range of perspectives and shall collectively have experience in the following areas:

"(I) Epidemiology.

"(II) Health services research.

"(III) Bioethics.

"(IV) Decision sciences.

"(V) Economics.

"(ii) DIVERSE REPRESENTATION OF HEALTH CARE COMMUNITY.—At least one member shall represent each of the following health care communities:

"(I) Consumers.

"(II) Practicing physicians, including surgeons.

"(III) Employers.

"(IV) Public payers.

"(V) Insurance plans.

"(VI) Clinical researchers who conduct research on behalf of pharmaceutical or device manufacturers.

"(4) APPOINTMENT.—The Comptroller General of the United States, in consultation with the chairs of the committees of jurisdiction of the House of Representatives and the Senate, shall appoint the members of the Commission.

"(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General of the United States shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship 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.

"(9) COMPENSATION.—While serving on the business of the Commission (including traveltime), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Director of the Commission.

"(10) 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.

"(11) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Secretary, in consultation with the Comptroller General deems necessary to assure the efficient administration of the Commission, the Commission may—

"(A) employ and fix the compensation of an Executive Director (subject to the approval of the Secretary, in consultation with the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

"(B) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

"(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

"(D) make advance, progress, and other payments which relate to the work of the Commission;

"(E) provide transportation and subsistence for persons serving without compensation; and

"(F) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

"(12) POWERS.—

"(A) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Executive Director, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

"(B) DATA COLLECTION.—In order to carry out its functions, the Commission shall—

"(i) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

"(ii) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate, and

"(iii) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

"(C) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data of the Commission, immediately upon request.

"(D) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the Comptroller General.

"(c) RESEARCH REQUIREMENTS.—Any research conducted, supported, or synthesized under this section shall meet the following requirements:

"(1) ENSURING TRANSPARENCY, CREDIBILITY, AND ACCESS.—

"(A) The establishment of the agenda and conduct of the research shall be insulated from inappropriate political or stakeholder influence.

"(B) Methods of conducting such research shall be scientifically based.

"(C) All aspects of the prioritization of research, conduct of the research, and development of conclusions based on the research shall be transparent to all stakeholders.

"(D) The process and methods for conducting such research shall be publicly documented and available to all stakeholders.

"(E) Throughout the process of such research, the Center shall provide opportunities for all stakeholders involved to review and provide comment on the methods and findings of such research.

"(2) USE OF CLINICAL PERSPECTIVE ADVISORY PANELS.—The research shall meet a national research priority determined under subsection (b)(2)(A) and shall examine the specific research inquiry framed by the clinical perspective advisory panel for the national research priority.

"(3) STAKEHOLDER INPUT.—The priorities of the research, the research, and the dissemination of the research shall involve the consultation of patients, health care providers, and health care consumer representatives through transparent mechanisms recommended by the Commission.

"(d) PUBLIC ACCESS TO COMPARATIVE EFFECTIVENESS INFORMATION.—

"(1) IN GENERAL.—Not later than 90 days after receipt by the Center or Commission, as applicable, of a relevant report described in paragraph (2) made by the Center, Commission, or clinical perspective advisory panel under this section, appropriate information contained in such report shall be posted on the official public Internet site of the Center and of the Commission, as applicable.

"(2) RELEVANT REPORTS DESCRIBED.—For purposes of this section, a relevant report is each of the following submitted by a grantee or contractor of the Center:

"(A) An interim progress report.

"(B) A draft final comparative effectiveness review.

"(C) A final progress report on new research submitted for publication by a peer review journal.

"(D) Stakeholder comments.

"(E) A final report.

"(3) ACCESS BY CONGRESS AND THE COMMISSION TO THE CENTER'S INFORMATION.—Congress and the Commission shall each have unrestricted access to all

deliberations, records, and nonproprietary data of the Center, immediately upon request.

"(e) DISSEMINATION AND INCORPORATION OF COMPARATIVE EFFECTIVENESS INFORMATION.—

"(1) DISSEMINATION.—The Center shall provide for the dissemination of appropriate findings produced by research supported, conducted, or synthesized under this section to health care providers, patients, vendors of health information technology focused on clinical decision support, appropriate professional associations, and Federal and private health plans.

"(2) INCORPORATION.—The Center shall assist users of health information technology focused on clinical decision support to promote the timely incorporation of the findings described in paragraph (1) into clinical practices and to promote the ease of use of such incorporation.

"(f) REPORTS TO CONGRESS.—

"(1) ANNUAL REPORTS.—Beginning not later than one year after the date of the enactment of this section, the Director of the Agency of Healthcare Research and Quality and the Commission shall submit to Congress an annual report on the activities of the Center and the Commission, as well as the research, conducted under this section.

"(2) RECOMMENDATION FOR FAIR SHARE PER CAPITA AMOUNT FOR ALL-PAYER FINANCING.—Beginning not later than December 31, 2009, the Secretary shall submit to Congress an annual recommendation for a fair share per capita amount described in subsection (c)(1) of section 9511 of the Internal Revenue Code of 1986 for purposes of funding the CERTF under such section.

"(3) ANALYSIS AND REVIEW.—Not later than December 31, 2011, the Secretary, in consultation with the Commission, shall submit to Congress a report on all activities conducted or supported under this section as of such date. Such report shall include an evaluation of the return on investment resulting from such activities, the overall costs of such activities, and an analysis of the backlog of any research proposals approved by the Commission but not funded. Such report shall also address whether Congress should expand the responsibilities of the Center and of the Commission to include studies of the effectiveness of various aspects of the health care delivery system, including health plans and delivery models, such as health plan features, benefit designs and performance, and the ways in which health services are organized, managed, and delivered.

"(g) COORDINATING COUNCIL FOR HEALTH SERVICES RESEARCH.—

"(1) ESTABLISHMENT.—The Secretary shall establish a permanent council (in this section referred to as the 'Council') for the purpose of—

"(A) assisting the offices and agencies of the Department of Health and Human Services, the Department of Veterans Affairs, the Department of Defense, and any other Federal department or agency to coordinate the conduct or support of health services research; and

"(B) advising the President and Congress on—

"(i) the national health services research agenda;

"(ii) strategies with respect to infrastructure needs of health services research; and

"(iii) appropriate organizational expenditures in health services research by relevant Federal departments and agencies.

"(2) MEMBERSHIP.—

"(A) NUMBER AND APPOINTMENT.—The Council shall be composed of 20 members. One member shall be the Director of the Agency for Healthcare Research and Quality. The Director shall appoint the other members not later than 30 days after the enactment of this Act.

"(B) TERMS.—

"(i) IN GENERAL.—Except as provided in clause (ii), each member of the Council shall be appointed for a term of 4 years.

"(ii) TERMS OF INITIAL APPOINTEES.—Of the members first appointed—

"(I) 8 shall be appointed for a term of 4 years; and

"(II) 7 shall be appointed for a term of 3 years.

"(iii) VACANCIES.—Any vacancies shall not affect the power and duties of the Council and shall be filled in the same manner as the original appointment.

"(C) QUALIFICATIONS.—

"(i) IN GENERAL.—The members of the Council shall include one senior official from each of the following agencies:

"(I) The Veterans Health Administration.

"(II) The Department of Defense Military Health Care System.

"(III) The Centers for Disease Control and Prevention.

"(IV) The National Center for Health Statistics.
"(V) The National Institutes of Health.
"(VI) The Center for Medicare & Medicaid Services.
"(VII) The Federal Employees Health Benefits Program.

"(ii) NATIONAL, PHILANTHROPIC FOUNDATIONS.—The members of the Council shall include 4 senior leaders from major national, philanthropic foundations that fund and use health services research.

"(iii) STAKEHOLDERS.—The remaining members of the Council shall be representatives of other stakeholders in health services research, including private purchasers, health plans, hospitals and other health facilities, and health consumer groups.

"(3) ANNUAL REPORT.—The Council shall submit to Congress an annual report on the progress of the implementation of the national health services research agenda.

"(h) FUNDING OF COMPARATIVE EFFECTIVENESS RESEARCH.—For fiscal year 2008 and each subsequent fiscal year, amounts in the Comparative Effectiveness Research Trust Fund (referred to in this section as the 'CERTF') under section 9511 of the Internal Revenue Code of 1986 shall be available to the Secretary to carry out this section.".

(b) COMPARATIVE EFFECTIVENESS RESEARCH TRUST FUND; FINANCING FOR TRUST FUND.—

(1) ESTABLISHMENT OF TRUST FUND.—

(A) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to trust fund code) is amended by adding at the end the following new section:

"SEC. 9511. HEALTH CARE COMPARATIVE EFFECTIVENESS RESEARCH TRUST FUND.

"(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Health Care Comparative Effectiveness Research Trust Fund' (hereinafter in this section referred to as the 'CERTF'), consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section and section 9602(b).

"(b) TRANSFERS TO FUND.—There are hereby appropriated to the Trust Fund the following:

"(1) For fiscal year 2008, $90,000,000.
"(2) For fiscal year 2009, $100,000,000.
"(3) For fiscal year 2010, $110,000,000.
"(4) For each fiscal year beginning with fiscal year 2011—

"(A) an amount equivalent to the net revenues received in the Treasury from the fees imposed under subchapter B of chapter 34 (relating to fees on health insurance and self-insured plans) for such fiscal year; and

"(B) subject to subsection (c)(2), amounts determined by the Secretary of Health and Human Services to be equivalent to the fair share per capita amount computed under subsection (c)(1) for the fiscal year multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of title XVIII of the Social Security Act during such fiscal year.

The amounts appropriated under paragraphs (1), (2), (3), and (4)(B) shall be transferred from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (established under section 1841 of such Act), and from the Medicare Prescription Drug Account within such Trust Fund, in proportion (as estimated by the Secretary) to the total expenditures during such fiscal year that are made under title XVIII of such Act from the respective trust fund or account.

"(c) FAIR SHARE PER CAPITA AMOUNT.—

"(1) COMPUTATION.—

"(A) IN GENERAL.—Subject to subparagraph (B), the fair share per capita amount under this paragraph for a fiscal year (beginning with fiscal year 2011) is an amount computed by the Secretary of Health and Human Services for such fiscal year that, when applied under this section and subchapter B of chapter 34 of the Internal Revenue Code of 1986, will result in revenues to the CERTF of $375,000,000 for the fiscal year.

"(B) ALTERNATIVE COMPUTATION.—

"(i) IN GENERAL.—If the Secretary is unable to compute the fair share per capita amount under subparagraph (A) for a fiscal year, the fair share per capita amount under this paragraph for the fiscal year shall be the default amount determined under clause (ii) for the fiscal year.

"(ii) DEFAULT AMOUNT.—The default amount under this clause for—

"(I) fiscal year 2011 is equal to $2; or

"(II) a subsequent year is equal to the default amount under this clause for the preceeding fiscal year increased by the annual percentage increase in the medical care component of the consumer price index (United States city average) for the 12-month period ending with April of the preceding fiscal year.

Any amount determined under subclause (II) shall be rounded to the nearest penny.

"(2) LIMITATION ON MEDICARE FUNDING.—In no case shall the amount transferred under subsection (b)(4)(B) for any fiscal year exceed $90,000,000.

"(d) EXPENDITURES FROM FUND.—

"(1) IN GENERAL.—Subject to paragraph (2), amounts in the CERTF are available to the Secretary of Health and Human Services for carrying out section 1822 of the Social Security Act.

"(2) ALLOCATION FOR COMMISSION.—Not less than the following amounts in the CERTF for a fiscal year shall be available to carry out the activities of the Comparative Effectiveness Research Commission established under section 1822(b) of the Social Security Act for such fiscal year:

"(A) For fiscal year 2008, $7,000,000.

"(B) For fiscal year 2009, $9,000,000.

"(C) For each fiscal year beginning with 2010, $10,000,000.

Nothing in this paragraph shall be construed as preventing additional amounts in the CERTF from being made available to the Comparative Effectiveness Research Commission for such activities.

"(e) NET REVENUES.—For purposes of this section, the term 'net revenues' means the amount estimated by the Secretary based on the excess of—

"(1) the fees received in the Treasury under subchapter B of chapter 34, over

"(2) the decrease in the tax imposed by chapter 1 resulting from the fees imposed by such subchapter.".

(B) CLERICAL AMENDMENT.—The table of sections for such subchapter A is amended by adding at the end thereof the following new item:

"Sec. 9511. Health Care Comparative Effectiveness Research Trust Fund.".

(2) FINANCING FOR FUND FROM FEES ON INSURED AND SELF-INSURED HEALTH PLANS.—

(A) GENERAL RULE.—Chapter 34 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subchapter:

"Subchapter B—Insured and Self-Insured Health Plans

"Sec. 4375. Health insurance
"Sec. 4376. Self-insured health plans
"Sec. 4377. Definitions and special rules

"SEC. 4375. HEALTH INSURANCE.

"(a) IMPOSITION OF FEE.—There is hereby imposed on each specified health insurance policy for each policy year a fee equal to the fair share per capita amount determined under section 9511(c)(1) multiplied by the average number of lives covered under the policy.

"(b) LIABILITY FOR FEE.—The fee imposed by subsection (a) shall be paid by the issuer of the policy.

"(c) SPECIFIED HEALTH INSURANCE POLICY.—For purposes of this section—

"(1) IN GENERAL.—Except as otherwise provided in this section, the term 'specified health insurance policy' means any accident or health insurance policy issued with respect to individuals residing in the United States.

"(2) EXEMPTION OF CERTAIN POLICIES.—The term 'specified health insurance policy' does not include any insurance policy if substantially all of the coverage provided under such policy relates to—

"(A) liabilities incurred under workers' compensation laws,

"(B) tort liabilities,

"(C) liabilities relating to ownership or use of property,

"(D) credit insurance,

"(E) medicare supplemental coverage, or

"(F) such other similar liabilities as the Secretary may specify by regulations.

"(3) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS.—

"(A) IN GENERAL.—In the case of any arrangement described in subparagraph (B)—

"(i) such arrangement shall be treated as a specified health insurance policy, and

"(ii) the person referred to in such subparagraph shall be treated as the issuer.

"(B) DESCRIPTION OF ARRANGEMENTS.—An arrangement is described in this subparagraph if under such arrangement fixed payments or premiums are received as consideration for any person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided.

"SEC. 4376. SELF-INSURED HEALTH PLANS.

"(a) IMPOSITION OF FEE.—In the case of any applicable self-insured health plan for each plan year, there is hereby imposed a fee equal to the fair share per capita amount determined under section 9511(c)(1) multiplied by the average number of lives covered under the plan.

"(b) LIABILITY FOR FEE.—

"(1) IN GENERAL.—The fee imposed by subsection (a) shall be paid by the plan sponsor.

"(2) PLAN SPONSOR.—For purposes of paragraph (1) the term 'plan sponsor' means—

"(A) the employer in the case of a plan established or maintained by a single employer,

"(B) the employee organization in the case of a plan established or maintained by an employee organization,

"(C) in the case of—

"(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

"(ii) a multiple employer welfare arrangement, or

"(iii) a voluntary employees' beneficiary association described in section 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),

"(E) by any organization described in section 501(c)(6), or

"(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40) of Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

"SEC. 4377. DEFINITIONS AND SPECIAL RULES.

"(a) DEFINITIONS.—For purposes of this subchapter—

"(1) ACCIDENT AND HEALTH COVERAGE.—The term 'accident and health coverage' means any coverage which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4375(c)).

"(2) INSURANCE POLICY.—The term 'insurance policy' means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended.

"(3) UNITED STATES.—The term 'United States' includes any possession of the United States.

"(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

"(1) IN GENERAL.—For purposes of this subchapter—

"(A) the term 'person' includes any governmental entity, and

"(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the fees imposed by this subchapter except as provided in paragraph (2).

"(2) TREATMENT OF EXEMPT GOVERNMENTAL PROGRAMS.—In the case of an exempt governmental program, no fee shall be imposed under section 4375 or section 4376 on any covered life under such program.

"(3) EXEMPT GOVERNMENTAL PROGRAM DEFINED.—For purposes of this subchapter, the term 'exempt governmental program' means—

"(A) any insurance program established under title XVIII of the Social Security Act,

"(B) the medical assistance program established by title XIX or XXI of the Social Security Act,

"(C) any program established by Federal law for providing medical care (other than through insurance policies) to individuals (or the spouses and dependents thereof) by reason of such individuals being—

"(i) members of the Armed Forces of the United States, or

"(ii) veterans, and

"(D) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

"(c) TREATMENT AS TAX.—For purposes of subtitle F, the fees imposed by this subchapter shall be treated as if they were taxes.

"(d) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States."

(B) CLERICAL AMENDMENTS.—

(i) Chapter 34 of such Code is amended by striking the chapter heading and inserting the following:

"CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

"SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

"SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

"Subchapter A—Policies Issued By Foreign Insurers".

(ii) The table of chapters for subtitle D of such Code is amended by striking the item relating to chapter 34 and inserting the following new item:

"CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES".

(C) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to policies and plans for portions of policy or plan years beginning on or after October 1, 2010.

SEC. 905. IMPLEMENTATION OF HEALTH INFORMATION TECHNOLOGY (IT) UNDER MEDICARE.

(a) IN GENERAL.—Not later than January 1, 2010, the Secretary of Health and Human Services shall submit to Congress a report that includes—

(1) a plan to develop and implement a health information technology (health IT) system for all health care providers under the Medicare program that meets the specifications described in subsection (b); and

(2) an analysis of the impact, feasibility, and costs associated with the use of health information technology in medically underserved communities.

(b) PLAN SPECIFICATION.—The specifications described in this subsection, with respect to a health information technology system described in subsection (a), are the following:

(1) The system protects the privacy and security of individually identifiable health information.

(2) The system maintains and provides permitted access to health information in an electronic format (such as through computerized patient records or a clinical data repository).

(3) The system utilizes interface software that allows for interoperability.

(4) The system includes clinical decision support.

(5) The system incorporates e-prescribing and computerized physician order entry.

(6) The system incorporates patient tracking and reminders.

(7) The system utilizes technology that is open source (if available) or technology that has been developed by the government.

The report shall include an analysis of the financial and administrative resources necessary to develop such system and recommendations regarding the level of subsidies needed for all such health care providers to adopt the system.

SEC. 906. DEVELOPMENT, REPORTING, AND USE OF HEALTH CARE MEASURES.

(a) IN GENERAL.—Part E of title XVIII of the Social Security Act (42 U.S.C. 1395x et seq.) is amended by inserting after section 1889 the following:

"DEVELOPMENT, REPORTING, AND USE OF HEALTH CARE MEASURES

"SEC. 1890. (a) FOSTERING DEVELOPMENT OF HEALTH CARE MEASURES.—The Secretary shall designate, and have in effect an arrangement with, a single organization (such as the National Quality Forum) that meets the requirements described in subsection (c), under which such organization provides the Secretary with advice on, and recommendations with respect to, the key elements and priorities of a national system for establishing health care measures. The arrangement shall be effective beginning no sooner than January 1, 2008, and no later than September 30, 2008.

"(b) DUTIES.—The duties of the organization designated under subsection (a) (in this title referred to as the 'designated organization') shall, in accordance with subsection (d), include—

"(1) establishing and managing an integrated national strategy and process for setting priorities and goals in establishing health care measures;

"(2) coordinating the development and specifications of such measures;

"(3) establishing standards for the development and testing of such measures;

"(4) endorsing national consensus health care measures; and

"(5) advancing the use of electronic health records for automating the collection, aggregation, and transmission of measurement information.

"(c) REQUIREMENTS DESCRIBED.—For purposes of subsection (a), the requirements described in this subsection, with respect to an organization, are the following:

"(1) PRIVATE NONPROFIT.—The organization is a private nonprofit entity governed by a board and an individual designated as president and chief executive officer.

"(2) BOARD MEMBERSHIP.—The members of the board of the organization include representatives of—

"(A) health care providers or groups representing such providers;

"(B) health plans or groups representing health plans;

"(C) groups representing health care consumers;

"(D) health care purchasers and employers or groups representing such purchasers or employers; and

"(E) health care practitioners or groups representing practitioners.

"(3) OTHER MEMBERSHIP REQUIREMENTS.—The membership of the organization is representative of individuals with experience with—

"(A) urban health care issues;

"(B) safety net health care issues;

"(C) rural and frontier health care issues; and

"(D) health care quality and safety issues.

"(4) OPEN AND TRANSPARENT.—With respect to matters related to the arrangement described in subsection (a), the organization conducts its business in an open and transparent manner and provides the opportunity for public comment.

"(5) VOLUNTARY CONSENSUS STANDARDS SETTING ORGANIZATION.—The organization operates as a voluntary consensus standards setting organization as defined for purposes of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (Public Law 104–113) and Office of Management and Budget Revised Circular A–119 (published in the Federal Register on February 10, 1998).

"(6) EXPERIENCE.—The organization has at least 7 years experience in establishing national consensus standards.

"(d) REQUIREMENTS FOR HEALTH CARE MEASURES.—In carrying out its duties under subsection (b), the designated organization shall ensure the following:

"(1) MEASURES.—The designated organization shall ensure that the measures established or endorsed under subsection (b) are evidence-based, reliable, and valid; and include—

"(A) measures of clinical processes and outcomes, patient experience, efficiency, and equity;

"(B) measures to assess effectiveness, timeliness, patient self-management, patient centeredness, and safety; and

"(C) measures of under use and over use.

"(2) PRIORITIES.—

"(A) IN GENERAL.—The designated organization shall ensure that priority is given to establishing and endorsing—

"(i) measures with the greatest potential impact for improving the effectiveness and efficiency of health care;

"(ii) measures that may be rapidly implemented by group health plans, health insurance issuers, physicians, hospitals, nursing homes, long-term care providers, and other providers;

"(iii) measures which may inform health care decisions made by consumers and patients; and

"(iv) measures that apply to multiple services furnished by different providers during an episode of care.

"(B) ANNUAL REPORT ON PRIORITIES; SECRETARIAL PUBLICATION AND COMMENT.—

"(i) ANNUAL REPORT.—The designated organization shall issue and submit to the Secretary a report by March 31 of each year (beginning with 2009) on the organization's recommendations for priorities and goals in establishing and endorsing health care measures under this section over the next five years.

"(ii) SECRETARIAL REVIEW AND COMMENT.—After receipt of the report under clause (i) for a year, the Secretary shall publish the report in the Federal Register, including any comments of the Secretary on the priorities and goals set forth in the report.

"(3) RISK ADJUSTMENT.—The designated organization, in consultation with health care measure developers and other stakeholders, shall establish procedures to assure that health care measures established and endorsed under this section account for differences in patient health status, patient characteristics, and geographic location, as appropriate.

"(4) MAINTENANCE.—The designated organization, in consultation with owners and developers of health care measures, shall require the owners or developers of such measures to update and enhance such measures, including the development of more accurate and precise specifications, and retire existing outdated measures. Such updating shall occur not more often than once during each 12-month period, except in the case of emergent circumstances requiring a more immediate update to a measure.

"(e) USE OF HEALTH CARE MEASURES; REPORTING.—

"(1) USE OF MEASURES.—For purposes of activities authorized or required under this title, the Secretary shall select from health care measures—

"(A) recommended by multi-stakeholder groups; and

"(B) endorsed by the designated organization under subsection (b)(4).

"(2) REPORTING.—The Secretary shall implement procedures, consistent with generally accepted standards, to enable the Department of Health and Human Services to accept the electronic submission of data for purposes of—

"(A) effectiveness measurement using the health care measures developed pursuant to this section; and

"(B) reporting to the Secretary measures used to make value-based payments under this title.

"(f) CONTRACTS.—The Secretary, acting through the Agency for Healthcare Research and Quality, may contract with organizations to support the development and testing of health care measures meeting the standards established by the designated organization.

"(g) DISSEMINATION OF INFORMATION.—In order to make information on health care measures available to health care consumers, health professionals, public health officials, oversight organizations, researchers, and other appropriate individuals and entities, the Secretary shall work with multi-stakeholder groups to provide for the dissemination of information developed pursuant to this title.

"(h) FUNDING.—For purposes of carrying out subsections (a), (b), (c), and (d), including for expenses incurred for the arrangement under subsection (a) with the designated organization, there is payable from the Federal Hospital Insurance Trust Fund (established under section 1817) and the Federal Supplementary Medical Insurance Trust Fund (established under section 1841)—

"(1) for fiscal year 2008, $15,000,000, multiplied by the ratio of the total number of months in the year to the number of months (and portions of months) of such year during which the arrangement under subsection (a) is effective; and

"(2) for each of the fiscal years, 2009 through 2012, $15,000,000.".

SEC. 907. IMPROVEMENTS TO THE MEDIGAP PROGRAM.

(a) IMPLEMENTATION OF NAIC RECOMMENDATIONS.—The Secretary of Health and Human Services shall provide, under subsections (p)(1)(E) of section 1882 of the Social Security Act (42 U.S.C. 1395s), for implementation of the changes in the NAIC model law and regulations recommended by the National Association of Insurance Commissioners in its Model #651 ("Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act") on March 11, 2007, as

modified to reflect the changes made under this Act. In carrying out the previous sentence, the benefit packages classified as "K" and "L" shall be eliminated and such NAIC recommendations shall be treated as having been adopted by such Association as of January 1, 2008.

(b) REQUIRED OFFERING OF A RANGE OF POLICIES.—

(1) IN GENERAL.—Subsection (o) of such section is amended by adding at the end the following new paragraph:

"(4) In addition to the requirement of paragraph (2), the issuer of the policy must make available to the individual at least medicare supplemental policies with benefit packages classified as 'C' or '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) .

SEC. 908. IMPLEMENTATION FUNDING.

For purposes of implementing the provisions of this Act (other than title X), the Secretary of Health and Human Services shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t), of $40,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for fiscal year 2008.

TITLE X—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".

(b) LARGE CIGARETTES.—Paragraph (2) of section 5701(b) of such Code is amended by striking "$40.95 per thousand ($35.70 per thousand on cigarettes removed during 2000 or 2001)" and inserting "$88.20 per thousand".

(c) SMALL CIGARS.—Paragraph (1) of section 5701(a) of such Code is amended by striking "$1.828 cents per thousand ($1.594 cents per thousand on cigars removed during 2000 or 2001)" and inserting "$42 per thousand".

(d) LARGE CIGARS.—Paragraph (2) of section 5701(a) of such Code is amended—

(1) by striking "20.719 percent (18.063 percent on cigars removed during 2000 or 2001)" and inserting "44.63 percent", and

(2) by striking "$48.75 per thousand ($42.50 per thousand on cigars removed during 2000 or 2001)" and inserting "$1 per cigar".

(e) CIGARETTE PAPERS.—Subsection (c) of section 5701 of such Code is amended by striking "1.22 cents (1.06 cents on cigarette papers removed during 2000 or 2001)" and inserting "2.63 cents".

(f) CIGARETTE TUBES.—Subsection (d) of section 5701 of such Code is amended by striking "2.44 cents (2.13 cents on cigarette tubes removed during 2000 or 2001)" and inserting "5.26 cents".

(g) SNUFF.—Paragraph (1) of section 5701(e) of such Code is amended by striking "58.5 cents (51 cents on snuff removed during 2000 or 2001)" and inserting "$1.26".

(h) CHEWING TOBACCO.—Paragraph (2) of section 5701(e) of such Code is amended by striking "19.5 cents (17 cents on chewing tobacco removed during 2000 or 2001)" and inserting "42 cents".

(i) PIPE TOBACCO.—Subsection (f) of section 5701 of such Code is amended by striking "$1.0969 cents (95.67 cents on pipe tobacco removed during 2000 or 2001)" and inserting "$2.36".

(j) ROLL-YOUR-OWN TOBACCO.—

(1) IN GENERAL.—Subsection (g) of section 5701 of such Code is amended by striking "$1.0969 cents (95.67 cents on roll-your-own tobacco removed during 2000 or 2001)" and inserting "$7.4667".

(2) INCLUSION OF CIGAR TOBACCO.—Subsection (o) of section 5702 of such Code is amended by inserting "or cigars, or for use as wrappers for making cigars" before the period at the end.

(k) EFFECTIVE DATE.—The amendments made by this section shall apply to articles removed after December 31, 2007.

(l) FLOOR STOCKS TAXES.—

(1) IMPOSITION OF TAX.—On cigarettes manufactured in or imported into the United States which are removed before January 1, 2008, and held on such date for sale by any person, there is hereby imposed a tax in an amount equal to the excess of—

(A) the tax which would be imposed under section 5701 of the Internal Revenue Code of 1986 on the article if the article had been removed on such date, over

(B) the prior tax (if any) imposed under section 5701 of such Code on such article.

(2) AUTHORITY TO EXEMPT CIGARETTES HELD IN VENDING MACHINES.—To the extent provided in regulations prescribed by the Secretary, no tax shall be imposed by paragraph (1) on cigarettes held for retail sale on January 1, 2008, by any person in any vending machine. If the Secretary provides such a benefit with respect to any person, the Secretary may reduce the $500 amount in paragraph (3) with 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—

(A) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act, or

(B) such article is held on such date under the supervision of a customs officer pursuant to the 2d proviso of such section 3(a).

(6) DEFINITIONS.—For purposes of this subsection—

(A) IN GENERAL.—Terms used in this subsection which are also used in section 5702 of the Internal Revenue Code of 1986 shall have the respective meanings such terms have in such section.

(B) SECRETARY.—The term "Secretary" means the Secretary of the Treasury or the Secretary's delegate.

(7) CONTROLLED GROUPS.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this subsection.

(8) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with respect to the taxes imposed by section 5701 of such Code 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.".

(b) FUELS NOT USED FOR TAXABLE PURPOSES.—Section 6427 of such Code is amended by inserting after subsection (e) the following new subsection:

"(f) USE TO PROVIDE EMERGENCY MEDICAL SERVICES.—Except as provided in subsection (k), if any fuel on which tax was imposed by section 4081 or 4041 is used in an ambulance for a purpose described in section 4041(l)(2), the Secretary shall pay (without interest) to the ultimate purchaser of such fuel an amount equal to the aggregate amount of the tax imposed on such fuel. The preceding sentence shall not apply to any liquid used after December 31, 2012.".

(c) TIME FOR FILING CLAIMS; PERIOD COVERED.—Paragraphs (1) and (2)(A) of section 6427(i) of such Code are each amended by inserting "(f)," after "(d),".

(d) CONFORMING AMENDMENT.—Section 6427(d) of such Code is amended by striking "4041(l)" and inserting "4041(l)(1)".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to fuel used in transportation provided in quarters beginning after the date of the enactment of this Act.

I. INTRODUCTION

A. Purpose and Summary

The bill, H.R. 3162 (the "Children's Health and Medicare Protection Act of 2007"), amends titles XVIII, XIX, and XXI of the Social Security Act to extend and improve the CHIP program, to improve beneficiary protections under the Medicare, Medicaid, and CHIP, and amends the Internal Revenue Code of 1986 to provide revenue to fund these programs, among other purposes.

B. Background and Need for Legislation

> Every citizen will be able, in his productive years when he is earning, to insure himself against the ravages of illness in his old age.—President Lyndon B. Johnson

On July 30, 1965, President Lyndon B. Johnson signed into law the legislation creating Medicare. As we celebrate the 42nd anniversary of that momentous occasion, the Committee on Ways and Means has reported out favorably the Children's Health and Medicare Protection (CHAMP) Act of 2007. Indeed, the provisions of the CHAMP Act hew true to the promises made at enactment, and improve and protect Medicare as the program prepares for the forthcoming retirement of the baby boom generation. More action will be needed, but the changes contained in this legislation are a necessary first step toward getting the program back on track.

Over the last dozen years, and particularly during the last six years, Congress has spent little time maintaining and overseeing Medicare. The Medicare Modernization Act (MMA) of 2003, which added the option to purchase subsidized private drug coverage, contained a number of provisions that were unrelated to drug coverage and designed to privatize Medicare. The CHAMP Act reverses these actions, and strengthens the program. Medicare was originally designed not as a welfare program, but an inter-generational social compact into which everyone would pay and all would benefit. The CHAMP Act renews the nation's commitment to Medicare as a widely supported and valued social insurance program and core component of the nation's retirement safety net.

Perhaps the MMA's most insidious provisions were those that arbitrarily and vastly increased subsidies to health maintenance organizations (HMOs) and other private insurance plans through the Medicare Advantage (MA) program. As a result, MA plans are now paid an average of 13% more than it would cost to provide care in fee-for-service Medicare. In some areas, the overpayments exceed 50 percent of the cost of Medicare. Not surprisingly, the government's Chief Actuary has stated that under current law it costs more, not less, for the government to pay for care through the private plans. And those overpayments will continue into perpetuity—at no point under current law does the Chief Actuary estimate that private plans will actually save money for the Medicare program. Until very recently payments for Medicare HMOs were actually five percent less than the cost of delivering care through Medicare because the plans said they could offer Medicare's benefits at a lower cost. It is only in recent years that payments to the plans in-

creased so dramatically. For several decades, HMOs existed as an option in Medicare without today's substantial overpayments.

The Medicare Payment Advisory Commission (MedPAC), the HHS Inspector General, the Congressional Budget Office, and the Administration's own Chief Medicare Actuary agree that MA plans are overpaid. These overpayments were designed to help private plans lure beneficiaries away from fee-for-service Medicare. Eventually, as per the agenda advanced by the former Representative Bill Thomas when he lead the Medicare Commission following the Balanced Budget Act of 1997, the objective of the MMA was to turn Medicare into a voucher program under which beneficiaries would be given a fixed amount of money and be forced to fend for themselves in a private insurance market. This misguided goal ignores the history of Medicare's creation, namely that private insurance companies did not want to insure elderly patients or people with disabilities.

The CHAMP Act follows the recommendations of MedPAC to level the playing field between Medicare and the private plans by eliminating the overpayments over a multi-year period. MA plans claim that the overpayments are returned to beneficiaries in the form of extra benefits. But private plans often charge higher cost-sharing for needed benefits, and there are no data proving that overpayments are actually spent on extra benefits. Indeed, major MA plans have repeatedly touted the profitability of the Medicare business to their investors. We also know that MA plans often charge more for vital Medicare benefits home health, hospital stays, nursing home stays and chemotherapy.

Eliminating the excess payments is not just good policy. It also protects the Medicare Trust Fund and reduces Part B premiums. The Committee has been advised as of the writing of this report that the CMS Office of the Actuary projects that the CHAMP Act as reported out of the Committee would extend the life of the Medicare Trust Fund by three years, largely because the MA subsidies are eliminated. In addition, limiting MA payments to the Medicare rates will also reduce premiums. Under current law, even though fewer than 2 in 10 beneficiaries are in MA plans, the overpayments have raised Medicare premiums for all beneficiaries by nearly $700 million just in this year.

The CHAMP Act reinvests the savings from reducing MA spending are reinvested in the CHAMP Act to guarantee better health care to people instead of additional profits to insurance executives and shareholders. The key Medicare improvements include benefit improvements, expansions and streamlining of programs designed to keep Medicare affordable for beneficiaries with limited incomes, an interim proposal to address problems in the physician payment formula and additional payment policy refinements, including provisions that are targeted to maintain access in rural areas.

Preventive benefits improve health and reduce long-term costs. Historically, Congress has had to act to improve preventive benefits in Medicare. Under the CHAMP Act, the Centers for Medicare and Medicaid Services (CMS) will now be allowed to add preventive benefits without Congressional action. To promote use of these important benefits, the CHAMP Act eliminates cost-sharing and ex-

cludes from the deductible all current and future preventive benefits.

The CHAMP Act also improves mental health coverage. For years, Medicare beneficiaries with mental illness have been treated as second-class citizens, forced to pay a 50 percent co-insurance in the outpatient setting when virtually all other outpatient services are subject to co-insurance of just 20 percent. The CHAMP Act ensures mental health parity in Medicare by reducing cost-sharing to 20 percent.

The CHAMP Act will help millions of low-income beneficiaries who struggle each month to pay for health care costs. The limited income subsidy (LIS) program in Part D and the combined Medicare Savings Programs (MSP) for non-drug benefits provide help with cost-sharing for beneficiaries who meet certain requirements. The CHAMP Act makes real improvements in these programs, including the asset tests, streamlining application procedures, improving coordination between the programs and the agencies that administer them, and expanding eligibility. These changes will help ensure that beneficiaries with limited income obtain the benefits to which they are entitled.

The CHAMP Act also takes a number of steps to help beneficiaries successfully navigate the new drug program. These improvements will ensure access to necessary drugs, reduce costs for certain beneficiaries, and ensure low-income and adversely affected beneficiaries have an opportunity to change plans.

While Medicare provides the same benefits for every beneficiary, racial disparities persist in access to those benefits. For example, in 2004, two-thirds of whites 65 years and older received flu vaccines, compared with just 45 percent of African Americans and 55 percent of Hispanics. The CHAMP Act will reduce disparities by requiring CMS to collect and report new disparities data, improving outreach to limited English proficient populations, and improving support for beneficiaries entering the program that were previously uninsured.

The CHAMP Act makes substantial changes to the physician payment formula, both to avert fee cuts that will otherwise occur in 2008 and 2009, and to plan for the future. With an emphasis on primary and preventive care, the groundwork laid in the CHAMP Act should help move us toward a better payment system for physicians in the future.

These changes combine to put Medicare back on track to meeting the needs of all beneficiaries in a modern world. It reverses the most pernicious aspects of the MMA, both in terms of privatization and its efforts to arbitrarily limit Medicare's funding. And it puts a firm focus on prevention and core improvements to the program to ensure it meets the needs of all beneficiaries.

The CHAMP Act is supported by more than 90 organizations including the AARP, the AMA, the NAACP and many others representing senior citizens, people with disabilities, physicians, hospitals, children and others. [See appendix A for list of supporters as of this date]

The bulk of the CHAMP Act is financed through adjusting current Federal health spending. The only new funding source in this bill is increasing the current Federal excise tax on cigarettes by

$0.45 a pack. The tobacco tax is sound fiscal and health policy. Raising the cost of cigarettes is the best way to stop children from starting to smoke in the first place.

Although title I (relating to the State Children's Health Insurance Program or "S–CHIP") and title VIII (relating to Medicaid), are not technically before the Committee on Ways and Means, it is important to note that the Congressional Budget Office (CBO) estimates that this legislation provides health care for more than 5 million low-income children who were previously uninsured, and maintains coverage for six million children who are currently covered by S–CHIP. Together, 11 million children receive health care as a result of the CHAMP Act. In contrast, the President's budget would have severely under-funded S–CHIP, leading one million children to lose coverage. When S–CHIP was created, eligibility levels were set at 200 percent of the poverty level or 50 percentage points above where a state's Medicaid eligibility level was. This does not change in the CHAMP Act. The program remains focused on children in low-income working families—and the numbers prove it will make a real difference.

Ensuring affordable comprehensive health care to those in need is a core function of our government. The American people want our children to have health insurance, and want to guarantee Medicare for our senior citizens and people with disabilities. The CHAMP Act does both.

C. Legislative History

Background

H.R. 3162 was introduced in the House of Representatives on July 24, 2007, and was referred to the Committee on Ways and Means and the Committee on Energy and Commerce.

Subcommittee action

The Subcommittee on Health of the Committee on Ways and Means held 15 hearings and made one request for written comments for the record in the 110th Congress. These hearings explored various aspects of the Medicare program and how it could be reformed and strengthened. The following is a list of these hearings in chronological order:

February 13, 2007: President's Fiscal Year 2008 Budget with Acting CMS Administrator Norwalk

March 1, 2007: MedPAC's Annual March Report with MedPAC Chairman Glenn M. Hackbarth

March 6, 2007: MedPAC's Report on the Sustainable Growth Rate (SGR)

March 8, 2007: Medicare Program Integrity

March 14, 2007: Genetic Non-Discrimination

March 21, 2007: Medicare Advantage

March 27, 2007: Mental Health and Substance Abuse Parity

April 25, 2007: 2007 Medicare Trustees Report

May 3, 2007: Medicare Programs for Low-Income Beneficiaries

May 10, 2007: Options to Improve Quality and Efficiency Among Medicare Physicians

May 15, 2007: Payments to Certain Medicare Fee-For-Service Providers
May 22, 2007: Medicare Advantage Private Fee-For-Service Plans
June 12, 2007: Strategies to Increase Information on Comparative Clinical Effectiveness
June 21, 2007: Beneficiary Protections in Medicare Part D
June 26, 2007: Ensuring Kidney Patients Receive Safe and Appropriate Anemia Management Care
July 26, 2007: Request for Written Comments on Medicare Therapy Caps and Refined and Alternative Payment Methodologies

Full committee action

The Committee on Ways and Means marked up the bill on July 26th, 2007 and ordered the bill, as amended, favorably reported.

APPENDIX A

List of organizations supporting H.R. 3162, the "Children's Health and Medicare Protection (CHAMP) Act of 2007"

AARP
Acute Long Term Hospital Association (ALTHA)
AFL–CIO
Alliance for Better Health Care (ABHC)
Alliance for Retired Americans
Alliance of Dedicated Cancer Centers
American Academy of Audiology (AAA)
American Academy of Child and Adolescent Psychiatry
American Academy of Family Physicians (AAFP)
American Academy of Ophthalmology (AAO)
American Academy of Pediatrics (AAP)
American Association for Marriage and Family Therapy
American Association of Geriatric Psychiatry
American Association of Neurological Surgeons
American Association of Orthopaedic Surgeons
American Association of School Administrators
American Cancer Society Cancer Action Network
American Clinical Laboratory Association
American College of Nurse Midwives
Amercian College of Obstetricians and Gynecologists (ACOG)
American College of Osteopathic Family Physicians
American College of Osteopathic Internists
American College of Physicians (ACP)
American College of Surgeons (ACS)
American Counseling Association
American Dental Hygenists' Association
American Diabetes Association
American Dietetic Association
Amercian Federation of State, County, and Municipal Employees
American Federation of Teachers (AFT)
American Gastroenterological Association
American Heart Association
American Hospital Association (AHA)
American Lung Association
American Medical Association (AMA)

American Mental Health Counselors Association
American Nurses Association
American Osteopathic Association (AOA)
American Psychological Association
American Society for Therapeutic Radiology and Oncology (ASTRO)
Amercian Speech-Language Hearing Association
Association of American Medical Colleges
Association of University Centers on Disabilities (AUCD)
Bazelon Center for Mental Health Law
California Medical Association (CMA)
Campaign for Tobacco-Free Kids
Catholic Health Association
Center for Medicare Advocacy
Child Welfare League of America
Children's Dental Health Project
Children's Defense Fund
Clinical Social Work Association
Coalition for Health Services Research
Coalition of Full Service Community Hospitals
Coalition to Preserve Rehabilitation
College of American Pathologists
Congress of Neurological Surgeons
Consortium for Citizens with Disabilities (CCD)
Consumers Union
Disability Policy Collaboration
Easter Seals
Families USA
Federation of American Hospitals (FAH)
First Focus
Friends Committee on National Legislation
Friends of National Quality Forum (Includes 18 Organizations)
Generic Pharmaceutical Association (GPhA)
Genzyme Corporation
HIV Medicaid/Medicare Working Group (Includes 18 Organizations)
HIV Medicine Association
Infectious Diseases Society of America (ISDA)
Juvenile Diabetes Research Foundation International
Lutheran Services in America
March of Dimes
Medicare Cost Contractors Alliance
Medicare Rights Center
Nationial Alliance on Mental Illness (NAMI)
National Association for the Advancement of Colored People (NAACP)
National Association of Insurance Commissioners
National Association of Social Workers
National Association of Urban Hospitals
National Committee to Preserve Social Security and Medicare
Natonal Council for Community Behavioral Health Care
National Council on Aging (NCOA)
National Education Association
National Hispanic Medical Association
National Medical Association

National Partnership for Women and Families
National Rural Health Association
Premier
Society of General Internal Medicine
Society of Thoracic Surgeons
Title II Community AIDS National Network
Washington State Labor Council

II. EXPLANATION OF THE BILL

TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS

SUBTITLE A—IMPROVEMENT IN BENEFITS

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

Current law

Medicare Part B covers physicians' services, outpatient hospital services, durable medical equipment, and other medical services. The program generally pays 80% of the approved amount (generally a fee schedule or other predetermined amount) for covered services in excess of the annual deductible ($131 in 2007). The beneficiary is liable for the remaining 20%. The coinsurance for hospital outpatient services can be as high as 40%. The deductible and/or coinsurance are waived for certain services, primarily preventive services.

Explanation of provision

The provision would define preventive services as: prostate cancer screening tests, colorectal cancer screening tests, diabetes outpatient self-management training services, screening for glaucoma for certain individuals, medical nutrition therapy services for certain individuals, an initial preventive physical exam, cardiovascular screening blood tests, diabetes screening tests, ultrasound screening for abdominal aortic aneurysm for certain individuals, pneumococcal and influenza vaccine and their administration, hepatitis B vaccine and its administration for certain individuals, screening mammography, screening pap smear and screening pelvic exam, and bone mass measurement as these services are currently defined under the program. The term also includes the new category additional preventive services.

The provision would add this new category, additional preventive services, to Medicare's list of medical and other health services. This term would mean items and services, including mental health services, not otherwise covered under Medicare that the Secretary determined to be reasonable and necessary for the prevention or early detection of an illness or disability. In making this determination, the Secretary would be required to take into account evidence-based recommendations by the United States Preventive Services Task Force and other appropriate organizations. The Secretary would be further required to use the process for making national coverage determinations.

The provision would eliminate coinsurance for all of Medicare's current preventive services for which coinsurance is currently ap-

plied and waive application of the Medicare Part B deductible for these services as well. The provision would eliminate the application of coinsurance or the Part B deductible to any new preventive services that are added to Medicare as well.

The provision would include all preventive services, including the new additional preventive services category, within the definition of the initial preventive physical exam.

The provision would apply to services furnished on or after January 1, 2008.

Reason for change

Preventive benefits are a vital service—the provision of which will prevent people from developing illnesses that would otherwise prove very costly.

In order to add new preventive benefits to Medicare today, Congress must act on each one. This provision allows the Medicare agency, in consultation with the United States Preventive Services Task Force—the recognized experts on preventive medicine—to add new preventive services to Medicare without requiring Congressional action. The goal is to speed adoption of preventive services to Medicare beneficiaries and to make those determinations based on the best scientific evidence.

Another problem with Medicare's preventive benefits today is that utilization rates are very low. To help address that problem, the provision eliminates both the coinsurance and application of the deductible for preventive services. By eliminating all beneficiary cost-sharing for these services, more people should utilize the services. This is the same rationale used by health insurance companies that rarely charge enrollees for well-child visits.

The Secretary of HHS has the authority to define populations at risk of developing glaucoma for the purposes of extending Medicare coverage for glaucoma screening to these groups. To date, the Secretary has extended glaucoma screening benefits to the following groups: individuals with diabetes, individuals with a family history of glaucoma, African Americans over the age of 50, and Hispanics age 65 and older. Evidence indicates that Hispanics have a higher risk for glaucoma than those of predominantly European ancestry, and that the risk is even higher for Hispanics over the age of 60. Given the elevated risk for Hispanics below the age of 65, the Committee urges the Secretary to use his authority to expand Medicare coverage of glaucoma screening services to Hispanics over the age of 50.

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

Current law

The Medicare Part B deductible does not apply to colorectal cancer screening tests.

Explanation of provision

The provision would specify that the waiver of the deductible would apply regardless of the coding, subsequent diagnosis, or the

removal of tissue or other matter or procedure performed in connection with and as a result of the screening test. The provision would apply to items and services furnished on or after January 1, 2008.

Reason for change

Current law prohibits the application of the Medicare Part B deductible for screening colonoscopies. However, if a patient has a screening colonoscopy and the physician finds polyps that need to be removed during the screening exam, it is relabeled a diagnostic procedure and the deductible is applied. This policy is unfair to beneficiaries who are told that the screening colonoscopy would bypass the deductible. This provision would therefore ensure that a screening colonoscopy avoids the deductible regardless of whether the procedure becomes diagnostic.

SECTION 203. PARITY FOR MENTAL HEALTH COINSURANCE

Current law

Medicare Part B generally pays 80% of the approved amount (generally a fee schedule or other predetermined amount) for covered services in excess of the annual deductible. However, different rules apply with respect to certain mental health services. Medicare pays 62½% of covered expenses incurred in connection with the treatment of mental, psychoneurotic, and personality disorders of a person who is not a hospital inpatient. As a result Medicare generally pays 50% rather than 80% of Medicare's recognized amount.

Explanation of provision

The provision would increase Medicare's payment for outpatient mental health services to 80% of Medicare's recognized amount. This provision would go into effect in 2008.

Reason for change

Medicare's current coverage for outpatient mental health services is discriminatory in that beneficiaries are required to pay 50% of the cost rather than the standard 20% coinsurance required for other Part B services. This provision brings parity to outpatient mental health services in Medicare.

SUBTITLE B—IMPROVING, CLARIFYING, AND SIMPLIFYING FINANCIAL ASSISTANCE FOR LOW-INCOME MEDICARE BENEFICIARIES

SECTION 211. IMPROVING ASSETS TESTS FOR MEDICARE SAVINGS PROGRAM AND LOW-INCOME SUBSIDY PROGRAM

Current law

Federal assistance is provided to certain low-income persons to help them meet Medicare Part D premiums and cost-sharing. Specifically, the low-income subsidy (LIS) is provided for persons with incomes below 150% of the federal poverty level and assets below specified amounts. The definitions of income and assets are linked directly or indirectly to the definitions used under current Medicaid law.

The LIS population is divided into two main groups with the first group divided into subgroups for purposes of determining cost-sharing requirements. The first group includes all persons who: (1) are enrolled in a prescription drug plan (PDP or a Medicare Advantage prescription drug plan (MA–PD plan); (2) have incomes below 135% of the federal poverty level ($13,783 for an individual and $18,481 for a couple in 2007); and (3) have resources in 2007 below $6,120 for an individual and $9,190 for a couple (increased each year by the percentage increase in the consumer price index, or CPI). (The 2007 resource limits are generally publicized as $7,620 and $12,190 because $1,500 per person is excluded for burial expenses.) The first group also includes: (1) dual eligibles (persons entitled to the full range of benefits under their state's Medicaid program); (2) recipients of Supplemental Security Income (SSI) benefits; or (3) enrollees in Medicare Savings Programs.

The second low-income subsidy group includes all other persons who (1) are enrolled in a PDP plan or MA–PD plan; (2) have incomes below 150% of poverty ($15,315 for an individual and $20,535 for a couple in 2007); and (3) have resources in 2007 below $10,210 for an individual and $20,410 for a couple (increased in future years by the percentage increase in the CPI). The publicized resources limits of $11,710 and $23,410 include a $1,500 per person burial allowance.

Certain low-income individuals who are aged or have disabilities, as defined under SSI, and who are eligible for Medicare are also eligible for premium and cost-sharing assistance paid for by Medicaid under the Medicare Savings Program (MSP). Eligible groups include Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualifying Individuals (QI–1s). QMBs have incomes no greater than 100% of the federal poverty level (FPL) and assets no greater than $4,000 for an individual and $6,000 for a couple. SLMBs meet QMB criteria, except that their incomes are greater than 100% of FPL but do not exceed 120% FPL.

Explanation of provision

The provision would modify the maximum resources levels. Beginning in 2009, the level would be the same for both Part D low-income subsidy groups. In 2009, the level would be $17,000 for an individual and $34,000 for a couple. In subsequent years, it would be the previous year's level increased by $1,000 for an individual and $2,000 for a couple. The provision would further specify that these maximum resources levels would also apply for determining eligibility for Medicare Savings programs. The provision would apply to eligibility determinations for periods beginning on or after January 1, 2009.

Reason for change

Millions of low-income Medicare beneficiaries do not qualify for financial assistance under the Part D low-income subsidy or the Medicare Savings Programs because they have a small nest egg that exceeds the maximum resource levels allowed under the programs' assets tests. The asset test is a barrier even for those who

do meet its strict limits because it requires people to fill out a daunting and invasive application form.

Increasing asset limits allows more people to qualify for the LIS, thereby closing the "doughnut hole" for those who can least afford it. The increase also allows more low-income people to qualify for MSP assistance with Medicare premiums and cost-sharing. Together these benefits can be worth thousands of dollars a year to low-income beneficiaries.

SECTION 212. MAKING QI PROGRAM PERMANENT AND EXPANDING ELIGIBILITY

Current law

Certain low-income individuals who are aged or have disabilities, as defined under SSI, and who are eligible for Medicare are also eligible to have their Medicare Part B premiums paid for by Medicaid under the Medicare Savings Program (MSP). Eligible groups include Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualifying Individuals (QIs). QMBs have incomes no greater than 100% of the federal poverty level (FPL) and assets no greater than $4,000 for an individual and $6,000 for a couple. SLMBs meet QMB criteria, except that their incomes are greater than 100% of FPL but do not exceed 120% FPL.

QIs meet the QMB criteria, except that their income is between 120% and 135% of poverty. Further, they are not otherwise eligible for Medicaid. Unlike the QMB and SLMB programs, federal spending under the QI program is subject to annual limits. The QI program is currently slated to terminate September 30, 2007.

Explanation of provision

The provision would make the QI program permanent. It would also eliminate the funding limitation, thereby expanding eligibility to all persons meeting the income and resources criteria. The provision would provide 100% FMAP for payments under the QI 14 program. These provisions would be effective October 1, 2007. The provision would also set the resources standard for the QI program at 150% of poverty, effective January 1, 2008.

Reason for change

The QI program has never attained maximum enrollment in part due to reauthorizations made for short periods of time, and often at the very last minute just before the program was scheduled to expire. Such instability is less than optimal for the states that administer the program and beneficiaries who rely on the benefit. It runs counter to the goal of the Medicare program of providing health care security to those in greatest need. Because health costs increase faster than incomes, protections for low income seniors are critical. In 2007, the Part B premium is approximately $1200 per year per senior, which constitutes approximately 8 percent of income for a senior at 150% of poverty. Making the QI program permanent will ensure all seniors have this protection on an annual basis.

Without this provision, beneficiaries currently receiving QI and the Part D low-income subsidy (LIS) would lose QI completely in October 2007 and would be required to apply and qualify separately for LIS. Increasing the income eligibility level to 150% corresponds with the eligibility limit for LIS, making administration of the two programs easier.

SECTION 213. ELIMINATING BARRIERS TO ENROLLMENT

Current law

In general, federal law stipulates few documentation requirements for Medicaid applicants, including persons who apply for coverage under the Medicare Savings Program (MSP). State policies on this issue vary based on the eligibility group, but a considerable amount of documentation may be required to determine whether an individual meets financial eligibility requirements for Medicaid. Although states have flexibility to collect income and asset information through self-declaration alone, they also have the ability to require supporting documentation.

Under the low-income subsidy (LIS) program under Part D, full benefit dual eligibles, QMBs, SLMBs, QIs, and recipients of SSI are deemed subsidy-eligible individuals for up to one year. Other persons, or their personal representatives, have to apply for assistance. Applicants may apply either at state Medicaid offices or Social Security offices. Applicants are required to provide information from financial institutions, as requested, to support information in the application, and to certify as to the accuracy of the information provided.

State Medicaid programs make LIS eligibility determinations for persons applying to the state Medicaid agency. These individuals are subject to the same income eligibility determination process as is applied to QMBs. Under this process, states may not apply income disregards allowed under section 1902(r)(2) authority (allows states, with the Secretary's approval, to disregard certain income amounts when calculating an applicant's income level, among others).

The Commissioner of the Social Security Administration (SSA) is required to make such LIS determinations for persons applying at SSA offices. No specific time frame is established for these determinations.

Determinations that the individual is a subsidy eligible individual remain in effect for a period specified by the Secretary, but not greater than 1 year. Eligibility was redetermined in 2006 for 2007; persons were notified in September 2006 if their subsidy status was changing. Redeterminations and appeals are to be handled by the same agency making the initial determination.

Current law requires the Commissioner of Social Security to conduct outreach efforts to identify persons potentially eligible for assistance under the MSP program and to notify such persons of the availability of assistance. Outreach efforts are to be coordinated with the states.

Explanation of provision

The provision would specify that persons applying for the Part D LIS would be permitted to qualify on the basis of self-certification of income and resources without the need to provide additional documentation. A subsidy eligible individual (or particular class of such an individual, such as a full subsidy individual or partial subsidy individual) would be deemed to continue to be eligible without the need for any annual or periodic application unless and until the individual notified a federal or state official responsible for such determinations that the individual's eligibility conditions changed so that the individual was no longer a subsidy eligible individual or no longer within such class of such individuals.

The provision would require the Secretary to take all reasonable steps to encourage states to provide, under the MSP program, for administrative verification of income and automatic reenrollment as newly provided for under the low-income subsidy program.

The provision would extend the outreach requirements currently applicable for the Commissioner of Social Security. The Commissioner would be required to provide applicants for Medicare Part A benefits information describing the LIS and MSP programs, an application for enrollment under the low-income subsidy program as well as an application form for MSP (developed pursuant to the current requirement for a Model Form). The Commissioner would also be required to provide such individuals with information on how they could obtain assistance in completing the form and how they could contact the appropriate State Health Insurance Assistance Program (SHIP).

The Commissioner would be required to make such application forms available in local social security offices. The Commissioner would be required to provide training to SSA employees who were involved in receiving social security and Medicare Part A benefit applications; the training would be to assist applicants in completing an MSP application. Persons so trained would be required to provide such assistance upon request. Employees completing such an application would be required, subject to the applicant's consent, to transmit it to the appropriate State Medicaid agency. The Commissioner would be required to coordinate outreach activities with state outreach activities.

States would be required to accept MSP applications and to act on them in the same manner, and subject to the same deadlines, as if the applicants had submitted them directly.

The provision would require the Secretary to translate the Model Form used for MSP applications into at least 10 languages (other than English) that are most often used by persons applying for social security or Medicare Part A benefits. The Secretary would make such translated forms available to the states and to the Commissioner of Social Security.

The provision would amend the Internal Revenue Code by adding a new Section 6103(l)(21) relating to the disclosure of return information for purposes of providing low-income subsidies under Medicare. The Secretary of the Treasury, upon written request from the Commissioner of Social Security, would be required to disclose with respect to any taxpayer identified by the Commissioner as potentially eligible for low-income subsidies (based on information other

than return information): (1) whether the adjusted gross income of the taxpayer exceeded the amounts specified in order to meet the maximum low-income subsidy levels of 135% of the federal poverty level; (2) whether such gross income was between 135% and 150% of the federal poverty level; (3) whether rollover distributions from an employer deferred compensation plan, an individual retirement plan, or a commercial annuity were reported to the Secretary; (4) whether the return was a joint return; and (5) the applicable year. The applicable year would be the most recent taxable year for which information was available in the IRS taxpayer information systems, or if no return was filed that year, the prior year. If no return was filed for both years, the Secretary of the Treasury would be required to notify the Commissioner of such fact. Return information could not be disclosed after the date that was two years after enactment.

The provision would include safeguards for information disclosure. Within 18 months of enactment, the Secretary of the Treasury, after consultation with the Commissioner of Social Security, would be required to submit a written report to Congress regarding the use of disclosures.

Reason for change

Administrative barriers often prevent low-income beneficiaries from getting the financial help they are eligible for under the law. This section requires SSA to administratively verify income and assets of individuals applying for the LIS—that is, SSA must use available information to verify income and assets without requiring the beneficiary to present paper documentation. For seniors with limited mobility, eliminating in-person documentation will greatly facilitate enrollment for millions.

Most low-income beneficiaries will continue to be low-income in perpetuity. These beneficiaries also have very low, often diminishing assets rather than assets that increase over time. Allowing beneficiaries determined eligible for LIS to automatically remain in the program without annually recertifying income and assets, provides stability and reduces the administrative burden on SSA caused by the redetermination process. In 2006, SSA rolled over LIS eligibility to 2007 unless new information came to light showing beneficiaries no longer qualified. To ensure such customer-friendly procedures continue, this provision generally prohibits SSA from conducting LIS redeterminations.

Enrollment rates for MSP are very low. The Congressional Budget Office estimates that only one-third of those eligible are enrolled. The Secretary of Health and Human Services will encourage states to follow the same best practices being used for LIS, for the MSP, allowing states to use administrative verification and automatic recertification to improve enrollment numbers and stability.

Many beneficiaries are not signed up for the extra help available through the MSP and LIS because they are simply unaware that they qualify. For example, many of the more than 2 million low-income individuals who applied to SSA for the low-income subsidy likely qualify for Part B assistance under the MSP but were never made aware of this important program. Beneficiaries will be much more likely to apply for benefits when SSA offices make LIS and

MSP applications available to individuals applying for Medicare benefits. Social Security Administration assistance in completing applications and coordination with the states will also streamline the application process for beneficiaries.

The MSP application to be provided is the uniform, simplified application developed by the Secretary under 1905(p)(5). Social Security offices throughout the country should use this uniform, simplified application (rather than a State-specific application) so that SSA can assist individuals in completing the application in the most efficient manner, and so that SSA does not need to train its employees in the unique program rules of a wide range of State programs. It is not the intent of the Committee that the administrative costs of this new workload be borne by SSA; rather, they should be financed by the Medicaid program. States would retain the responsibility for the taking of applications that are not nationally uniform or for obtaining State-specific supplemental information.

Medicare beneficiaries with limited English proficiency are among the hardest to reach and enroll in MSP. Translation of a simplified MSP application form into at least ten of the languages most often used by applicants for low-income assistance programs will ensure more beneficiaries apply and receive the extra help provided by the MSP.

There are between 3 and 4 million low-income beneficiaries who are likely eligible for, but not enrolled in, the Part D LIS. The SSA has conducted some outreach to these beneficiaries, but has been unable to sufficiently target those beneficiaries most likely eligible for help through the LIS. Allowing SSA to better target these beneficiaries by obtaining limited income and resource data from the Secretary of Treasury will increase the effectiveness of outreach efforts, and ensure more beneficiaries are enrolled in the LIS.

The Committee intends that the Social Security Administration will take immediate action on the authority granted to it to make a request for information from the Treasury Secretary. Upon receipt of that information, the Commissioner should take immediate action to target notices to the population identified as being most likely eligible for the LIS. Specifically the Commissioner should send a letter to each beneficiary identified who has not already applied for the LIS program, or has applied but been determined ineligible based on resources. This notice should include: a statement that the individual is likely eligible for the LIS; a description of the amount of premium and cost-sharing subsidies for which the individual would likely be eligible; an application for enrollment in the LIS program; and, information on how the individual may obtain assistance completing such application, including information on how the individual may contact the State Health Insurance Assistance Program (SHIP) for the state in which the individual is located. If an individual does not respond to the initial letter the Commissioner should make additional attempts to contact the individual.

SECTION 214. ELIMINATING APPLICATION OF ESTATE RECOVERY

Current law

Since 1993, Medicaid law has required states to recover, from the estate of the beneficiary, amounts paid by the program for certain long-term care, related services and other services at state option. Estate recovery applies when: (1) an individual age 55 years and older receives Medicaid assistance for nursing facility services, home and community-based services and related hospital and prescription drug services; and (2) an individual of any age is an inpatient in a nursing facility or an intermediate care facility for the mentally retarded and is not reasonably expected to be discharged from the institution and return home. Also included are dual eligibles entitled to Medicare Part A and/or Part B and who are eligible for full Medicaid benefits.

Explanation of provision

The provision would exempt from estate recovery any Medicaid payments for premiums, deductibles, and coinsurance made on behalf of an individual eligible under the Medicare Savings Program (MSP). The provision would take effect as of January 1, 2008.

Reason for change

The possibility of having cost-sharing protections received during one's lifetime recovered from a beneficiary's estate after death has long been identified as a barrier to enrollment in MSP in studies commissioned by the Centers for Medicare and Medicaid Services, reports from the Government Accountability Office and reports of private, non-profit advocacy organizations. Although the law does not require states to recover Medicare Savings Program benefits, it allows them to do so and at least 21 states reported in 2005 that they recover some or all of such benefits. Removing this barrier to enrollment in MSP opens up the possibility of substantial new benefits for those who chose not to enroll in the past out of concern about estate recovery.

SECTION 215. ELIMINATION OF PART D COST-SHARING FOR CERTAIN NON-INSTITUTIONALIZED FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS

Current Law

Full benefit dual eligibles who are residents of a medical institution or nursing facility have no Part D cost-sharing. Other full benefit dual eligible individuals with incomes up to 100% of poverty have cost-sharing for all costs up to the out-of-pocket threshold of $1 for a generic drug prescription or preferred multiple source drug prescription and $3.10 for any other drug prescription. These cost-sharing amounts increase each year by the Consumer Price Index. Other dual eligibles have cost-sharing for all costs up to the out-of-pocket threshold of $2.15 for a generic drug or preferred multiple source drug and $5.35 for any other drug. These cost-sharing amounts increase annually by the annual percentage increase in per capita beneficiary expenditures for Part D covered drugs.

Explanation of provision

The provision would specify that cost-sharing would not apply to persons who are full benefit dual eligibles and with respect to whom a determination was made that but for the provision of home and community based care, the individual would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded and such care would be paid for by Medicaid. Such home and community based care would be that provided under Section 1915 of the Social Security Act or under a waiver under Section 1115 of such act. The provision would apply to drugs dispensed on or after January 1, 2009.

Reason for change

For decades, policy makers at the state and federal level have made efforts to eliminate the bias toward institutionalization for those needing long term care services by providing benefits for needed health care services in community-based settings. Studies have shown that people needing long term care prefer to receive benefits in the community and that often such benefits can be provided at less cost than similar benefits in an institution.

Most people who receive long-term care services under Medicaid are required to pay nearly all their income to their care providers, saving only a small personal needs allowance to cover costs of clothing and incidentals. This is true whether they receive services in an institution or in the community. The Medicare Modernization Act for purposes of Part D made a distinction between beneficiaries who received care in a community setting and those in an institution, or nursing home. Beneficiaries in institutions were exempted from Part D cost-sharing, but those in the community—who were equally poor—were not. This provision in the Medicare drug bill was a setback to decades of federal and state policy to move toward care in community settings.

Extending the protection against cost-sharing to any dually eligible beneficiary who, as a condition of receiving services, is required to pay all but a small amount of his or her income to the care providers, will allow individuals with high drug usage to remain in the community for services rather than becoming institutionalized as a way of ensuring that they get necessary drugs.

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

Current law

The definitions of income and assets used for making eligibility determinations for the Part D low-income subsidy (LIS) generally follow that used for determining eligibility under the QMB, SLIMB, and QI programs (which in turn link back to the definitions used for purposes of the SSI program). There are, however, some differences. For purposes of LIS determinations, only liquid resources (or those that could be converted to cash within 20 days) and real estate that is not the applicant's primary residence is considered. Liquid resources include such things as checking and savings accounts, stocks, and bonds. Vehicles are excluded because they are

not considered liquid assets. The first $1,500 of burial expenses are also excluded.

Explanation of provision

The provision would exclude support and maintenance furnished in kind from the definition of income. The provision would also specify additional items to be excluded when making resources determinations. These additional exclusions would be any part of the value of any life insurance policy and any balance in any pension or retirement plan. The provision would take effect on January 1, 2009 and apply to determinations of eligibility for months beginning January 2009.

Reason for change

Many beneficiaries are discouraged from applying for the Part D Low-Income Subsidy (LIS) because of the complexity of calculating income and resources on the LIS application.

Beneficiaries currently must report as income the market value of in-kind support and maintenance (ISM) they receive from family members, charities, and others. For example, if their church brings a hot meal once a week or their daughter pays their utility bills, it must be reported. This calculation includes payments made for food, rent, and utilities, which can be very difficult to calculate. The amount of assistance a beneficiary gets from family and friends may fluctuate monthly, depending on expenses and when bills are due. The fair market value of some expenses, such as sewage and garbage collection is particularly difficult to calculate. Very few LIS applications are denied because of significant ISM income. Exempting this assistance from income determinations, and removing this difficult question from the LIS application will make it easier for beneficiaries to calculate their income and remove a real barrier to applying for LIS.

Applications for the LIS also require reporting of the cash surrender value of life insurance for calculation of the assets test. Beneficiaries often do not have the information about cash surrender value readily available, nor do they know how to obtain the information needed. Because they do not have or cannot obtain the information, beneficiaries do not complete that portion of the LIS application. Removing this information from the asset test calculation will simplify the application form and will allow more people to qualify for the LIS.

The current application also requires beneficiaries to report the balance of pension or other retirement accounts as an asset. These balances are often part of an annuity that supplements Social Security income, and are not like cash in the bank. Beneficiaries already report distributions from these accounts as income. It is not fair to treat the accounts as resources as well, since the accounts were intended to provide income over the course of retirement. Traditional defined benefit pension plans are already treated only as income; the pensions themselves do not count as resources. Exempting the balance of retirement accounts is a matter of equity. For many beneficiaries their 401(k) and other pension and retirement savings accounts represent their only retirement savings. Periodic distributions during retirement often constitute the only

income beneficiaries have to supplement their Social Security benefits and should not be double counted as income and resources.

Combined, removing the questions from the LIS application regarding the value of in-kind support and maintenance, the cash surrender value of life insurance, and the value of retirement accounts will greatly simplify the application process and increase accessibility to this important benefit. These questions are difficult to respond to accurately, and because of the strongly worded signature page, which mentions prison time for false statements, many people are fearful that they are completing the application incorrectly, despite the fact that they are doing so in good faith. These changes will simply the application process, both for the beneficiary and for the purposes of administration. Most importantly, simplifying the application process will extend access to the LIS program for more needy seniors and people with disabilities.

SECTION 217. COST-SHARING PROTECTIONS FOR LOW-INCOME SUBSIDY ELIGIBLE INDIVIDUALS

Current law

Non-institutionalized persons who are low-income subsidy (LIS) individuals are required to pay nominal cost-sharing charges. Full benefit dual eligible individuals with incomes under 100% of poverty are required to pay (in 2007) cost-sharing charges of $1 per prescription for generic or preferred drugs that are multiple source drugs and $3.10 per prescription for other drugs. Other persons with incomes under 135% of poverty and other Medicaid dual eligibles, MSP recipients and SSI recipients are subject to cost-sharing charges (in 2007) of $2.15 per prescription for generic or preferred drugs that are multiple source drugs and $5.35 per prescription for other drugs.

Low-income subsidy persons not meeting the requirements as full subsidy eligible persons have (in 2007) a $53 deductible, 15% cost-sharing for all costs up to the out-of-pocket threshold, and cost-sharing for costs above the out-of-pocket threshold of $2.15 per prescription for generic or preferred drugs that are multiple source drugs and $5.35 per prescription for other drugs.

Each year, the cost-sharing amounts for full benefit dual eligibles below 100% of poverty are increased by the increase in the CPI. The cost-sharing amounts for all other persons are increased by the annual percentage increase in per capita beneficiary expenditures for Part D covered drugs.

Explanation of provision

The provision would limit aggregate cost-sharing in a year to 2.5% of income.

Reason for change

Beneficiaries receiving the low-income subsidy (LIS) tend to be high utilizers of prescription drugs. The poorest of this group, those dually eligible for Medicare and Medicaid, fill, on average, 10 more prescriptions than other Medicare beneficiaries. As these individuals are sicker and take more drugs—the costs add up quickly.

While Part D cost-sharing for those receiving the LIS—currently capped at $2.15 and $5.35 for most LIS beneficiaries—may seem nominal to some, it is higher than many low income beneficiaries previously paid under Medicaid and it is indexed to increase each year. Additionally, those who receive the partial LIS are required to pay 15% of the drug cost as their cost-sharing. For an expensive brand name drug like Fuzeon for HIV/AIDS, this amount could be over $300/month, or about twenty-five percent of the monthly income of a person receiving the partial subsidy.

Cost-sharing has been shown in studies to be a barrier to care: higher co-payments tend to cause low-income people to decrease utilization of essential and preventive health care, and can trigger the subsequent use of more expensive services such as emergency room care or hospitalization. Under this provision, those eligible for the lowest cost-sharing will pay no more than $255/year out-of-pocket; those with the highest cost-sharing requirements will pay no more than about $385/year (in 2007 numbers).

SECTION 218. INTELLIGENT ASSIGNMENT IN ENROLLMENT

Current law

The Medicare Modernization Act required the Secretary to establish a process for the enrollment, disenrollment, termination, and change of enrollment in Part D. As part of the process, the law required automatic enrollment for full benefit dual eligibles who failed to enroll in a PDP or MA–PDP plan. Individuals are enrolled with the plan in the region that has a premium not exceeding the premium subsidy amount. If more than one such plan is available, enrollment among these plans is made on a random basis. Nothing prevents an individual from declining such enrollment or disenrolling from the plan in which they are enrolled and enrolling in a different plan. Further, full benefit dual eligibles can change plan enrollment at any time, with enrollment in the new plan effective the following month. The auto-enrollment process is ongoing for persons newly establishing eligibility. In July 2006, CMS announced that it was implementing a process for auto-enrolling prospective full benefit dual eligibles.

Explanation of provision

The provision would specify that no Part D full benefit dual eligible individual could be enrolled in a plan that did not meet certain requirements. The plan's formulary would have to cover 95 percent of the 100 most commonly prescribed generic covered Part D drugs and 95 percent of the 100 most commonly prescribed brand name covered Part D drugs for the population entitled to Part A or enrolled in Part B. The calculations would be based on non-duplicative prescriptions. The plan would be required to have a network of pharmacies that substantially exceeded the minimum requirements for prescription drug plans in the state and that provided access in areas where lower income individuals reside. The plan (except for a new plan, as defined by the Secretary) would have to have an above average score on quality ratings made by the Secretary on prescription drugs plans. Further, the total cost of providing coverage under the plan (consistent with the new require-

ments) would have to be among the lowest 25th percentile of prescription drug plans under Part D in the state. The provision would further stipulate that in case no plan met these requirements, the Secretary would be required to implement the provision to the greatest extent possible. This would be done with the goal of protecting beneficiary access to drugs without increasing the cost relative to the auto-enrollment process as in existence before the date of enactment. The provision would take effect for enrollments effected on or after November 15, 2009.

Reason for change

Random assignment is a useful tool to enroll dual eligible beneficiaries in the Part D drug program; unfortunately, it has turned out to be a bad policy for beneficiaries and taxpayers. Enrolling individuals based solely on below average premiums is not a good surrogate for either quality or savings. The current system assigns many dual-eligible beneficiaries to plans that do not cover some or even many of the most commonly prescribed drugs, forcing many of these individuals to go without necessary drugs or to switch plans.

Current policy also randomly assigns dual-eligibles to plans with widely varying costs to the taxpayer. Often these beneficiaries are assigned to plans where the cost of a package of commonly-prescribed drugs is higher than it is in plans that are not eligible to receive randomly-assigned beneficiaries. This provision will help low-income beneficiaries by ensuring better coverage of key drugs, while giving more attention to the quality of the plans they are assigned to. It will help taxpayers by ensuring that assignment decisions consider the total cost of providing a package of drugs, not just the premium cost.

SUBPART C—PART D BENEFICIARY IMPROVEMENTS

SECTION 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

Current law

PDP sponsors and MA–PD plans are required to offer a minimum set of benefits, referred to as "qualified coverage." "Qualified coverage" is defined as either "standard prescription drug coverage" or "alternative prescription drug coverage" with at least actuarially equivalent benefits (i.e., having at least equivalent dollar value). In both cases, access must be provided to negotiated prices for drugs.

For 2007, the "standard prescription drug coverage" is defined as follows: (1) $265 deductible paid by the beneficiary; (2) then 75% of costs paid by the program and 25% of costs paid by the beneficiary up to the initial coverage limit ($2,400, accounting for $798.75 in total out-of pocket costs and $2,400 in total spending); (3) then 100% of costs paid by beneficiary for drug spending falling in the coverage gap between $2,400 and $5,451.25 ($3,051.25, accounting for total beneficiary out-of-pocket spending of $3,850); and (4) then all costs paid by program over $5,451.25 in total spending except for nominal beneficiary cost-sharing. Each year, the dollar

amounts are increased by the annual percentage increase in average per capita aggregate expenditures for covered outpatient drugs for Medicare beneficiaries for the 12-month period ending in July of the previous year.

For purposes of calculating beneficiaries' out-of-pocket costs, costs are only considered incurred if they are incurred for the deductible, cost-sharing, or benefits not paid because they fall in the coverage gap (sometimes referred to as the "doughnut hole"). Incurred costs do not include amounts for which no benefits are provided because a drug is excluded under a particular plan's formulary. Costs are treated as incurred, and thus treated as true out-of-pocket (TROOP) costs only if they are paid by the individual (or by another family member on behalf of the individual), paid on behalf of a low-income individual under the low-income subsidy (LIS) provisions, or under a state pharmaceutical assistance program. Any costs for which the individual is reimbursed by insurance or otherwise do not count toward the TROOP amount.

Explanation of provision

The provision would include costs paid by the Indian Health Service, Indian tribe or tribal organization or an urban Indian organization (as defined in Section 4 of the Indian Health Care Improvement Act) toward the out-of-pocket threshold. It would also include costs paid under an AIDS Drug Assistance Program under Part B of Title XXVI of the Public Health Service Act. The provision would apply to costs incurred on or after January 1, 2009.

Reason for change

The Medicare Modernization Act (MMA) prevents drug spending by other government programs from counting toward the calculation of so-called true out-of-pocket costs (TrOOP), with one exception, state pharmaceutical assistance programs. The law excluded Indian Health Service (IHS) spending, and AIDS Drug Assistance Programs (ADAPs) were excluded by regulation.

Allowing this assistance to count toward a beneficiary's out of pocket spending is critical because it determines when "catastrophic coverage" begins. Catastrophic coverage is the coverage level that individuals with exceptionally high drug costs ($3,850 in out-of-pocket costs in 2007) reach wherein their cost sharing falls from roughly 25% of drug costs to 5% of drug costs. Under current rules, ADAP and IHS spending does not count as out-of-pocket spending, so it does not help individuals reach the catastrophic coverage level. Because ADAP and IHS spending does not count toward TrOOP, these programs cannot stretch their limited funding as far as possible, despite unmet need and waiting lists for services.

Allowing ADAP and IHS assistance to count towards TrOOP will allow beneficiaries to get to the catastrophic coverage that all other beneficiaries enjoy while freeing up needed funds for ADAP and IHS programs to help meet other health care needs.

SECTION 222. PERMITTING MID-YEAR CHANGES IN ENROLLMENT FOR FORMULARY CHANGES ADVERSELY IMPACTING AN ENROLLEE

Current law

Plans can change their formularies at the beginning of a year. During the year, the law permits plans to remove drugs from a formulary or change the preferred or tier status of a drug only after giving notice to the Secretary, affected enrollees, physicians, pharmacies and pharmacists. Some persons expressed concerns that beneficiaries might select an individual plan based on its coverage of a particular drug, which might be subsequently dropped from the list. In response, in April 2006, CMS provided a guidance document to Part D plan sponsors outlining its approach to formulary plan changes during a plan year. The guidance document noted that both industry best practices and the best interests of Medicare beneficiaries called for limited formulary changes during the plan year. Generally, plans can expand formularies, modify therapeutic categories and classes only to account for new therapeutic uses and newly approved drugs, and make formulary maintenance changes.

The guidance document stated that plans could make other formulary changes, such as removing drugs from the formulary, moving drugs to a less preferred tier status, or adding utilization management requirements only in accordance with specified procedures. The document further stated that plans should make such formulary changes during the year only if enrollees currently taking the affected drugs were exempted from the change for the remainder of the plan year. CMS stated its expectation that plans would continue to comply with this policy in subsequent years, and would include such assurances in plans' future bids and contracts.

Explanation of provision

The provision would establish a special open enrollment period for an individual to change plans during a period other than during the annual open enrollment period. The provision would apply to an individual enrolled in a prescription drug plan (or a MA-PD plan) who was prescribed a drug while enrolled in the plan and the formulary of the plan materially changed (other than at the end of the contract year) such as to reduce coverage or change the cost-sharing of the drug. The provision would not apply in cases where the drug was removed from the formulary because of a recall or withdrawal issued by the Food and Drug Administration. The provision would apply to contract years beginning on or after January 1, 2009.

Reason for change

Beneficiaries choose prescription drug plans based on a number of factors, not the least of which is whether a plan covers the drugs they are currently taking. Though CMS has imposed certain restrictions on plan formulary changes, there is no protection for beneficiaries who are nonetheless harmed by a mid-year formulary change. This provision will allow adversely affected beneficiaries to choose a new plan, and will discourage plans from making mid-year formulary changes for highly prescribed drugs.

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

Current law

Prescription drug plans and MA–PD plans are not allowed to include benzodiazepines in their formularies.

Explanation of provision

The provision would remove the exclusion of benzodiazepines from those drugs prescription drug plans are required to include in their formularies. The provision would apply to prescriptions dispensed on or after January 1, 2009.

Reason for change

Benzodiazepines are a class of drugs commonly and safely used to manage health conditions including anxiety disorders, seizures, and other medical conditions. This class of drugs includes such frequently prescribed medications as Klonopin and Ativan. There is no clinical justification to exclude benzodiazepines from Medicare. Eliminating the current law exclusion from coverage for benzodiazepines will ensure beneficiaries have access to this important class of drugs.

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

Current Law

Medicare law defines covered drugs and biologicals as those included (or approved for inclusion) in specified compendia or approved by the pharmacy and drug therapeutics committee of the medical staff of the hospital furnishing the drug. The term drugs also include drugs or biologicals used in an anticancer chemotherapeutic regimen for a medically accepted indication. The term medically accepted indication includes any use which has been approved by the Food and Drug Administration (FDA). The term also includes another use if the drug itself has been approved by the FDA and the use has been supported by one or more citations (or approved for inclusion) in one or more compendia specified in the law or other authoritative compendia identified by the Secretary, unless the Secretary determines that the use is not medically appropriate or the use is identified as not indicated in one or more compendia. The Secretary may revise the list of compendia as appropriate. CMS has proposed a formal process for accepting and acting on requests for changes to the list of compendia.

Under Medicare Part D, formularies of prescription drug plan and MA–PD plans must include drugs within each therapeutic category and class of covered Part D drugs, although not necessarily all drugs within such categories and classes. The Secretary was required to request the United States Pharmacopeia to develop a list of categories and classes that could be used by prescription drug plans and to revise such classifications from time to time to reflect changes in therapeutic uses of covered drugs and the additions of new covered drugs. A plan sponsor can not change the therapeutic

categories and classes, other than at the beginning of a year, except as the Secretary may permit to take into account new therapeutic uses and newly approved covered Part D drugs.

Explanation of provision

The provision would permit the Secretary to apply the same process for updating compendia used under Part D as is used for purposes of Part B.

Reason for change

In Medicare, Part B drugs and biological products are covered if listed in one of three compendia. One of the compendia, American Medical Association's Drug Evaluation is no longer in existence. A second compendium, U.S. Pharmacopeia—Drug Index, is changing its ownership and name. The third compendium, American Hospital Formulary Service—Drug Information, is still being utilized. CMS has expressed concern about this situation and under its authority to revise the list of Part B compendia has issued a proposed rule to make needed revisions to the list of Part B compendia utilized by the agency.

It is extremely important for Medicare patients to have timely access to drugs and biological products, but the Secretary does not currently have the same authority to add compendia to Part D as is currently happening in Part B. The process for updating Part B compendia at outlined in the proposed rule should be used to update Part D compendia as well.

This provision allows the Secretary to use a similar process for updating Part D compendia as is currently taking place in Part B. The Committee believes that both Part D and Part B compendia should be updated simultaneously using this process as soon as feasible. The Secretary should take into account that compendia that may be appropriate for Part B, may not be appropriate for Part D, and vice versa.

SECTION 225. CODIFICATION OF SPECIAL PROTECTIONS FOR SIX PROTECTED DRUG CLASSIFICATIONS

Current law

Under Medicare Part D, formularies of prescription drug plans and MA-PD plans must include drugs within each therapeutic category and class of covered Part D drugs, although not necessarily all drugs within such categories and classes. CMS has required plans to cover all or substantially all drugs in the following six classes: anticonvulsants, antineoplastics, antiretrovirals, antidepressants, antipsychotics, and immunosuppressives. CMS stated that it instituted the policy because it felt it necessary to ensure that Medicare beneficiaries reliant on these drugs would not be substantially discouraged from enrolling with Part D plans and to mitigate the risks and complications associated with interruption of therapy for vulnerable populations. Under the policy, plan sponsors can not implement prior authorization or step therapy requirements that are intended to steer beneficiaries to preferred alternatives within classes for enrollees already taking a drug.

Explanation of provision

The provision would codify the CMS requirement. Specifically plans would be required to include all or substantially all drugs in the following therapeutic classes: anticonvulsants, antineoplastics, antiretrovirals, antidepressants, antipsychotics, and immunosuppressives. A sponsor of a prescription drug plan would only be permitted to use prior authorization or step therapy for the initiation of medications within one of these classifications if approved by the Secretary. However, such prior authorization or step therapy could not be used in the case of antiretrovirals or in the case of individuals already stabilized on a drug treatment regimen. The amendment would apply for plan years beginning on or after January 1, 2009.

Reason for change

The current policy requiring Part D plans to cover "all or substantially all" drugs in the six classes is sub-regulatory and can be changed or eliminated by CMS at anytime. This is an essential consumer protection that should not be substantially changed or allowed to expire.

These drug classes were initially selected for extra protection because they are critical to some of Medicare's most vulnerable beneficiaries including individuals with HIV/AIDS, cancer, serious mental illness such as schizophrenia and bi-polar disorder, epilepsy, autoimmune disorders, and organ transplant recipients. Unlike other drug classes, where drugs may be chemically similar and it may be safe to substitute one drug for another, drugs in these classes are less interchangeable. Physicians need the flexibility to prescribe all of the drugs within these classes to meet the individualized needs of their patients. Coverage of nearly all of the drugs in these categories is standard practice among state Medicaid programs and private insurers.

Many of the drugs in these classes are the latest generation pharmaceuticals, which remain on patent. This means that they can often be among the most costly drugs available. This creates added risks that plans will attempt to restrict access for financial considerations without due concern for the patient's best interests. Overzealous prior authorization and cost-sharing requirements imposed on drugs in these classes could be used by plans to steer the sickest patients away from these drugs or could limit access in ways that are detrimental to patient health.

SECTION 226. ELIMINATION OF MEDICARE PART D LATE ENROLLMENT PENALTIES PAID BY LOW-INCOME SUBSIDY-ELIGIBLE INDIVIDUALS

Current law

A late enrollment penalty is assessed on persons who go for 63 days or longer after the close of their initial Part D enrollment period without creditable coverage and subsequently enroll in Part D. The penalty is based on the number of months the individual does not have creditable coverage. The premium that would otherwise apply is increased for each month without creditable coverage.

In 2006, CMS established a special enrollment period for persons eligible for a low-income subsidy. Specifically, persons deemed eligi-

ble for a low-income subsidy after the close of the initial enrollment period on May 15, 2006, could still enroll in a Part D plan in 2006. These late enrollees were not subject to the late enrollment penalty otherwise applicable to persons who missed the 2006 enrollment deadline. This policy was extended for an additional year through 2007.

Explanation of provision

The provision would eliminate the late enrollment penalties for low-income subsidy eligible individuals, beginning January 2008.

Reason for change

The Centers for Medicare and Medicaid Services (CMS) estimates that 3.2 million low-income Medicare beneficiaries remain unenrolled in Part D and have no other drug coverage. Though CMS has waived the late enrollment penalty for Low-Income Subsidy (LIS) recipients for 2006 and 2007, the potential for the imposition of a late enrollment penalty may hinder efforts by the Social Security Administration and community-based organizations to reach out to low-income Medicare beneficiaries and enroll them in Part D and the LIS.

The late enrollment penalty is counter-productive for low-income beneficiaries. These beneficiaries are the least able to afford late penalties and the most likely to be discouraged from enrollment in Part D because of a penalty. The principal purpose of a late enrollment penalty—to encourage enrollment in Part D by beneficiaries with low drug spending who don't want to pay premiums does not apply to recipients of the low income subsidy who qualify for coverage at no premium.

Eliminating the Part D late enrollment penalty makes Part D consistent with Part B. Enrollees in Medicare Savings Programs, which help pay premiums and cost sharing under Part B, are exempt from the Part B late enrollment penalty.

SECTION 227. SPECIAL ENROLLMENT PERIOD FOR LOW-INCOME SUBSIDY ELIGIBLE INDIVIDUALS

Current law

The law establishes special enrollment periods for individuals enrolling in Part D outside of the annual open enrollment period. In 2006, CMS established a special enrollment period for persons eligible for a low-income subsidy. Specifically, persons deemed eligible for a low-income subsidy after the close of the initial enrollment period on May 15, 2006, could still enroll in a Part D plan in 2006. This policy was extended for an additional year through 2007.

Explanation of provision

The provision would establish a new special enrollment period for persons deemed to be low-income subsidy eligible individuals. The period would be the 90-day period beginning on the date the individual received notification that he or she was a subsidy eligible individual. The special period could apply to individuals currently enrolled in a prescription drug plan or an MA–PD plan on the date of such determination.

The provision would require the Secretary to provide for a facilitated enrollment for persons were deemed low income subsidy eligible persons but who failed to enroll in a prescription drug plan or MA–PD plan during the special enrollment period. The process would provide for enrollment in the prescription drug plan or MA–PD plan that was most appropriate for the individual, as determined by the Secretary. Nothing would prevent such individual from declining enrollment or changing enrollment.

The provision would apply with respect to subsidy determination made for months beginning with January 2008.

Reason for change

In 2006 and 2007, CMS allowed Low-Income Subsidy (LIS) eligible beneficiaries to sign up for a plan at anytime. Under this provision Medicare beneficiaries who qualify for the LIS may enroll in a Part D or Medicare Advantage plan with drug coverage without waiting for the annual election period (November 15 through December 31).

This section allows immediate access to drug coverage for the 3.2 million low-income Medicare beneficiaries who remain without drug coverage and unenrolled in the low-income subsidy. Providing immediate access to drug coverage will greatly facilitate efforts by SSA and community-based organization to find and enroll this hard-to-reach population.

SUBTITLE D—REDUCING HEALTH DISPARITIES

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

Current law

No provision.

Explanation of provision

This provision would require the Secretary to collect data on race, ethnicity and the primary language of Medicare applicants and beneficiaries to be used in analyses related to health disparities. The Secretary would: (1) use, 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; (2) use the standards developed for the collection of language data as described below; (3) where practicable, collect data for additional population groups if such groups can be aggregated into the minimum race and ethnicity categories; and (4) where practicable, collect the data through self-reporting.

In collecting this data for applicants and recipients who are minors or otherwise legally incapacitated, the Secretary would require that the data be collected from the parent or legal guardian of such an applicant or recipient and that the preferred language of the parent or legal guardian of such an applicant or recipient be collected. The Secretary would also be required to systematically analyze the data at least annually using the smallest appropriate units of analysis feasible to detect racial and ethnic disparities in health and health care and when appropriate, for men and women sepa-

rately. The Secretary would report the results of these analyses annually to the Director of the Office for Civil Rights, the Committee on Health, Education, Labor, and Pensions and the Committee on Finance of the Senate, and the Committee on Energy and Commerce and the Committee on Ways and Means of the House of Representatives. The Secretary would also ensure that the provision of assistance to an applicant or recipient of assistance is not denied or otherwise adversely affected because of the failure of the applicant or recipient to provide race, ethnicity, and primary language data.

This provision specifies that nothing in this subsection shall be construed to permit the use of the information collected in a manner that would adversely affect any individual providing any such information, nor to require health care providers to collect data.

The data collected for these purposes would be protected, through the promulgation of regulations by the Secretary or otherwise, under the same privacy protections as the Secretary applies to other health data under regulations promulgated under the Health Insurance Portability and Accountability Act of 1996 (HIPAA) relating to the privacy of individually identifiable health information and other protections. The Secretary would also ensure that the data is protected from all inappropriate internal use by any entity that collects, stores, or receives the data, including use of such data in determinations of eligibility (or continued eligibility) in health plans, and from other inappropriate uses, as defined by the Secretary.

In collecting this data, the Secretary would develop and implement a plan to improve the collection, analysis, and reporting of racial, ethnic and primary language data within the Medicare program. In consultation with the National Committee on Vital Health Statistics, the Office of Minority Health, and other appropriate public and private entities, the Secretary would make recommendations on how to: (1) collect the aforementioned data while minimizing the cost and administrative burdens of data collection and reporting; (2) expand awareness that data collection, analysis, and reporting by race, ethnicity, and primary language is legal and necessary to assure equity and non-discrimination in the quality of health care services; (3) ensure that future patient record systems have data code sets for racial, ethnic, and primary language identifiers and that such identifiers can be retrieved from clinical records, including records transmitted electronically; (4) improve health and health care data collection and analysis for more population groups if such groups can be aggregated into the minimum race and ethnicity categories; (5) provide researchers with greater access to racial, ethnic, and primary language data, subject to privacy and confidentiality regulations; and (6) safeguard and prevent the misuse of the data collected.

The data collected on race, ethnicity and primary language would be obtained, maintained, and presented (including for reporting purposes and at a minimum) in accordance with the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity. Not later than 1 year after the date of enactment, the Director of the Office of Minority Health, in consultation with the Office for Civil Rights of the

Department of Health and Human Services, would develop and disseminate Standards for the Classification of Federal Data on Preferred Written and Spoken Language.

The Secretary would be able, either directly or through grant or contract, to provide technical assistance to enable a health care program or an entity operating under the Medicare program to comply with the requirements of this section. Assistance provided under this subsection may include assistance to: (1) enhance or upgrade computer technology that will facilitate racial, ethnic, and primary language data collection and analysis; (2) improve methods for health data collection and analysis including additional population groups beyond the Office of Management and Budget categories if such groups can be aggregated into the minimum race and ethnicity categories; (3) develop mechanisms for submitting collected data subject to existing privacy and confidentiality regulations; and (4) develop educational programs to raise awareness that data collection and reporting by race, ethnicity, and preferred language are legal and essential for eliminating health and health care disparities.

Acting through the Director of the Agency for Health Care Research and Quality and in coordination with the Administrator of the Centers for Medicare and Medicaid Services, the Secretary would develop a number of analyses using the racial, ethnic and primary language data. These would include: (1) identifying appropriate quality assurance mechanisms to monitor for health disparities under the Medicare program; (2) specifying the clinical, diagnostic, or therapeutic measures which should be monitored; (3) developing new quality measures relating to racial and ethnic disparities in health and health care; (4) identifying the level at which data analysis should be conducted; and (5) sharing data with external organizations for research and quality improvement purposes, in compliance with applicable Federal privacy laws.

Not later than 2 years after the date of enactment, and biennially thereafter, the Secretary would submit to the appropriate committees of Congress a report on the effectiveness of data collection, analysis, and reporting on race, ethnicity, and primary language under the Medicare program. The report would evaluate the progress made with respect to the data collection, analysis and reporting improvement plan described above or subsequent revisions thereto. The provision authorizes to be appropriated such sums as may be necessary for each of fiscal years 2008 through 2012 to carry out this section.

Reason for change

While it is widely recognized that racial and ethnic disparities exist in Medicare, it is difficult to determine the extent to which disparities exist without having adequate data. Collecting such data will help CMS to establish baseline information about racial and ethnic disparities within Medicare which will assist in the development of interventions to address disparities and measure progress toward that goal.

SECTION 232. ENSURING EFFECTIVE COMMUNICATION BY THE CENTERS FOR MEDICARE AND MEDICAID SERVICES

Current law

Congress passed Title VI of the Civil Rights Act of 1964 to ensure that federal money is not used to support programs or activities that discriminate on the basis of race, color, or national origin. The United States Supreme Court has treated discrimination based on language as national origin discrimination. Therefore, recipients of federal funds (including hospitals, nursing homes, state Medicaid agencies, managed care organizations, home health agencies, health service providers, human service organizations, and any other health or human services federal fund recipient, as well as subcontractors, vendors, and subrecipients) are required to take reasonable steps to ensure that persons with limited English proficiency have meaningful access to programs and activities. The Department of Health and Human Services has issued guidance, including a four-factor analysis, that implicates the "mix" of language services that should be offered, including oral and written interpretation services.

Explanation of provision

This provision would require the Secretary of Health and Human Services to conduct a study examining ways that Medicare should pay for language services, using the results from the demonstration program described in Section 233. The study would be required to include an analysis of the following: (1) how to develop and structure appropriate payment systems for language services for all Medicare service providers; (2) the feasibility of adopting a payment methodology for on-site interpreters, including independent contractors and agency employees, so that such interpreters could directly bill Medicare for services provided in support of physician office services for Medicare patients with limited English proficiency; (3) the feasibility of Medicare contracting directly with agencies that provide off-site interpretation, including telephonic and video interpretation, so that such contractors would directly bill Medicare for the services provided in support of physician office services for Medicare patients with limited English proficiency; (4) the feasibility of modifying the existing Medicare resource-based relative value scale (RBRVS) by using adjustments, such as multipliers or add-ons, when a patient has limited English proficiency; and (5) how adjustments to the RBRVS for when a patient has limited English proficiency would be funded and how such funding would affect physician payments, a physician's practice, and beneficiary cost-sharing. In considering payment methods, the Secretary could allow variations in types of service providers, available delivery methods, and costs for providing language services. The costs could include (1) the type of language services provided, such as the provision of health care or health care related services directly in a non-English language by a bilingual provider or use of an interpreter; (2) the type of interpretation services provided, such as in-person, telephonic, or video interpretation; (3) the methods and costs of providing language services, including the costs of providing language services with internal staff or through contract

with external independent contractors and/or agencies; (4) providing services for languages not frequently encountered in the United States; and (5) providing services in rural areas. The Secretary would be required to submit a report on the study to the appropriate committees of Congress within a year of the expiration of the demonstration program.

If a Medicare Part C organization fails substantially to provide language services to limited English proficient beneficiaries enrolled in the plan, as required, then the Secretary would be allowed to place sanctions on the organization.

Reason for change

In addition to evaluating the effectiveness of culturally and linguistically appropriate care, as directed in Section 233, Medicare needs to determine specific payment modifications that should be made in order to reimburse for these services. If both of these functions are not performed, CMS will not be able to establish an effective program for delivering culturally and linguistically appropriate services. Furthermore, providing for sanctions against health plans will assure greater compliance with the requirements under the law.

SECTION 233. DEMONSTRATION TO PROMOTE ACCESS FOR MEDICARE BENEFICIARIES WITH LIMITED ENGLISH PROFICIENCY BY PROVIDING REIMBURSEMENT FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES

Current law

No provision.

Explanation of provision

This provision would require the Secretary of Health and Human Services (HHS), acting through the Centers for Medicare and Medicaid Services (CMS), to award 24 3-year demonstration grants to eligible Medicare service providers within one year of the enactment of the Act. The purpose of the demonstrations would be to improve effective communication between Medicare service providers and Medicare beneficiaries who are limited English proficient. Each 3-year grant must be less than or equal to $500,000.

To be eligible for a grant, an entity would be required to (1) be a service provider under Medicare Part A, B, C, or D, and (2) prepare and submit a timely and complete application to the Secretary.

To the extent feasible, the Secretary would be required to award the grants to an equal number of service providers under each part of Medicare (Parts A, B, C, and D), such that 6 providers, sponsors, or organizations under each of the 4 parts would receive grants. For example, the number of Part D sponsors receiving grants would be equal to the number of Part C organizations receiving grants, which would be equal to the number of part B service providers receiving grants. The Secretary would be required to give priority consideration to applicants that have developed partnerships with community organizations or with agencies with experience in language access. The Secretary would be required to ensure

that variation exists among grantees in the type of service provider, and the languages needed and their frequency of use. The demonstration projects would be required to be a mix of urban and rural settings, be located in at least two geographic regions, and in at least two large metropolitan statistical areas with diverse populations.

A grantee would be allowed to use the grant funds to pay for the provision of competent language and translation services to Medicare beneficiaries who are limited English proficient. The grantee could provide either health care (or health care related) services through a bilingual health care provider or competent interpreter services, such as on-site interpretation, telephonic interpretation, or video interpretation. The grantee would be permitted to use bilingual providers, staff, or contract interpreters. Up to 10% of the grant funds could be used to pay for required reporting and administration costs associated with the provision of competent language services.

Grantees who are also Medicare Part C organizations or Part D sponsors would be required to ensure that their network providers, including physicians and pharmacies, receive at least 50% of the grant funds to pay for the provision of competent language services to Medicare beneficiaries who are limited English proficient.

Payments to grantees would be required to be calculated based on the estimated number of limited English proficient Medicare beneficiaries in a grantee's service area. These calculations would be required to use either (1) the number of limited English proficient who speak English less than "very well" derived from the Bureau of the Census, or other State-based study the Secretary determines is likely to yield accurate data, or (2) the grantee's own data. The grantee's data could be used if it is routinely collected in a manner that the Secretary deems to be accurate, and if the grantee's data shows greater numbers of limited English proficient individuals than the data from Bureau of the Census or other State-based study.

Payments would be contingent on grantees reporting their costs of providing language services. The Secretary would be allowed to terminate the grant, and solicit applications from new grantees, if a grant fails to provide such reports.

Payment would also be contingent on grantees utilizing competent bilingual staff, or competent interpretation or translation services. The interpretation or translation services must meet State standards; if the grantee is operating in a state without statewide standards, the grantee would be required to utilize interpreters who follow the National Council on Interpreting in Health Care's Code of Ethics and Standards of Practice. These standards would not be required if either (1) a beneficiary, who has been informed of the availability of free interpreter and translation services, requests the use of family, friends, or other individuals untrained in interpretation or translation, or (2) a medical emergency arises where the delay directly associated with a competent interpreter or translation service would jeopardize the health of the patient. In the first case, the grantee would be required to document the request in the beneficiary's record. The second case would not exempt emergency rooms, or similar entities that regularly provide health

care services in medical emergencies, from having in place systems to provide competent interpreter and translation services without undue delay.

Grantees would be required to (1) ensure that appropriate staff receive ongoing education and training in linguistically appropriate service delivery; (2) ensure the linguistic competence of bilingual providers; (3) offer and provide appropriate language services at no additional charge to each patient with limited English proficiency at all points of contact, in a timely manner, and during all hours of operation; (4) notify Medicare beneficiaries of their right to receive language services in their primary language; (5) post signage in the languages of the commonly encountered group or groups present in the service area of the organization; and (6) ensure that primary language data are collected for recipients of language services, in a manner that is consistent with the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If the recipient of language services is a minor or incapacitated, then the primary language of the parent or legal guardian would be collected and utilized.

Grantees would be required to provide, at the conclusion of each grant year, reports to the Secretary that include the following information: (1) the number of Medicare beneficiaries to whom language services are provided; (2) the languages of those beneficiaries; (3) the types of language services provided, such as the use of a bilingual health care provider or use of an interpreter; (4) the type of interpretation, such as in-person, telephonic, or video interpretation; (5) the methods of providing language services, such as staff or contracts with external independent contractors or agencies; (6) the length of time for each interpretation encounter; (7) the costs of providing language services, which may be actual or estimated, as determined by the Secretary.

The limited English proficient beneficiaries would not be required to pay cost-sharing or co-pays for language services provided through the demonstration.

The Secretary would be required to conduct an evaluation of the demonstration program and submit a report to the appropriate committees of Congress within one year after completion of the program. The report would be required to include: (1) an analysis of the patient outcomes and costs of furnishing care to the limited English proficient beneficiaries participating in the project as compared to the outcomes and costs of those not participating; (2) the effect of delivering culturally and linguistically appropriate services on beneficiary access to care, utilization of services, efficiency and cost-effectiveness of health care delivery, patient satisfaction, and select health outcomes; and (3) recommendations regarding the extension of the demonstration project to the entire Medicare program.

Nothing in this section of the provision would limit otherwise existing obligations of recipients of Federal financial assistance under title VI of the Civil Rights Act of 1964 or any other statute.

There would be authorized to be appropriated $10,000,000 for each fiscal year of the demonstration.

Reason for change

Although recipients of federal funds are required to offer language services, Medicare does not reimburse for these services. Testing alternative methods of delivering culturally and linguistically appropriate services will enable Medicare to apply best practices and vastly improve both access to and quality of services to beneficiaries with limited English proficiency.

SECTION 234. DEMONSTRATION TO IMPROVE CARE TO PREVIOUSLY UNINSURED

Current law

No provision.

Explanation of provision

This provision would require the Secretary of Health and Human Services (HHS) to establish, within one year of the date of enactment of the Act, a 2-year demonstration project to determine the greatest needs and most effective methods of outreach to Medicare beneficiaries who were previously uninsured. The demonstration would be required to include at least 10 sites, and shall include state health insurance assistance programs, community health centers, community-based organizations, community health workers and other service providers under Medicare Parts A, B, and C. Part C grantees would be required to document that all previously uninsured enrollees receive the "Welcome to Medicare" physical exam. The Secretary would be required to conduct an evaluation of the demonstration, and submit a report to Congress within one year of the completion of the project. The report would be required to include (1) an analysis of the effectiveness of outreach activities targeting beneficiaries who were previously uninsured, and (2) the effect of such outreach activities on beneficiary access to care, utilization of services, efficiency and cost-effectiveness of health care delivery, patient satisfaction, and select health outcomes. Examples of outreach activities include revising outreach and enrollment materials (including the potential for use of video information), providing one-on-one counseling, working with community health workers and amending the Medicare and You handbook.

Reason for change

Medicare beneficiaries who were previously uninsured can have difficulty acquainting themselves with the program. Providing additional outreach and support may help these beneficiaries access the benefits they are entitled to, and improve their health overall.

SECTION 235. OFFICE OF THE INSPECTOR GENERAL REPORT ON COMPLIANCE WITH AND ENFORCEMENT OF NATIONAL STANDARDS ON CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) IN MEDICARE

Current law

Congress passed Title VI of the Civil Rights Act of 1964 to ensure that federal money is not used to support programs or activities that discriminate on the basis of race, color, or national origin.

The United States Supreme Court has treated discrimination based on language as national origin discrimination. Therefore, recipients of federal funds (including hospitals, nursing homes, state Medicaid agencies, managed care organizations, home health agencies, health service providers, human service organizations, and any other health or human services federal fund recipient, as well as subcontractors, vendors, and subrecipients) are required to take reasonable steps to ensure that persons with limited English proficiency have meaningful access to programs and activities. The Department of Health and Human Services has issued guidance, including a four-factor analysis, that implicates the "mix" of language services that should be offered, including oral and written interpretation services.

Explanation of provision

This provision would require the Inspector General of the Department of Health and Human Services (HHS) to prepare and publish a report, within two years of the date of enactment of the Act, that includes the following: (1) an examination of the extent to which Medicare providers and plans are complying with the Office of Civil Rights' Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons and the Office of Minority Health's Culturally and Linguistically Appropriate Services Standards in health care; (2) a description of the costs or savings related to the provision of language services; and (3) recommendations on improving compliance with and enforcement of Culturally and Linguistically Appropriate Services (CLAS) Standards. Within one year of the report's publication date, the Department of HHS would be required to implement any changes resulting from any deficiencies identified in the report.

SECTION 236. IOM REPORT ON IMPACT OF LANGUAGE ACCESS SERVICES

Current law

No provision.

Explanation of provision

This provision would require the Secretary of Health and Human Services to enter into an arrangement with the Institute of Medicine for the Institute to prepare and publish a report, within three years, on the impact of language access services on the health and health care of limited English proficient populations. The report would be required to include the following: (1) recommendations on the development and implementation of policies and practices by health care organizations and providers for limited English proficient patient populations; (2) a description of the effect of providing language access services on the quality of health care, access to care, and reduced medical error; and (3) a description of the costs or savings related to the provision of language access services.

SECTION 237. DEFINITIONS

Current law

No current law.

Explanation of provision

This provision would define the terms bilingual, competent interpreter services, competent translation services, effective communication, interpreting/interpretation, health care services, health care-related services, language access, language services, limited English proficient, Medicare program, and service provider. A bilingual individual would be defined as one who has sufficient degree of proficiency in two languages and can ensure effective communication can occur in both languages. Competent interpreter services would be defined as a trans-language rendition of a spoken message in which the interpreter comprehends the source language and can speak comprehensively in the target language to convey the meaning intended in the source language. Such an interpreter would know health and health-related terminology and provide accurate interpretations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source message. Competent translation services would be defined as a trans-language rendition of a written document in which the translator comprehends the source language and can write comprehensively in the target language to convey the meaning intended in the source language. Such a translator would know health and health-related terminology and provide accurate translations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source document. Effective communication would be defined as an exchange of information between the provider of health care or health care-related services and the limited English proficient recipient of interpretation services that enables interpretation service recipients to access, understand, and benefit from health care or health care-related services. Interpreting or interpretation would be defined as the transmission of a spoken message from one language into another, faithfully, accurately, and objectively. Health care services would be defined as services that address physical as well as mental health services in all care settings. Health care-related services would be defined as human or social services programs or activities that provide access, referrals, or links to health care. Language access would be defined as the provision of language services to an individual of limited English proficiency that are designed to enhance that individual's access to, understanding of or benefit from health care or health care-related services. Language services would be defined as the provision of health care services directly while using at least one of the following: a non-English language, interpretation, translation, or signage. An individual of limited English proficiency would be defined as one who speaks a primary language other than English, and who cannot speak, read, write or understand the English language at a level that permits the individual to effectively communicate with clinical or non-clinical staff at an entity providing health care or health care related services. The Medicare program would be defined as the programs under parts A through D of title XVIII of the Social Security Act. A service provider would be defined as any supplier, provider of services, or entity under contract to provide coverage, items or services

under any part of title XVIII of the Social Security Act (i.e. the Medicare program).

TITLE III—PHYSICIANS' SERVICE PAYMENT REFORM

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

Current law

Medicare pays for services of physicians and certain nonphysician practitioners on the basis of a fee schedule. With a few exceptions, most physicians' services are considered together in the calculation of the fee schedules, related expenditure targets and annual updates. In some instances, special rules apply to the calculation of Medicare fees for some services including anesthesia, radiology, and nuclear medicine.

The Medicare physician fee schedule assigns relative values to services that reflect physician work (i.e., the time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative values are adjusted for geographic variations in costs. The adjusted relative values are then converted into a dollar payment amount called the conversion factor. The single conversion factor for 2007 is $37.8975, the same level as in 2005 and 2006.

Several factors enter into the current calculation of the annual update (and increase or decrease) of Medicare physician fees. These include (1) the Medicare economic index (MEI), which measures inflation in the inputs needed to produce physicians' services; (2) the sustainable growth rate (SGR), which is essentially a target for Medicare spending growth for physicians' services; and (3) an adjustment that modifies the update, which would otherwise be allowed by the MEI, to bring spending in line with the SGR target. The SGR target is not a limit on expenditures. Rather, the fee schedule update reflects the success or failure in meeting the target. If expenditures exceed the target, the update for a future year is reduced. This is what occurred for 2002. Fee reductions were also slated to occur in subsequent years; however, legislation has prevented this from occurring through 2007. Most recently, the Tax Relief and Health Care Act of 2006 (TRHCA, P.L. 109–432) kept the 2007 conversion factor at the 2006 level. Physicians who voluntarily report certain quality measures that meet the reporting criteria can receive bonus payments of 1.5% for the six-month period from July 1, 2007 to December 31, 2007.

Under the current update formula, a reduction in the conversion factor will occur for the next several years. In the absence of legislation, payment rates will be reduced by about 10% in 2008 and around 5% annually for at least several years thereafter. The 2008 estimate reflects the fact that TRHCA specified that the 2007 override of the statutory formula was to be treated as if it did not occur. Therefore, the starting base for the calculation is 5% below the actual 2007 conversion factor.

Explanation of provision

The provision would create six new categories of physicians' services beginning January 1, 2008: (1) 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 the recommendations of the United States Preventive Services Task Force; (2) evaluation and management services not described in (1); (3) imaging services (defined as imaging and computer-assisted imaging services, including X-ray, ultrasound [including echocardiography], nuclear medicine [including positron emission tomography], magnetic resonance imaging, computed tomography, and fluoroscopy, but excluding diagnostic and screening mammography) and diagnostic tests (other than clinical diagnostic laboratory tests); (4) major procedures; (5) anesthesia services; and (6) minor procedures and any other physicians' services not described above.

The provision would eliminate the single conversion factor currently applied to all physician services and establish a separate conversion factor for each of the six newly created service categories. Beginning with 2008, the target growth rate for each service category would be computed and applied separately using the same method for computing the sustainable growth rate except that: (1) "physicians' services" would refer to the physicians' services included in the appropriate service category; (2) the estimate of the annual average percentage growth in real gross domestic product per capita (divided by 100) during the 10-year period ending with the applicable period involved would be increased by 0.03 for the primary care and preventive services category; and (3) a national coverage determination would be treated as a change in regulation and thus incorporated into the Secretary's estimate of the percentage change (divided by 100) in expenditures for all physicians' services in the fiscal year (compared with the previous fiscal year).

Beginning with 2008, the conversion factors would be computed and updated separately for each service category by taking into account the amount of actual expenditures attributable to the services in a specified category for the preceding year increased by the target growth rate for that category. Spending on "incident-to" services (i.e., clinical diagnostic laboratory tests, radiology services, and drugs covered under Part B) would not be included in the calculation of allowed expenditures for any service category. For anesthesia services, the 2008 conversion factor would be based on the special conversion factor for anesthesia services (equal to 46 percent of the single conversion factor established for other physicians' services) multiplied by the update to the conversion factor for anesthesia services. In subsequent years, the conversion factors would be based on the conversion factor for the service category adjusted by the update (see section 3).

The cumulative adjustment component—or "overhang" (the debt remaining from the SGR formula)—would be applied to the initial target growth rate for each service category. The computation of the cumulative adjustment component is the proportion of total actual pre-2008 expenditures for Medicare physicians' items and

services for the service category to the total actual expenditures for all Medicare physicians' services. Calculations of the cumulative overhang would be the difference (positive or negative) between the amount of the allowed expenditures for physicians' services in the service category through the end of the prior year and the amount of the actual expenditures for physicians' services in the service category during that period.

The provision would establish a floor for updates so that the conversion factors for each service category would be no less than 0.5% for 2008 and 2009. The limits on the update adjustment factors would remain the same as under current law for a service category for a year, except that in years 2010 and 2011 the update may not be less than minus 0.14.

The Secretary would include information on the change in the annual rate of growth of actual Medicare Part B expenditures for clinical diagnostic laboratory tests or drugs, biologicals, and radiopharmaceuticals in the annual physician fee schedule proposed rule. The report would include an analysis of the reasons for such excess expenditures and recommendations for addressing them in the future.

Reason for change

For the past several years, Congress has failed to make substantive changes to the SGR mechanism. CBO has estimated that the accumulated debt from the SGR will be $60 billion by the end of CY 2007. While it is widely recognized that Medicare's physician reimbursement system is in need of reform, solutions are not well developed. Overriding the cuts in 2008 and 2009 with positive updates will stabilize physician spending and provide the time necessary for long term solutions to mature.

Witnesses testified before the Subcommittee on Health in March that creating multiple expenditure targets would allow CMS to focus provider and policy-maker attention on rapidly growing categories of service, and enable Congress to shift resources toward services that are underprovided or otherwise of greater value to beneficiaries. For example, allowing higher growth for primary care and preventive services infuses additional resources into these services to encourage their use. Furthermore, removing labs, drugs, and other "incident to" services from the calculation will result in the targets being more closely aligned with actual spending for physician services, rather than drug price inflation.

When developing service categories, the Secretary should evaluate the merit of including the professional component of imaging services to the minor procedures/other services category. Such treatment would be consistent with the treatment of the professional component for pathology services.

In addition, the Committee believes that the Secretary should classify radiation therapy services that are not paid by a global fee in the minor procedures and other services category, rather than in the imaging services category. Radiation therapy works by damaging the DNA within cancer cells and destroying the ability of the cancer cells to reproduce. When these damaged cells die, the patients' body naturally eliminates them. These radiation oncology procedures are used to treat cancer patients. While medical imag-

ing is a component of radiation oncology procedures, these services are not considered to be imaging services. This recommendation is consistent with MedPAC's classification of physician services.

SECTION 302. IMPROVING ACCURACY OF RELATIVE VALUES UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE

Current law

Medicare pays for services of physicians and certain nonphysician practitioners on the basis of a fee schedule. The fee schedule assigns relative values to services that reflect physician work (i.e., the time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The work relative value units (RVUs) incorporated in the initial fee schedule were developed after extensive input from the physician community. Refinements in existing values and establishment of values for new services have been included in the annual fee schedule updates. This refinement and update process is based in part on recommendations made by the American Medical Association/Specialty Society Relative Value Update Committee (RUC) which receives input from over 100 specialty societies.

Not less often than every five years, to the extent the Secretary determines to be necessary, the relative values are adjusted to take into account changes in medical practice, coding changes, new data on relative value components, or the addition of new procedures. The Secretary is required to publish an explanation of the basis for such adjustments and to consult with the Medicare Payment Advisory Commission and organizations representing physicians. The 2007 fee schedule reflects the results of the third five-year review.

CMS initiates the five-year review process by requesting public comments on potentially misvalued RVUs. The majority of comments are submitted by physician specialty societies; in addition CMS identifies codes that it believes need review. These codes are then submitted to the RUC. Specialty societies may make presentations on proposed changes to the RUC based on approved survey instruments. The RUC assesses the evidence. It may approve the specialty society's recommendation, refer it back to the society or modify it. Final recommendations are submitted to CMS which then conducts its own review. CMS then publishes proposed values in the Federal Register for public comment. These comments are reviewed before publication of the final values. The most recent five-year review resulted in significant increases in values for evaluation and management services; however, the impact was reduced by the budget neutrality adjustment.

Explanation of provision

This provision would require the Secretary to establish an expert panel to identify misvalued physicians' services. The panel would conduct data analysis to identify physicians' services for which the relative value is potentially misvalued, particularly those which are overvalued, and assess whether those misvalued services warrant review through existing processes. The panel would also advise the Secretary as part of the periodic review (not less than every five years) and adjustments in relative values.

The panel would be appointed by the Secretary and be composed of members with expertise in medical economics and technology diffusion, members with clinical expertise, physicians (particularly those not directly affected by changes in the Medicare physician fee schedule, such as those employed by the Veterans Administration or a physician who has a full time faculty appointment at a medical school), carrier medical directors, and representatives of private payor health plans. In appointing members to the expert panel, the Secretary would assure racial and ethnic diversity on the panel and may consider appointing a liaison from organizations with experience in the consideration of coding changes to the panel.

The Secretary would consult with the expert panel and: (1) in conjunction with the RUC five-year review, conduct a five-year review of physicians' services that have experienced substantial changes in length of stay, site of service, volume, practice expense, or other factors that may indicated changes in physician work; (2) identify new services to determine if they are likely to experience a reduction in value over time and forward a list of the services identified to the RUC for review in the next five-year review cycle; and (3) for physicians' services that are otherwise unreviewed by the RUC, periodically review a sample of relative value units within different types of services to ensure the accuracy of the relative values contained in the Medicare physician fee schedule.

The provision would give the Secretary the authority to reduce the work component for services with accelerated volume growth without using the RUC process beginning January 1, 2009. In consultation with the expert panel described above, the Secretary would be able to reduce the work value units for a particular physicians' service if the annual rate of growth in expenditures for the service provided under Medicare for 2006 or a subsequent year exceeds the average annual rate of growth in expenditures for all Medicare physicians' services by more than 10 percentage points. The Secretary would take into account clinical evidence supporting or refuting the merits of such accelerated growth.

The Secretary would also be granted the authority to adjust payments for efficiency gains for new procedures. The Secretary may apply a methodology, based on supporting evidence, under which there is imposed a reduction over a period of years in specified value units in the case of a new (or newer) procedure to take into account inherent efficiencies that are typically or likely to be gained during the period of initial increased application of the procedure.

Reason for change

Traditionally the five-year review has led to more increases in work RVUs than decreases. MEDPAC and other observers have stated that more attention needs to be given to overvalued services in order to maintain the integrity of the fee schedule.

Rapid rises in the volume of administratively priced services can be a warning sign of incorrect incentives; this problem can be addressed by giving the Secretary authority to impose a downward adjustment in the price of rapidly rising services (after taking into account evidence of clinical benefit that would justify growth) to be reconsidered by outside consultants during the five year review.

SECTION 303. PHYSICIAN FEEDBACK MECHANISM ON PRACTICE PATTERNS

Current law

No provision.

Explanation of provision

By June 1, 2008, the Secretary of Health and Human Services would be required to develop and implement a mechanism to measure resource use on a per capita and an episode basis in order to provide feedback to physicians who participate in the Medicare program on how their practice patterns compare to physicians generally, both in the same locality as well as nationally. This feedback would not be subject to disclosure under the Freedom of Information Act.

Reason for change

MedPAC has recommended that CMS measure physicians' resource use over time and share results with physicians. It states that physicians would be able to assess their practice styles, evaluate whether they tend to use more resources than their peers or what evidence-based research (if available) recommends, and revise practice styles as appropriate. It notes that in the private sector use of feedback has had a small downward trend on resource use. It states that its use by Medicare has the potential to be more successful since it is the single largest purchaser of health care and therefore its reports should command more attention. MedPAC states that using the results for physician education would provide CMS and physicians with experience with the measurement tool and allow for refinements. Once experience and confidence were gained, it could be use the results for payment or to create other incentives.

In an April 2007 report (Focus on Physician Practice Patterns Can Lead to Greater Program Efficiency), GAO explored linking physician compensation to efficiency-defined as providing and ordering a level of services sufficient to meet a patient's needs but not excessive given a patient's health status. The analysis focused on generalists, namely physicians who defined their specialty as general practice, internal medicine, or family practice. The report categorized physicians who treated a disproportionate share of overly expensive patients as outlier generalists. The report found outlier generalist physicians in all twelve metropolitan areas studied. GAO found that Medicare patients who saw outlier generalists were more likely to have been hospitalized, more likely to have been hospitalized multiple times, and more likely to have used home health services. They were, however, less likely to have been admitted to a skilled nursing facility.

The GAO report noted that certain public and private health care purchasers routinely evaluate physicians in their networks using measures of efficiency and other factors. It noted that the purchasers it studied linked their evaluation results to a range of incentives, from steering patients toward the most efficient providers to excluding physicians from the provider's network because of inefficient practice patterns. GAO noted that while CMS has the tools

available to evaluate physician practices it may not have the flexibility that other purchasers have to link physician profiling results to a range of incentives to encourage efficiency.

SECTION 304. PAYMENTS FOR EFFICIENT PHYSICIANS

Current law

No provision.

Explanation of provision

This provision would create incentive payments under the Medicare program for participating physicians practicing in areas identified as an efficient area. From January 1, 2009 through December 31, 2010, physicians practicing in counties or equivalent areas that are in the lowest fifth percentile based on per capita spending for Medicare Part A and Part B would receive an amount equal to 5% of the Medicare payment amount. For purposes of paying the additional amount, if the Secretary uses the 5-digit postal ZIP code where the services are furnished, the dominant county of the postal code shall be used in determining if the area entitles the physician for additional payment. There would be no administrative or judicial review of the designation of the county or area as a low per-capita Medicare expenditure area, or the assignment of a postal ZIP code to a county or area. For each year, the Secretary would identify and post low volume areas as part of the proposed and final rule to implement the annual physician fee schedule. The Secretary would post the list of counties identified on the CMS internet website.

Reason for change

Certain regions of the country have very low volume of services to Medicare beneficiaries. This could be caused by problems with access to physician services or highly efficient practice by local physicians. The incentive payments would either address problems with access or reward efficient practice.

SECTION 305. RECOMMENDATIONS ON REFINING THE PHYSICIAN FEE SCHEDULE

Current law

No provision.

Explanation of provision

The provision would modify the physician fee schedule by requiring the Secretary to analyze and recommend ways to consolidate coding for procedures and to increase use of bundled payments. No later than December 31, 2008, the Secretary of Health and Human Services would be required to complete an analysis of those procedures under the Medicare physician fee schedule for which there is no global payment methodology being applied for which a "bundled" payment methodology would be appropriate, and submit a report on such analysis and recommendations on increasing the use of "bundled" payments under the Medicare physician fee schedule.

Reason for change

Long term strategies for refining the physician reimbursement system are not well developed. Bundling services is one approach recommended by MedPAC and witnesses at two separate Subcommittee hearings this year.

SECTION 306. IMPROVED AND EXPANDED MEDICAL HOME DEMONSTRATION PROJECT

Current law

Section 204 of the Tax Relief and Health Care Act of 2006 mandated a Medicare medical home demonstration project. The demonstration is to be conducted in up to eight states to provide targeted, accessible, continuous and coordinated family-centered care to Medicare beneficiaries who are deemed to be high need (with multiple chronic or prolonged illnesses that require regular medical monitoring, advising or treatment). CMS anticipates selecting a contractor to provide assistance in the design of the Medical Home Demonstration by September, 2007. Implementation is expected by late September, 2008.

Explanation of provision

The provision would require the Secretary to establish an expanded medical home Medicare demonstration project ("expanded project"), which would supersede the project initiated under section 204 of the Tax Relief and Health Care Act of 2006. The expanded project's purposes are: (1) to guide the redesign of the health care delivery system to provide accessible, continuous, comprehensive, and coordinated care to Medicare beneficiaries; and (2) to provide care management fees to personal physicians delivering continuous and comprehensive care in qualified medical homes.

The expanded project would operate for three years, beginning not later than October 1, 2009 and would include a nationally representative sample of physicians serving urban, rural, and underserved areas throughout the United States. The project would be designed to encourage the participation of physicians in practices with fewer than four full-time equivalent physicians, as well as physicians in larger practices in rural and underserved areas. To facilitate the participation of physicians in such practices, the Secretary would provide additional technical assistance to such practices during the first year of the expanded project. Up to 500 medical homes would be selected to participate in the expanded project, with priority given to the selection of up to 100 HIT-enhanced medical homes, and the selection of other medical homes that serve communities whose populations are at higher risk for health disparities.

Any Medicare beneficiary who is served by a medical home participating in the expanded project would be able to elect to participate in the expanded project. Beneficiaries who elect to do so would be eligible for enhanced medical home services under the project with no cost sharing for the additional services, and for a reduction of up to 50 percent in the coinsurance for services furnished by the medical home under the Medicare physician fee schedule. The Secretary would develop standard recruitment materials and election

processes for Medicare beneficiaries who are electing to participate in the expanded project.

The Secretary would establish a process for selection of a qualified standard setting and certification organization for this expanded project. This organization would: (1) establish standards for medical practices to qualify as medical homes or as HIT-enhanced medical homes; and (2) provide for the review and certification of medical practices as meeting such standards.

The provision specifies several standards for the implementation of the expanded project. The term "medical home" would mean a physician-directed practice that has been certified by the organization described above, as meeting the following standards: (1) the practice applies standards for access to care and communication with participating beneficiaries; (2) the practice has readily accessible, clinically useful information on participating beneficiaries that enables the practice to treat such beneficiaries comprehensively and systematically; (3) the practice maintains continuous relationships with participating beneficiaries by implementing evidence-based guidelines and applying them to the identified needs of individual beneficiaries over time and with the intensity needed by such beneficiaries; (4) the practice both collaborates with participating beneficiaries to pursue their goals for optimal achievable health and assesses patient-specific barriers to communication and conducts activities to support patient self-management; (5) the practice has in place the resources and processes necessary to achieve improvements in the management and coordination of care for participating beneficiaries; and (6) the practice monitors its clinical process and performance (including outcome measures) in meeting the applicable standards and provides information in a form and manner specified by the Secretary with respect to such process and performance.

The term "HIT-enhanced medical home" means a medical home that has been certified, by the organization described above, as using a health information technology system that includes at least the following elements: (1) an electronic health record system (see below); (2) e-prescribing and computerized physician order entry; (3) an outcome measurement system that supports the secure, confidential provision of clinical process and outcome measures approved by the National Quality Forum to the Secretary for use in a confidential manner for provider feedback and peer review and for outcomes and clinical effectiveness research; (4) the capability for patient education through facilitating the engagement of participating beneficiaries in the management of their own health through education and support systems and providing the tools for shared decision-making; (5) support of basic standards, such that the electronic health record, e-mail communications, patient registries, and clinical-decision support tools, are integrated in a manner to better achieve the basic standards for a medical home described above.

The electronic health record (EHR) system must also meet the following standards: (i) the EHR system must have the capability of interoperability with secure data acquisition from health information technology systems of other health care providers in the area served by the home; or the capability to securely acquire clin-

ical data delivered by such other health care providers to a secure common data source; (ii) the EHR must protect the privacy and security of health information; (iii) the EHR must have the capability to acquire, manage, and display all the types of clinical information commonly relevant to services furnished by the home, such as complete medical records, radiographic image retrieval, and clinical laboratory information; and (iv) the record must be integrated with decision support capacities that facilitate the use of evidence-based medicine and clinical decision support tools to guide decision making at the point-of-care based on patient-specific factors.

The Secretary would used the clinical process and performance measures, including outcome measures, provided by the practices to the Secretary in a confidential manner for feedback and peer review for medical homes and for outcomes and clinical effectiveness research. After the first two years of the expanded project, these data may be used for adjustment in the monthly medical home care management fee (see below).

Under the expanded Medicare medical home project, the Secretary would provide a monthly medical home care management fee payment to the personal physician of each participating beneficiary. In determining the amount of the fee, the Secretary would consider the operating expenses, the added value services, a risk adjustment, a HIT adjustment, and a performance-based payment.

The Secretary would consider the additional practice expenses for the delivery of services through a medical home, taking into account the additional expenses for an HIT-enhanced medical home. Such expenses would include costs associated with: (i) structural expenses, such as equipment, maintenance, and training costs; (ii) enhanced access and communication functions; (iii) population management and registry functions; (iv) patient medical data and referral tracking functions; (v) provision of evidence-based care; (vi) implementation and maintenance of health information technology; (vii) reporting on performance and improvement conditions; and (viii) patient education and patient decision support, including print and electronic patient education materials.

The value of additional physician work would also be a factor in the Secretary's determination of the management fee. This includes the value of activities such as augmented care plan oversight, expanded e-mail and telephonic consultations, extended patient medical data review (including data stored and transmitted electronically), and physician supervision of enhanced self-management education, and expanded follow-up accomplished by nonphysician personnel, in a medical home that is not adequately taken into account in the establishment of the Medicare physician fee schedule.

Finally, the Secretary would also take into consideration the development of an appropriate risk adjustment mechanism to account for the varying costs of medical homes based upon characteristics of participating beneficiaries, the variation of the fee based on the extensiveness of use of the health information technology in the medical home, and a performance-based adjustment based on performance of the home in achieving quality or outcomes standards, to be applied after the first two years of the expanded project.

For the purposes of the expanded project, the term "personal physician" means, with respect to a participating Medicare bene-

ficiary, a physician 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.

The expanded project would be funded through monies for the original demonstration as well as $500,000,000 of additional funds from the Federal Supplementary Medical Insurance Trust Fund (Part B). This would include the payments of the monthly medical home care management fees described above, reductions in coinsurance for participating beneficiaries, and funds for the design, implementation, and evaluation of the expanded project. The Secretary would monitor the expenditures under the expanded project and could terminate the project early so that expenditures would not exceed the amount of funding provided for the project.

The Secretary would provide and submit to Congress an annual report on the project and an evaluation of the project, by a date specified by the Secretary. The Secretary would also provide for an evaluation of the expanded project and would submit to Congress, not later than 18 months after the date of completion of the project, a report on the project and on the evaluation of the project.

Reason for change

The medical home concept envisions a health care system where patient care is coordinated and integrated through a physician-guided multidisciplinary team enabled by a radically transformed practice setting. The practice would manage patient-centered care across a variety of settings according to the needs of the patient through the promotion of continuous care relationships as well as application of the chronic care model, shared decision-making principles, and health information technology. The idea has been described as early as 1967 by the American Academy of Pediatrics' Council on Pediatric Practice. The practice management and financing innovations relevant to the patient-centered medical home have been implemented in a variety of other industrialized countries which achieve better primary care, care-coordination, and health outcomes than does the US.

Recent research has shown that patient populations at risk for health disparities may particularly benefit from the accessible, coordinated, comprehensive care delivered through the patient-centered medical home; therefore transforming practices serving these populations is a major focus of the revised and expanded demonstration. Office applications of health information technology offer new opportunities to achieve even better care coordination, disease management, and patient empowerment; therefore another focus of this revised demonstration is to evaluate the effectiveness of the "HIT-enhanced medical home." While some of these medical home concepts have already been applied in the U.S., they are often in large pre-paid group practices or academic medical centers. Therefore the demonstration retains a focus on recruiting smaller physician practices where much of the care occurs for Medicare beneficiaries, and adds resources for technical assistance to these

small practices. The National Committee for Quality Assurance (NCQA) has several years experience using its "Physician Practice Connections" process to certify physician offices; NCQA has been actively developing an approach for multi-component, multi-level certification of the "Patient-Centered Medical Home," similar to that described in the legislation.

The demonstration requires that to be eligible the personal physician must provide accessible, continuous, coordinated and comprehensive care. In most cases, primary care physicians (e.g. family medicine or general internal medicine), would be best suited to the role of personal physician for the medical home demonstration. However, a medical specialist with his or her office care team could also fulfill the role of personal physician, so long as they were committed to providing comparable accessibility, continuity, coordination and most importantly, comprehensiveness of care.

In giving the Secretary authority for developing the monthly medical home care management fee payment, the Secretary can explore alternative formulations, including the possibility of bundling some current fee-for-service payments into the monthly medical home care management fee. This is consistent with Section 305 which directs the Secretary to make recommendations on increasing the use of "bundled" payments under the Medicare physician fee schedule.

SECTION 307. REPEAL OF PHYSICIAN ASSISTANCE AND QUALITY INITIATIVE FUND

Current law

TRHCA authorized $1.35 billion for 2008 for a Physician Assistance and Quality Initiative Fund to be available to the Secretary for physician payment and quality improvement initiatives. The initiatives may include adjustments to the conversion factor.

Explanation of provision

The provision would repeal the Physician Assistance and Quality Initiative Fund established by TRHCA.

Reason for change

Congress prematurely implemented a quality bonus as part of PQRI. Quality measures are not well developed and the cost and complexity of implementing this program vary dramatically across specialties and practice. Problems with the reimbursement system more broadly are a higher priority for scarce administrative resources at this time.

SECTION 308. ADJUSTMENT TO MEDICARE PAYMENT LOCALITIES

Current law

Medicare payments to physicians vary according to geographic areas called Medicare payment localities or fee schedule geographic areas. There are currently 89 localities; some are statewide, while others are substate areas. Medicare makes a separate geographic adjustment to each component of the physician fee schedule: a work adjustment, a practice expense adjustment, and a malpractice adjustment. These adjustments are intended to reflect the variation

in the costs of providing services in different parts of the country. These three components are weighted and then added together to produce an indexed relative value unit for the service for the locality.

The payment locality structure for the current Medicare's physician fee schedule was established in 1996 and took effect January 1, 1997. Before adoption of the current structure, there were 210 existing separate payment localities, of which 22 were then-existing statewide localities. The statewide localities remained statewide localities in the transition. Localities were established in the remaining 28 States by comparing the area cost differences of the localities within these states. The existing localities within these remaining 28 States were ranked by costs in descending order. The geographic adjustment factor (GAF) of the highest cost locality within a state was compared to the weighted average GAF of lower price localities. If the difference between these GAFs exceeded 5 percent, the highest locality remained a distinct locality. If the GAFs associated with all the localities in a State did not vary by at least 5 percent, the State 55 became a statewide locality. If the highest-priced locality remained a distinct locality, the process was repeated for the second highest price locality and so on until the variation among remaining localities fell below the 5 percent threshold. The objective was to ensure that the statewide or residual state locality has relatively homogenous resource costs. Subsequent to this process, 3 additional states with multiple localities were converted to statewide localities. Currently, there are 89 separate payment localities of which 34 are statewide.

MMA made temporary changes to the geographic adjusters. It raised the geographic adjustment for the work component of the fee schedule to 1.000 in any area where the multiplier would otherwise be less. This provision applied from 2004–2006. The Tax Relief and Health Care Act of 2006 extended the provision for an additional year—through 2007. MMA further directed the GAO to conduct a study of the geographic adjusters. A GAO report issued in March 2005 concluded that all three adjusters were valid in their fundamental design, and appropriately reflected broad patterns of geographic differences in running a practice. The report made several recommendations for improving the data and methods used to construct the data. CMS stated that implementing many of the recommendations was not feasible at this time.

Some observers have recommended that changes be made to the composition of some of the current localities. In particular, some critics argue that costs in a few communities have increased significantly faster in the years since the payment localities were initially established than in other parts of the same locality or when compared with other adjacent localities. They argue that the Medicare physician payments are inequitable and are based on calculations that are no longer appropriate. CMS has stated that it will consider requests for locality changes when there is demonstrated consensus within the state medical association for the change. CMS has also stated that any changes must be made in a budget-neutral fashion for the state. Thus, if higher geographic practice cost indices (and thus payments) are applied in one part of the state, they

must be offset by lower indices (and payments) in other parts of the state.

California offers an example of this problem. Two counties in California (Santa Cruz and Sonoma) are assigned to a larger payment locality ("Rest of California"). In the years since the payment localities were initially established, the cost and expenditure measures used to calculate geographic adjusters for Medicare physician payment have increased more quickly in those areas than in the "Rest of California" payment locality. In addition, the adjusters for these areas are lower than those applicable in neighboring counties. In the August 8, 2005 proposed physician fee schedule, CMS offered a proposal to address the problem. However, it failed to win the support of the majority stakeholders because offsetting reductions would be required in other areas. The final regulation, therefore, included no change for 2006.

More recently, in the July 12, 2007 proposed rule for the 2008 physician fee schedule, CMS proposed three options for addressing the situation. The first option would use the existing locality structure and apply a rule whereby if a county GAF is more than 5 percent greater than the GAF for the locality in which the county resides it would be removed from the current locality. A separate locality would be established for each county that is removed. Based on the new fully phased-in GPCI data (for CY 2009), application of this approach in California would remove three counties (Santa Cruz, Monterey, and Sonoma) from the Rest of California payment locality and Marin county from the Marin/Napa/Solano payment locality and create separate payment localities for each of these counties. This approach would focus on counties for which there is the biggest difference between the county GAF and the locality GAF. Compared to the fully phased-in CY 2009 GAFs that would occur under the current locality structure, under this option, the GAFs for Santa Cruz, Monterey and Sonoma would increase by 7.59 percent, 5.83 percent, and 5.51 percent respectively, and the GAF for the Rest of California locality would decrease by 0.49 percent. The GAF for Marin would increase by 5.19 percent while the GAF for Napa/Solano would decrease by 4.33 percent. The GAFs for all other California localities would not change.

The second option is similar to option 1, but the new localities would be structured differently. The same 5 percent threshold methodology would apply, but instead of creating four new localities in which each county becomes its own new locality, the three counties that are removed from the Rest of California locality would become one new locality. Marin County would still be removed from the Marin/Napa/Solano locality to become its own locality. This approach would remove three counties (Santa Cruz, Sonoma, and Monterey) from the Rest of California payment locality, and Marin County from the existing Marin/Napa/Solano payment locality. This approach would group together counties from the Rest of California locality that have the greatest difference between the county and locality GAF. These three counties have similar cost structures and grouping them together into one new locality would be consistent with CMS's goal of homogeneous resource costs within a locality. In addition, it would create fewer localities making it administratively simpler for both the Medicare program

and for physicians who might practice in multiple localities. Compared to the fully phased-in CY 2009 GAFs that would occur under the current locality structure, under this option, the GAFs for the new Santa Cruz/Sonoma/Monterey locality would increase by 6.3 percent, and the GAF for the Marin County locality would increase by 5.19 percent. The GAFs would decrease by 0.49 percent for the Rest of California locality and by 4.33 percent for the Napa/Solano locality.

The third option would apply a methodology similar to the one used in the 1997 locality revisions but applied at the county level rather than the "existing locality" level. The counties would be sorted by descending GAFs and the highest county would be compared to the second highest. If the difference is less than 5 percent, the counties were included in the same locality. The third highest would then be compared to the highest county GAF. This iterative process would continue until a county has a GAF difference that is more than 5 percent. When this occurs, that county becomes the highest county in a new payment locality and the process is repeated for all counties in the State. This approach would group counties within a State into localities based on similarity of GAFs even if the counties were not geographically contiguous and would reduce the number of payment localities in California from 9 to 6, each based on counties or aggregates of counties, with the resulting localities reflecting similar geographic adjustment factors (GAFs). This option would not address the issue of a county or locality having costs very different from those of an adjoining county or locality. Under this option, it would still be possible for neighboring counties or localities to have significantly different cost structures and the associated problems such as incentives to relocate across county lines would still exist. CMS claims that this option would be the most administratively burdensome option to implement because of the significant systems changes and provider education that would be required to reconfigure the California localities in this manner. It would also place a greater burden on practicing physicians who are more likely to experience a change in his or her practice's locality. The county-by-county impact of this option is detailed in Table 9, 72 Fed. Reg. 38141 (July 12, 2007).

Explanation of provision

The provision would require the Secretary to revise the fee schedule areas for California for services furnished on or after January 1, 2008 using the county-based geographic adjustment factor as specified in option 3 (table 9) in the proposed rule for the 2008 physician fee scheduled published at 72 Fed. Reg. 38122 (July 12, 2007). In the transition from the existing payment localities to the new payment localities, for services provided January 1, 2008 through December 31, 2010, the new GAF would apply unless there is a loss, in which case the old GAF would apply. In other words, the higher of the two GAFs as calculated under the existing or the new methodology would apply.

No later than January 1, 2011, the Secretary would review and make revisions to fee schedule areas in all states where there is more than one Medicare physician payment fee schedule area. The Secretary may revise the fee schedule areas in these states using

the same methodology used for California. Any such revisions would be made effective concurrently with the application of the periodic (3-year) review of geographic adjustment factors required by law for 2011.

Reason for change

A GAO report issued July 2007 confirmed significant problems with inaccurate pricing that result from Medicare's current payment localities. Among the methodologies examined to revise payment localities, the GAO determined that the county-based GAF approach achieved the greatest balance between price accuracy and administrative feasibility. The Committee believes that testing this approach first in California will help guide the implementation of revisions in the future. In order to minimize the effect of resources shifting from rural to urban that result from this change, the Committee provides resources to counties in California that would be adjusted downward.

SECTION 309. PAYMENT FOR IMAGING SERVICES

Current law

Medicare pays for outpatient imaging services through the physician fee schedule. The DRA modified the payment rules for certain imaging services. Specifically, the law capped the technical component of the payment for services performed in a doctor's office at the level paid to hospital outpatient departments for such services. The limitation does not apply to the professional component (i.e., the physician's interpretation). Services subject to the cap are: X-rays, ultrasound (including echocardiography), nuclear medicine (including positron emission tomography), magnetic resonance imaging, computed tomography, and fluoroscopy. Diagnostic and screening mammographies are excluded. The provision was effective January 1, 2007. DRA also exempted certain reduced expenditures from the budget neutrality calculation. Specifically these were reduced expenditures attributable to the multiple procedure payment reduction under the November 2005 physician fee schedule regulation. The payment reduction is 25% for certain imaging procedures performed on contiguous body areas.

The Mammography Quality Standards Act (MQSA) of 1992 added a new Section 354 to the Public Health Service (PHS) Act. The section required the Secretary to develop standards for equipment and personnel in mammography facilities. Enforcement of MQSA standards is achieved through accreditation, certification, and annual inspection. All mammography facilities must be accredited by an accrediting body (approved by HHS) before the facility can gain certification from the government. The Food and Drug Administration (FDA) was assigned primary responsibility for implementing MQSA. Costs to FDA related to annual inspections of mammography facilities are covered by user fees collected from the facilities. Other MQSA activities are funded by appropriation.

Explanation of provision

The provision would incorporate certain certification standards for imaging services. Specifically, it would specify that no Medicare

Part B payment could be made for either the technical component or the professional component of diagnostic imaging services unless the services met the certification standards applicable to mammography facilities under Section 354(b)(1) of the Public Health Service (PHS) Act. The provision would not apply to physicians who bill either the technical component or the professional component if the service is furnished on equipment that has been certified. Diagnostic imaging services subject to this requirement would be: all imaging modalities including diagnostic magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), nuclear medicine procedures, X-rays, sonograms, ultrasounds, echocardiograms, and such emerging diagnostic imaging technologies as specified by the Secretary. The requirement would apply to diagnostic imaging services furnished on or after January 1, 2010. The requirement would apply to diagnostic imaging services that are ultrasound services furnished on or after January 1, 2012.

The provision would specify that the provisions of Section 354 of the PHS Act (as in effect June 1, 2007) would apply with respect to the provision of diagnostic imaging services and to a diagnostic imaging services facility (and to the process of accrediting such facilities) in the same manner that such provision applies with respect to mammograms and to a mammography facility (and to the process of accrediting such mammography facilities). For purposes of applying Section 354 of the PHS Act, any reference to "mammography" or "breast imaging" would be deemed a reference to "diagnostic imaging services." Any reference to mammogram or film would be deemed a reference to an image. Any reference to a "mammography facility" or facility under Section 354 would be deemed a reference to a diagnostic imaging services facility. Any reference to radiological equipment used to image the breast would be deemed a reference to radiological equipment used to provide diagnostic imaging services. Any reference to radiological procedures or radiological would be deemed a reference to medical imaging services or medical imaging. Any reference to a medical physicist would be deemed to include a reference to a magnetic resonance scientist or the appropriate qualified expert as determined by the accrediting body. In applying the provision relating to the submission of an application, the reference to "type of each x-ray machine, image receptor and processor" would be deemed a reference to type of imaging equipment and the reference to submitting the application to the Secretary would be deemed to include through the appropriate accreditation body. The reference to standards established by the Secretary would be deemed a reference to standards established by an accreditation body and approved by the Secretary. The Secretary would be required to approve an accreditation body meeting the requisite standards. The provision would link accreditation by an approved accreditation body to applicable quality standards. The required annual report would be submitted to the Senate Committee on Finance and the House Committees on Energy and Commerce and the Committee on Ways and Means.

The provision would further specify that in applying Section 354(f) of the PHS Act relating to quality standards, each reference to standards established by the Secretary would be deemed a ref-

erence to standards established by an accreditation body involved and approved by the Secretary; a reference to radiation dose would be deemed a reference to a radiation dose as appropriate; a reference to radiological standards would be deemed a reference to medical imaging standards, as appropriate; and each reference to patient would be deemed a reference to a patient if requested by the patient.

The provision would specify that in applying Section 354(g) of the PHS Act relating to inspections each reference to the Secretary or state or local agency would be deemed to include a reference to an accreditation body; a reference to annual inspections would be deemed to be a reference to the audits carried out in facilities at least every three years, and a reference to inspections would be deemed a reference to audits conducted during the previous year.

The provision would clarify application of dates in Section 354 to the new requirements. The date by which the Secretary was required to promulgate regulations for approval of an accreditation authority would be nine months after enactment. The frequency requirement for inspections would be every three years. The date that the Secretary would first be required to furnish annual performance information would be January 1, 2011. For ultrasound services, the date that the Secretary would first be required to furnish annual performance information would be January 1, 2013.

The provision would specify that the following provisions of Section 354 would not apply: (1) subsections relating to accreditation and quality standards to the extent they require physicians to meet requirements; (2) certain provisions relating to ultrasound; (3) subsection relating to standards for special techniques for mammograms of patients with breast implants; (4) subsection relating to an inspection demonstration program; (5) subsection relating to the national advisory committee report on access in rural and health professional shortage areas; (6) subsection relating to breast cancer screening surveillance research grants; and (7) subsections relating to funding.

The provision would specify that if there were more than one accreditation body for a treatment modality that qualified for approval, the Secretary would approve at least two such bodies. The provision would require the Secretary to establish standards for accreditation bodies that require the timely integration of new technology by such bodies and that require the accreditation body involved to evaluate the annual medical physicist survey (or annual medical survey of another appropriate qualified expert chosen by the accreditation body) of a facility upon onsite review of such facility.

The provision would require the Secretary to establish additional quality standards: (1) for qualifications and licensure or certification of nonphysician personnel; (2) that require the facility to maintain records of the credentials of physicians and nonphysician personnel; (3) for qualifications and responsibilities of medical directors and other personnel with supervisory roles; (4) that require the facility to have procedures ensuring patient safety; and (6) for the establishment of a quality control program to be implemented under the supervision of a medial physicist.. The equipment standards would have to include standards requiring the establishment

and maintenance of a quality assurance program at each facility. The personnel requirement would have to include continuing medical education standards, as specified by the Secretary and updated at least every three years.

The provision would specify that any diagnostic imaging services facility accredited before January 1, 2010 (or January 1, 2012 in the case of ultrasounds) by an accrediting body approved by the Secretary would be deemed to be an approved accreditation body if the facility submitted required proof. The Secretary could require that an accreditation of an emergency technology used in the provision of a diagnostic imaging service as a condition of Medicare payment at such time as the Secretary determined there was sufficient empirical and scientific information to properly carry out the accreditation process for such technology. The provision would further include a definition of terms.

The provision would make several payment adjustments with respect to imaging services. It would require the Secretary to adjust the number of practice expense relative value units for imaging services so that the number of units reflected a 75%, rather than 50%, presumed rate of utilization.

The provision would adjust the technical component discount on single session imaging to consecutive body parts. The reduction would be increased from 25% to 50%.

The provision would set a limit on the assumed interest rate assumption for capital expenditures used by the Secretary when computing the practice expense component. The Secretary would be required to reflect the prevailing market rate, but in no case higher than 11%.

The provision would direct the Secretary to not accept or pay a claim for imaging unless the claim is made separately for each component of such services. The provision would apply to claims for imaging services furnished on or after the first day of the first month beginning more than one year after enactment.

Reason for change

MedPAC and other observers have expressed concerns that sizeable volume increases, particularly for imaging services, needed to be addressed. MedPAC has further noted that providers vary in their ability to perform quality imaging services. It therefore recommended that the Congress direct the Secretary to set standards for providers who bill Medicare for performing and interpreting diagnostic imaging services.

MedPAC has also recommended reducing the technical component for a second image on a contiguous body part. When a second image on an adjacent body part is taken, the clerical time, preparation, and supplies needed for the second image are significantly reduced. This provision would bring Medicare payment policy in line with private payers.

Recent MedPAC analysis found two problems with the current calculation of practice expenses for imaging providers. First, CMS assumes that the equipment is used half the time the practice is open for business. MedPAC found that most imaging equipment is actually in use over 90 percent of the time. Low assumptions about equipment use artificially inflate the price Medicare pays for imag-

ing services. Second, the CMS assumption about the interest rate paid for acquiring capital equipment is too high. A recent survey of loans indicated that the average annual interest rate over the last five years ranged from 5.3 percent to 6.0 percent. Assuming a higher interest rate artificially inflates Medicare prices. Combined these provisions would bring CMS assumptions in line with the current market and improve the accuracy of Medicare's prices.

Finally, disallowing global billing for imaging services is necessary to conform to the other changes being made (e.g., accreditation, multiple expenditure targets) and enable Medicare to better track utilization of imaging services.

SECTION 310. REDUCING FREQUENCY OF MEETINGS OF THE PRACTICING PHYSICIANS ADVISORY COUNCIL

Current law

Section 1868(a) of the Social Security Act established a Practicing Physicians Advisory Council ("Council") to discuss certain proposed changes in regulations and carrier manual instructions related to physician services identified by the Secretary. The council members are appointed by the Secretary, based upon nominations submitted by medical organizations representing physicians. The Council is composed of 15 physicians, each of whom has submitted at least 250 Medicare claims for physicians' services in the previous year. At least 11 of the members of the Council are doctors of medicine or osteopathy (not doctors of dentistry or dental surgery, podiatry, optometry, or chiropractic) and the members of the Council include both physicians participating in Medicare as well as nonparticipating physicians and physicians practicing in rural areas and underserved urban areas. The Council is statutorily required to meet quarterly.

Explanation of provision

The provision would change the statutory requirement for the Council to meet at least once a year or as determined necessary by the Secretary.

Reason for change

Staffing the Council's quarterly meetings requires a tremendous amount of time and resources. Many observers have questioned the effectiveness of the Council's contributions given the multitude of other forums for physicians to provide guidance to CMS. Limiting the number of Council meetings required during the year will free up administrative resources for other priorities, such as those being implemented by this Act.

TITLE IV—MEDICARE ADVANTAGE REFORM

SUBTITLE A—PAYMENT REFORM

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

Current law

Medicare Advantage (MA) rates for monthly capitation payments to the plans are now set by a process based on county level benchmarks and MA plan bids.

County benchmarks are set, for any year, by an update to the previous year's payment in a local area by the MA national growth percentage increase or, in years when rebasing occurs, by 100 percent of Fee-For-Service (FFS) in the county. The county payment levels now reflect a variety of historical calculations. These calculations include a national floor, a large urban floor, a blended rate of county and national FFS costs, a minimum update, and 100 percent of FFS costs in the county rebased in 2004, 2005 or 2007. Payments for regional PPOs and determined by a combination of benchmarks and plan bids. Payments for Indirect Medical Education costs for MA enrollees treated in teaching hospitals are included both in the MA county benchmarks and in payments made directly by Medicare to the hospitals. The annual increase in MA payments is reduced by a phase-out of budget neutral risk adjustment payments through 2010. Programs for All-inclusive Care for the Elderly (PACE) programs are paid amounts based on the county benchmarks for MA plans.

Plans submit bids representing their estimated costs for providing required Parts A and B benefits in June of each year for the next calendar year. If a plan's bid is less than the benchmark, its payment equals its bid plus a rebate of 75 percent of the difference and the remaining 25 percent of the difference is retained by the federal government. If a plan's bid is equal to or above the benchmark, its payment is the benchmark.

Beginning in 2004 and at a minimum every third year, CMS rebases FFS payment rates to reflect more recent county growth trends.

A stabilization fund, with funding of $3.5 billion in 2012 and 2013, is available to encourage regional PPO MA plans to enter into and/or to remain in the MA program. The stabilization fund is authorized through December 2013.

Explanation of provision

This section would phase-out payments to MA plans in excess of 100 percent of average FFS costs in each county over four years to 100 percent of FFS cost in the county in 2011.

The calculation of the MA county benchmarks would not change for 2008. In 2009, MA plan county benchmarks would be a blend of ⅔ of the 2008 county benchmark inflated to the 2009 level and ⅓ of 100 percent projected FFS in the county. In 2010, the blend would be ⅓ of the benchmark and ⅔ of 100 percent FFS in the county. In 2011, and subsequent years, all MA benchmarks would be set at the level of 100 percent of FFS costs in the county.

If a MA plan bid exceeds 106 percent of the county FFS amount for 2009 or 103 percent of the FFS amount in 2010, then that MA plan could not enroll any new enrollees for that year during the annual coordinated election period or during the year. "New enrollee" would not include an individual who was enrolled in a plan offered by the organization in the month immediately before the month in which the individual was eligible to enroll in such a Medicare Part C plan offered by the organization.

The phase-out of payments in excess of 100 percent of FFS costs would include a change so that the calculation of the 100 percent FFS amount for a Medicare Part C in a county area would exclude costs attributable to indirect medical education payments. For a Medicare Part C plan which covers more than one MA local area, the FFS amount would be weighted for each area by the proportion of enrollees in the plan that reside in the county, as posted by the CMS in the April bid notice. PACE programs would continue to be paid at current county rates. Beginning in 2009, fee-for-service rates would be rebased annually.

The regional PPO stabilization fund would be repealed.

Effective date

For plan capitation rates beginning with 2009.

Reason for change

When Medicare Health Maintenance Organizations were first paid on a full-risk capitation basis in 1985, they were paid at 95 percent of the average adjusted per capita costs (AAPCC) in fee-for-service Medicare at the county level. New Medicare policies enacted in 1997, 2000 and 2003 now pay Medicare Advantage (MA) plans an average of 12 percent more than costs in fee-for-service Medicare.

Overpayments to MA plans exceed $1,000 per MA enrollee per year. The national total of MA overpayments is $8 billion in 2007. CBO estimates that overpayments will total $65 billion by 2012 and $160 billion over the next 10 years. The fact and amount of overpayments to MA plans are not in question. The Congressional Budget Office, the Medicare Payment Advisory Commission and others have documented these amounts in testimony before the Committee and in numerous reports.

The Medicare Payment Advisory Commission (MedPAC) has recommended since 2001 that overpayments to MA plans should be eliminated. MedPAC recommends a level playing field where MA plans are paid the same—not more but not less—than average costs in FFS Medicare in the same county.

This provision provides for a phase-out of overpayments to MA plans as a blend of 100 percent of FFS costs and the historical benchmarks in each county. This approach to reducing overpayments follows an option described by MedPAC in its June 2007 report. The phase-out of overpayments to MA plans would last four years though 2011. This four year phase-out is the same length of time that the current increase in MA spending has taken place, over four years from 2004 to 2007.

The phase-out of MA overpayments to 100 percent fee-for-service costs in each county results in a reduction in Medicare costs of $50

billion over five years and $157 billion over 10 years. These reduced Medicare costs would result in a reduction in the Part B premium paid by beneficiaries of $2 per month and the extension of the solvency of the Part A trust fund by two years.

CBO now estimates that current 12 percent overpayments to MA plans will lead to a large increase in MA enrollment over the next 10 years, from 7 million enrollees in 2006 to over 12 million in 2012. The substantial majority of these 5 million projected new MA enrollees would be in the private fee-for-service (PFFS) and local PPO plans. These plans now certify that they cannot provide A & B services at 100 percent of FFS by submitting bids at 112 percent and 108 percent of FFS costs for 2007.

The Program for All-Inclusive Care for the Elderly (PACE) is a very small program in Medicare that covers the most frail elderly beneficiaries who would otherwise be in nursing homes. Unlike other MA plans, PACE providers fully integrate Medicare and Medicaid benefits, including long-term care. They are also unable to alter benefits or raise premiums on their beneficiaries. Because of its unique nature, the PACE programs would continue to be paid at current levels.

This section includes a provision intended to limit new enrollment in MA plans that indicate that they cannot compete in a program moving toward MA payments equal to 100 percent fee-for-service costs in 2011. Plans that bid above 106 percent of county FFS costs for 2009 or 103 percent of FFS costs for 2010 could not enroll new beneficiaries in those years.

SUBTITLE B—BENEFICIARY PROTECTIONS

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

Current law

Marketing materials and application forms from MA plans cannot be distributed to eligible enrollees unless two conditions are met: (1) they have been submitted for the Secretary's review at least 45 days prior to distribution, and (2) the Secretary has not disapproved their distribution. If an MA plan uses model marketing materials developed by the Secretary, the review period is reduced from 45 to 10 days.

Each MA plan is required to conform to fair marketing standards. The standards are required to include a prohibition against providing cash or other monetary rebates as enrollment incentives, and may include a prohibition against an MA plan or agent completing an election form on behalf of any individual. When applying the standards, the Secretary can disapprove materials that are inaccurate or misleading.

The Secretary has the authority to establish solvency and other standards applicable to MA plans. Federal standards preempt state laws except in the areas of licensing and solvency.

MA plans enter into contracts with the Secretary to participate in the Medicare program. The Secretary has the authority to impose sanctions on MA plans that violate the terms of the contract. Specifically, there are 7 types of violations: (1) failing to provide medically necessary items and services; (2) imposing beneficiary

premiums in excess of those permitted under the law; (3) expelling or refusing to re-enroll individuals in violation of this part; (4) discouraging or denying enrollment among eligible individuals expected to require future medical services; (5) misrepresenting or falsifying information furnished to the Secretary or an individual; (6) failing to abide by rules prohibiting interference between a medical provider and patient, or rules related to balance billing; and (7) contracting with providers excluded from the Medicare program.

The Secretary can impose civil monetary penalties ranging from $25,000 to $100,000 depending on the nature of the violation. For each type of violation, the Secretary can impose a maximum penalty of $25,000. Specifically, for violations related to discouraging enrollment among eligible individuals or misrepresenting information furnished to the Secretary, the Secretary can impose a maximum penalty of $100,000. For violations related to charging excess beneficiary premiums, the Secretary can impose an additional $15,000 for each beneficiary not enrolled as a result of the practice.

The Secretary has the authority to charge each MA and PDP plan a fee equal to the plan's pro rata share (as determined by the Secretary) of the total fees the Secretary collects from MA plans in a year. These fees are available, without further appropriation, for outreach and enrollment activities related to MA, including the State Health Insurance and Assistance Program (SHIPs). SHIPs operate in every state and provide counseling services to beneficiaries on Medicare-related topics. For years 2006 and beyond, the law authorizes $200,000,000 minus the fees collected from MA and PDP plans for these activities. Also, for years 2006 and beyond, fees cannot exceed the lesser of the cost of conducting these outreach and enrollment activities or the applicable portion of $200,000,000. The applicable portion is defined as: 1) for MA plans, the Secretary's estimate of the total proportion of expenditures under this title that are attributable to expenditures made under this part; or 2) for PDP plans, the Secretary's estimate of the total proportion of expenditures under this title that are attributable to expenditures made to Part D plans.

Explanation of provision

This section would request NAIC to develop model Medicare private plan regulations. This provision would establish new marketing and advertising standards for Part C and Prescription Drug Plans (PDPs) for state enforcement. Specifically, the National Association of Insurance Commissioners (NAIC) would be requested to develop model regulations in 5 related areas: (1) marketing, (2) enrollment, (3) broker and agent training and certification, (4) agent and broker commissions, and (5) market conduct. The regulations would be due to the Secretary one year after the enactment of this legislation. This provision also proposes guidelines for the NAIC to follow in developing these regulations.

In the area of marketing, regulations would be required to address the sales and advertising techniques used by private plans, their agents, and brokers. Cold calls, unsolicited door-to-door sales, cross-selling and co-branding would be prohibited. The model regulations would be required to address the marketing practices of plans that serve dual-eligibles, populations with limited English

proficiency, and beneficiaries in senior living facilities. The regulations would also be required to address the plan's marketing practices at educational events.

In the area of enrollment, the regulations would be required to address the disclosures Medicare private plans, their agents, and brokers make to beneficiaries during enrollment as well as a process for affirmative beneficiary sign-off before enrollment, and, for Part C plans, for beneficiary call-back to confirm enrollment. The regulations would also be required to address, either through beneficiary disclosure or verification, beneficiary understanding related to plan type, plan attributes (i.e. premiums, cost sharing, formularies, benefits, and access), plan quality, and the fact that plan attributes can change annually.

In the area of broker and agent training and certification, the regulations would be required to establish requirements and procedures for the appointment, certification, re-certification, and training of brokers and agents that market and sell Medicare private plans that are consistent with existing state appointment and certification procedures.

In the area of agent and broker commissions, the regulations would be required to establish standards for setting fair and appropriate commissions. Three types of commissions and payments would be prohibited: (1) differential commissions based on plan type, (2) first year commissions that are greater than 200% of subsequent year commissions, and (3) payments of extra bonuses and incentives such as trips, gifts, and other types of non-commission cash payments. When developing these standards, the NAIC would be required to consider the potential for fraud and abuse and beneficiary steering, as well as address the ability of state commissioners to investigate commission structures. The NAIC would be required to also consider requiring agents and brokers to disclose commissions to a beneficiary upon request.

Finally, in the areas of market conduct, the regulations would be required to establish standards for Medicare private plans, private plan agents and brokers, and state review of Medicare private plans. Standards would be required to include timely payment of claims, beneficiary complaint reporting and disclosure, and state reporting of marketing violations and sanctions.

The provision would set a number of conditions for the implementation of the NAIC model regulations. If the regulations were submitted on a timely basis—one year after the enactment of this legislation—the following would apply: (1) the Secretary would be required to publish the regulations in the Federal Register and request public comment on whether the regulations were consistent with this statute; and (2) not later than 6 months after publication, the Secretary would be required to publish its determination on whether the regulations were consistent with the statute in a 2nd Federal Register notice. If they were consistent, the Secretary would be required to adopt the regulations as the marketing and enrollment standards for Medicare private plans. If the Secretary determined that the regulations were not consistent with the statute, the Secretary would be required to propose marketing and enrollment standards and request public comment. Not later than six months after requesting public comment on the proposed stand-

ards, the Secretary would be required to adopt the regulations as the marketing and enrollment standards for private plans.

If the regulations are not submitted on a timely basis, the following would apply: (1) the Secretary would publish a notice in the Federal Register stating this fact; (2) not later than 6 months after publication, the Secretary would propose marketing and enrollment standards consistent with this statute. The regulations would be published in a second Federal Register notice with a request for public comments; and (3) not later than 6 months after publication of the proposed regulations, the Secretary would promulgate final regulations that would constitute the marketing and enrollment standards for MA plans.

When developing these regulations, the NAIC or the Secretary would be required to consult with a balanced working group composed of issuers of Medicare private plans, consumer groups, beneficiaries, State Health Insurance Assistance Programs, and others. Finally, the Secretary would be required to establish effective dates for implementation consistent with the following: (1) the effective date for regulations pertaining to the operations of Medicare private plans would be plan years beginning on or after such date, but not later than one year after the regulations were published; (2) For regulations not related to the operations of Medicare private plans, the effective date would be any date specified by the Secretary provided its not later than one year after the regulations were published.

The provision would require that any plan, agent, or broker that violated any of the marketing and enrollment standards added by this provision would be subject to sanctions. Furthermore, this provision would not prohibit states from imposing sanctions against Medicare private plans, agents, and brokers for violations of these standards. States would have the sole authority to regulate plan agents and brokers.

This section would expand the exception to the preemption of the state role. This provision would add another exception to the federal preemption statute. Beginning July 1, 2008, standards established by the Secretary would preempt state law except those related to licensing, plan solvency, and the marketing and enrollment standards adopted under this statute.

This section requires that the regulations establishing marketing and enrollment standards apply to Prescription Drug Plans (PDPs). It also provides that MA plan contracts are required to include marketing and advertising standards. Starting January 1, 2011, this provision would require that contracts between Medicare private plan organizations and the Secretary meet all marketing and enrollment standards, including those enforced by the state.

This section provides that violations of marketing and enrollment standards would become subject to sanctions. Federal sanctions for marketing and enrollment violations would apply to Medicare private plans. State sanctions would apply to private plans, brokers and agents.

The civil monetary penalties that can be imposed on plans that violate terms of their contract would be doubled. This would include, but not be limited to violations of the marketing and enrollment standards adopted under this section. The revised penalties

would apply to violations occurring on or after the enactment date of this legislation.

This section provides for the disclosure of market and advertising contract violations and imposed sanctions. Beginning in 2009, the Secretary would be required to post an annual report on its website that lists each Medicare private plan organization the Secretary has terminated from participation in the program, the basis for the termination, as well as any applicable sanctions.

This section provides for standard definitions of benefits and formats for use in marketing materials. By January 1, 2010 the Secretary, in consultation with NAIC and a working group established to consult on marketing and advertising requirements, would be required to develop standard descriptions and definitions of benefits for use in marketing materials. For plan years beginning on January 1, 2011, the Secretary would be required to disapprove marketing materials that did not use these standard descriptions and definitions.

This provision would specify funding amounts for SHIPs. For FY09, no less than $55,000 would be available for SHIPs, for FY10 no less than $65,000, for FY11 no less than $75,000, and for FY12 and subsequent years no less than $85,000. This provision would also increase funding for Medicare outreach and enrollment activities for years 2009 through 2012. In 2009, there would be $255,000,000 available for outreach and enrollment activities, for 2010 $265,000,000, for 2011 $275,000,000, and for 2012 and each succeeding year $285,000,000. All amounts would be reduced by the fees collected from MA and PDP plans by the Secretary. In any year, amounts in excess of $200,000,000 would be used to support SHIPs and the remaining amount to support activities related to outreach and enrollment. For years 2009 and beyond, fees cannot exceed the lesser of the cost of conducting these outreach and enrollment activities or the applicable portion of the amounts specified above.

Effective date

Upon enactment.

Reason for change

Thousands of Medicare beneficiaries across the country have reported unscrupulous and questionably legal behavior by agents, brokers and plans offering Medicare Advantage and Part D plans. In spite of warnings and recommendations from the NAIC and consumer groups, the CMS marketing guidelines allow practices known to be harmful to consumers. Current CMS guidelines allow for cross-selling of other insurance products, unsolicited phone calls to Medicare beneficiaries and the selling of policies near pharmacies. In addition, the guidelines provide no limits on commissions and incentives.

This provision will create strong new marketing and enrollment standards as developed by an expert panel of stakeholders impaneled by the NAIC. The model regulations will: limit unscrupulous marketing activities, ensure appropriate beneficiary education, set standards for agent and broker appointment training and certification, and limit commissions.

Under current law, states are preempted from imposing strong marketing guidelines against agents, brokers and plans. CMS has proven they are unable, and/or unwilling, to take the actions necessary to stop the bad actors. In the past states have proven they are able and willing to protect beneficiaries from bad actors.

These regulations will protect consumers and give CMS and the states the tools they need to adequately enforce consumer protections.

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

Current law

Each MA plan must provide all items and services (other than hospice) for required benefits under Part A and B to individuals entitled to Part A and enrolled in Part B, with cost sharing for those services as required under Part A and B, or an actuarially equivalent level of cost sharing.

Dual eligibles are persons entitled to the full range of benefits under their state's Medicaid program.

Qualified Medicare beneficiaries (QMBs) are those aged or disabled individuals that are entitled to have some of their Medicare cost sharing and Part B premiums paid by the federal-state Medicaid program, but are not entitled to coverage of Medicaid plan services.

Explanation of provision

Beginning on January 1, 2009, plans would be prohibited from offering benefits with cost sharing requirements that are greater than the cost sharing requirements imposed under the traditional Medicare program. The "actuarially equivalent" standard included in the statute would be eliminated. Medicare private plans would not be prohibited from using flat co-payments or per diem rates in lieu of the cost sharing amounts imposed under Part A and B Medicare, as long as they did not exceed the level of cost sharing under traditional Medicare.

This provision would also prohibit plans from imposing cost-sharing for dual-eligible individuals or qualified Medicare beneficiaries enrolled in a Medicare Part C plan that exceeds the cost-sharing amounts permitted under the Medicare and Medicaid statutes. This provision would apply to plan years beginning on or after January 1, 2008.

Effective date

For plan contract years beginning in 2009 and in 2008.

Reason for change

While Medicare Advantage plans often seek to attract beneficiaries with reduced cost-sharing amounts, they rarely tell beneficiaries that MA plans are allowed to vary co-payments and deductibles so that out-of-pocket costs may be substantially higher for individual services than in fee-for-service Medicare.

For example, a fee-for-service Medicare beneficiary with an average seven day hospital stay would pay only the $992 standard de-

ductible, but in an MA plan could be subject to $2,275 in out-of-pocket costs after being charged a $325 co-payment for each 72 days in the hospital. Fee-for-service Medicare charges no co-payments for home health visits while some Medicare Advantage plans charge up to 20 percent co-insurance.

These examples are merely illustrative. In many MA plans, enrollees are charged more not just for home health and hospitalizations, but also for skilled nursing facilities, durable medical equipment, Part B drugs with cancer chemotherapy being the biggest service, and inpatient mental health services.

This provision provides truth-in-advertising for MA plans by requiring the plans to cover all of Medicare's benefits with no greater cost-sharing than is charged in the fee-for-service Medicare program. It would preserve the ability of MA plans to use flat co-payments and per diem rates in lieu of deductibles and co-insurance charged in traditional Medicare, but it would prohibit enrollee out-of-pocket costs from exceeding what their costs would have been in fee-for-service Medicare.

This section also protects Medicare-Medicaid dual-eligible beneficiaries by making sure MA plans do not charge these low-income enrollees more in cost-sharing than they would pay under Medicaid in the state.

SECTION 413. MA PLAN ENROLLMENT MODIFICATIONS

Current law

Institutionalized MA eligible individuals are allowed continuous open enrollment during the year and can change their MA election any time.

Special Election Periods allow beneficiaries the option to discontinue or change their enrollment in an MA plan outside of the annual coordinated election period. The circumstances in which an enrollee can exercise this option include: (1) an MA plan terminates its participation in the MA program or in a specific area, (2) an individual's place of residence changes, (3) the MA plan violates a provision of its contract or misrepresents the plan's provisions in marketing the plan, or (4) other exceptional conditions as provided by the Secretary. CMS has used the exceptional conditions authority to allow Medicare-Medicaid dual eligibles to enroll or disenroll from a MA plan in any month.

Certain Medicare beneficiaries may be eligible for financial assistance either through one of the Medicare Savings programs or through subsidized Part D coverage. Qualified Medicare Beneficiaries (QMBs) are aged or disabled persons with incomes at or below the federal poverty level, and also meet certain requirements. An individual who qualifies as a QMB may have their Medicare cost-sharing charges and Part B premium paid by the federal-state Medicaid program. Specified Low-Income Beneficiaries (SLMBs) meet the QMB criteria, except that their income is between 100% and 120% of the federal poverty level. For SLMBs, their Medicaid protection is limited to payment of the Medicare Part B monthly premium. Beneficiaries with incomes below 150% of the federal poverty line, and meet certain resource requirements as defined in the statute are eligible to receive subsidized Part D

drug coverage, either through a prescription drug plan (PDP) or an MA prescription drug plan (MA–PD).

The law guarantees issuance of specified Medigap policies for persons who leave MA plans. First, the law applies to individuals who: (1) were enrolled in a Medigap policy; (2) subsequently terminated enrollment in that policy and enrolled in a MA plan for the first time; and (3) terminated enrollment with the MA organization within 12 months. Second, an individual upon turning 65 joins a MA plan and subsequently leaves the plan within one year.

Explanation of provision

This provision codifies the current CMS policy by providing specific statutory authority for the continuous open enrollment option that is now limited to institutionalized individuals, to full benefit dual-eligible individuals and qualified Medicare beneficiaries (QMBs). The provision would change the continuous open enrollment period to allow institutionalized, dual-eligible individuals, and QMBs to disenroll from MA plans and return to traditional Medicare at any time.

This provision would expand the categories of beneficiaries eligible to participate in Special Election Periods to include specified low-income Medicare beneficiaries (SLMBs) and beneficiaries enrolled in private plans in which enrollment has been suspended for not meeting the terms of their contract. The Secretary would be required to take into account the health or well-being of the individual when determining the exceptional conditions in which individuals may be allowed to take advantage of a Special Election Period.

This provision would increase from one year to two years the length of time certain categories of individuals who leave Part C plans have to enroll in a Medigap plan. The provision would apply on or after the enactment date of this legislation.

The provision would prohibit the Secretary from enrolling Medicaid-eligible individuals as dual-eligibles or qualified Medicare beneficiaries in a Part C plan without explicit permissions from the individual or authorized representative of the individual. The provision would not apply to PDPs and would apply on or after the enactment date of this legislation.

Effective date

Upon enactment.

Reason for change

Dual eligibles and beneficiaries who qualify for assistance with their Part B premiums are more likely to suffer from mental illness or cognitive impairments, making them vulnerable targets for predatory MA marketing schemes. A number of MA plans have, in fact, targeted dual eligibles for enrollment in their MA plans, disrupting access to providers and resulting in higher co-payments for this vulnerable population. This provision guarantees these individuals will be able to change plans or return to fee-for-service Medicare for their coverage.

Plans in some states have been allowed, in some instances, to automatically enroll dual-eligible beneficiaries in Medicare Advan-

tage plans. These plans are not always the best option for beneficiaries. This section bars CMS from auto-enrolling dual eligibles in Medicare Advantage plans, a practice that can subject these individuals to restrictive provider networks and higher co-payments.

Individuals who experience disruptions in their medical treatment or are unable to access specific physician specialists because of restrictions imposed by their MA plan are now barred from disenrolling from their MA plans to pursue a course of medical treatment. This section requires CMS to take account of the health or well being of the individual when determining if they can change MA plans or return to fee-for-service Medicare.

Plans that commit egregious contract violations—consistently barring access to medically necessary treatment as a matter of policy, failing to have the necessary reserves to pay benefits; engaging in widespread predatory marketing schemes—can have their enrollment frozen by CMS. This provision also allows members of these plans to change plans or return to fee-for-service Medicare.

Beneficiaries should not be disadvantaged when returning to fee-for-service Medicare after being a member of a Medicare Advantage plan. By extending the time period for guaranteed re-issue of a Medigap policy, these individuals will be able to return to their coverage under fee-for-service Medicare and a Medigap policy.

SECTION 414. INFORMATION FOR BENEFICIARIES ON MA PLAN ADMINISTRATIVE COSTS

Current law

The Secretary must provide for activities to disseminate information to current and prospective Medicare beneficiaries about MA plans, including, but not limited to benefits, cost sharing, service area, access, out-of-area coverage, emergency coverage, and supplemental benefits.

By the first Monday in June, each local MA health plan must submit to the Secretary an aggregate monthly bid amount (which includes separate bids for required services, any offered supplemental benefits, and any offered drug benefits) for each MA plan it intends to offer in the upcoming calendar year. The bid is based on the average revenue requirements in the payment area for an enrollee with a national average risk profile. The Secretary has the authority to evaluate and negotiate the plan's bid amounts and its proposed benefit packages except for PFFS and MSA plans.

Each contract with an MA organization provides the Secretary with the right to audit and inspect any book and record of the organization that pertain to: (1) the ability of the organization to bear the risk of potential financial losses, or (2) services performed or determination of amounts payable under the contract.

Explanation of provision

Beginning in 2009, no later than October 1 of each year, the Secretary would be required to publish the following for each Medicare Part C plan contract offered: (a) the medical loss ratio of the plan in the previous year; (b) per enrollee payment as adjusted to reflect a risk score of 1.0, based on factors described in statute; and (c) the average risk score.

Each Medicare Part C organization would be required to submit necessary data, including information about the medical loss ratio including: (a) the costs for the plan in the previous year for total medical expenses, with separate calculations for required Medicare benefits and supplemental benefits and for non-medical expenses of marketing and sales, direct administration, indirect administration, and net cost of private reinsurance; (b) gain or loss margin; (c) total revenue requirement, computed as the total of medical and non-medical expenses and gain or loss margin, multiplied by the gain or loss margin; and (d) percent of revenue ratio, computed as the total revenue requirement expressed as a percentage of revenue.

For 2008 and 2009, the data would be required to be consistent in content with data reported as part of the Medicare Part C plan bid in June 2007. The data submitted relating to medical loss ratio for a year would be submitted no later than June 1 of the following year. Beginning with 2010, the data would be based on the standardized elements and definitions. Data would have to be audited by an independent third party auditor.

The Secretary would be required to develop and implement standardized data elements and definitions for the calculation of the medical loss ratio for Medicare Part C plans, after consulting with representatives of Part C organizations, experts on health plan accounting systems, and representatives of the National Association of Insurance Commissioners. The Secretary would publish a report describing the elements and definitions no later than December 31, 2008.

For a Medicare Part C plan, for a year, the Medical Loss Ratio would be defined as the ratio of aggregate benefits, excluding non-medical expenses, to the aggregate amount of basic and supplemental premiums collected for the plan and year and payments made by Medicare, including those for prescription drugs. The ratio would be computed without regard as to whether or not the benefits and premiums were for required or supplemental benefits under the plan.

A contract with a Part C organization would provide the Secretary with the right to audit and inspect any book or record of a Part C organization that pertains to compliance with maintaining the required medical loss ratio and the extent to which administrative costs comply with the applicable requirements for such costs under the Federal Acquisition Regulation.

Beginning in 2010, if the Secretary determined that an MA plan had failed to have a medical loss ratio of at least .85, the MA plan would be subject to the following requirements: (1) for that contract year, the Secretary would reduce the blended benchmark amount for the second succeeding year by the percentage point difference between .85 and the plan's medical loss ratio; (2) for 3 consecutive years, the plan could not enroll new enrollees for coverage during the second succeeding year; and (3) the plan would not be allowed to continue if it failed to have such a medical loss ratio for 5 consecutive years.

Beginning January 2008, the Secretary would publish, on the CMS web site or otherwise, actual enrollment in each Medicare Part C plan by county, no later than 30 days after the end of each month.

The Secretary would be required to make publicly available data and other information in new formats that could be readily used for analysis of the Part C program and would contribute to the understanding of the organization and operation of such program.

The Medicare Payment Advisory Commission (MEDPAC) would conduct a study related to the need and feasibility of providing for different medical loss ratios for different types of Part C plans, including coordinated care group plans, coordinated care independent practice association plans, preferred provider organization plans, and private fee-for-service plans. A report on the study would be due to Congress one year after this legislation is enacted.

Effective date

Upon enactment.

Reason for change

Medicare Advantage plans claim to provide significant extra benefits, but neither the plans nor CMS can quantify whether any of the MA overpayments are actually spent on improved benefits. Plans are now reported to spend an average of 13 percent of their Medicare payments on administrative costs and profits.

The Medical Loss Ratio is the percentage of health plan payments actually spent on direct patient care. In the current MA bidding process, plans report the data on administrative costs and the other factors necessary for the calculation of a Medical Loss Ratio as part of their annual bid submission. Unfortunately for beneficiaries and policy makers, CMS does not disclose the MA plan data and MLRs so beneficiaries do not know how much individual plans are spending on administrative costs or reaping in profits. Disclosure of these ratios will help beneficiaries choose efficient plans and will help policy makers make future program improvements.

MA plans should provide care in an efficient manner. This section provides for a minimum MLR of .85 for MA plans beginning in 2010 so that beneficiaries and taxpayers would not pay more than 15 cents per dollar for administrative costs and profits. Plans that are not efficient and cannot meet the Medicare Loss Ratio threshold of 0.85 in 2010 or subsequent years, would face a reduction in their benchmarks and limits on new enrollment. MA plans would eventually be excluded from the MA program if they did not meet the requirement for five consecutive years.

Currently the financial and other data reported by MA plans are not standardized across plans and plan types and cannot be compared on an apples to apples basis. Standardized data elements and definitions for the reporting of MA plan data regarding Medical Loss Ratios would be developed in 2008. These standardized data and definitions would provide beneficiaries an improved basis for the comparison of the relative efficiency of individual MA plans.

This section provides for CMS to publish monthly on it's web site information on actual MA plan enrollment by plan by county. The Committee believes that the MA plan specific data published monthly by CMS should include an expansion of the current Monthly MA Enrollment by State/County/Contract data file that CMS posts on its web site and should include separate enrollment

for each plan as a subtotal within the contract and county. The County/Contact file should be revised to include: an additional breakdown within each contact/county of the total enrollment by plan. Further, the file should be expanded to provide plan codes which allow users to distinguish general MA plans by contract type from SNP plans; enrollment of individuals identified separately from enrollees in employer groups; and those that are Medicaid dually eligible versus other enrollees. CMS should provide actual enrollment data for all contracts at the county level by discontinuing its current practice of excluding data for plans with fewer than 10 enrollees in the county.

This section also requires CMS to make publicly available data and other information on the MA program in formats that can be readily used for analysis. The Committee believes that CMS should release data and other information on MA plans including: the data on Medicare eligibles at the county level that CMS historically released but has not since December 2005. The Monthly MA Summary Report should be modified to: breakdown enrollment in local CCP plans into HMO, local PPO and local POS plans; exclude CMP pilot enrollees; show figures for individual versus group enrollment; divide plan enrollment between SNP and other types of plans; and indicate the number of enrollees in each plan that is dually Medicaid eligible. CMS should also modify the Annual Plan Report to include enrollment not just for plans but for the contract-county-plan combination.

SUBTITLE C—QUALITY AND OTHER PROVISIONS

SECTION 421. REQUIRING ALL MA PLANS TO MEET EQUAL STANDARDS

Current law

All MA plans, except Private Fee-For-Service (PFFS) plans and Medical Savings Account (MSA) plans must have a quality improvement program. The quality improvement program must have a chronic care improvement program and must provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes.

The Secretary has the authority to waive or modify requirements that hinder the design of, the offering of, or the enrollment in MA plans that (1) have contracts between MA organizations and employers, labor organizations or the trustees of a fund established by one or more employers or labor organizations to furnish benefits to the entity's employees and/or former employees of the labor organization, or (2) are offered by employers, labor organizations or the trustees of a fund established by one or more employers or labor organizations.

Explanation of provision

For 2009, a Medicare Part C organization offering a PFFS plan or MSA Plan would be required have a quality improvement program and to submit the same information on the same performance measures as preferred provider organization (PPO) plans. Beginning in 2010, a Medicare Part C organization offering a PPFS plan or an MSA would be required to submit the same information on the same performance measure as Medicare HMOs.

Beginning January 1, 2009, employer sponsored Part C plans would be required to have 90 percent of the Medicare beneficiaries enrolled in the plan reside in a county in which the organization offers a Medicare Part C local plan. With respect to employer sponsored Part C plans, the Secretary would only be allowed to waive or modify requirements that were in effect before the date of enactment of this bill.

Effective date

Plan contract years beginning in 2009 and upon enactment.

Reason for change

This section, together with other provisions of Title IV, levels the playing field between different types of MA plans.

MedPAC, in its June 2007 report, indicates that it both supports equity between MA plans and FFS Medicare program and equity in the treatment of different plan types within the private plan sector. The MedPAC June report states "The Commission favors a level planning field for all plan types, unless special circumstances dictate otherwise."

Medicare HMOs have reported comprehensive data on the quality of care provided to their members for a decade. This includes clinical data termed HEDIS and patient satisfaction data termed CAHPS. Reports on the quality of care by plans were part of the response to the concerns about the quality of care in managed care plans ten years ago. Currently, the MA private fee-for-service and PPO plans do not submit HEDIS and CAHPS quality data similar to that submitted by HMOs.

The National Committee for Quality Assurance (NCQA) has studied the issue of equity and reports that it would be feasible for all types of MA plans to submit the same quality data. This section follows the NCQA recommendations and phases-in a level-playing field for all MA plans over three years through 2010.

This section equalizes the playing field across types of MA plans by requiring PFFS and PPO plans to report the same quality data reported by HMOs beginning in 2010. This section also protects Medicare beneficiaries by requiring all MA employer plans, including PFFS plans, to continue to meet the current local plan requirement and insures that the provisions of the CHAMP Act apply to employer plans.

CMS has proposed, beginning in 2008, to allow employers to provide their retirees PFFS plans in areas of the nation where the PFFS organization does not have a local plan. These plans cannot guarantee adequate availability of providers. This new policy will allow a former employer to choose a PFFS plan for retirees with no guarantee that providers in the area where the retirees live will accept payment from the PFFS plan.

This provision would simply continue the current policy that has worked well. Medicare plans have contracted with employers to provide coverage for their retirees for many years. The 90 percent standard allows some retirees to move to another area. The Committee understands that that the 90 percent policy would accommodate current retiree enrollment patterns.

SECTION 422. DEVELOPMENT OF NEW QUALITY REPORTING MEASURES ON RACIAL DISPARITIES

Current law

Under the quality improvement program required for MA plans, the types of data that may be collected are limited to data on quality, outcomes, and beneficiary satisfaction that were collected by the Secretary as of November 1, 2003. The Secretary may only change the required types of data after consulting with MA organizations and private accrediting bodies, and then submitting a report to Congress on the reasons for such changes.

Explanation of provision

By October 1, 2009, the Secretary would be required to develop quality measures for Part C plans that measure disparities in the amount and quality of health services provided to racial and ethnic minorities. Beginning January 1, 2010, the Secretary would require Medicare Part C organizations to submit data, including but not limited to data similar to data submitted for other quality measures, which permit analysis of disparities among racial and ethnic minorities in health services, quality of care and health outcomes, and health status.

Not later than 2 years after the date of enactment and biennially thereafter, the Secretary would be required to submit a report to Congress including the following information: (1) a description of the methods by which MA plan quality assurance programs address disparities for racial and ethnic minorities; (2) a evaluation of the impact of such programs on reducing health disparities and improving health outcomes, continuity and coordination of care, management of chronic conditions, and consumer satisfaction; (3) recommendations on ways to reduce health outcome disparities among racial and ethnic minorities; and (4) data for each Part C plan from HEDIS and other sources reporting the disparities in the amount and quality of health services furnished by the plan to racial and ethnic minorities.

Effective date

Plan contract years beginning in 2010 and upon enactment.

Reason for change

Recent reports by health services researchers at Harvard indicate that disparities in care to minorities vary widely in MA plans just as they do in the fee-for-service system. MA plans have the organizational ability to reduce disparities. NCQA, together with physicians and others working to improve quality of care in health plans, have indicated an interest in developing HEDIS and other measures of racial and ethnic disparities for MA plans.

This section would increase the attention and response to disparities in care provided to minorities by managed care plans all across the nation. NCQA would develop and plans would report new HEDIS quality measures to assess disparities in health services provided to racial and ethnic minorities beginning in 2010. This section provides for MA plans to submit data that would permit analysis of disparities among minorities in the utilization of

health services, quality of health care and health outcomes, and health status. The Committee believes that this data should be made available in public use data sets that could be used to analyze disparities in care and health status.

This would be an important step in addressing disparities in the nation's health care system as managed care leaders have observed: "If you measure it, we will improve it"

HHS would also report every-other-year on disparities in care to minorities in MA plans. This report would be best source of information on the status of care to minorities in managed care plans. It would also be a regular source of information on the status of the development new quality measures on disparities and, once developed and implemented, of the performance of individual MA plans on those measures.

SECTION 423. STRENGTHENING AUDIT AUTHORITY

Current law

The Secretary is required to provide for the annual auditing of the financial records (including data relating to Medicare utilization and cost, including allowable costs for risk corridors for regional plans) of at least ⅓ of the organizations offering MA plans.

The Secretary is authorized to exercise other protections against fraud and beneficiary protections in addition to the annual audits of financial records. These additional protections include: (1) the authority to inspect or otherwise evaluate the quality, appropriateness and timeliness of services performed under the contract, (2) the authority to audit and inspect any books and records of the organization that relate to the ability of the organization to bear the risk of potential financial losses or to services performed or determinations of amounts payable under the contract, (3) the requirement that organizations provide written notice to beneficiaries in advance of a plan's termination, (4) the requirement that plans report financial information to the Secretary according to the regulations of the Secretary, and (5) the requirement that organizations notify the Secretary of loans or other financial arrangements which are made between the organization and subcontractor, affiliates, and related parties.

Explanation of provision

Beginning January 1, 2009, MA plan audits would also be required to include audits of plan information submitted for risk adjustment purposes.

The Secretary would be authorized, in connection with conducting audits and other activities to take action, including pursuit of financial recoveries necessary to address deficiencies identified in the audit or other activities. The Secretary would require each contract with a Medicare part C organization to include terms that inform the organization of the statutorily defined protections against fraud and beneficiary protections. The Secretary's expanded authority under this portion of the bill would also apply to Prescription Drug Plans under Medicare Part D.

Effective date

Upon enactment.

Reason for change

MA risk adjustment data is important as it is responsible for the allocation of a significant portion of the $70 billion a year that Medicare pays to individual MA plans. MA plan risk adjustment data is now not routinely audited. This section provides that the data that plans submit for risk adjustment would be audited in a similar fashion to other MA data.

Since MA plans that report they have sicker members are paid more by Medicare, MA plans have an incentive to increase the coding intensity of their enrollees. CMS reported in April of this year that MA plan risk scores increased by an average of 2.5 percentage points per year more rapidly than FFS risk scores from 2004 to 2006.

CMS reported earlier this year that it did not have clear statutory authority to address deficiencies in MA plan audits. This section would also give CMS authority to address deficiencies in MA plans audits.

SECTION 424. IMPROVING RISK ADJUSTMENT FOR MEDICARE ADVANTAGE PAYMENTS

Current law

The law requires that the Secretary make a number of adjustments to the monthly payments to MA health plans, including adjustment for demographics and health status (i.e. risk adjustment—which increases payments to plans for "sicker" enrollees and reduces payment for "healthier" enrollees).

Explanation of provision

The Secretary would be required to submit a report to Congress, no later than 1 year after enactment, that evaluated the adequacy of the MA risk adjustment system, including at least the following: (1) the need and feasibility of improving the adequacy of the risk adjustment system in predicting costs for beneficiaries with co-morbid conditions and associated cognitive impairments; (2) the need and feasibility of including further gradations of diseases and conditions, such as the degree of severity of congestive heart failure; (3) the feasibility of measuring differences in coding over time between Medicare Part C plans and the Medicare traditional fee-for-service program and, to the extent differences exists, the options for addressing them; and (4) the feasibility and value of including part D and other drug utilization data in the risk adjustment model.

Effective date

Upon enactment.

Reason for change

The current MA risk adjustment system—although it is not fully phased-in—was developed almost 10 years ago and there has been

little new research on improvement to the risk adjustment system since then.

This section provides for a report to the Committee on the adequacy of the MA risk adjustment system with a focus on its accuracy in predicting the costs of enrollees with multiple chronic diseases and recommend needed revisions. This CMS study would prompt a new look at this issue with a special focus on the costs of plan members who have multiple chronic illnesses.

SECTION 425. ELIMINATING SPECIAL TREATMENT OF PRIVATE FEE-FOR-SERVICE PLANS

Current law

The amount of cost sharing per MA enrollee for covered services can be no more than the actuarial value of the deductible, coinsurance, and co-payment under traditional Medicare. Generally providers may bill enrollees in PFFS plans up to 15 percent above the fee schedule the plan uses.

In contrast to traditional Medicare, possible extra-billing extends to all categories of providers, including hospitals. PFFS plans must provide enrollees with a clear statement of the amount of the beneficiary's liability, including any balance billing amounts. Similarly, hospitals must provide advance notice before receipt of inpatient services and certain other services, for which the amount of balance billing could be substantial.

By the first Monday in June of each year, all local MA health plans must submit to the Secretary an aggregate monthly bid amount (which includes separate bids for required services, any offered supplemental benefits, and any offered drug benefits) for each MA plan it intends to offer in the upcoming calendar year. The Secretary has the authority to evaluate and negotiate the plan's bid amounts and its proposed benefit packages. The Secretary does not have the authority to review and negotiate the bid amounts for PFFS plans.

Explanation of provision

Beginning in 2009, this provision would eliminate providers' ability to bill enrollees in PFFS plans more than the fee schedule amount for Medicare services.

This provision would also eliminate the exemption for PFFS plans from the Secretary's authority to review and negotiate MA plan bid amounts. This provides the Secretary the authority to review and negotiate the bid amounts for PFFS plans in the same manner as with other Part C plans.

Effective date

Plan contact years beginning in 2009.

Reason for change

MedPAC, in its June 2007 report, indicates that it supports equity in the treatment of different plan types within the private plan sector. The June report states "The Commission favors a level planning field for all plan types, unless special circumstances dictate otherwise."

Only PFFS plan providers, within the MA program, now have the explicit authority to extra-bill Medicare beneficiaries. This includes inpatient hospitals that never extra-bill in fee-for-service Medicare. This section equalizes the playing field across types of MA plans by eliminating the specific special authority for Private Fee-for-Service plan providers to extra-bill PFFS plan members by 15 percent.

Private-Fee-for-Service plan bids are not now reviewed by CMS as are the bids for HMOs and PPO plans. This section would provide for a more level playing field for PFFS plans by providing CMS review of annual bids by PFFS in the same way as other types of MA plans.

SECTION 426. RENAMING OF MEDICARE ADVANTAGE PROGRAM

Current law

The program under part C of Medicare is named the Medicare Advantage program.

Explanation of provision

The Medicare Advantage program would be renamed the Medicare Part C program.

Effective date

Upon enactment.

Reason for change

The Medicare Advantage program was renamed in the Medicare Modernization Act of 2003 in an attempt to convince beneficiaries that private plans were better than fee for-service Medicare. The Medicare program should not make judgments about the comparative value of different types of Medicare benefits.

The Medicare hospital benefit is referred to as Part A, physician and associated benefits are referred to as Part B, and even the privately run prescription drug program is called Part D. Changing the name of Medicare Advantage to Medicare Part C creates uniformity in the names of the major parts of the Medicare program and eliminates confusion for beneficiaries.

SUBTITLE D—EXTENSION OF AUTHORITIES

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

Current law

Specialized Medicare Advantage plans for Special Needs Beneficiaries or Special Needs Plans (SNPs) are plans that serve special needs beneficiaries. Special needs beneficiaries are defined as Medicare Advantage eligible enrollees who are institutionalized (as defined by the Secretary), are entitled to Medicaid, or would benefit from enrollment in a SNP for individuals with severe or disabling chronic conditions. The law gives SNPs the authority to limit enrollment in these plans to special needs beneficiaries only, for periods before January 1, 2009. CMS requires Medicare health plans to report on performance measures from the National Committee

for Quality Assurance's (NCQA) Health Plan Employer Data and Information Set (HEDIS), which includes the Consumer Assessment of Health Plans Study (CAHPS) and the Health Outcomes Survey (HOS).

Explanation of provision

The authority to limit enrollment in SNPs to only special need beneficiaries would be extended for periods before January 1, 2012. As of January 1, 2009, the definition of a SNP would be changed to require that these plans met either of the following conditions: (1) at least 90 percent of the enrollees were institutionalized as determined under regulation in effect as of July 1, 2007; or (2) at least 90 percent of enrollees were also entitled to Medicaid and were full-benefit dual eligible individuals for Medicare and Medicaid or qualified Medicare beneficiaries. Also, beginning January 1, 2009, SNPs would be required to meet additional requirements for enrollment and chronic care SNPs would be eliminated.

SNPs would be required to meet other requirements. SNPs for institutionalized individuals would be required to: (1) have an agreement with the State that included provisions regarding cooperation on the coordination of care for such individuals, including a description of the manner that the State Medicaid program will pay for the cost of services for individuals eligible under Medicaid for acute care and long-term care services; (2) have contracts with long-term care facilities and other providers in the area that are sufficient to provide care for institutionalized individuals; and (3) report to the Secretary information on additional quality measures as specified by the Secretary.

SNPs for dual eligible individuals would be required to have an agreement with the State Medicaid agency that included provisions regarding payment, enrollment and marketing, and to have an agreement with the State Medicaid agency for capitation payments, beginning in 2011, to cover costs of supplemental benefits for both full benefit and qualifying dually eligible Medicare and Medicaid individuals. The out-of-pocket cost for services under Medicare parts A and B for enrollees could not exceed the out-of-pocket costs for the same services permitted for individuals under Medicaid. The plan would report to the Secretary information on additional quality measures as specified by the Secretary.

The Secretary would be required to develop new quality measures appropriate to meeting the needs of beneficiaries enrolled in SNPs for institutionalized and for dually eligible individuals not later than January 1, 2010.

These provisions would take effect on January 1, 2009, but would not apply to plans that that were operating as a part State integrated Medicaid-Medicare program that had been approved by CMS on January 1, 2004.

In the case of a chronic care SNP, the plan could not continue to be offered unless it was offered before January 1, 2008. No new members could be enrolled, and there could be no expansion of the service area. The Secretary would be required to provide for an orderly transition of those plans which no longer qualify as SNPs and their enrollees.

Effective date

Plan contract years beginning in 2009.

Reason for change

SNPs are just regular MA plans that are allowed, under Section 1859(f), to limit their membership to a specific set of Medicare beneficiaries. Since the SNP authority was first enacted as part of the Medicare Modernization Act of 2003 three and one-half years ago, CMS has not required SNP plans to live up to their name as special.

This section would extend and revise the authority for SNP plans that were first enacted as part of MMA in 2003 and will expire at the end of 2008. All SNP plans would continue to be full-fledged MA plans and would continue to be required to meet all of the requirements to be a MA plan except that their enrollment may be limited to a statutorily defined special sub-group of Medicare beneficiaries. These plans would continue to be paid under the same system and amounts as other MA plans.

SNP Medicaid dual eligible plans are not required to serve only dual Medicare-Medicaid eligible individuals or to have agreements with the states that they operate in to coordinate financing and care for low-income Medicaid-Medicare dual eligibles. SNP institutional plans are not required to serve only frail patients in long-term care institutions or to have contracts with nursing homes sufficient to serve their enrollees.

This section would require dual-SNPs to have 90 percent enrollees that are Medicaid beneficiaries and agreements to coordinate financing and care with State Medicaid agencies. Institutional-SNPs would have 90 percent enrollees who are residents of long-term care facilities, contracts with nursing homes, and agreements to coordinate care with States that finance over half of long-term care.

The authority for chronic disease SNPs in not extended as there is nothing special about chronic disease for Medicare plans. Over 60 percent of Medicare beneficiaries have two or more chronic diseases and all MA plans are required to have a Chronic Care Improvement Program under Section 1852(e)(2). All MA plans submit HEDIS data on diabetes, hypertension, chronic obstructive pulmonary disease, rheumatoid arthritis and other chronic conditions.

The new authority for dual Medicare-Medicaid SNPs would require that dual-SNP plans have an agreement with a State Medicaid agency to coordinate the financing of care of dual eligibles. The new authority for institutional SNPs would require that institutional-SNP plans have 90 percent enrollees that are residents of long-term care facilities, contracts with long-term care facilities, and an agreement with a State Medicaid agency to cooperate on the coordination of care for nursing home residents.

The provisions of this section would not apply to apply to previous state-Federal demonstration programs in Massachusetts, Minnesota and Wisconsin. They would also not apply to plans operating as Medicare demonstration projects that predominantly serve individuals with end-stage renal disease.

SECTION 432. EXTENSION AND REVISION OF AUTHORITY FOR MEDICARE REASONABLE COST CONTRACTS

Current law

Cost-based plans are those that are reimbursed by Medicare for the actual cost of furnishing covered services to Medicare beneficiaries. These plans are allowed to operate indefinitely, unless at least two other plans of the same type (i.e., either two local or two regional plans) serve for the entire year in the cost contract's service area. After January 1, 2008, any cost-based plan that operates within the service area of either two local or two regional plans will not have its contract with Medicare renewed.

Explanation of provision

This provision would extend for three additional years—from January 1, 2008 to January 1, 2011—the length of time a cost-based plan could continue operating in an area where either two local or two regional Medicare Advantage plans had entered.

Any reasonable cost contract that was extended or renewed after the enactment of this bill would be required to comply with substantially similar requirements as other Medicare Part C organizations and plans, as follows: (1) approval of marketing materials and application forms; (2) ongoing quality improvement programs and treatment of accreditation, as such provisions apply to local preferred provider organization plans; (3) grievance mechanisms; (4) coverage determination, reconsiderations, and appeals; (5) limitations on physician incentive plans; (6) uniform premiums among individual enrolled in the plan; (7) restriction on the imposition of premium taxes, with respect to payment to organization; (8) relationship to State laws; and (9) timelines for contract renewal and beneficiary notification.

Effective date

Plan contract years beginning in 2009.

Reason for change

Cost plan enrollees are older than the average Medicare beneficiary and are particularly vulnerable to the type of confusion that results from Medicare program changes. Extending cost plan authority through 2011 will ensure cost plan beneficiaries—many of whom have been in their plans for years—maintain a stable Medicare health plan choice. This provision also requires cost plans to meet certain reporting and quality standards that other Medicare private plans already meet.

TITLE V—PROVISIONS RELATING TO MEDICARE PART A

SECTION 501. INPATIENT HOSPITAL PAYMENT UPDATES

Current law

Acute care hospitals paid under Medicare's inpatient prospective payment system (IPPS) that submit the required quality data in FY2007 and each subsequent year receive the increase in the hospital market basket (MB) as their payment update. Hospitals that do not submit the required data will receive the MB minus 2 per-

centage points. Certain IPPS exempt hospitals such as cancer hospitals are paid Medicare's reasonable costs subject to certain limits or hospital-specific target amounts. These target amounts are updated annually generally by the MB.

Explanation of provision

Hospitals that submit the required quality data in FY2008 would receive the MB increase minus 0.25 percentage points as their payment update. Hospitals that do not submit the required data will receive the MB minus 2.25 percentage points. This would not apply to discharges before January 1, 2008. Target amounts for certain IPPS exempt hospitals would be increased by the MB minus 0.25 percentage points in FY2008. The would apply only with respect to cost reporting periods beginning during FY2008 and not with respect to the computation for any succeeding cost reporting period by substituting 0.1875 percentage point for 0.25 percentage point.

Reason for change

The Medicare Payment Advisory Commission (MedPAC) makes annual recommendations regarding automatic payment updates in the law for Medicare providers. When MedPAC testified before the Ways and Means Health Subcommittee to on these recommendations for 2008, it was noted that the decision to recommend a full update for hospitals was a close call and that, in fact, hospitals were in robust financial condition. Given that information, the provision makes a very small reduction in their update for 2008 of 0.25 percent. The Committee notes that this market basket adjustment only applies for the last three quarters of FY2008.

SECTION 502. PAYMENT FOR INPATIENT REHABILITATION FACILITY (IRF) SERVICES

Current law

Starting January 1, 2002, payments to inpatient rehabilitation facilities (IRFs) are made under a discharge-based prospective payment system where one payment covers capital and operating costs. Each year, the per discharge payment amount is increased by an update factor based on the increase in the market basket index.

IRFs are either freestanding hospitals or distinct part units of other hospitals that are exempt from Medicare's inpatient prospective payment system (IPPS) used to pay acute care, general hospitals. The Medicare statute gives the Secretary the discretion to establish the criteria that facilities must meet in order to be considered an IRF. Since 1983, CMS has required that a facility must treat a certain proportion of patients with specified medical conditions in order to qualify as an IRF and receive higher Medicare payments. The rule was suspended temporarily and reissued in 2004 with a revised set of qualifying conditions and a transition period for the compliance threshold as follows: 50 percent from July 1, 2004 and before July 1, 2005; 60 percent from July 1, 2005 and before July 1, 2006; 65 percent from July 1, 2006 and before July 1, 2007 and at 75 percent from July 1, 2007 and thereafter. During the transition period, secondary conditions (comorbidities) would be

considered as qualifying conditions. The Deficit Reduction Act extended the 60 percent compliance threshold an additional year. Accordingly, the IRF compliance threshold remains at 60 percent until July 1, 2007; 65 percent from July 1, 2007 until July 1, 2008, and at 75 percent from July 1, 2008 and thereafter.

IRFs are one post-acute provider participating in Medicare. Generally speaking, Medicare pays an IRF a predetermined, fixed amount per discharge, depending upon a patient's impairment level, functional status, co-morbid conditions and age which determine the case-mix group (CMG) assignment. Skilled nursing facilities (SNFs) are another post acute provider participating in Medicare. SNFs are paid a predetermined per diem amount for each day of care, adjusted for a patient's condition.

Explanation of provision

In FY2008, the update factor would be 1 percent. The adjustment only applies for the last three quarters of FY2008.

The IRF compliance threshold will remain at no greater than the 60 percent compliance rate for cost reporting periods beginning on or after July 1, 2006. The Secretary would be required to consider comorbidities as qualifying conditions.

The provision would create a special payment rule for patients in IRFs admitted for three applicable medical conditions: unilateral knee replacement, unilateral hip replacement, and unilateral hip fracture. Instead of the IRF standardized amount, starting October 1, 2008, discharges with applicable medical conditions would be paid based on a modified standardized amount. This modified amount would be based on an amount equal to the sum of (1) the average per stay SNF payment rate for that condition; (2) an amount equal to 25 percent of the difference between the overhead costs included in the average IRF per stay payment for the applicable condition and those costs included in the average SNF payment for such condition; and (3) an amount equal to 33 percent of the difference between the patient care costs included in the average IRF per stay payment for the applicable condition and those costs included in the average SNF payment for such condition. This modified standardized amount would be adjusted by the weighting factor associated with the CMG for the applicable medical condition, the IRF outlier policy and the applicable area wage index value. The modified standardized amount would be updated annually, except in those fiscal years when the amount is rebased (recalculated). The modified standardized amount would be required to be rebased periodically, but in no case less than once every 5 years. These provisions would apply until the Secretary implements an integrated, site-neutral payment methodology for post acute care. These provisions would not be subject to administrative or judicial review.

For discharges from April 1, 2008 through September 30, 2008, the standardized payment amount would be $9,507 for unilateral knee replacements; $10,398 for unilateral hip replacements; and $10,958 for unilateral hip fractures. These amounts are the estimated amounts that would have been calculated under the previous provision had it been effective for this period. Such standardized payments would be multiplied by the relative weights case-mix

group and tier published in the final rule for inpatient rehabilitation facility services for FY2008 to obtain the applicable payment amounts. These payments would be able to be implemented by program instruction or otherwise and would not be subject to administrative or judicial review.

Not later than one year after this legislation is enacted, the Secretary, in consultation with physicians (including geriatricians and psychiatrists); administrators of acute care hospitals, IRFs, SNFs, and other facilities providing rehabilitation services; Medicare beneficiaries; trade organizations; and MedPAC, would submit to the House Committee on Ways and Means and the Senate Finance Committee a report that includes the following: (1) an examination of Medicare beneficiaries' access to rehabilitation services; (2) alternatives to the 75 percent compliance threshold for determining exclusion criteria for IRF designation, including clinical appropriateness of admissions and criteria considering patient's functional status, diagnosis, co-morbidities, and other factors; and (3) an examination of conditions for which individuals are commonly admitted to IRFs to determine appropriate care settings as well as any variation in patient outcomes and costs across settings of care. In developing the report, the Secretary would be required to consider (1) the potential effect of the 75 percent threshold on access to rehabilitation care by Medicare beneficiaries; and (2) a comparative analysis that examines quality, cost, and patient outcomes of inpatient rehabilitation services among different post-acute care settings including readmissions to acute care hospitals and extended lengths of stay in other post-acute care settings.

Reason for change

The Committee followed the recommendation of the Medicare Payment Advisory Commission (MedPAC) with regard to the annual update for IRFs. The Committee notes that this market basket adjustment only applies for the last three quarters of FY2008.

The provision provides relief from the continued phase-in of the 75 percent rule.

The Committee fails to see clear research indicating whether patient outcomes are better or worse in inpatient rehabilitation facilities as compared to skilled nursing facilities for unilateral hip replacements, unilateral knee replacements, or hip fractures. In the absence of clear clinical data, the Committee believes that the burden is on the provider to show evidence as to why a higher payment rate is justified. The absence of this evidence provides the rationale for lowering the IRF payment rate. The Committee notes that while IRFs will receive a lower payment for these three conditions, the payment rate will still be higher than that received by skilled nursing facilities.

The lack of research on the potential effects of the 75 percent rule on beneficiary access to care is a problem that will be addressed by the HHS report. The Committee will use this forthcoming report to guide its work as it reconsiders implementation of the 75 percent rule in the future.

SECTION 503. LONG-TERM CARE HOSPITALS

(a) Definition of Long-Term Care Hospital

Current law

A long-term care hospital (LTCH) is an acute care general hospital that has a Medicare inpatient average length of stay greater than 25 days. Since 2002, LTCHs have been paid under its own prospective payment system (PPS). Provisions establishing this PPS are contained in Section 123 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (BBRA) and Section 307 of the Medicare, Medicaid and SCHIP Benefits Improvement and Protection Act of 2000 (BIPA). These LTCH–PPS provisions have not been incorporated into the Social Security Act. Each year, the LTCH base rate (per discharge payment amount) is updated.

Explanation of provision

This provision would establish 1886(m) of the Social Security Act (SSA) entitled "Prospective Payment for Long-Term Care Hospitals" which would provide specific references to the sections of BBRA and BIPA that contain the LTCH–PPS provisions. The base rate for LTCH's rate year (RY) 2008 (from July 1, 2007 through June 30, 2008) would be the same as that used for discharges in the previous rate year. (from July 1, 2006 through June 30, 2007). This provision would not apply to discharges occurring on July 1, 2007 and before January 1, 2008.

Reason for change

The Committee followed the recommendation of the Medicare Payment Advisory Commission (MedPAC) with regard to the annual update for LTCHs. The Committee notes that this market basket adjustment only applies for second half of rate year 2008.

(b) Payment for Long-Term Care Hospital Services; Patient and Facility Criteria

Current law

A long-term care hospital (LTCH) is an acute care general hospital that has a Medicare inpatient average length of stay greater than 25 days. Presently, LTCHs are not explicitly permitted in statute to be units of other facilities. LTCHs are not permitted to operate distinct part units.

CMS established a new LTCH policy for cost reporting periods beginning on or after July 1, 2007 to indicate if a freestanding LTCH was acting as a unit of independent host hospitals. The regulation had originally been applied only to those LTCHs established as hospitals-within-hospitals (HwHs) or satellite hospitals. The policy (referred to as the "25 percent rule") limits the proportion of patients who can be admitted from a co-located or host hospital during a cost reporting period and be paid under the LTCH–PPS. After the threshold is reached, the LTCH is paid the lesser of the LTCH–PPS rate or the acute hospital PPS rate. Through September 30, 2007, the HwH threshold for most admissions from a host hospital is 50 percent. After that date, the threshold is low-

ered to 25 percent. The expansion of the policy to freestanding LTCHs will occur on a phased in basis over a three-year transition period. There are some exceptions to the 25 percent rule. Generally, for rural HwHs, the applicable percentage is the lesser of 75 percent or the percentage admitted in Rate Year 2005. The 75 percent threshold is in place for cost reporting periods beginning before July 1, 2008, after which it is lowered to 50 percent. Urban single HwHs or those located in metropolitan statistical areas (MSAs) with dominant hospitals—those with one-fourth or more of acute care cases for the MS—also have a threshold of 50 percent.

A short-stay outlier under the LTCH prospective payment system is a discharge for stays that are considerably shorter than the average length of stay for a long term care DRG (five-sixths of the geometric average length of stay for each DRG). These short-stay outliers have an adjustment made to their payment that allows Medicare to pay less than cases that receive a full episode of care. Recent policy changes added a new class of short-stay outliers. For discharges occurring on or after July 1, 2007, if the length of stay for a particular LTC–DRG is less than or equal to one standard deviation from the geometric average length of stay, under a CMS policy the method for determining the payment amount for these cases is the least of: (a) 120 percent of LTC–DRG specific per diem amount multiplied by the length of stay for that case; (b) 100 percent of the hospital specific cost-to-charge ratio by the allowable charges for the case; or (c) the adjusted standard federal payment by the LTC–DRG weight; or (d) an amount comparable to the hospital inpatient prospective payment per diem.

Under CMS policy, the Secretary reviews the payment system and may make a one-time prospective adjustment to the long-term care hospital prospective payment system rates on or before July 1, 2008, so that the effect of any significant difference between actual payments and estimated payments for the first year of the long-term care hospital prospective payment system is not perpetuated in the prospective payment rates for future years.

Explanation of provision

This provision would establish section 1861(ccc) in the SSA that would define an LTCH as an institution which: (1) is primarily engaged in providing inpatient services by or under the supervision of a physician to Medicare beneficiaries whose medically complex require a long hospital stay and LTCH services; (2) has a Medicare inpatient average length of stay greater than 25 days; (3) satisfies Medicare's hospital definition; and, (4) meets certain facility criteria. An LTCH would have a patient review process documented in the medical record that screens patients prior to admission for appropriateness of an LTCH admission, validates within 48 hours of admission that patients meet LTCH admission criteria, regularly evaluates patients throughout their stay for continuation of LTCH care and assesses available discharge options when a patient no longer needs LTCH care. Also, the institution would have active physician involvement with patients, physician-directed treatment with physician on-site availability on a daily basis and consulting physicians on call and capable of being with the patient within a moderate period of time. The institution would be required to have

interdisciplinary teams, including physicians, to prepare and treat patients using individualized patient treatment plans. Finally, an LTCH would be required to meet the patient criteria relating to patient mix and severity appropriate to the medically complex cases that LTCHS are designed to treat. This provision would apply to discharges occurring on or after January 1, 2008.

In addition, the provision would establish new patient criteria for LTCH prospective payment. To be eligible, an LTCH would be required to admit not less than a specified majority of patients with a high level of severity (as defined by the Secretary) who are assigned to one or more of these major diagnostic categories: circulatory diagnoses; digestive, endocrine, and metabolic diagnoses; infection disease diagnoses; neurological diagnoses; renal diagnoses; respiratory diagnoses; skin diagnoses; or other major diagnoses as selected by the Secretary. These major diagnostic categories are those mutually exclusive medical categories included in the August 1, 2002 Federal Register. This provision would apply to discharges occurring on or after January 1, 2008.

If the Secretary does not include rehabilitation services within one of the major diagnostic categories, then the Secretary would be required to approve distinct part rehabilitation units in certain LTCHs. Services in these units would not be reimbursed under the LTCH–PPS, but would be subject to IRF payment rates and policies. Eligible LTCHs would be those classified as an LTCH on or before October 1, 2004, and accredited by the Commission on Accreditation of Rehabilitation Facilities. These hospitals would be able to establish a distinct part rehabilitation unit in accordance with the requirements for regular hospitals including any regulations associated with these units except that the one-year waiting period applicable to the conversion of hospital beds into distinct-part IRFs would not apply. The above provisions would apply to discharges on or after January 1, 2008.

No later than one year from enactment, the Secretary would be required to submit a report to the appropriate Congressional committees that contained recommendations regarding the promulgation of national LTCH facility and patient criteria established above. In the report, the Secretary would consider recommendations contained in the MedPAC June 2004 report on LTCH facility and patient criteria to ensure that admitted LTCH patients are medically complex and receive appropriate services. The Secretary would be required to implement the criteria after rulemaking no later than one year after the submittal of the report. The criteria would be used to screen patients in determining the medical necessity of admissions, continuation, and discharge from a LTCH and should take into account the medical judgment of the patient's physician.

Starting for discharges on October 1, 2007, the Secretary would be required to contract with one or more appropriate fiscal intermediaries or Medicare administrative contractors to review the medical necessity of LTCH admissions and continued stays for individuals entitled to benefits under Medicare Part A. The reviews would be conducted annually and on a hospital-specific basis in accordance with rules established by the Secretary. The sample methodology would be required to: (1) provide for a statistically

valid and representative sample of admissions sufficient to provide results at a 95 percent confidence interval; and (2) guarantee that at a minimum 75 percent of the overpayments received by LTCHs for medically unnecessary admissions or continued stays would be identified and recovered, and that related days of care would not count toward the inpatient length of stay requirement of greater than 25 days. The Secretary would be required to establish a denial rate for the reviews that, if exceeded, would require further review of the medical necessity of such admissions and continued stays. These provisions would cease to apply by the later of January 1, 2013 or the implementation date of the national LTCH facility and patient criteria specified above. As of this date, the Secretary would then determine whether to continue to guarantee recovery of 75 percent of the overpayments received by LTCHs. The costs of these reviews would be funded by not more than 40 percent of the aggregate overpayments recouped by the Secretary from LTCHs for medically unnecessary admissions and continued stays.

The Secretary would impose a temporary moratorium on the certification of new LTCHs and satellite facilities as well as LTCH beds and satellite facility beds. The moratorium would terminate at the end of the four-year period beginning at the enactment date. The moratorium would not apply to an LTCH hospital, satellite facility or additional beds that are under development as of the enactment date. To be considered under development, the hospital or satellite facility would be required to meet any of the following criteria: (a) 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 LTCH and the hospital has expended before the date of enactment at least 10 percent of the estimated cost of the project or (if less) $2.5 million; (b) actual construction, renovation or demolition for the LTCH has begun; and the hospital has expended before the date of enactment at least 10 percent of the estimated cost of the project or (if less) $2.5 million; (c) a certificate of need or other necessary approvals from the State have been obtained; (d) the hospital documents that within 3 months after the date of enactment it is within a 6-month LTCH demonstration period (to establish that it has a greater than 25 day average length of stay).

The moratorium would not apply to an existing LTCH that requests an increase in the number of its beds, if the Secretary determines there is a need to accommodate: (a) infectious disease issues for isolation of patients; (b) bedside dialysis services; (c) single-sex accommodation issues; (d) behavioral issues; or (e) State or local requirements. The moratorium would also not apply to an existing LTCH bed increase request because of the closure of an LTCH or a significant decrease in the number of LTCH beds in a State where there is only one other LTCH. There would be no administrative or judicial review of a Secretary's decision on these exceptions.

During a 5-year period beginning with the enactment of this provision, the Secretary would not apply the 25 percent rule or a similar policy to freestanding LTCHs or certain LTCH HwHs (referred to as "grandfathered LTCHs") that have been considered to be free-

standing. These changes shall apply to discharges occurring on or after October 1, 2007 and before October 1, 2012.

The provision would retain the 75 percent threshold for applicable LTCHs (HwHs or satellite facilities) in rural areas or LTCHs that are co-located with an urban single or MSA dominant hospital. For other HwHs or satellite facilities, the admission threshold from a co-located hospital would stay at 50 percent. These changes would apply to discharges occurring on or after October 1, 2007 and before October 1, 2012.

The Secretary would not be able to apply the new short-stay outlier policy during the 5-year period.

The Secretary would not be able to make the one-time prospective adjustment to LTCH prospective payments during the 5-year period.

Reason for change

The Committee followed the recommendation of MedPAC with regard to the need to establish patient and facility criteria for LTCHs. LTCHs are the most expensive setting of post-acute care under Medicare, and establishment of these criteria are necessary in order to ensure that the right patients are served in LTCHs.

The Committee shares MedPAC's concerns about the growth of LTCHs, especially because new LTCHs often locate in market areas where others already exist rather than in areas with none. Furthermore, there is no evidence of lack of access to needed care in areas where LTCHs do not exist. The limited, qualified moratorium of LTCHs will limit the growth of LTCHs while the patient and facility criteria are being developed.

The Committee understands the importance of ensuring that LTCHs are the appropriate setting for care both upon admission, and during a patient's stay. Thus, the Committee is creating medical necessity reviews for admission and continued stay at LTCHs.

The Committee also provides regulatory relief in order to ensure payment stability for LTCHs while patient and facility criteria are developed and implemented.

(c) Separate Classification for Certain Long-Stay Cancer Hospitals

Current law

As established by the Balanced Budget Act of 1997, there is one "subclause II" long term care hospital identified in 1886(d)(1)(B)(iv)(II) of the Social Security Act (SSA). It has an average length of stay greater than 20 days and had 80 percent or more of its annual Medicare inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease in the 12 month cost reporting period that ended in FY1997.

Explanation of provision

This provision would create a separate classification for a certain long-stay cancer hospital under Section 1886(d)(1)(B)(vi) of the SSA. Starting for cost reporting periods after the date of enactment, Medicare payments to this hospital would be based on the rates in effect for the cost reporting period for the hospital during

FY2001 increased by the applicable update factor. This hospital would include satellite or remote site locations that met the applicable Medicare provider based regulations and other applicable State licensure and certification requirements.

Reason for change

The one "subclause II" hospital currently in existence is a unique entity. It is not appropriate to include this facility in the larger class of long-term care hospitals.

SECTION 504. INCREASING THE DSH ADJUSTMENT CAP

Current law

Medicare will increase its payments to hospitals that qualify for a disproportionate share hospital (DSH) adjustment. In many instances, the size of a hospital's DSH adjustment will depend upon the number of patient days provided to poor Medicare patients or Medicaid patients. However, small urban hospitals and many rural hospitals have their DSH adjustment capped at 12 percent.

Explanation of provision

The provision would raise the DSH adjustment cap for these hospitals to 16 percent for discharges occurring in FY2008 and to 18 percent for discharges in FY2009. For discharges on or after October 1, 2009, the DSH adjustment cap would revert to 12 percent.

Reason for change

This provision raises the cap on the DSH adjustment for rural and small urban hospitals so that they are closer to the DSH adjustment that applies to other hospitals. It will also ensure the continued viability of hospitals serving vulnerable populations in rural areas.

SECTION 505. PPS—EXEMPT CANCER HOSPITALS

Current law

Five types of specialty hospitals (psychiatric, rehabilitation, long-term care, children's and cancer hospitals) and two types of distinct-part units in general hospitals (psychiatric and rehabilitation) have been exempt from the inpatient prospective payment system (IPPS) for acute care hospitals. Historically, they have been paid on a reasonable cost basis, subject to TEFRA payment limitations and incentives. Accordingly, each provider's reimbursement is subject to a ceiling or target amount that serves as an upper limit on operating costs. Children's and cancer hospitals are still paid on a reasonable cost basis, subject to TEFRA limits where a hospital's target amount is based on the five most recent settled cost reporting periods that the Secretary had prior to the enactment of the Balanced Budget Act of 1997. Psychiatric hospitals, inpatient rehabilitation, and long-term care hospitals have separate prospective payment systems. Presently there are 11 freestanding IPPS exempt cancer hospitals.

Explanation of provision

The Secretary may set up a process whereby a hospital receiving reasonable cost reimbursement during cost reporting periods before October 1, 1999 would be able to request a new target amount. Beginning during FY2008, the target amount would be based on the five most recent settled cost reporting periods prior to the enactment of this clause. This recalculation (or re-basing) would not apply to long-term care hospitals.

Three additional cancer hospitals (exempt from IPPS) would be established starting for cost reporting periods on or after January 1, 2006. Certain hospitals would have this IPPS exempt classification apply to cost reporting periods beginning on or after January 1, 2006. One would take effect on January 1, 2008. Certain of the IPPS exempt facilities would be permitted to resubmit their Medicare cost report incorporating a cancer hospital provider number for the purposes of outpatient hospital reimbursement and calculating its target amount for the first cost reporting period on or after January 1, 2006. Payments owed to any hospital for periods occurring before the enactment of this provision would be made expeditiously, but in no event later than one year from enactment. Certain requirements would be waived for one of these hospitals. This hospital would not qualify as an IPPS exempt hospital for any cost reporting period where less than 50 percent of its total discharges have a principal finding of neoplastic disease. The Secretary would accept self-certification by the hospital of such fact for the first cost reporting period.

No later than March 1, 2009, MedPAC would be required to submit a report that evaluates (1) measures of payment adequacy and Medicare margins for PPS-exempt cancer hospitals; (2) margin information for PPS cancer hospitals that were previously affiliated with another hospital; and (3) payment adequacy for cancer discharges paid for under Medicare's IPPS.

Reason for change

The existing 11 PPS-exempt cancer hospitals have not had their payments rebased since the Balanced Budget Act of 1997. While their payments are trended forward for inflation, this inflationary factor has not kept pace with the advances in cancer care that have occurred during the past decade. This provision grants the Secretary the authority to rebase payments for these providers.

Three additional PPS-exempt cancer hospitals are created to respond to the needs in those communities.

The Committee is concerned that acute care hospitals in the future will seek PPS-exempt status for their cancer hospitals as a way to remove a cost center from the IPPS system. The MedPAC study will explore this issue.

SECTION 506. SKILLED NURSING FACILITY PAYMENT UPDATE

Current law

Skilled Nursing Facilities are paid through a prospective payment system (PPS) which is composed of a daily ("per-diem") urban or rural base payment amount that is then adjusted for case mix and area wages. The federal per diem payment is intended to cover

all the services provided to the beneficiary that day, including room and board, nursing, therapy, and prescription drugs. The urban and rural federal per diem payment rates are increased annually by an update factor that is determined, in part, by the projected increase in the SNF market basket (MB) index. This index measures changes in the costs of goods and services purchased by SNFs. Each year, the update of the payment rate also includes, as appropriate, an adjustment to account for the MB forecast error for previous years.

Explanation of provision

The provision would eliminate the MB update for FY 2008. The FY2008 update shall not apply to payment for days before January 1, 2008. For each subsequent fiscal year, the rate would be increased by the skilled nursing facility MB percentage change for the fiscal year involved.

Reason for change

The Medicare Payment Advisory Commission (MedPAC) makes annual recommendations regarding automatic payment updates in the law for Medicare providers. They recommended a zero percent update for skilled nursing facilities and the Committee followed their advice. The Committee notes that this market basket change is effective for only the last three quarters of FY2008.

The Committee would highlight that skilled nursing facilities directly benefit by the extension of the exceptions process for therapy services included in this act and by removing clinical social workers from the SNF consolidated billing requirement. Furthermore, the payment change for inpatient rehabilitation facilities for unilateral hip replacements, unilateral knee replacements, and hip fractures, will enable nursing homes to compete on a more level playing field with IRFs.

SECTION 507. REVOCATION OF UNIQUE DEEMING AUTHORITY OF THE JOINT COMMISSION

Current law

In order to receive Medicare payments, providers, and most suppliers must meet certain requirements specified in statute and regulation established by the Secretary. Generally, state agencies, under contract with CMS as specified by Section 1864 of the Social Security Act, survey providers and certain suppliers to determine compliance with the conditions or standards set forth in the statute and regulations. Alternatively, a provider can be deemed to meet these requirements if it has been accredited by an approved national accreditation body which has demonstrated that its inspection program ensures that all applicable conditions are met or exceeded.

Under Section 1865(a), a hospital that is accredited by the Joint Commission of Healthcare Organizations (JCAHO) is deemed to meet conditions of participation, except those for utilization review, discharge planning, or other requirements imposed on hospitals under Section 1861(e)(9) that are higher than JCAHO requirements. For JCAHO to be able to deem compliance in these areas,

the Secretary is required to determine that JCAHO's process is at least equivalent to the standards promulgated by CMS.

Under Section 1865(b), the Secretary has the authority to grant deeming authority to approved national organizations that accredit other provider entities if these national accrediting organizations demonstrate that Medicare's conditions and requirements are met. The Secretary must consider an organization's accreditation requirements, its survey procedures, the adequacy of available resources for survey activities and the provision of information for enforcement activities, monitoring procedures, and ability to provide necessary validation data when evaluating its application as a deeming entity. Provider entities in this case are defined as providers of services, suppliers, facilities, clinics, agencies or laboratories excluding end-stage renal disease facilities or durable medical equipment suppliers (DME). Under this provision, the Secretary must grant deemed status to any provider entity, except skilled nursing facilities (SNFs), if private accreditation demonstrates compliance with program requirements; with respect to SNFs, the Secretary may grant such deemed status but is not mandated to do so.

Explanation of provision

This provision would revoke the unique authority granted to the Joint Commission of Healthcare Organizations (JCAHO) to accredit hospitals for participation in Medicare. Hospitals, like other Medicare provider entities, would be accredited by national accrediting organizations approved by the Secretary. The Secretary would have the authority to recognize JCAHO as a national accreditation body, and the Committee encourages the Secretary to do so. While this provision would not take effect until 18 months after the legislation is enacted and would not affect those hospitals currently being accredited or under accreditation by JCAHO, the Committee is exploring whether a longer time period (e.g., 24 months) would be needed to ensure a seamless transition.

Reason for change

Under current law, Joint Commission of Healthcare Organizations (JCAHO) is not required to respond to requests by CMS to change its policies or procedures for any reason. Although this provision would revoke JCAHO's unique authority, the Committee believes there is value in having JCAHO continue to serve as a major accrediting organization. The Committee's intent in removing the statutory protection afforded to JCAHO is driven by the need to assure accountability in the process. By treating JCAHO like other accrediting organizations in Medicare, CMS will be able to ask for changes in their process or standards if concerns are raised about the adequacy of standards, enforcement or criteria. Concerns have been raised about whether this provision would ease standards on hospitals, but the Committee has been assured that this will not be the case. The statute at section 1865(b)(1) makes deeming contingent upon a finding by the Secretary "that all of the applicable conditions or requirements of this title . . . are met *or exceeded* . . ." [emphasis added]. Concerns have also been raised about validation surveys, which are the most scientific and objective method

of holding accreditors accountable. All accreditation organizations approved by CMS are subject to validation surveys. As a practical matter, however, many accrediting organizations have not been subject to validation surveys because they accredit relatively few providers. The Committee expects that if JCAHO were to continue as a major accrediting organization, they would continue to be subject to validation surveys.

SECTION 508. TREATMENT OF MEDICARE HOSPITAL RECLASSIFICATIONS

Current law

Section 508 of the Medicare Prescription Drug, Improvement and Modernization Act of 2003 provided $900 million for a one-time, 3 year geographic reclassification of certain hospitals which were otherwise unable to qualify for administrative reclassification to areas with higher wage index values. These reclassifications were extended from March 31, 2006 to September 30, 2007 by the Tax Relief and Health Care Act of 2006. This extension was exempt from any budget neutrality requirements.

Certain statutory protections have been established for hospitals' wage index amounts. For instance, the wage index in a state's urban areas can not be lower than its rural wage index. Certain urban areas cross state boundaries. In those instances, the rural floor in each state would apply to hospitals in counties that are located in that state. Also, this wage index protection does not apply to hospitals that reclassify into the urban areas through the Medicare Geographic Classification Review Board (MGCRB) administrative process. These reclassified hospitals would not get the higher rural wage index amount.

Certain hospitals have been reclassified into different areas with higher wage index values by legislation.

Explanation of provision

The provision would extend the Section 508 reclassifications until September 30, 2009. Hospitals that were reclassified through the Secretary's authority to make exceptions and adjustments during the FY2005 rulemaking process would have their reclassification extended until September 30, 2009. A hospital that has been reclassified under Section 508 (as extended) would not prevent the group reclassification of otherwise eligible hospitals.

A rural hospital that is a rural referral center and a sole community center with at least 250 beds that is redesignated to an urban area in a non-location state would receive a wage index that is no less than the rural wage in that non-location state. The hospital would not have received a Section 508 reclassification.

Hospitals that reclassify into urban areas under the MGCRB process would get the rural wage index if that rural floor was applicable to other hospitals in the urban area. This provision would apply to discharges occurring on or after October 1, 2008.

A hospital located in Putnam County Tennessee with a reclassified wage index that would expire on September 30, 2007 would have such reclassification extended through September 30, 2008.

The Secretary would reclassify any hospital in Orange County New York that received a Section 508 reclassification into New

York-White Plains-Wayne NY-NJ urban area. Such reclassification would be treated as a MGCRB reclassification as of October 1, 2008, and be subject to budget neutrality requirements.

The large urban area of New York, New York would include hospitals required by state law to have a single governance structure if certain requirements are met: (1) the law was enacted prior to June 30, 2007; (2) the hospitals are located in a city with a population of more than 20,000 and no less than 30,000; and (3) such hospitals are less than 0.74 miles apart. Such reclassification would be treated as a MGCRB reclassification as of October 1, 2008, and be subject to budget neutrality requirements.

The large urban area of Buffalo-Niagara Falls, New York would include Chautauqua County, New York. There would be no reduction in the hospital wage index for Erie County, New York or any adjoining county as a result of this provision except for that associated with the budget neutrality requirements associated with a MGCRB reclassification. This provision is effective October 1, 2008.

A hospital in Burlington County, New Jersey would be reclassified into the New York-White Plains NY–NJ urban area if the acute care hospital is licensed as a specialty hospital by the State where it is located; specializes in the treatment of cardiac, vascular, and pulmonary diseases; and has at least 100 beds. Such reclassification would be treated as a MGCRB reclassification as of October 1, 2008, and be subject to budget neutrality requirements.

A hospital that is located in a core-based statistical area (or urban area) with certain characteristics such as (1) a population of at least 500,000 but not more than 750,000 as reported by the 2000 Census (2) a population that was at least 10,000 below the population reported in the 1990 Census and (3) at least 5 but not more than 7 acute care hospitals would be reclassified. It would also have to demonstrate that its average hourly wage is not less than 96 percent of the urban area where it is located. It would be reclassified to a urban area that is within the same State and is adjacent to the area where the hospital is located with an average hourly wage that is closest to, but does not exceed its own average hourly wage. This provision would apply to hospitals in Orange County New York that were described above. Such reclassification would be treated as a MGCRB reclassification as of October 1, 2008, and be subject to budget neutrality requirements.

Reason for change

This provision extends the MMA Section 508 geographic reclassifications designations, and allows for other geographic reclassification designations, so that these hospitals may better compete with neighboring hospitals.

SECTION 509. MEDICARE CRITICAL ACCESS HOSPITAL DESIGNATIONS

Current law

Critical access hospitals (CAHs) are limited-service facilities that are located more than 35 miles from another hospital or 15 miles in certain circumstances; offer 24-hour emergency care; have no more than 25 acute care inpatient beds and have a 96-hour average length of stay. Until January 1, 2006, states could waive the CAH

mileage requirements and designate an entity as a necessary provider of health care and qualify it as a CAH.

Explanation of provision

The State of Minnesota would be able to designate one hospital in Cass County Minnesota as a necessary provider of health care on or after January 1, 2006. The hospital would have been granted an exception by the State to an otherwise applicable statutory restriction on hospital construction or licensing prior to the date of enactment. A hospital located in Butler County, Alabama would be designated a critical access hospital.

Reason for change

This provision allows for two critical access hospitals in order to better meet the health care needs in those communities.

TITLE VI—OTHER PROVISIONS RELATING TO MEDICARE PART B

SUBTITLE A—PAYMENT AND COVERAGE IMPROVEMENTS

SECTION 601. PAYMENT FOR THERAPY SERVICES

Current law

The Balanced Budget Act of 1997 established annual per beneficiary payment limits for all outpatient therapy services provided by non-hospital providers. The limits applied to services provided by independent therapists as well as to those provided by comprehensive outpatient rehabilitation facilities (CORFs) and other rehabilitation agencies. The limits did not apply to outpatient therapy services provided by hospitals.

Beginning in 1999, there were two beneficiary limits. The first was a $1,500 per beneficiary annual cap for all outpatient physical therapy services and speech language pathology services. The second was a $1,500 per beneficiary annual cap for all outpatient occupational therapy services. Beginning in 2002, the amount was to increase each year by the Medicare economic index (MEI). Subsequent legislation delayed implementation of the cap from 2000–2005 (except for a brief period in 2003). The caps went into effect again beginning January 1, 2006. The 2007 caps are each $1,780.

The Deficit Reduction Act of 2005 (DRA) required the Secretary to implement an exceptions process for 2006 for cases in which the provision of additional therapy services was determined to be medically necessary. The process, as established by CMS, allowed for two types of exceptions. The first category was automatic exceptions. Automatic exceptions were allowed for certain specified conditions or complex situations. An exception request to the contractor was not required when services related to the conditions and complexities were appropriately provided and documented. The second category of exceptions was manual exceptions granted on the basis of a written request. The Tax Relief and Health Care Act of 2006 (TRHCA) extended the exception process through 2007. CMS has specified that for 2007, only the automatic process applies.

Explanation of provision

The provision would extend the exceptions process through 2009. It would also require the Secretary, in consultation with appropriate stakeholders, to conduct a study on refined and alternative payment systems for physical therapy services, occupational therapy services, and speech language pathology services. The study would consider the creation of multiple payment caps for such services to better reflect costs associated with specific health conditions. It would also consider the development of a prospective payment system, including an episode-based system of payments for such services. Further, the report would consider the data needed for development of a system of multiple payment caps (or alternative payment methodology) for such services and the availability of data. The Secretary would be required to submit a report to Congress on the study by January 1, 2009.

Reason for change

There is wide consensus that the therapy cap created in the Balanced Budget Act of 1997 is not good health policy, yet to permanently repeal the cap is a very costly proposition. The provision extends the exceptions process for two additional years and requires the Secretary to conduct a study to determine a better payment methodology for the future.

SECTION 602. MEDICARE SEPARATE DEFINITION OF OUTPATIENT SPEECH LANGUAGE PATHOLOGY SERVICES

Current law

Medicare Part B covers outpatient services of physical therapists, occupational therapists, and speech language pathologists. The coverage and payment rules are essentially the same, except that speech therapy performed in independent practice can not be paid for under the program. In the law, outpatient speech language pathology is included within the definition of outpatient physical therapy.

Explanation of provision

The provision would establish a separate definition for outpatient speech language pathology services. It would permit speech language pathologists practicing independently to bill Part B subject to the same conditions applicable to physical and occupational therapists in independent practice. The provision would apply to services furnished on or after January 1, 2008.

The provision would specify that nothing in the section shall be construed to affect existing regulations and policies of the Centers for Medicare and Medicaid Services that require physician oversight of care as a condition of payment for speech language pathology services under Part B.

Reason for change

This is a technical amendment that simply assures that speech language pathologists are treated the same as physical and occupational therapists in the law. This technical change will allow independent speech language pathologists to be reimbursed by Medi-

care. This change will help assure access to speech therapy services to Medicare beneficiaries especially in rural and other underserved areas.

SECTION 603. INCREASED REIMBURSEMENT RATE FOR CERTIFIED NURSE MIDWIVES

Current law

Current law specifies that the fee schedule amount for a service furnished by a certified nurse midwife can in no case exceed 65 percent of the fee schedule amount for the same service performed by a physician.

Explanation of provision

The provision would remove the limitation. It would apply to services furnished on or after April 1, 2008.

Reason for change

Nurse midwives are currently the lowest paid of all non-physicians in Medicare. Yet, they practice independently and provide access to needed services in communities where gynecologists or obstetricians may not be readily available. In order to increase access to gynecological and obstetric services for Medicare beneficiaries, the provision increases the reimbursement for nurse midwife services from 65 percent of the fee schedule to 100 percent.

SECTION 604. ADJUSTMENT IN OUTPATIENT HOSPITAL FEE SCHEDULE INCREASE FACTOR

Current law

Each year, the hospital outpatient department conversion factor is increased by an amount that is loosely based on increases in the hospital market basket index.

Explanation of provision

Under this provision, the Medicare's increase in hospital outpatient department payments for services furnished in 2008 would be established as market basket increase reduced by 0.25 percentage points.

Reason for change

The Medicare Payment Advisory Commission (MedPAC) makes annual recommendations regarding automatic payment updates in the law for Medicare providers. When MedPAC testified before the Ways and Means Health Subcommittee on these recommendations for 2008, it was noted that the decision to recommend a full update for hospitals was a close call and that, in fact, hospitals were in robust financial condition. Given that information, the provision makes a very small reduction in their update for 2008.

The Committee believes that beneficiaries with chronic cardiac disease should have a broad choice of rehabilitation programs available to meet their needs. Intensive cardiac rehabilitation programs are more vigorous than most cardiac rehabilitation programs. Generally these programs consist of organized treatment that includes medical evaluation, prescribed exercise, education

and nutritional counseling including a prescribed dietary plan. Usually, these programs are provided by teams of health care practitioners including a physician, nurse practitioner, physician assistant, clinical social worker, qualified psychologist, registered dietician, nutrition professional, or others, including practitioners furnishing services incident to a physician's service.

The Committee is aware that these programs usually take up to 72 hours in as many as six one-hour sessions in one day. Therefore, we encourage CMS, as appropriate, to make clear that these programs can bill Medicare for multiple sessions of services in a single day. Also, where appropriate, we encourage CMS to allow coverage for up to 72 total hours for such programs. To be sure that these programs are likely to be effective the Secretary should require that such program must have shown, in peer-reviewed published research, that it has positively affected the progression of coronary heart disease; or reduced the need for coronary bypass surgery; or reduced the need for percutaneous coronary interventions. In addition, each such program must have shown, in peer-reviewed published research, that it did at least five of the following: reduced low density lipoprotein, or reduced triglycerides, or reduced body mass index, or reduced systolic blood pressure, or reduced diastolic blood pressure, or reduced or eliminated the need for cholesterol, blood pressure and diabetes medications.

The Committee believes that cardiac rehabilitation program described should be paid on par with the Medicare OPD fee schedule amount established under the prospective payment system for hospital outpatient department service for cardiac rehabilitation.

SECTION 605. EXCEPTION TO 60-DAY LIMIT ON MEDICARE RECIPROCAL BILLING ARRANGEMENTS IN CASE OF PHYSICIANS ORDERED TO ACTIVE DUTY IN THE ARMED FORCES

Current law

By law Medicare payment may be made to a physician for physicians' services (and services furnished incident to such services) furnished by a second physician to patients of the first physician provided certain conditions are met. The first physician has to be unable to provide the service. The services must be furnished pursuant to an arrangement between the two physicians that is either informal and reciprocal or involves per diem or other fee-for-time compensation for such services. The services cannot be provided by the second physician over a continuous period of time of more than 60 days. Finally, the claim must include the second physician's unique identifier and indicate that it meets Medicare requirements for payment to the first physician.

Explanation of provision

The provision would permit such services to be provided over a continuous time period of over 60 days, if during all of the longer period the first physician has been called or ordered to active duty as a member of a reserve component of the Armed Forces. The amendment would apply to services furnished on or after the date of enactment.

Reason for change

This provision is necessary because of current military needs in Iraq and Afghanistan. Physicians who serve in the armed forces reserves or in the Guard are out of the country for more than the 60-day limit for Medicare reciprocal billing arrangements and could lose their practices without this change.

SECTION 606. EXCLUDING CLINICAL SOCIAL WORKER SERVICES FROM COVERAGE UNDER THE MEDICARE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM AND CONSOLIDATED PAYMENT

Current law

Skilled Nursing Facilities are paid through a prospective payment system (PPS) which is composed of a daily ("per-diem") urban or rural base payment amount that is then adjusted for case mix and area wages. The PPS provides a bundled payment for services provided to the beneficiary that day, including room and board, nursing, therapy, and prescription drugs. Some services that residents receive are excluded from the SNF PPS. Such services include physician services, certified nurse-midwife services, qualified psychologist services, services of a certified registered nurse anesthetist, among others. These services are paid for by Medicare under other provider payment systems.

Medicare defines clinical social worker services as those services performed by a clinical social worker for the diagnosis and treatment of mental illnesses. Clinical social workers must: (1) possess a master's or doctor's degree in social work; (2) have performed at least two years of supervised clinical social work; and (3) be licensed or certified as a clinical social worker by the State in which the services are performed (or in the case of an individual in a State which does not provide for licensure or certification, individuals must have completed at least 2 years or 3,000 hours of post-master's degree supervised clinical social work practice under the supervision of a master's level social worker in an appropriate setting (as determined by the Secretary), and meets such other criteria as the Secretary establishes.)

Explanation of provision

The provision would exclude clinical social worker services from the SNF PPS. The provision would apply to items and services furnished on or after January 2008.

Reason for change

The provision treats clinical social workers identically to psychologists and psychiatrists with regard to their treatment of Medicare beneficiaries in nursing homes. Making this change will ensure better access to mental health services for Medicare beneficiaries in nursing homes.

SECTION 607. COVERAGE OF MARRIAGE AND FAMILY THERAPISTS AND MENTAL HEALTH COUNSELOR SERVICES

Current law

Medicare provides coverage for mental health services, subject to certain limitations. Medicare Part B will make direct payments to physicians, clinical psychologists, and clinical social workers for such services. Medicare does not make direct payments for services provided by marriage and family therapists and mental health counselors. Their services are generally paid as incident to a physician's professional services. They may also be included as part of covered facility services such as those provided by a skilled nursing facility.

Explanation of provision

The provision would include "marriage and family therapist services" and "mental health counselor services" within the definition of "medical and other health services" covered under Medicare Part B. The term marriage and family therapist services would be defined as services performed by marriage and family therapists for the diagnosis and treatment of mental illnesses. Such services would be those which the individual was legally authorized to perform under state law (or the state regulatory mechanism provided by state law) of the state in which the services were performed. Such services would also have to be covered under Part B and be of the type which would otherwise be covered if furnished by a physician or as incident to a physician's professional services. Payment would only be made if no facility or other provider charged or was paid for such services.

The term marriage and family therapist would be defined as an individual who: (1) possessed a master's or doctoral degree which qualified the individual for licensure or certification as a marriage and family therapist pursuant to state law; (2) performed at least 2 years of clinical supervised experience in marriage and family therapy after obtaining the degree; (3) was licensed or certified as a marriage and family therapist in the state such services were performed.

The provision would define mental health counselor services as services performed by mental health counselors for the diagnosis and treatment of mental illnesses. Such services would be those which the individual was legally authorized to perform under state law (or the state regulatory mechanism provided by state law) of the state in which the services were performed. Such services would also have to be covered under Part B and be of the type which would otherwise be covered if furnished by a physician or as incident to a physician's professional services. Payment would only be made if no facility or other provider charged or was paid for such services.

The term mental health counselor would be defined as an individual who: (1) possessed a master's or doctoral degree which qualifies the individual for licensure or certification in mental health counseling in the state where the services were performed; (2) performed at least 2 years of supervised mental health counselor practice after obtaining the degree; (3) was licensed or certified as a

mental health counselor or professional counselor in the state where the service was performed.

Payment for covered services would be made under Medicare Part B. Payment would equal the lesser of 80 percent of the lesser of the actual charge for the service or 75 percent of the amount paid to a psychologist for such services. All services provided by marriage and family therapists and mental health counselors would be paid on an assignment basis. Further, services provided by marriage and family therapists and mental health counselors would be added to the list of services excluded from payment as part of the skilled nursing facility prospective payment system.

The bill would include services provided by marriage and family therapists and mental health counselors in the definition of covered rural health clinic services and covered federally qualified health center services.

The provision would require the Secretary to develop criteria for marriage and family therapist services paid directly under Part B. Under the criteria, the therapist would have to agree to consult with a patient's attending or primary care physician in accordance with such criteria. The criteria would be developed taking into consideration concerns for patient confidentiality. Similarly, the Secretary would be required to develop such criteria for mental health counselor services.

The provision would apply to services provided on or after January 1, 2008.

Reason for change

In states that have licensed or certified marriage and family therapists and mental health counselors, these practitioners provide mental health services to people under age 65. Few states did so when Medicare was first created in 1965. This provision updates Medicare coverage by allowing them to treat Medicare beneficiaries as well, subject to state law.

SECTION 608. RENTAL AND PURCHASE OF POWER-DRIVEN WHEELCHAIRS

Current law

Wheelchairs, including power-driven wheelchairs, are covered by Medicare under the capped-rental category of the durable medical equipment (DME) benefit. Medicare pays for power-driven wheelchairs in one of two ways: either Medicare will pay the supplier a monthly rental amount during the beneficiary's period of medical need (though payments are not to exceed 13 continuous months), or, payment is made on a lump-sum basis at the time the supplier furnishes the chair, if the beneficiary chooses the lump-sum payment option. If the reasonable lifetime of a power-driven wheelchair is reached, or the wheelchair is lost or irreparably damaged, Medicare will pay for a replacement. The beneficiary may elect to have the replacement purchased through monthly rental payments not to exceed 13 months, or a lump-sum payment.

The Secretary is required to establish a competitive acquisition program for specified durable medical equipment; the competitive acquisition program would replace the Medicare fee schedule pay-

ments. The program is to be phased-in, starting in 10 of the largest metropolitan statistical areas (MSAs) in 2007; expanding to 80 of the largest MSAs in 2009 and remaining areas after 2009. The Secretary is permitted to phase-in first items and services with the highest cost and highest volume, or those items and services that the Secretary determines to have the largest savings potential first, which includes power-driven wheelchairs. Originally, the bids for the first round of the Medicare DMEPOS competitive bidding program were due on July 13, 2007. The Secretary extended the deadline to September 25, 2007.

Explanation of provision

For all power-driven wheelchairs furnished on or after January 1, 2008, the provision would eliminate the option to purchase a power-driven wheelchair with a lump-sum payment at the time the supplier furnished the chair. The provision would not eliminate the lump-sum purchase option for replacing a power-driven wheelchair. The provision would not apply to DMEPOS competitive bidding areas for bids submitted before September 25, 2007.

Reason for change

By eliminating the first month full purchase option, the provision reduces waste in the Medicare program as there are a sizeable number of wheelchairs which are purchased in the first month, but end up not needing to be used beyond the 13 month window. Furthermore, this change protects beneficiaries from the burden of paying the cost-sharing associated with the wheelchair in one lump sum, as would be the case under a first-month purchase.

The Committee is concerned about the practical requirements of special needs patients whose complex conditions such as quadriplegia and Louis Gehrig's disease have encouraged the outright purchase of mobility devices rather than short- or long-term rentals. These special needs patients will require wheelchairs that are highly customized, use complex technologies, and are in use for very long periods—if not the rest of the patient's lifetime. In enforcing this provision, the Committee directs the Secretary to take into consideration the practical requirements of special needs patients whose complex conditions such as quadriplegia and Louis Gehrig's disease have encouraged the outright purchase of mobility devices rather than short- or long-term rentals.

SECTION 609. RENTAL AND PURCHASE OF OXYGEN EQUIPMENT

Current law

Medicare Part B pays for certain items of durable medical equipment including oxygen and oxygen equipment. The Deficit Reduction Act (DRA P.L. 109–171) changed how long Medicare would make rental payments for oxygen equipment. It changed from the entire period of medical need, to a rental period of 36 months. After 36 months of rental payments, the supplier is required to transfer the title of the equipment to the beneficiary. Payments for maintenance and servicing (for parts and labor not covered by the supplier's or manufacturer's warranty) are made if the Secretary determines them to be reasonable and necessary. In the case of an indi-

vidual receiving oxygen equipment on December 31, 2005, the 36-month period began January 1, 2006.

The final rule implementing the oxygen provision in DRA was published in the Federal Register on November 9, 2006. The final rule established a new class of oxygen equipment for which Medicare would make an additional payment. The new class represented oxygen generating portable equipment, also known as portable concentrators or transfilling systems. Rental payments to suppliers for beneficiaries receiving this type of equipment are increased by $64 per month in 2007 above the stationary equipment rental payment of $177 per month in 2007 when stationary and portable equipment is provided.

The Secretary is required to establish a competitive acquisition program for specified durable medical equipment; the competitive acquisition program would replace the Medicare fee schedule payments. The program is to be phased-in, starting in 10 of the largest metropolitan statistical areas (MSAs) in 2007; expanding to 80 of the largest MSAs in 2009 and remaining areas after 2009. The Secretary is permitted to phase-in first items and services with the highest cost and highest volume, or those items and services that the Secretary determines to have the largest savings potential first, which includes oxygen and oxygen equipment. Originally, the bids for the first round of the Medicare DMEPOS competitive bidding program were due on July 13, 2007. The Secretary extended the deadline to September 25, 2007.

Explanation of provision

The provision would decrease the length of time Medicare would rent oxygen equipment from 36 continuous months to 18 continuous months for oxygen equipment, excluding oxygen generating portable equipment. The law does not change for oxygen generating portable equipment, which will continue to be subject to the 36 month rental limit. Payments for reasonable and necessary servicing and maintenance will occur after the 18 and 36 month rental period end, respectively.

The provision would not apply to contracts entered into under the Durable Medical Equipment Competitive Acquisition Program for bids submitted prior to September 25, 2007. The provision would apply to equipment furnished on or after January 1, 2008. In the case of a beneficiary receiving oxygen equipment on December 31, 2007, the 18-month period would begin on January 1, 2008, but in no case would it exceed 36 continuous months.

The Secretary would be required to conduct a study to examine the service component and equipment component of the provision of oxygen to Medicare beneficiaries. The study would assess: (a) the type of services provided and variation across suppliers in providing services; (b) whether the services were medically necessary or affected patient outcomes; (c) whether the Medicare program pays appropriately for equipment in connection with the provision of oxygen; (d) whether the program pays appropriately for necessary services; (e) whether the payment should be divided between equipment and services, and if so, how; and (f) how the payment rate compares to the competitively bid rate. The Secretary would

be required to submit the report to Congress not later than 18 months after the date of enactment of this Act.

Reason for change

Evidence from the Health and Human Services Inspector General shows that Medicare is dramatically overpaying for oxygen equipment. In 2006, an oxygen concentrator cost $587 and yet reimbursements over the 36-month window exceed $7215. There is absolutely a cost to the service component that goes along with the provision of the equipment, but there is no evidence that service totals more than $6600 in thirty-six months. The President recommended that the rental window be moved from 36-months to 13 months. This provision takes a more conservative approach and reduces the rental period from 36 to 18 months. There is no change for oxygen generating portable equipment, which remains at a 36-month rental period. The provision also requires a study to disaggregate the cost of the service from the equipment with the goal of developing a more rational payment system for home oxygen in the future.

SECTION 610. ADJUSTMENT FOR MEDICARE MENTAL HEALTH SERVICES

Current law

Medicare pays for mental health services under the physician fee schedule.

Explanation of provision

The provision would increase the amount otherwise payable by 5 percent for certain specified services. The increase would apply for the period beginning January 1, 2008 and ending December 31 of the year before the effective date of the first five year review of work relative values conducted after January 1, 2008. The services to which the increase would apply would be procedure codes: (1) in the categories of psychiatric therapeutic procedures furnished in office or other outpatient facility settings or inpatient hospital, partial hospital or residential care facility settings; and (2) which cover insight oriented, behavior modifying, or supportive psychotherapy and interactive psychotherapy services in the Healthcare Common Procedure Coding System established by the Secretary. The Secretary could implement the provision by program instruction or otherwise.

Reason for change

This provision responds to the unintended outcome of the most recent review of the work relative value units for physician payment in which clinical psychologists and clinical social workers received significant cuts in their overall allowed charges. This reduction came about because clinical psychologists and clinical social workers do not bill for evaluation and management codes which received an increase. The negative financial impact on psychologists and social workers' was exacerbated by the fact that their reimbursement is heavily weighted by work relative value units, which received a cut.

The reduction in payment for psychologists and social workers could endanger people's access to needed mental health treatments. To address that concern, the provision provides a temporary five percent add on payment for the codes most often billed by psychologists and clinical social workers. This temporary payment is eliminated after the next five-year review of the work relative value units.

SECTION 611. EXTENSION OF BRACHYTHERAPY SPECIAL RULE

Current law

The Medicare Modernization Act of 2003 (MMA) required Medicare's outpatient prospective payment system to make separate payments for specified brachytherapy sources. As mandated by the Tax Relief and Health Care Act of 2006 (TRHCA), until January 1, 2008, this separate payment will be made using hospitals' charges adjusted to their costs.

Explanation of provision

The provision would extend cost reimbursement for brachytherapy services until January 1, 2009.

Reason for change

Brachytherapy is a form of treatment for various types of cancer including prostate, breast, liver, lung, brain, rectum, head and neck, cervical and skin. Treatment for these deadly diseases involves the implantation of radiation sources also known as seeds. There are currently twelve types of sources available to patients. Because of the low-volume of some brachytherapy treatments, sufficient data is just now becoming available for the Centers for Medicare and Medicaid Services (CMS) to implement a prospective payment system for these treatments. The Committee believes that by 2009 CMS will be able to implement an appropriate prospective payment system for brachytherapy.

SECTION 612. PAYMENT FOR PART B DRUGS

Current law

The Medicare Modernization Act (MMA) revised the way Part B pays for covered drugs. Payments for most Part B drugs are based on an average sales price (ASP) payment methodology. Alternatively, beginning in 2006, drugs can be provided through the competitive acquisition program (CAP). Each year, each physician is given the opportunity either to receive payment using the ASP methodology or to obtain drugs and biologicals through the CAP.

Under the ASP methodology, Medicare's payment for Part B drugs equals 106% of the applicable price for a multiple source drug or single source drug, subject to the beneficiary deductible and coinsurance. Applicable prices are derived from data reported by manufacturers under the Medicaid program. The applicable price for multiple source drugs is the volume-weighted average of the ASPs calculated by National Drug Code (NDC) for each calendar quarter. The applicable price for single source drugs is the lesser of the volume-weighted ASP or the wholesale acquisition cost.

MMA included language specifying how to calculate a volume-weighted ASP based on information reported by manufacturers. The reporting unit was the lowest identifiable quantity of the drug (e.g., one milliliter, one tablet). However, the MMA allowed the Secretary, beginning in 2004, to use a different reporting unit. The Secretary used his discretion and changed to the amount of the drug represented by the NDC. The amount of the drug represented by one NDC may differ from the amount represented by another NDC.

In February 2006, the Office of the Inspector General (OIG) of the Department of Health and Human Services issued a report (OEI–03–05–00310) which stated that the method used by CMS was incorrect because it did not use billing units consistently throughout the equation. It stated that although CMS used billing units to standardize ASPs across NDCs for each HCPCS code, it did not similarly standardize sales volume across NDCs.

Under the CAP program, contractors can only supply covered drugs and biologicals directly to the prescribing physician's office. Drugs cannot be delivered to a satellite office where the prescribing physician may actually administer the treatment. Drugs also cannot be delivered beneficiaries, except where beneficiaries currently receive them in their homes or other non-physician office settings.

The MMA included language requiring single source drugs that were in the same billing code on October 1, 2003 to be treated as multiple source drugs. This required a change in the reimbursement for certain inhalation drugs, blending the single source drug with the multiple source drugs in one ASP.

Explanation of provision

The provision would require the Secretary to use consistent volume weighting in the computation of the ASP, using the formula recommended by the February 2006 Inspector General's report; this requirement would apply with respect to payment for drugs and biologicals furnished on or after July 1, 2008.

The provision would modify the CAP program. It would permit continuous open enrollment and selection of a CAP vendor. It would also specify that an election and selection would continue to be effective without the need for any periodic reelection or reapplication or selection. It would specify that vendors would not be prevented from delivering drugs and biologicals to the site in which they are to be administered. The provision would also require the Secretary to conduct an outreach and education program on the CAP. Further, the Secretary would only be permitted to rebid CAP contracts for periods on or after the expiration of the contract in effect on the date of enactment.

The provision would establish, beginning January 1, 2008, a special rule for the payment calculation for inhalation drugs furnished through items of DME. The payment amount would equal the lower of: (1) the ASP calculation using the current provision treating certain single source drugs in the same billing code as multiple source drugs; or (2) the ASP calculation without using the provision.

Reason for change

The Office of Inspector General's study on the methodology used to calculate ASP found that of prices published in the first quarter of 2005, 46 percent of codes had a reimbursement amount that was higher than it should have been, resulting in an estimated $115 million loss to Medicare in 2005. For 13 percent of codes, CMS's reimbursement amount was lower than it should have been, representing an estimated $5 million loss to providers in 2005. Requiring CMS to use the alternative methodology developed by OIG will ensure proper reimbursement amounts for all Part B drugs, eliminating both Medicare overpayments and underpayments.

The Competitive Acquisition Program (CAP) was created in MMA as an alternative to the ASP reimbursement scheme. This program provides physicians' access to Part B drugs without the concern of obtaining the drug at less than the current 106% of ASP reimbursement rate. There have been three main enrollment periods for physicians to join the CAP, but physicians have been wary about joining a new and untested drug distribution program.

Allowing continuous enrollment in the CAP will increase the number of physicians in the program and allow physicians who cannot purchase drugs at 106% of the ASP reimbursement rate to join the program at any time. The Committee recognizes that there are administrative actions that must be taken to enroll and ensure proper payment in the CAP program. The effective date of a physician's enrollment in the CAP shall not be more than 60 days from the receipt of the enrollment forms by the carrier.

Physicians have also expressed concern about some of the current restrictions in the CAP program, specifically, where the CAP vendors can deliver prescribed drugs. Many Part B drugs are delivered in a physician's main office, but others may be delivered in a satellite office or at another medical facility. Clarifying that CAP venders are allowed to deliver drugs directly to the site of administration assures that drugs are in the right place at the right time and limits issues associated with transportation of drugs to the administration site.

Physicians in the CAP are also currently required to re-elect a CAP vendor during subsequent open enrollment periods. This requires the physician to take affirmative action to remain in the program even if they have no intention of returning to the ASP payment system or choosing another CAP vendor. Allowing physicians to stay in the CAP program with their current vendor without reapplication will ensure continuity in the administration of drugs to patients and reduce administrative burdens on physicians and CAP vendors. The Committee intends that physicians enrolled in 2007 will be automatically reenrolled for the service period beginning January 1, 2008.

As the CAP program continues to grow, vendors must adjust to the changes in this provision while continuing to provide physicians all the Part B drugs prescribed. Once the CAP market has stabilized new vendors will be allowed to bid on joining the CAP program when the current contracts expire in 2009.

Under a provision of the MMA known as the grandfather clause, some Part B drugs have been bundled together under a single ASP. Inhalation drugs are one such class of drugs, and CMS recently

combined the ASPs for generic albuterol and brand name levalbuterol. When this change occurred, reimbursement for the brand name drug decreased substantially, while reimbursement for the generic increased substantially. The Committee is concerned that the profit spread created by increasing reimbursement for generic albuterol will cause physicians to use only albuterol even if levalbuterol may be more clinically appropriate. This provision merely requires albuterol to be reimbursed at its historic rate while reimbursing levalbuterol at the lower of its historic ASP or the bundled rate.

SUBTITLE B—EXTENSION OF MEDICARE RURAL ACCESS PROTECTIONS

SECTION 621. 2-YEAR EXTENSION OF FLOOR ON MEDICARE WORK GEOGRAPHIC ADJUSTMENT

Current law

Medicare's physician fee schedule assigns relative values to services that reflect physician work (i.e., the time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative values are adjusted for geographic variations in costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor.

The geographic adjustment factors are indices that reflect the relative cost difference in a given area in comparison to a national average. An area with costs above the national average would have an index greater than 1.00 while an area with costs below the average would have an index below 1.00. Unlike the other geographic adjustments, the work adjustment factor reflects only one-quarter of the cost differences in an area. The Secretary is required to periodically review and adjust the geographic indices.

MMA required the Secretary to increase the value of any work geographic index that was below 1.00 to 1.00 for services furnished on or after January 1, 2004 and before January 1, 2007. TRHCA extended the provision for an additional year, for services provided before January 1, 2008.

Explanation of provision

The provision would extend the floor through December 31, 2009.

Reason for change

Rural physicians put in as much time, skill, and intensity into their work as physicians in urban areas. This provision ensures that rural physicians are paid at least the average rate for their work.

SECTION 622. 2-YEAR EXTENSION OF SPECIAL TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE

Current law

The Balanced Budget Act of 1997 specified that independent labs that had agreements with hospitals on July 22, 1999, to bill directly for the technical component of pathology services could con-

tinue to do so in 2001 and 2002. The provision has been periodically extended. TRHCA applied the provision in 2007.

Explanation of provision

The provision would be extended through December 31, 2009.

Reason for change

This provision is needed in order to continue allowing direct billing for the technical component for independent labs that have agreements with independent laboratories. Without this extension, hospitals will incur an additional cost that is not included in the payment rate under the prospective payment system. This provision protects rural beneficiaries' access to laboratory services.

SECTION 623. 2-YEAR EXTENSION OF MEDICARE REASONABLE COSTS PAYMENTS FOR CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITAL PATIENTS IN CERTAIN RURAL AREAS

Current law

Generally, hospitals that provide clinical diagnostic laboratory services under Part B are reimbursed using a fee schedule. Hospitals with under 50 beds in qualified rural areas (certain rural areas with low population densities) receive 100 percent of reasonable cost reimbursement for the clinical diagnostic laboratories covered under Part B that are provided as outpatient hospital services. Reasonable cost reimbursement for laboratory services provided by these hospitals will end July 1, 2007.

Explanation of provision

This provision would extend reasonable cost reimbursement for clinical laboratory services provided by qualified rural hospitals until July 1, 2009.

Reason for change

Often, a local rural hospital is the only lab facility in the area. Even though performing lab work is the same in the hospital or in the nursing home, the hospital is reimbursed at a lower rate if the lab specimen is not drawn at the hospital. This drives up costs and may lead to access issues. This provision is needed in order to continue providing reasonable cost reimbursement for small rural hospitals (under 50 beds) in low density population rural areas for lab services as part of their outpatient services.

SECTION 624. 2-YEAR EXTENSION OF MEDICARE INCENTIVE PAYMENT PROGRAM FOR PHYSICIAN SCARCITY AREAS

Current law

MMA provided for an additional 5 percent in payments for certain physicians in scarcity areas for the period January 1, 2005 through December 31, 2007. The Secretary was required to calculate, separately for practicing primary care physicians and specialists, the ratios of such physicians to Medicare beneficiaries in the county, rank each county (or equivalent area) according to its ratio for primary care and specialists separately, and then identify those scarcity areas with the lowest ratios which collectively rep-

resented 20 percent of the total Medicare beneficiary population in those areas.

Explanation of provision

The provision would extend the add-on payments through December 31, 2009. During 2008 and 2009, the Secretary would be required to use the primary care scarcity areas and specialty care scarcity areas that the Secretary was using on December 31, 2007.

Reason for change

Only 10 percent of physicians practice in rural America even though more than a quarter of the population lives in these areas. This provision preserves a five percent incentive payment for doctors practicing in underserved areas to help recruit and retain physicians where they are needed and in order to ensure access to health care services in rural areas.

SECTION 625. 2-YEAR EXTENSION OF MEDICARE INCREASE PAYMENTS FOR GROUND AMBULANCE SERVICES IN RURAL AREAS

Current law

Ambulance services are paid on the basis of a national fee schedule, which is being phased-in. The fee schedule establishes seven categories of ground ambulance services and two categories of air ambulance services. The payment for a service equals a base rate for the level of service plus payment for mileage. Geographic adjustments are made to a portion of the base rate. Additionally, the base rate is increased for air ambulance trips originating in rural areas and mileage payments are increased for all trips originating in rural areas. There is a 25 percent bonus on the mileage rate for trips of 51 miles and more.

The national fee schedule is fully phased-in for air ambulance services. For ground ambulance services, payments through 2009 are equal to the greater of the national fee schedule or a blend of the national and regional fee schedule amounts. The portion of the blend based on national rates is 80 percent for 2007–2009. In 2010 and subsequently, the payments in all areas will be based on the national fee schedule amount.

For the period July 2004–December 2006, the law provided for a temporary increase in payments for ground ambulance services. The increase was 2 percent in rural areas and 1 percent in other areas.

Explanation of provision

The provision would reinstate the ground ambulance bonus payments for rural areas for the period beginning on January 1, 2008 and ending December 31, 2009.

Reason for change

This provision helps to cover the cost of providing ambulance services in rural areas.

SECTION 626. EXTENDING HOLD HARMLESS FOR SMALL RURAL HOSPITALS UNDER THE HOPD PROSPECTIVE PAYMENT SYSTEM

Current law

Small rural hospitals (with no more than 100 beds) that are not sole community hospitals can receive additional Medicare payments if their outpatient payments under the prospective payment system are less than under the prior reimbursement system. For calendar year (CY) 2006, these hospitals will receive 95 percent of the difference between payments under the prospective payment system and those that would have been made under the prior reimbursement system. The hospitals will receive 90 percent of the difference in CY2007 and 85 percent of the difference in CY2008.

Explanation of provision

The provision would establish that these small rural hospitals would receive 90 percent of the payment difference for service furnished after CY2006 and ending December 31, 2009.

Reason for change

This provision protects small rural hospitals from the financial losses they would face under the outpatient prospective payment system. Eligible hospitals will receive a partial hold harmless payment until the end of CY2010.

SUBTITLE C—END STAGE RENAL DISEASE PROGRAM

SECTION 631. CHRONIC KIDNEY DISEASE DEMONSTRATION PROJECTS

Current law

No provision.

Explanation of provision

The Secretary, acting through the Director of the National Institutes of Health (NIH), would be required to establish demonstration projects to: (1) increase public and medical community awareness (particularly of those who treat patients with diabetes and hypertension) about the causal factors, prevention, diagnosis, and treatment of chronic kidney disease; (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 of the Centers for Disease Control and Prevention (CDC). The Secretary would select at least 3 States in which to conduct this demonstration, taking into account the number of individuals with ESRD who are enrolled in part B of Medicare and ensure participation of individuals who reside in rural and urban areas. The demonstration projects would be conducted for no longer than 5 years, beginning January 1, 2009. The Secretary would be required to conduct an evaluation of the demonstration projects. Within 12 months after completion of the projects, the Secretary would be required to submit a report to Congress including the

evaluation and recommendations for appropriate legislative and administrative action.

Reason for change

The prevalence and incidence of diabetes (which is a risk factor for end stage renal disease), and ESRD are both on the rise. Public education, targeted screening, and surveillance are all needed in order to better reach at-risk populations and improve prevention. This provision is based on Section 101 of H.R. 1193, the Kidney Care Quality and Education Act of 2007.

SECTION 632. MEDICARE COVERAGE OF KIDNEY DISEASE PATIENT EDUCATION SERVICES

Current law

No provision.

Explanation of provision

Medicare coverage would be expanded to include coverage for kidney disease education services, defined as education services: (1) furnished to an individual with stage IV chronic kidney disease who, according to accepted clinical guidelines identified by the Secretary, would require dialysis or a kidney transplant; (2) furnished, upon the referral of the physician managing the individual's kidney condition, by a qualified person; (3) designed to provide comprehensive information regarding the management of co-morbidities (including delaying the need for dialysis), prevention of uremic complications, and options for renal replacement therapy; (4) designed to ensure that individuals have the opportunity to actively participate in the choice of therapy; and (5) tailored to meet the needs of the individual involved. Qualified person would mean a physician, physician assistant, nurse practitioner, or clinical nurse specialist who provides services that are paid under the Medicare fee-schedule, but would not include a renal dialysis facility. The Secretary would be required to set standards for the content of the educational services, after consulting with physicians and others as required by statute, excluding to the extent possible those who have received industry funding from a drug or biological manufacturer or dialysis facility. The Secretary would be required to monitor and to promulgate regulations to carry out this section, to ensure that beneficiaries entitled to these services received them in a timely manner to maximize the benefit of the services. Individuals would be eligible for no more than 6 sessions of kidney disease education services.

No later than September 1, 2010, GAO would be required to submit a report to Congress on the following: (1) the number of Medicare beneficiaries who are eligible for kidney disease education services and who received the services; (2) the extent to which there is a sufficient number of physicians and eligible providers to furnish these services and whether renal dialysis facilities and their employees should be included as an eligible entity to furnish such services; and (3) recommendations for facilities and their employees to structure education services that are objective, unbiased and provide options and alternative locations for renal replacement

therapy and management of co-morbidities that may delay the need for dialysis. These provisions would be effective January 1, 2009.

Reason for change

Individuals with stage IV chronic kidney disease are pre-dialysis. This education benefit will ensure that Medicare beneficiaries with stage IV CKD understand their treatment options and may help to potentially delay onset of the need for dialysis. Provision of patient education designed to delay dialysis may be a conflict of interest when undertaken at a dialysis center. Therefore, a study is necessary to determine whether sufficient providers exist to provide this benefit, and to consider if and how dialysis centers can provide unbiased education. This provision is based on Section 102 of H.R. 1193, the Kidney Care Quality and Education Act of 2007.

SECTION 633. REQUIRED TRAINING FOR PATIENT CARE DIALYSIS TECHNICIANS

Current law

Program regulations require each staff member of a facility to be currently licensed or registered in accordance with applicable federal, state, or local laws.

Explanation of provision

A provider of services or a renal dialysis facility could not use an individual as a patient care dialysis technician for more than 12 months during 2009, or at any time thereafter, unless the individual completed a training program in chronic kidney failure dialysis care and treatment and was certified by a nationally recognized certification entity for dialysis technicians. An exception would be made for those who were enrolled in a training program and those who had performed such services for at least 5 years. Individuals who had not provided services for which they were paid, for 24 consecutive months since their last training, would be required to complete a new training program or be required to become recertified. Providers of services or renal dialysis facilities would be required to provide regular performance review and in-service education to assure competency of individuals who perform dialysis-related services.

Reason for change

There is concern about varying levels of training and experience at dialysis facilities. Required certification and training of dialysis technicians is needed in order to ensure quality patient care. This provision is based on Section 105 of H.R. 1193, the Kidney Care Quality and Education Act of 2007.

SECTION 634. MEDPAC REPORT ON TREATMENT MODALITIES FOR PATIENTS WITH KIDNEY FAILURE

Current law

No provision.

Explanation of provision

No later than March 1, 2009, the Medicare Payment Advisory Commission (MedPAC) would be required to submit a report to the Secretary and to Congress evaluating the barriers to increasing the number of Medicare ESRD beneficiaries electing home dialysis services. The report would include the following: (1) a review of Medicare home dialysis demonstration projects initiated before the date of enactment of this Act, including recommendations for future demonstrations or changes to the Medicare program to test models that could improve access to home dialysis; (2) a comparison of current costs and payments between Medicare home dialysis and in-center and hospital dialysis; (3) an analysis of the adequacy of Medicare reimbursement for patient training for home dialysis and recommendations for ensuring appropriate payments for home dialysis training; (4) a catalogue and evaluation of the incentives and disincentives in the current reimbursement system that influence whether patients receive home dialysis services or other treatment modalities; (5) an evaluation of patient education services and how they impact patients' treatment choices; and (6) recommendations for implementing incentives to encourage patients to use home dialysis or other Medicare treatment modalities. MedPAC would be required to consider a variety of perspectives, including those of physicians, other health care professionals, hospitals and others as required by statute.

Reason for change

The vast majority of Medicare beneficiaries with ESRD receive dialysis in-center, rather than at home. According to the Medicare Payment Advisory Commission, home dialysis patients are more satisfied with their care than in-center patients. Furthermore, among individuals who prioritize working and traveling, home dialysis may lead to higher health-related quality of life than in-center dialysis. This study is needed in order to better understand whether there are barriers to home dialysis, and if so, what changes are needed to ensure proper reimbursement for home dialysis. This provision builds on Section 104 of H.R. 1193, the Kidney Care Quality and Education Act of 2007.

SECTION 635. ADJUSTMENT FOR ERYTHROPOIETIN STIMULATING AGENTS (ESAS)

Current law

Medicare reimbursement for dialysis services includes: (1) the composite rate, which covers services, including dialysis; and (2) a drug add-on adjustment for the difference between the payment amounts for separately billable drugs and biologicals and their acquisition costs, as determined by Inspector General Reports. Drugs that are billed separately are paid based on the average sales price (ASP) + 6%. The Medicare reimbursement rate for Erythropoietin (Epoetin alpha, or brand name Epogen) is $9.104 per 1,000 units (this price changes quarterly and is effective July 1, 2007–September 30, 2007). Darbepoetin alfa (brand name Aranesp) is not generally marketed to freestanding dialysis facilities. It is however, marketed to hospitals which purchase the drug to treat anemia in

patients with chronic kidney disease, certain types of cancer, and ESRD patients receiving dialysis at the hospital's facility. The reimbursement rate for darbepoetin alfa used for ESRD for July 1, 2007–September 30, 2007 is $3.048 per microgram.

Explanation of provision

The payment amount for epoetin alpha furnished by a large dialysis facility during 2008 or 2009 to a patient with ESRD would be equal to the lesser of $8.75 per 1,000 units (rounded to the nearest 100 units) or 102 percent of the ASP for such drug or biological. The payment amounts for darbepoetin alfa furnished by a large dialysis facility during 2008 or 2009 to a patient with ESRD would be equal to the lesser of $2.92 per microgram or 102 percent of the ASP for such drug or biological. A large dialysis facility would be defined as one that was owned or managed by a corporate entity that as of July 24, 2007, owned or managed 300 or more such providers or facilities and included a successor to such a corporate entity. This provision would not affect the amount of a drug add-on payment. This provision is effective January 1, 2008.

Reason for change

The Department of Health and Human Services Office of the Inspector General has conducted several studies documenting the fact that Medicare reimbursement for erythropoietin stimulating agents (epoetin alpha and darbepoetin alfa) exceeds acquisition costs for dialysis centers. A recent HHS OIG study found that while Medicare's reimbursement for epoetin alpha was $9.48 per 1000 units in the third quarter of 2006, large dialysis organization were able to acquire it for $8.55, constituting a $0.93 profit for each 1,000 units purchased. There is concern that the profit margin available to dialysis centers creates incentives for higher dosing of Epogen, which can result in health risks if red blood cell levels are raised above recommended levels. According to a March 2007 "black box warning" from the Food and Drug Administration (FDA), raising red blood cell levels above certain levels puts patients at great risk of blood clots, strokes, heart attacks and deaths. This provision addresses the unwarranted overpayments that Medicare is currently making to the large dialysis organizations.

SECTION 636. SITE NEUTRAL COMPOSITE RATE

Current law

Dialysis services are offered in three outpatient settings: hospital-based facilities, independent facilities, and the patient's home. There are two methods for payment. Under Method I, facilities are paid a prospectively set amount, known as the composite rate, for each dialysis session, regardless of whether services are provided at the facility or in the patient's home. The composite rate is derived from audited cost data and adjusted for the national proportion of patients dialyzing at home versus in a facility, and for area wage differences. Hospital-based dialysis facilities receive an upwards adjustment to the composite rate. Beneficiaries electing home dialysis may choose not to be associated with a facility and may make independent arrangements with a supplier for equip-

ment, supplies, and support services. Payment to these suppliers, known as Method II, is made on the basis of reasonable charges, limited to 100 percent of the median hospital composite rate, except for patients on continuous cycling peritoneal dialysis, when the limit is 130 percent of the median hospital composite rate.

Explanation of provision

Beginning January 1, 2008, the payment for providers of dialysis services furnished by hospital-based facilities would be the same as the rate for such services furnished by renal dialysis facilities that are not hospital based, except that in applying the geographic index to hospital-based facilities, the labor share would be based on the labor share otherwise applied for such facilities.

Reason for change

The change creates a site neutral reimbursement rate for dialysis services. Site neutral payment is a goal of the Medicare reimbursement system.

SECTION 637. DEVELOPMENT OF ESRD BUNDLING SYSTEM; CONTINUOUS QUALITY IMPROVEMENT INITIATIVE

Current law

Medicare reimbursement for dialysis services is paid based on a basic case-mix adjusted prospective payment system for dialysis services furnished either at a facility or in a patient's home. The basic case-mix adjusted system has two components: (1) the composite rate, which covers services, including dialysis; and (2) a drug payment adjustment for the difference between the payment amounts for separately billable drugs and biologicals and their acquisition costs, as determined by Inspector General Reports. Additionally, certain drugs, biologicals and laboratory tests are billed separately.

The Secretary is required to update the basic case-mix adjusted payment amounts annually beginning with 2006, but only for that portion of the case-mix adjusted system that is represented by the add-on adjustment and not for the portion represented by the composite rate.

Explanation of provision

Beginning January 1, 2010, the Secretary would implement a bundled payment system under which a single payment would be made for Medicare renal dialysis services, ensuring that the estimated total payment for 2010 for Medicare renal dialysis services and items furnished would equal 96 percent of payments that would have been made if the bundled payment system had not been implemented. The term "renal dialysis services" would include: (1) items and services which were included in the composite rate as of December 31, 2009; (2) erythropoietin stimulating agents (ESAs) furnished to individuals with ESRD; (3) other drugs, biologicals, and diagnostic laboratory tests that the Secretary identifies as commonly used in the treatment of such patients and for which payment was made separately under Medicare prior to enactment of this Act, and drugs and biologicals for which there is

an oral equivalent form; and (4) home dialysis training for which prior to enactment of this Act was made separately. The term "renal dialysis services" would not include vaccines. The Secretary could determine payments on the basis of services furnished during a week, month, or another unit. The payment system would include adjustments for: (1) case mix that could take into account patient weight, body mass index, co-morbidities, length of time on dialysis, age, race, ethnicity, and other factors; (2) high cost outliers, including variations in the amount of ESAs necessary for anemia management; and (3) other appropriate measures as determined by the Secretary, such as geography, pediatric services, volume, rural versus urban location, and size. The Secretary could phase-in the payment system for providers and facilities that had pediatric patients, low volume, operated in rural areas or were not large dialysis organizations. The phase-in would be required to be fully implemented for services furnished on or after January 1, 2013. The Secretary would annually increase the bundled payment amounts by same increase that would have applied to the drug-add on adjustment required under current law.

In addition to the bundled payment amount, providers and facilities would receive an additional amount if they met the specified performance standard for the period, and beginning in 2009, the specified reporting requirements. The four periods would be July 1, 2008 to December 31, 2008, CY2009, CY2010, and a multi-month period in 2011, as specified by the Secretary.

The additional payment would be a percentage of the Secretary's estimate of the payment base, for a given year. The Secretary's estimate would be based on claims submitted no later than 2 months after the end of the performance period. The applicable percentage would equal 1% in 2008, 2% in 2009, 3% in 2010, and 4% in 2011. For a year in which the performance period was less than an entire year, the applicable percentage would be multiplied by the ratio of the number of months in the year to the number of months in the performance period. In 2010 and 2011, the applicable percentage would be multiplied by the ratio of the pre-bundling payment amount to the post-bundling payment amount.

The payment base for a provider or facility for a performance period before 2010 would be an amount determined under the composite rate for services furnished by the provider or facility during the performance period including the drug payment adjustment. For 2010 and 2011, the payment base amount would be the bundled payment. The quality incentive payment for 2008, 2009, and 2010 would be in the form of a single consolidated payment. The provider or facility would receive this amount for 2011 within 3 to 9 months of the end of the performance period. If the Secretary determined that the total payments for a performance period would exceed $50,000,000 in 2008, $100,000,000 in 2009, or $150,000,000 in 2010, then the Secretary would reduce, in a pro rata manner, the amount of the payments for each provider or facility for the period, so as to eliminate any projected excess. If the Secretary determined that the total quality bonus payments for 2011 would exceed $200,000,000, then the Secretary would reduce, in a uniform manner, the applicable percentage to eliminate any such projected excess.

To receive this additional payment, the performance standards for a provider or facility in 2008 would require that at least 92 percent of ESRD individuals receiving erythropoietin have an average hematocrit of 33 percent or more, and less than a certain percentage of patients, as defined by the Secretary, receiving erythropoietin have an average hematocrit of 39 percent or more. To receive the additional payment in 2009 and 2010, the performance standard would be satisfactory performance relative to the national average on: (1) measures of anemia management specified by the Secretary, including measures of hemoglobin levels or hematocrit levels for ESAs that are consistent with the labeling for dosage approved by the Food and Drug Administration; and (2) other measures endorsed by the National Quality Forum, including to the extent feasible, those relating to iron management, dialysis adequacy, vascular access, and patient access as the Secretary may specify. For 2011, the Secretary would determine a composite score for the performance of a provider or facility on the performance measures. In order to receive an additional payment in 2011, a provider or facility would be required to substantially improve performance or exceed a performance standard, as measured with a composite score, in addition to the performance standard for 2009 and 2010.

Beginning in 2009, the reporting requirements for receiving the additional amount would include those specified by the Secretary, taking into account measures endorsed by the National Quality Forum, and including, to the extent feasible, measures on iron management, dialysis adequacy, vascular access and patient satisfaction. The provider or facility submitting information would be required to attest to its completeness and accuracy.

There would be no administrative or judicial review of the determination of the measure applicable to services furnished by eligible professionals, the determination of a satisfactory report, the determination of the payment limitations, and the determination of the bonus incentive payment. There would also be no administrative or judicial review of the identification of renal dialysis services included in the bundled payment, the adjustment of outliers, the identification of facilities to which the phase-in may apply, and the determination of bundled payment amounts. The determination could not be treated as a determination of an appeal for benefits.

The Secretary would identify or establish an appropriate group or organization, for example the ESRD Networks, to provide technical assistance to consistently low-performing facilities or providers that are in the bottom quintile.

The Secretary would provide an annual written notification to each individual receiving dialysis services that informs the individual of the composite scores and other relevant quality measures, compares the scores and measures with average local and national scores and measures, and provides information on how to access additional information on quality of other providers and facilities. The Secretary would provide certificates indicating the composite score, to facilities and providers to display in patient areas. The Secretary would establish a web-based list to indicate the composite score of each provider and facility. The Secretary would develop recommendations for applying the quality incentive payments to all physicians who receive the monthly capitated payment with

respect to ESRD items and services for each year, including recommendations: (1) to include pediatric specific measures for physicians with at least 50% of their patients under 18 years of age; and (2) on how to structure quality incentive payments for physicians who demonstrate improvement in quality or attain quality standards.

No later than January 1, 2013, the Secretary would submit a report to Congress on the implementation of the bundled payment system and the quality initiative. The report would include the following information: (1) a comparison of the aggregate payment under the bundled system to the costs of such items and services; (2) the changes in utilization rates for ESAs; (3) the mode of administering ESAs, including the proportion receiving the agents intravenously compared to subcutaneously; (4) the frequency of dialysis; (5) other differences in practice patterns; (6) the performance of facilities and providers; and (7) other recommendations for legislative and administrative actions, as determined appropriate by the Secretary. No later than January 1, 2015, the Secretary would be required to submit a report to Congress including requirements 2–7 of the previous report and a comparison of the result of the bundled payment system during the 2-year period beginning on January 1, 2013 and the result of such payment system during the previous 2-year period.

Reason for change

Both the Medicare Payment Advisory Commission and the Government Accountability Office have recommended that Congress create a bundled payment for dialysis services. Bundling services under a single payment rate is a fundamental principle of Medicare payment policy for most types of services. A bundled rate has advantages for achieving efficiencies and clinical flexibility. The Committee assumes that a bundled payment rate will result in far more efficient behavior on the part of dialysis providers, and the bulk of the savings garnered from increased efficiencies in 2008 through 2011 are reinvested into quality incentive payments.

The Committee has taken steps to ensure that the bundled payment system pays adequately for high cost cases, including the cost of erythropoietin stimulating agents for managing anemia. The Committee is requiring an outlier pool to guarantee sufficient reimbursement for high-cost cases, as well as a case mix adjuster that will modify payment rates to reflect patient characteristics linked to higher costs.

The Committee has also included provisions to ensure appropriate anemia management under a bundled payment system. In addition to ensuring appropriate payment via an outlier pool and case mix adjuster, the Committee also includes a strong quality reporting and incentive payment system. In order to be eligible for bonuses, dialysis centers must meet a performance standard for anemia management. Additional measures of quality patient care will be added in future years. The composite score methodology used to determine quality incentive payments in 2011 builds on Section 203 of H.R. 1193, the Kidney Care Quality and Education Act of 2007.

The Committee is aware of research indicating that African Americans may require higher doses of ESAs in order to manage their anemia. It is the intent of the Committee that the outlier pool, case mix adjuster, and quality reporting and incentive payments will serve as safeguards to ensure that the new payment system is flexible enough to allow for appropriate reimbursement for high cost cases due to higher ESA needs. The Committee will seek a report from the Government Accountability Office that will explore the potential implications of the bundled payment system for racial and ethnic minorities, and the Committee will revisit the policy, if warranted, upon receiving the report. The Committee is steadfast in its commitment to a policy that ensures that all dialysis beneficiaries receive the ESAs they need in order to manage their anemia.

The Committee has addressed concerns of certain providers by allowing for payment adjustments for providers that are low-volume, rural, pediatric, or non-large dialysis organizations. If these providers face differing cost structures, the Secretary has the authority to create payment adjustments to reflect such costs. Furthermore, in addition to the two years leading up to the bundled system in 2010, the Secretary has the authority to phase-in the bundled payment system for low-volume, rural, pediatric, or non-large dialysis organizations.

The incentives for more efficient behavior will result in changes in practice patterns that may take several years to unfold. Thus, two reports from HHS are necessary in order to ensure the Congress understands how clinical practice has changed under the bundled payment. The Congress will also needed information on the cost structure in the new system and the quality of patient care.

SECTION 638. MEDPAC REPORT ON ESRD BUNDLING SYSTEM

Current law

No provision.

Explanation of provision

No later than March 1, 2012, MedPAC would be required to submit a report to Congress on the implementation of the ESRD bundling payment system, including an analysis of: (1) the overall adequacy of the payment for all such services; (2) a comparison of the adequacy of payment for services furnished by (a) a large dialysis facility (one that was owned or managed by a corporate entity that as of July 24, 2007, owned or managed 300 or more such providers or facilities and included a successor to such a corporate entity), (b) a provider or facility that is not large, (c) a hospital-based facility, (d) a free-standing facility, (e) a facility in an urban area, and (f) a facility in a rural area; (3) the financial status of providers and facilities, including access to capital, return on equity, and return on capital; (4) the adequacy of payment under the bundling payment system and the adequacy of quality improvement payments, in ensuring that Medicare payments for such services are consistent with costs for such services; and (5) any recommendations for modifying the payment system.

Reason for change

The modernized bundled payment system creates new incentives for more efficient behavior on the part of providers. A rigorous MedPAC study is needed so that the Congress can assess the payment adequacy of the new system.

SECTION 639. OIG STUDY AND REPORT ON ERYTHROPOIETIN

Current law

No provision.

Explanation of provision

No later than January 1, 2009, the Inspector General of the Department of Health and Human Services would be required to conduct a study and submit a report to Congress with recommendations on dosing guidelines, standards, protocols, and algorithms for ESAs recommended or used at large dialysis facilities (facilities owned or managed by a corporate entity that as of July 24, 2007, owned or managed 300 or more such providers or facilities and included a successor to such a corporate entity) and those that are not large. The study would examine these guidelines, standards, protocols, and algorithms for: (1) consistency with the labeling of the Food and Drug Administration; (2) the extent of which physicians sign standing orders for ESAs that are consistent with providers or facilities; (3) the extent to which the prescribing decisions of physicians for ESAs are independent of these measures or recommendations of an anemia management nurse or other appropriate employee of the provider or facility; and (4) the role of the medical director and the financial relationship between the medical director hired by a provider or facility.

Reason for change

The Committee is very concerned that the current reimbursement structure for erythropoietin stimulating agents encourages higher dosage levels. To the extent higher dosing results in higher red blood cell levels, there can be a health risk. According to a March 2007 "black box warning" from the Food and Drug Administration (FDA), raising red blood cell levels above certain levels puts patients at great risk of blood clots, strokes, heart attacks and deaths.

Thus, the Committee is very concerned that some dialysis organizations may be using dosing guidelines, standards, protocols, and algorithms to guide ESA dosing that are inconsistent with the FDA label for ESAs. During a Health Subcommittee hearing held on June 26, 2007, a FDA witness criticized the dosing guidelines of one of the large dialysis organizations as inconsistent with the FDA label, underscoring the problematic nature of these dosing guidelines. The Committee is also concerned about the financial relationship between medical directors and the dialysis organizations where they serve, and the extent to which prescribing decisions are independent of dosing guidelines, standards, protocols, and algorithms. This Inspector General report is needed to explore these issues.

SUBTITLE D—MISCELLANEOUS

SECTION 651. LIMITATION ON EXCEPTION TO THE PROHIBITION OF CERTAIN PHYSICIAN REFERRALS FOR HOSPITALS

Current law

Physicians are generally prohibited from referring Medicare patients for certain services to facilities in which they (or their immediate family members) have financial interests. However, among other exceptions, physicians are not prohibited from referring patients to whole hospitals in which they have ownership or investment interests. Providers that furnish substantially all of its designated health services to individuals residing in rural areas are exempt as well.

Explanation of provision

Only hospitals meeting certain requirements would be exempt from the prohibition on self referral. Hospitals with a Medicare provider agreement on July 24, 2007 and no increase in the number of operating rooms and beds after the date of enactment that meet other specified requirements would be exempt from this self-referral ban. These requirements would address conflicts of interest, bona fide investments and proportional returns, and patient safety. Hospitals would have 18 months to comply with these standards if they wish to maintain the ability to self-refer. These standards would apply to rural hospitals in the same manner as they apply to all other hospitals.

Specifically, to address conflicts of interest, an exempt hospital would (1) submit an annual report containing the identity of each physician owner and any other owners of the hospital as well as information on the nature and extent of all ownership interests in the hospital; (2) have procedures in place to require that any referring physician owner discloses to each patient (by a time that would permit the patient to make a meaningful decision regarding the receipt of care) their ownership interest in the hospital and, if applicable, any such ownership interest of the treating physician; and (3) not condition ownership, either directly or indirectly, on the physician owners making or influencing referrals to the hospital or otherwise generating business for the hospital. Information from the annual report would be published and updated annually on the Internet website of the Centers for Medicare and Medicaid Services.

Exempt hospitals would ensure bona fide investment and proportional returns by meeting the following requirements: (1) physician owners could not own more than 40% of the value of the investment interest held in the hospital; (2) the ownership interest of any individual physician owner could not exceed 2% of the total investment interests held in the hospital or in any entity whose assets include the hospital; (3) any ownership interest offered to a physician could not be offered on more favorable terms than those offered to an individual who is not a physician owner; (4) the hospital could not directly or indirectly provide loans or financing for physician investments in the hospital; (5) the hospital could not directly or indirectly guarantee a loan, make a payment toward a loan, or

otherwise subsidize a loan for any individual physician owner or group of physician owners that is related to acquiring any ownership interest in the hospital; (6) investment returns would be required to distributed to investors in the hospital in an amount that is directly proportional to the capital investment by the hospital investor; (7) physician owners would not receive directly or indirectly any guaranteed receipt of or right to purchase other business related interests in the hospital, including the purchase or lease of any property under the control of other investors in the hospital or located near the premises of the hospital; and (8) physician owners would not be offered an opportunity to purchase or lease any property under the control of the hospital or any other investor in the hospital on more favorable terms than the terms offered to an individual who is not a physician owner.

To ensure patient safety, those exempt hospitals that do not have any physician available on the premises to provide services during all hours in which the hospital is providing services to such a patient would be required to disclose such fact to the patient before admitting the patient. Following such a disclosure, the hospital would receive a signed acknowledgement of the fact from the patient. Also hospital would be required to have capacity to provide assessment and initial treatment for patients as well as to refer and transfer patients to hospitals with the capability to treat the patients' needs.

For the purposes of this subsection, a physician owner would be defined as a physician (or an immediate family member of such a physician) with a direct or indirect ownership interest in the hospital.

The Secretary would be required to establish policies and procedures to ensure compliance with these requirements, beginning on their effective date. The enforcement efforts would be able to include unannounced site reviews of hospitals. Beginning no later than 18 months from the date of enactment, the Secretary would be required to conduct audits to determine if hospitals violate the above requirements.

Reason for change

When originally enacted, the physician self-referral laws included an allowance for physicians to have ownership in a full hospital. It was included because, at the time, there were a number of rural hospitals in particular where such ownership arrangements were in effect. Ownership in a whole hospital was not viewed as a significant incentive for self-referral because of the breadth of services offered in such a facility. However, the physician self-referral law explicitly prohibited ownership in "a subdivision of a hospital" because of the concern that if physicians owned only their particular part of a hospital, there would be an incentive for self-referral.

Since enactment of the self-referral laws, entities have been created that identify and license themselves as "hospitals" under state law. However, these facilities no longer provide the full range of services a layperson would consider a hospital. Instead, they've chosen to limit their services to a narrow band of services. These bands have also tended to be profit centers from the hospital—most commonly cardiac procedures and orthopedic procedures. In effect,

they've taken a "subdivision of a hospital" and made it a free-standing hospital in order to circumvent the prohibition in the physician self-referral laws which prohibit self-referral when the ownership is "merely in a subdivision of a hospital."

These entities are typically called "specialty hospitals" or "limited service hospitals". The Medicare Payment Advisory Commission and other experts have studied these facilities and raised concerns about them performing unnecessary procedures and increasing health care spending. In fact, there have been at least two instances in which patients have died in these facilities because there was no doctor to care for them when they had complications post-surgery. This provision is scored by CBO as saving $700 million over five years and nearly 3 billion over ten years—providing credence to the argument that self-referral creates increased utilization.

It is no longer the case that most rural community hospitals have financial arrangements that include physician ownership. Given that change, and the concern about self-referral to these specialty hospitals, this provision eliminates the whole hospital exception all together. The provision grandfathers existing facilities if they are willing to meet a strong set of financial and quality standards going forward.

TITLE VII—PROVISIONS RELATING TO MEDICARE PARTS A AND B

SECTION 701. HOME HEALTH PAYMENT UPDATE FOR 2008

Current law

Home health agencies (HHAs) are paid under a prospective payment system (PPS) that began on October 1, 2000. Payment is based on 60-day episodes of care for beneficiaries, subject to several adjustments, with unlimited episodes of care in a year. The payment covers skilled nursing, therapy, medical social services, aide visits, medical supplies, and others. Durable medical equipment is not included in the home health PPS. The base payment amount, or national standardized 60-day episode rate, is increased annually by an update factor that is determined, in part, by the projected increase in the home health market basket (MB) index. This index measures changes in the costs of goods and services purchased by HHAs. Starting in 2007, HHAs are required to submit to the Secretary health care quality data. A HHA that does not submit the required quality data will receive an update of the MB minus two percentage points. This reduction would only apply to the fiscal year in question.

Explanation of provision

The provision would eliminate the MB update for home health payments for 2008. Home health agencies would still be subject to the data quality provision. The home health payment update for subsequent years would equal the projected increase in the home health market basket, subject to the quality data provision.

Reason for change

Congress relies on the Medicare Payment Advisory Commission (MedPAC) for expert advice on payments for Medicare providers. This year, MedPAC recommended a zero update for home health providers. They based this recommendation on evidence that the industry has high Medicare margins, reaching nearly 17% in 2005, that there is continued growth in numbers of providers in this arena, and there were no access problems for patients. Given MedPAC's recommendation, the Committee chose to freeze home health payments for 2008.

SECTION 702. 2-YEAR EXTENSION OF TEMPORARY MEDICARE PAYMENT INCREASE FOR HOME HEALTH SERVICES FURNISHED IN RURAL AREAS

Current law

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, (P.L. 108–173) provided for a one-year 5% additional payment for home health services furnished in rural areas. The temporary payment began for episodes and visits ending on or after April 1, 2004 and before April 1, 2005. It was made without regard to certain budget neutrality provisions and was not included in the base for determination of payment updates. The Deficit Reduction Act of 2005 (P.L. 109–171) extended the payments for rural home health episodes or visits beginning on or after January 1, 2006 and before January 1, 2007.

Explanation of provision

The provision would renew these additional payments for rural home health episodes and visits beginning on or after January 1, 2008 and before January 1, 2010.

Reason for change

The Committee remains concerned about access to quality health care for Medicare beneficiaries in rural areas. Given that concern, and the fact that this legislation provides a freeze for the overall home health payment update, the Committee chose to provide for a two-year extension of the 5% add-on payment for rural home health services.

SECTION 703. EXTENSION OFF MEDICARE SECONDARY PAYER FOR BENEFICIARIES WITH END-STAGE RENAL DISEASE FOR LARGE GROUP PLANS

Current law

Under Medicare Secondary Payer (MSP) rules, Medicare is prohibited from making payments for any item or service when payment has been made or can reasonably be expected to be made by a third party payer. For individuals with Medicare entitlement based solely on End-Stage Renal Disease (ESRD), MSP rules apply for those covered by an employer-sponsored group plan, regardless of the employer size or current employment status. Medicare entitlement based on ESRD usually begins with the third month after the month in which the beneficiary starts a regular course of dialysis, referred to as the three-month waiting period. In addition to

the waiting period, for individuals whose Medicare eligibility is based solely on ESRD, any group health plan coverage they receive through their employer or their spouse's employer is the primary payer for the first 30 months of ESRD benefit eligibility, referred to as the 30-month coordination period. After 30 months, Medicare becomes the primary insurer.

Medicare coverage ends 12 months after the month the beneficiary stops dialysis treatment or 36 months after the month the beneficiary has a successful kidney transplant. However, if Medicare coverage ends, and then begins again, based on ESRD, the 30-month coordination period will also begin again.

A large group health plan is a plan offered by an employer that normally employed at least 100 employees on a typical business day during the preceding calendar year. This also applies to certain smaller plans that are part of a multiple or multi-employer plan.

Explanation of provision

Beginning January 1, 2008, the coordination period for ESRD MSP would be extended to from 30 months to 42 months, but only for those individuals who receive group coverage through a large group health plan.

Reason for change

This legislation puts forth significant reforms in Medicare's End Stage Renal Disease program. The decision to extend Medicare Secondary Payer requirements from 30 to 42 months is part of that overall ESRD program reform and helps finance that package. It would not be a provision the Committee supported on its own.

The provision is limited to large employers with more than 100 employees because of concern that smaller employers would face premium increases for all of their employees if an ESRD patient needed to be covered for another year. Larger employers are more easily able to spread that cost across a larger pool of covered lives.

It is important to note that this policy in no way impacts Medicare coverage for people suffering from ESRD who have no private health insurance. They will still become eligible 3 months after beginning dialysis.

SECTION 704. PLAN FOR MEDICARE PAYMENT ADJUSTMENT FOR NEVER EVENTS

Current law

The Tax Relief and Health Care Act of 2006 (P.L. 109–432) directs the Inspector General in the Department of Health and Human Services to study and report to Congress on: (1) the incidences of never events (those listed and endorsed as serious reportable events by the National Quality Forum or NQF as of November 16, 2006) for Medicare beneficiaries; (2) the extent to which the Medicare program paid, denied payment, or recouped payment for services furnished in connection with such events, and the extent to which beneficiaries paid for them; and (3) the administrative processes of the Centers for Medicare and Medicaid Services to detect such events and to deny or recoup payments for related

services. The OIG was appropriated $3 million to carry out this section; these funds are available until January 1, 2010.

According to NQF never events are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and indicate a real problem in the safety and credibility of a health care facility. Examples of "never events" include surgery on the wrong body part; foreign body left in a patient after surgery; mismatched blood transfusion; major medication error; severe "pressure ulcer" acquired in the hospital; and preventable post-operative deaths.

Explanation of provision

The Secretary would be required to develop a plan to reduce or eliminate payments for hospital based never events beginning in FY2010. A hospital based never event would be defined as an event involving the delivery (or failure to deliver) physician services, inpatient or outpatient hospital services, ambulatory surgery center facility in which there is an error in medical care that is clearly identifiable, usually preventable and serious in consequences to patients and that indicates a deficiency in the safety and process controls for such services.

The plan would establish criteria to assess whether an event meets the following characteristics: (1) the event is clearly identifiable and measurable and feasible to include in a reporting system; (2) the event is usually preventable, taking into account the complexity of medical care where certain medical events are not always avoidable; (3) the event is serious and could result in death, loss of a body part, disability, or more than transient loss of a body function; and (4) the event is indicative of a problem in safety systems and process controls and is indicative of the reliability of the quality of the services provided by the physician, hospital, or ambulatory surgical center.

In developing the plan, the Secretary would consider: (1) mechanisms used by hospitals and physicians in reporting and coding services that would reliably indicate never events; and (2) modifications in billing and payment mechanisms that permit efficient and accurate reduction or elimination of payments for never events. The plan would prioritize services to be considered never events and for which payments should be reduced or eliminated. The Secretary would be required to consult with affected parties that are relevant to payment reductions in response to never events.

No later than June 1, 2008, the Secretary would submit a report to Congress on this plan, including relevant recommendations.

Reason for change

The Committee does not believe it is responsible public policy to pay for mistakes that are made by health care providers. Unfortunately, the Committee was informed that the Centers for Medicare and Medicaid Services could not readily enact a policy that prohibited payment for these so-called "never events." Therefore, this provision requires the Secretary of Health and Human Services to make corrections in their systems to allow for the prohibition of payment for never events and to report to Congress by June 1, 2008 explaining how that can be done.

SECTION 705. REINSTATEMENT OF RESIDENCY SLOTS

Current law

Medicare pays for the direct and indirect graduate medical education expenses in teaching hospitals with approved physician training programs. The Balanced Budget Act of 1997 (BBA) generally capped the total number of allopathic and osteopathic residents reimbursed under Medicare at the level that existed for the cost reporting period ending in calendar year 1996. The limit does not include dental or podiatry residents. Rural hospitals, and hospitals that established new training programs before August 5, 1997, will be partially exempt from the cap. Also, MMA provided for the redistribution of unused residency slots to other teaching hospitals. Other exceptions apply to hospitals with new programs established after that date.

Explanation of provision

If one or more hospitals with approved medical residency training programs as of January 1, 2000 closes, the Secretary would increase the otherwise applicable resident limit by not more than 10 of another hospital located in the same metropolitan division of the core base statistical area of the closed hospital. In no event would the resident limit be increased above 50 by the application of this provision. The receiving hospitals would have to: (1) receive additional funds for serving a disproportionate share of low income patients; (2) have a medical residency training program in internal medicine that was accredited by the American Osteopathic Association on or after January 1, 2004; (3) have a provider number and resident limit as of January 1, 2000 and remain open as of October 1, 2007; and (4) did not receive an increase in its resident limit under redistribution provisions of MMA. This provision would be effective for cost reporting periods beginning on or after July 1, 2005.

A hospital with a dual accredited osteopathic and allopathic family practice program that had its resident limit adjusted under the MMA redistribution provisions would receive an adjustment if such reduction was determined using a cost report that was subsequently revised between September 1, 2006 and September 15, 2006. This revision would have resulted in a higher resident level than that which served as the basis for the MMA redistribution calculation. The resident adjustment would be effective as if it were included in MMA and would apply to portions of cost reporting periods occurring on or after July 1, 2005.

Reason for change

The Committee understands that when implementing Section 422 of the Medicare Modernization Act, "redistribution of unused resident positions," the Centers for Medicare and Medicaid Services (acting through its fiscal intermediary), erred in its removal of residency slots from one institution. This provision restores those slots.

The Committee is also allowing for the reinstatement of slots to the remaining hospital when a hospital closed in a particular geographic area, in order to ensure a certain number of residency slots in that area.

TITLE IX—MISCELLANEOUS

SECTION 901. MEDICARE PAYMENT ADVISORY COMMISSION STATUS

Current law

The Medicare Payment Advisory Commission (MedPAC) is an independent federal body established by the Balanced Budget Act of 1997 to advise the U.S. Congress on issues affecting the Medicare program. The Commission's statutory mandate is to: (1) advise the Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, and (2) analyze access to care, quality of care, and other issues affecting Medicare.

Explanation of provision

This provision would establish MedPAC as an agency of Congress.

Reason for change

MedPAC's status as an agency of Congress is not clearly defined. Without this change, the retirement benefits of MedPAC employees will remain under question.

SECTION 902. REPEAL OF TRIGGER PROVISION

Current law

The Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trust funds are overseen by a board of trustees who make annual reports to Congress. The MMA (Subtitle A of title VIII) requires the trustees' report to include an expanded analysis of Medicare expenditures and revenues. Specifically, a determination must be made as to whether or not general revenue financing will exceed 45% of total Medicare outlays within the next seven years. General revenues financing is defined as total Medicare outlays minus dedicated financing sources (i.e., HI payroll taxes; income from taxation of Social Security benefits; state transfers for prescription drug benefits; premiums paid under Parts A, B, and D; and any gifts received by the trust funds).

Explanation of provision

Subtitle A of title VIII of the MMA would be repealed.

Reason for change

The 45% threshold is an artificial and misleading measure of Medicare's fiscal health. Its continuation builds a case for unnecessary and radical changes to the Medicare program and makes it more difficult to address any future funding shortfalls.

SECTION 903. REPEAL OF COMPARATIVE COST ADJUSTMENT (CCA) PROGRAM

Current law

A six-year program will begin in 2010 to examine comparative cost adjustment (CCA) in designated CCA areas. Payments to local MA plans in CCA areas will, in part, be based on competitive bids

(similar to payments for regional MA plans), and Part B premiums for individuals enrolled in traditional Medicare may be adjusted, either up or down. This program will be phased in and there is also a 5% annual limit on the adjustment, so that the amount of the adjustment to the beneficiary's premium for a year cannot exceed 5% of the amount of the monthly Part B premium, in non-CCA areas.

Explanation of provision

The CCA program would be repealed.

Reason for change

The CCA is an ideological attempt to fundamentally change Medicare from an entitlement to benefits to a defined contribution program. This concept was rejected by the Bipartisan Commission on the Future of Medicare in 1999.

SECTION 904. COMPARATIVE EFFECTIVENESS RESEARCH

Current law

There are very few provisions in current Medicare statutes that address comparative clinical effectiveness. Section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act (MMA) of 2003 authorizes AHRQ to conduct and support evidence syntheses and research to meet the priorities and requests for scientific evidence and information identified by the Medicare, Medicaid and SCHIP programs. These activities include developing information with respect to: (1) outcomes, comparative clinical effectiveness, and appropriateness of health care items and services, including prescription drugs, and (2) strategies for improving the efficiency and effectiveness of such programs, including the ways in which such items and services are organized, managed, and delivered under such programs.

Through the process stipulated in the MMA, the Secretary developed a priority list for comparative clinical effectiveness research that addresses the following 10 conditions targeted to Medicare beneficiaries: (1) arthritis and non-traumatic joint disorders (muscle, bone, and joint conditions); (2) cancer (cancer); (3) chronic obstructive pulmonary disease and asthma (breathing conditions); (4) dementia including Alzheimer's disease (brain and nerve conditions); (5) depression and other mood disorders (mental health); (6) diabetes mellitus (diabetes); (7) ischemic heart disease (heart and blood vessel conditions); (8) peptic ulcer disease and dyspepsia (digestive system conditions); (9) pneumonia (breathing conditions); and (10) stroke and hypertension (heart and blood vessel conditions). Subsequent lists will include conditions relevant to the Medicaid and SCHIP programs.

Under the Section 1013 authority, AHRQ established the Effective Health Care Program, comprised of three parts: (1) the development of comparative effectiveness reviews that focus on treatments for the priority conditions by synthesizing currently available scientific evidence, including both published and unpublished studies, comparing treatments, including drugs, to determine relative benefits and risks, and wherever possible, measuring the out-

comes for subpopulation groups and identifying major gaps in the existing knowledge base; (2) the conduct of rapid-cycle research to address specific issues, including the major gaps identified in part (1), that do not necessitate larger, more time-consuming randomized clinical trials; and (3) the dissemination and translation of effectiveness research to real-world quality improvements. These efforts are sometimes referred to as evidence synthesis, evidence generation, and evidence translation.

To carry out Section 1013, MMA authorized $50 million for fiscal year 2004, and "such sums as may be necessary for each fiscal year thereafter." Congress has appropriated $15 million a year for AHRQ's comparative effectiveness endeavors.

Explanation of provision

The provision would establish a Center for Comparative Effectiveness Research ("Center") within the Agency for Healthcare Research and Quality. The Center would conduct, support, and synthesize research (including research conducted or supported under section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically.

The duties of the Center would be to: (1) conduct, support, and synthesize research relevant to the comparative clinical effectiveness of the full spectrum of health care treatments, including pharmaceuticals, medical devices, medical and surgical procedures, and other medical interventions; (2) conduct and support systematic reviews of clinical research, including original research; (3) use methodologies such as randomized controlled clinical trials as well as other various types of clinical research, such as observational studies; (4) submit to the Comparative Effectiveness Research Commission, the Secretary, and Congress appropriate relevant reports; (5) encourage, as appropriate, the development and use of clinical registries and the development of clinical effectiveness research data networks from electronic health records, post marketing drug and medical device surveillance efforts, and other forms of electronic health data; and (6) not later than 180 days after the date of the enactment, develop methodological standards to be used when conducting studies of comparative clinical effectiveness and value (and procedures for use of such standards) in order to help ensure accurate and effective comparisons and update such standards at least biennially.

An independent Comparative Effectiveness Research Commission ("Commission"), established by the Secretary, would have oversight responsibility over the Center and would evaluate the Center's activities to ensure that highly credible research and information result from such research. The duties of the Center would include: (1) determining national priorities for research and, in making such determinations, consult with patients and health care providers and payers; (2) monitoring the appropriateness of use of the Health Care Comparative Effectiveness Research Trust Fund (CERTF) described below with respect to the timely production of comparative

effectiveness research determined to be a national priority; (3) identifying highly credible research methods and standards of evidence for such research to be considered by the Center; (4) reviewing and approving the methodological standards (and updates to such standards) developed by the Center; (5) entering into an arrangement under which the Institute of Medicine of the National Academy of Sciences would conduct an evaluation and report on standards of evidence for such research; (6) supporting forums to increase stakeholder awareness and permit stakeholder feedback on the efforts of the Agency of Healthcare Research and Quality to advance methods and standards that promote highly credible research; (7) making recommendations for public data access policies of the Center that would allow for access of such data by the public while ensuring the information produced from research involved is timely and credible; (8) appointing a clinical perspective advisory panel for each research priority established, which would frame the specific research inquiry to be examined with respect to such priority to ensure that the information produced from such research is clinically relevant to decisions made by clinicians and patients at the point of care; (9) making recommendations for the priority for periodic reviews of previous comparative effectiveness research and studies conducted by the Center; (10) routinely reviewing processes of the Center with respect to such research to confirm that the information produced by such research is objective, credible, consistent with standards of evidence established under this section, and developed through a transparent process that includes consultations with appropriate stakeholders; (11) at least annually, providing guidance or recommendations to health care providers and consumers for the use of information on the comparative effectiveness of health care services by consumers, providers and public and private purchasers; (12) making recommendations for a strategy to disseminate the findings of research conducted and supported under this section that enables clinicians to improve performance, consumers to make more informed health care decisions, and payers to set medical policies that improve quality and value; (13) providing for the public disclosure of relevant reports; and (14) submitting to Congress an annual report on the progress of the Center in achieving national priorities for the provision of credible comparative effectiveness information produced from such research to all interested parties.

The members of the Commission would represent a broad range of perspectives. The Commission would consist of the Director of the Agency for Healthcare Research and Quality, the Chief Medical Officer of the Centers for Medicare and Medicaid Services, and up to 15 additional members who would represent broad constituencies of stakeholders including clinicians, patients, researchers, third-party payers, consumers of Federal and State beneficiary programs. Collectively, the members would have experience in epidemiology, health services research, bioethics, decision sciences, and economics. At least one member would represent each of the following health care communities: consumers, practicing physicians—including surgeons, employers, public payers, insurance plans, and clinical researchers who conduct research on behalf of pharmaceutical or device manufacturers.

Commission members would be appointed by the Comptroller General of the United States, in consultation with the chairs of the committees of jurisdiction of the House of Representatives and the Senate. The Comptroller General would also designate a member to serve as Chairman and a member to serve as Vice Chairman at their time of appointments, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General may designate another member for the remainder of that member's term. Initial appointments would be for 4 years for 8 appointees and 3 years for 7 appointees. Subsequently, appointments would be for a 4 year term for each member of the Commission.

To enhance effectiveness and coordination, the Comptroller General would be 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. In appointing the members of the Commission or a clinical perspective advisory panel described in paragraph the Comptroller General of the United States or the Commission, respectively, would take into consideration any financial conflicts of interest. Members of the Commission would be entitled to compensation (at the per diem equivalent of the rate provided for level IV of the Executive Schedule) and allowed travel expenses, as authorized by the Director of the Commission, while serving on the business of the Commission.

The Commission would transmit a copy of each report to the Secretary and make them available to the public. The Commission is empowered to provide guidance or recommendations to health care providers and consumers for the use of information on the comparative effectiveness at least annually (or more often should it deem necessary). This authority, combined with a mandate for independent resources for the functions of the Commission, allows the Commission to develop its own recommendations on the proper use at the point of care of the findings of comparative effectiveness research (conducted by the Center or elsewhere). Independent of the Secretary, the Commission can disseminate reports to the public of its own recommendations at least annually, or more often if needed.

The provision also specifies conditions for the hiring of a director, staff, experts, and consultants. To assure the efficient administration of the Commission, the Commission would be able to employ and fix the compensation of an Executive Director (subject to the approval of the Secretary, in consultation with the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service). The Commission would also be able to seek assistance and support from appropriate Federal departments and agencies as may be required in the performance of its duties, and to enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission. The Commission would be able to make advance, progress, and other payments which relate to the work of the Commission, provide transportation and subsistence for persons serving without compensation; and prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

The Commission would be given powers to obtain data required to perform its duties. The Commission would be able to secure information directly from any department or agency of the United States necessary. Upon request of the Executive Director, the head of that department or agency would furnish that information to the Commission on an agreed upon schedule. The Commission would: (i) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements as noted above, (ii) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate, and (iii) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

The Comptroller General would have unrestricted access to all deliberations, records, and nonproprietary data of the Commission, immediately upon request, and the Commission would be subject to periodic audit by the Comptroller General. Congress and the Commission would each have unrestricted access to all deliberations, records, and nonproprietary data of the Center, immediately upon request.

Any research conducted, supported, or synthesized under this section would have to meet certain requirements addressing transparency, credibility and access, use clinical advisory panels, and involve stakeholder input. The establishment of the agenda and the conduct of the research would be insulated from inappropriate political or stakeholder influence. The methods of conducting the research would be scientifically based and all aspects of the prioritization of research, conduct of the research, and development of conclusions based on the research would be transparent to all stakeholders. The process and methods for conducting such research would be publicly documented and available to all stakeholders. Throughout the process of such research, the Center would provide opportunities for all stakeholders involved to review and provide comment on the methods and findings of such research. The research conducted by the Center must meet a national research priority as determined by the Commission and must examine the specific research question framed by the clinical perspective advisory panel relevant to that national research priority.

The priorities of the research, the research, and the dissemination of the research would involve the consultation of patients, health care providers, and health care consumer representatives through transparent mechanisms recommended by the Commission.

The Commission's and Center's reports and information on comparative effectiveness would be publicly accessible. The Commission's and Center's reports subject to this provision would include: (1) an interim progress report, (2) a draft final comparative effectiveness review; (3) a final progress report on new research submitted for publication by a peer review journal; (4) stakeholder comments, and (5) a final report. Not later than 90 days after receiving a report from a Center, the Commission, a grantee or contractor of the Center, or the clinical perspective advisory panel, the appropriate information contained in the report would be posted on

the official public Internet site of the Center and of the Commission, as applicable.

The Center would provide for the dissemination of appropriate findings produced by research supported, conducted, or synthesized under this section to health care providers, patients, vendors of health information technology focused on clinical decision support, appropriate professional associations, and Federal and private health plans. The Center would assist users of health information technology focused on clinical decision support to promote the timely incorporation of the findings described above into clinical practices and to promote the ease of use of such incorporation.

Several reports are due to Congress as a result of this activity. First, the Director of the Agency of Healthcare Research and Quality and the Center for Comparative Effectiveness Research Commission would submit an annual report to Congress, within one year of the date of enactment, on the activities of the Center and the Commission, as well as the research conducted under this section. Second, not later than December 31, 2009, the Secretary would submit to Congress a recommendation for an annual fair share per capita amount (described below) in order to fund the CERTF. Finally, no later than December 31, 2011, the Secretary, in consultation with the Commission, would submit to Congress a report on all activities conducted or supported under this section as of such date. The report would include an evaluation of the return on investment resulting from such activities, the overall costs of such activities, and an analysis of the backlog of any research proposals approved by the Commission but not funded. The report would also address whether Congress should expand the responsibilities of the Center and of the Commission to include studies of the effectiveness of various aspects of the health care delivery system, including health plans and delivery models, such as health plan features, benefit designs and performance, and the ways in which health services are organized, managed, and delivered.

The Secretary would establish a permanent council ('Council') for the purpose of: (1) assisting the offices and agencies of the Department of Health and Human Services, the Department of Veterans Affairs, the Department of Defense, and any other Federal department or agency to coordinate the conduct or support of health services research; and (2) advising the President and Congress on the national health services research agenda, strategies with respect to infrastructure needs of health services research, and appropriate organizational expenditures in health services research by relevant Federal departments and agencies.

The Council would be composed of 20 members, including the Director of the Agency for Healthcare Research and Quality. The Director would appoint the other members not later than 30 days after the enactment of this Act. Ten of the initial 148 appointees would serve 4-year terms, while nine would serve 3-year terms. Subsequently, each member of the Council would be appointed for a term of 4 years. Any vacancies would not affect the power and duties of the Council and would be filled in the same manner as the original appointment.

The provision specifies the qualifications of Council members. The members would include one senior official from each of the fol-

lowing agencies: (1) the Veterans Health Administration; (2) the Department of Defense Military Health Care System; (3) the Centers for Disease Control and Prevention; (4) the National Center for Health Statistics; (5) the National Institutes of Health; (6) the Center for Medicare and Medicaid Services; and (7) the Federal Employees Health Benefits Program. The members of the Council shall include 4 senior leaders from major national, philanthropic foundations that fund and use health services research. The remaining members of the Council would be representatives of other stakeholders in health services research, including private purchasers, health plans, hospitals and other health facilities, and health consumer groups.

The Council would submit an annual report on the progress of the implementation of the national health services research agenda to Congress.

JOINT COMMITTEE ON TAXATION'S ANALYSIS AND EXPLANATION OF THE CERTF

In general

The provision establishes the Health Care Comparative Effectiveness Research Trust Fund ("CERTF") under the Internal Revenue Code (the "Code") to carry out the bill's provisions relating to comparative effectiveness research.

The following amounts are appropriated to the CERTF: $90,000,000 for fiscal year 2008; $100,000,000 for fiscal year 2009; and $110,000,000 for fiscal year 2010. For each fiscal year beginning with fiscal year 2011, the amount appropriated to the CERTF is (1) an amount equal to the net revenues received in the Treasury from the fees imposed on health insurance and self-insured plans under new Code sections 4375, 4376 and 4377 for such fiscal year, and (2) amounts determined by the Secretary of Health and Human Services to be equivalent to the fair share per capita amount for the fiscal year multiplied by the average number of individuals entitled to benefits under Medicare part A, or enrolled under Medicare part B, for such fiscal year. The amount transferred under (2) is limited to $90,000,000. Net revenues means the amount, as estimated by the Secretary of the Treasury, equaling the excess of the fees received in the Treasury on account of the new fee on health insurance and self-insured plans under Code sections 4375, 4376 and 4377, over the decrease in tax imposed by chapter one of the Code relating to the fees imposed by such sections.

The amounts appropriated for fiscal years 2008 through 2010, as well as the amounts transferred under (2), above, are to be transferred from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund, and from the Medicare Prescription Drug Account within such Trust Fund, in proportion to the total expenditures during such year that are made under Medicare for the respective trust fund or account.

The fair share per capita amount is an amount computed by the Secretary of Health and Human Services for such fiscal year that will result in revenues to the CERTF of $375,000,000 for the fiscal year. If the Secretary is unable to compute the fair share per capita

amount for a fiscal year, a default amount is used. The default amount is $2 for fiscal year 2011. For a subsequent year, the default amount is equal to the default amount for the preceding fiscal year increased by the annual percentage increase in the medical care component of the consumer price index for the 12-month period ending with April of the preceding fiscal year. Beginning not later than December 31, 2009, the Secretary of Health and Human Services must submit to Congress an annual recommendation for a fair share per capita amount for purposes of funding the CERTF.

At least the following amounts in the CERTF must be available to carry out the activities of the Comparative Effectiveness Research Commission established under the bill: $7,000,000 for fiscal year 2008; $9,000,000 for fiscal year 2009; and $10,000,000 for each fiscal year beginning with 2010.

Financing CERTF from fees on health plans

As discussed above, the CERTF is funded in part from fees imposed on health plans under new Code sections 4375 through 4377.

Under the provision, a fee is imposed on each specified health insurance policy equal to the fair share per capita amount multiplied by the average number of lives covered under the policy. The issuer of the policy is liable for payment of the fee. A specified health insurance policy includes any accident or health insurance policy issued with respect to individuals residing in the United States.[1] A specified health insurance policy does not include insurance if substantially all of the coverage provided under such policy relates to liabilities under workers' compensation laws, tort liabilities, liabilities relating to ownership or use of property, credit insurance, Medicare supplemental coverage, or other similar liabilities as the Secretary of Treasury may specify by regulations.

An arrangement under which fixed payments of premiums are received as consideration for a person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided, is treated as a specified health insurance policy. The person agreeing to provide or arrange for the provision of coverage is treated as the issuer.

In the case of an applicable self-insured health plan, a fee is imposed equal to the fair share per capita amount multiplied by the average number of lives covered under the plan. The plan sponsor is liable for payment of the fee. For purposes of the provision, the plan sponsor is: the employer in the case of a plan established or maintained by a single employer or the employee organization in the case of a plan established or maintained by an employee organization. In the case of (1) a plan established or maintained by two or more employers or jointly by one of more employers and one or more employee organizations, (2) a multiple employer welfare arrangement, or (3) a voluntary employees' beneficiary association described in Code section 501(c)(9), the plan sponsor is the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

[1] Under the provision, the United States includes any possession of the United States.

In the case of a rural electric cooperative or a rural telephone cooperative, the plan sponsor is the cooperative or association.

Under the provision, an applicable self-insured health plan is any plan providing accident or health coverage if any portion of such coverage is provided other than through an insurance policy if such plan is established or maintained (1) by one or more employers for the benefit of their employees or former employees, (2) by one or more employee organizations for the benefit of their members or former members, (3) jointly by one or more employers and one or more employee organizations for the benefit of employees or former employees, (4) by a voluntary employees' beneficiary association described in section 501(c)(9) of the Code, (5) by any organization described in section 501(c)(6) of the Code, or (6) in the case of a plan not previously described, by a multiple employer welfare arrangement (as defined in section 3(40) of the Employee Retirement Income Security Act of 1974 ("ERISA")), a rural electric cooperative (as defined in section 3(40) of ERISA), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of ERISA).

Governmental entities are not exempt from the fees imposed under the provision except in the case of certain exempt governmental programs. Exempt governmental programs include Medicare, Medicaid, SCHIP, and any program established by Federal law for proving medical care (other than through insurance policies) to members of the Armed Forces, veterans, or members of Indian tribes.

No amount collected from the fee on health insurance and self-insurance plans shall be covered over to any possession of the United States.

For purposes of the procedure and administration rules under the Code, the fee imposed under the provision is treated as a tax.

Effective date

The fee on health insurance and self-insured plans is effective with respect to policies and plans for portions of policy or plan years beginning on or after October 1, 2010.

Reason for change

Comparative clinical effectiveness means comparing the relative value of different clinical services, including prescription drugs, devices, tests, procedures and other items or services. All too often physicians and patients struggle to understand when a new drug, diagnostic test or surgical procedure will be most helpful, or how to choose among existing courses of treatment. This lack of clear information can create great confusion when it comes to difficult medical decisions. Various researchers find dramatic variation in the use of medical services across regions, providers and specialties, and those areas with the highest use of services don't show higher quality or better outcomes. Health policy experts across the political spectrum advocate that comparative information is a sorely needed public good and that greater investment in comparative effectiveness research is critical to assuring high-quality care and reducing unnecessary expenditures. Better information about the relative strengths and weaknesses of various products, procedures

and services will help physicians and patients make wise decisions and will help public and private payors equitably manage rising health care costs. Many other countries have already made major investments to provide this information to physicians, patients, and policy makers.

The legislation establishes a Center at the Agency for Healthcare Research and Quality to manage the conduct of the research (using infrastructure and expertise already in place), but establishes an independent Commission to be responsible for the most politically charged elements of a public effort to provide information on comparative clinical effectiveness. These are setting national research priorities, identifying clinically relevant research questions, setting standards for evidence of comparative effectiveness, and public reporting of recommendations based on comparative effectiveness research. In order to provide a consistent stream of public and private funding for comparative effectiveness research through a mechanism insulated from outside influence, the legislation will support the activities of both the Center and the Commission through the Comparative Effectiveness Research Trust Fund. This fund is derived by fees charged to all those payers who will benefit from the efficiencies gained by comparative effectiveness research, Medicare and all forms of private health insurance.

SECTION 905. IMPLEMENTATION OF HEALTH INFORMATION TECHNOLOGY (IT) UNDER MEDICARE

Current law

While the quality, safety, and efficiency benefits of the widespread adoption of health information technology (HIT) systems have been lauded by many, there are currently no requirements for the implementation of a system that meets a common set of criteria under the Medicare program, particularly in physicians' offices. However, a few initiatives do address the adoption of HIT among providers in the Medicare program. The Physician Quality Reporting Initiative, implemented as part of the Tax Relief and Health Care Act of 2006, includes structural quality measures addressing the adoption of health information technology systems, and CMS has a few demonstration projects in place to examine the impact of HIT on providers and beneficiaries. These include the Doctor's Office Quality—Information Technology project and the Vista-Office Electronic Health Record project.

The Doctor's Office Quality—Information Technology (DOQ–IT) project is working to support the adoption and effective use of information technology by physicians' office to improve quality and safety for Medicare beneficiaries by providing assistance to physician offices in adopting and using health information technology. The goals of the current phase of the VistA-Office Electronic Health Record (VOE) Project are to: (1) test the VOE software and implementation process in selected physician offices that are supported by qualified vendors; (2) conduct a gap analysis between VOE Beta Version 1.0 and HHS interoperability standards; (3) produce an evaluation of VOE by an independent evaluator; and (4) demonstrate that the vendor support model works.

Explanation of provision

The provision would require the Secretary to submit a report to Congress by January 1, 2010, that would include a plan to develop and implement a health information technology (health IT) system for all health care providers under the Medicare program. This plan would meet the following specifications: (1) the system protects the privacy and security of individually identifiable health information; (2) the system maintains and provides permitted access to health information in an electronic format (such as through computerized patient records or a clinical data repository); (3) the system utilizes interface software that allows for interoperability; (4) the system includes clinical decision support; (5) the system incorporates e-prescribing and computerized physician order entry; (6) the system incorporates patient tracking and reminders; and (7) the system utilizes technology that is open source (if available) or technology that has been developed by the government. The report would include recommendations regarding the level of subsidies needed for all such health care providers to adopt the system. The Secretary's report to Congress would also include an analysis of the impact feasibility and cost associated with the use of health information technology in medically underserved communities.

Reason for change

The benefits of health information technology are widely recognized. Yet, adoption of health information technology has been stalled by various private stakeholders attempting to preserve their own interests. This provision will help break through the current stalemate.

SECTION 906. DEVELOPMENT, REPORTING, AND USE OF HEALTH CARE MEASURES

Current law

No provision.

Explanation of provision

The provision would foster efforts to develop, report, and use health care measures in the Medicare program. No earlier than January 1, 2008 and no later than September 30, 2008, the Secretary would designate, and have in effect an arrangement with, a single organization (such as the National Quality Forum) that would provide the Secretary with advice on, and recommendations with respect to, the key elements and priorities of a national system for establishing health care measures.

The designated organization's duties would include: (1) establishing and managing an integrated national strategy and process for setting priorities and goals in establishing health care measures; (2) coordinating the development and specifications of such measures; (3) establishing standards for the development and testing of such measures; (4) endorsing national consensus health care measures; and (5) advancing the use of electronic health records for automating the collection, aggregation, and transmission of measurement information.

The designated organization must be a private non-profit entity governed by a board with an individual designated as president and chief executive officer. The members of the board of the organization would include representatives of: (1) providers or groups representing providers; (2) health plans or groups representing health plans; (3) groups representing consumers; (4) purchasers and employers or groups representing purchasers or employers; and (5) practitioners or groups representing practitioners. In addition, the membership of the entity must be representative of individuals with experience with urban health care issues, safety net health care issues, rural and frontier health care issues, and quality and safety issues.

The organization must conduct its business in an open and transparent manner and provide the opportunity for public comment with respect to matters related to the arrangement with the Secretary as described above. The organization would operate as a voluntary consensus standards setting organization and must have at least seven years experience in establishing national consensus standards.

The health care measures developed through this process would have to comply with a number of requirements. The designated organization would ensure that the measures established or endorsed in fulfillment of the organizations duties are evidence-based, reliable, and valid and include: (1) measures of clinical processes and outcomes, patient experience, efficiency, and equity; (2) measures to assess effectiveness, timeliness, patient self-management, patient centeredness, and safety; and (3) measures of under use and over use. In carrying out its duties under this title, the designated organization would ensure that priority is given to: (i) measures with the greatest potential impact for improving the effectiveness and efficiency of care; (ii) measures that may be rapidly implemented by group health plans, health insurance issuers, physicians, hospitals, nursing homes, long-term care providers, and other providers; (iii) measures which may inform health care decisions made by consumers and patients; and (iv) measures that apply to multiple services furnished by different providers during an episode of care.

The designated organization would issue a report by March 31 of each year (beginning with 2009) on the organization's recommendations for priorities and goals in establishing health care measures over the next five years. After receipt of the report the Secretary would publish the report in the Federal Register, including any comments of the Secretary on the priorities and goals set forth in the report.

The health care measures would be risk adjusted. The designated organization, in consultation with health care measure developers and other stakeholders, would establish procedures to assure that health care measures established and endorsed by the designated organization account for differences in patient health status, patient characteristics, and geographic location, as appropriate.

The designated organization would be required to revise and update the health care measures regularly. In consultation with the owners and developers of the health care measures, the designated organization would require the owners or developers of the health

care measures to update and enhance the measures, including developing more accurate and precise specifications, and retiring existing outdated measures. This updating would occur no more often than once during each 12-month period, except in the case of emergent circumstances requiring a more immediate update to a measure.

For purposes of activities authorized or required by this title, the Secretary would select from health care measures that are both recommended by multi-stakeholder groups and endorsed by the designated organization. The Secretary would implement procedures, consistent with generally accepted standards, to enable the Department of Health and Human Services to accept the electronic submission of data for the purpose of allowing for health care measurement using the health care measures developed pursuant to this section, and for reporting to the Secretary measures used to make value-based payments under this title.

The Secretary, acting through the Agency for Healthcare Research and Quality, would be able to contract with organizations to support the development and testing of health care measures meeting the standards established by the designated organization.

In order to make information on health care measures available to health care consumers, health professionals, public health officials, oversight organizations, researchers, and other appropriate individuals and entities, the Secretary would work with multi-stakeholder groups to provide for the dissemination of information on measurements developed pursuant to this title.

Funding for the activities specified in this provision, including for expenses incurred for the arrangement with the designated organization, would come from both the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (Medicare Part A and Part B trust funds) in the amount of $15 million for fiscal year 2008, pro-rated to reflect the portion of the year the designated organization is performing the duties described above, and $15 million for fiscal years 2009 through 2012.

Reason for change

The Medicare program has already introduced a variety or provider quality measures in recent years. Due to other provisions in this legislation, health information technology will improve, and information on the effectiveness and appropriateness of specific clinical services will increase. Accordingly there will be greater opportunities to implement valid, reliable, policy-relevant measures of provider performance. Presently there is no publicly sanctioned or supported arbiter of quality and performance measures in health care. This legislation will address this deficiency in the Medicare program.

SECTION 907. IMPROVEMENTS TO THE MEDIGAP PROGRAM

Current law

Most individuals have some coverage in addition to basic Medicare benefits. Some persons have private supplementary coverage obtained through an individually purchased policy, commonly referred to as a "Medigap" policy. Beneficiaries with Medigap insur-

ance typically have coverage for Medicare's deductibles and coinsurance; they may also have coverage for some items and services not covered by Medicare. Individuals generally select from one of 10 standardized plans, though not all 10 plans are offered in all states. The 10 plans are known as Plan A through Plan J. Issuers are required to offer at least the core package. The law incorporates by reference, as part of the statutory requirements, certain minimum standards established by the National Association of Insurance Commissioners (NAIC) and provides for modification where appropriate to reflect program changes. These minimum standards, known as the NAIC Model standards, are found in the NAIC Model Regulation; they are incorporated into Federal Regulations.

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA, P.L. 108–73) added two new standardized plan types, Plan K and Plan L. There are two key differences between the benefits included under these options and those offered under Plans A–H. First, Plans K and L eliminate first-dollar coverage for most Medicare cost-sharing. Second, both Plans K and L include an annual out-of-pocket limit on Medicare cost-sharing charges.

Explanation of provision

The provision would provide for the Secretary to implement changes in the NAIC model law and regulations recommended by the NAIC in its Model #651 ("Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act") on March 11, 2007. The provision would eliminate benefit packages "K" and "L," and the recommendation would be treated as having been adopted by the NAIC as of January 1, 2008.

The provision would require issuers of Medigap policies to offer, in addition to the core package, at least policies classified as "C" or "F." This change shall apply to Medicare supplemental policies issued on or after January 1, 2008.

Reason for change

The National Association of Insurance Commissioners Senior Issues Task Force has recommended changes to the Model law and regulations for Medigap policies. These changes are necessary in order to: (1) eliminate unnecessary and duplicative plans; (2) update the basic package that has not been modified since 1990; and (3) create new options with higher cost sharing and lower premiums. Adopting these changes will restore simplicity and provide more choices for Medicare beneficiaries. These amendments were developed in conjunction with and are supported by consumer groups, CMS, and industry representatives.

In addition to implementing the changes recommended by NAIC, CHAMP makes two additional changes to Medigap: (1) Requiring plans to offer the two most popular policies known as C and F to preserve beneficiary choice of plans; (2) Eliminating the statutorily required plans. These plans were enacted in the MMA to impose higher cost sharing. These are the only plans that are specifically written into the statute. Because they are written into the statute, they must be included in the NAIC model. Keeping these plans in

the statute restricts the NAIC's ability to make adjustments to reflect changes in Medicare and in the market. Further, since the revised NAIC model includes two new plans with additional cost sharing, the plans enacted in the MMA are unnecessary.

SECTION 908. IMPLEMENTATION FUNDING

Current law

Appropriated funds are generally used to administer and monitor the Medicare program. Administration funds can also be obtained through Medicare user fees or from direct transfers from the Medicare trust funds.

Explanation of provision

This provision requires the Secretary of Health and Human Service to transfer $40,000,000 from the Federal Supplementary Medical Insurance Trust Fund to CMS for purposes of administering the provisions of all the titles in the bill except Title X referring to revenues.

Reason for change

Implementing the myriad changes in this act will require a substantial investment in administrative funding for CMS. The Committee believes that more than $40,000,000 will be necessary to meet the goals set out in this act, and will work to increase the amount of implementation funding available to CMS.

TITLE X—REVENUES

A. Increase Excise Tax Rates on Tobacco Products and Cigarette Papers and Tubes

(Sec. 1001 of the bill and sec. 5701 of the Code)

PRESENT LAW

Rates of excise tax on tobacco products and cigarette papers and tubes

Tobacco products and cigarette papers and tubes manufactured in the United States or imported into the United States are subject to Federal excise tax at the following rates:[2]

- Cigarettes weighing not more than three pounds per thousand ("small cigarettes") are taxed at the rate of $19.50 per thousand ($0.39 per pack);
- Cigarettes weighing more than three pounds per thousand ("large cigarettes") are taxed at the rate of $40.95 per thousand, except that, if they measure more than six and one-half inches in length, they are taxed at the rate applicable to small cigarettes, counting each two and three-quarter inches (or fraction thereof) of the length of each as one cigarette;
- Cigars weighing not more than three pounds per thousand ("small cigars") are taxed at the rate of $1.828 per thousand;

[2] Sec. 5701. Except where otherwise stated, all section references are to the Internal Revenue Code of 1986, as amended (the "Code").

- Cigars weighing more than three pounds per thousand ("large cigars") are taxed at the rate equal to 20.719 percent of the manufacturer's or importer's sales price but not more than $48.75 per thousand;
- Cigarette papers are taxed at the rate of $0.0122 for each 50 papers or fractional part thereof, except that, if they measure more than six and one-half inches in length, they are taxable by counting each two and three-quarter inches (or fraction thereof) of the length of each as one cigarette paper;
- Cigarette tubes are taxed at the rate of $0.0244 for each 50 tubes or fractional part thereof, except that, if they measure more than six and one-half inches in length, they are taxable by counting each two and three-quarter inches (or fraction thereof) of the length of each as one cigarette tube;
- Snuff is taxed at the rate of $0.585 per pound, and proportionately at that rate on all fractional parts of a pound;
- Chewing tobacco is taxed at the rate of $0.195 per pound, and proportionately at that rate on all fractional parts of a pound;
- Pipe tobacco is taxed at the rate of $1.0969 per pound, and proportionately at that rate on all fractional parts of a pound; and
- Roll-your-own tobacco is taxed at the rate of $1.0969 per pound, and proportionately at that rate on all fractional parts of a pound.

Floor stocks tax and foreign trade zones

The Balanced Budget Act of 1997 increased excise taxes on tobacco products and cigarette papers and tubes.[3] That provision also imposed a tax ("floor stocks tax") on cigarettes removed before the effective date of the tax increase and held on that date for sale by any person. The amount of the floor stocks tax was the excess of the amount of tax on such items at the increased rate over the amount of tax at the old rate. Each person was allowed a $500 credit against the floor stocks tax.

Special tax and duty rules apply with respect to foreign trade zones. In general, merchandise may be brought into a foreign trade zone without being subject to the general customs laws of the United States. Such merchandise may be stored in a foreign trade zone or may be subjected to manufacturing or other processes there. The United States Customs and Border Protection agency of the Department of Homeland Security ("Customs") may determine internal revenue taxes and liquidate duties imposed on foreign merchandise in such foreign trade zones. Articles on which such taxes and applicable duties have already been paid, or which have been admitted into the United States free of tax, that have been taken into a foreign trade zone from inside the United States, may be held under the supervision of a customs officer. Such articles may later be released back into the United States free of further taxes and duties.[4]

[3] Pub. L. No. 105–33, sec. 9302 (1997).
[4] 19 U.S.C. sec. 81c(a).

Reasons for change

When Congress created CHIP in 1997, it was funded with increases in Federal excise taxes on tobacco products and cigarette papers and tubes. The Committee believes that it is appropriate to continue that funding source in reauthorizing CHIP. The well-documented health problems caused by the use of tobacco products place a significant burden on the health care system. Increasing the excise taxes on tobacco products will discourage the use of such products, particularly for children.

The Committee believes that the tax increases should, in general, be proportionate across the range of tobacco products and cigarette papers and tubes. The Committee believes, however, that in the interest of equity, small cigars and roll-your-own tobacco products, both of which are close substitutes for small cigarettes, should be taxed at a rate equivalent to that of small cigarettes. In addition, the Committee has determined that the present-law tax cap of $48.75 per thousand on large cigars is too low and results in large cigars being taxed at a much lower rate than other tobacco products, relative to their value and the amount of tobacco contained. The Committee believes that, in proportionately raising the tax rate on large cigars, it is appropriate to increase the cap on large cigars.

EXPLANATION OF PROVISION

Rate increases

Under the provision, the rates of excise tax on tobacco products and cigarette papers and tubes are increased, generally in a proportionate manner. The special rules under present law relating to large cigarettes and cigarette papers and tubes longer than six and one-half inches remain the same. The rates under the provision are as follows:

- Small cigarettes are taxed at the rate of $42.00 per thousand ($0.84 per pack);
- Large cigarettes are taxed at the rate of $88.20 per thousand;
- Small cigars are taxed at the rate of $42.00 per thousand (the same rate applied to small cigarettes);
- Large cigars are taxed at the rate equal to 44.63 percent of the manufacturer's or importer's sales price but not more than $1.00 per cigar;
- Cigarette papers are taxed at the rate of $0.0263 for each 50 papers or fractional part thereof;
- Cigarette tubes are taxed at the rate of $0.0526 for each 50 tubes or fractional part thereof;
- Snuff is taxed at the rate of $1.26 per pound, and proportionately at that rate on all fractional parts of a pound;
- Chewing tobacco is taxed at the rate of $0.42 per pound, and proportionately at that rate on all fractional parts of a pound;
- Pipe tobacco is taxed at the rate of $2.36 per pound, and proportionately at that rate on all fractional parts of a pound; and

- Roll-your-own tobacco is taxed at the rate of $7.4667 per pound, and proportionately at that rate on all fractional parts of a pound. The rate for roll-your-own tobacco is intended to approximate the rate for small cigarettes.

Floor stocks tax and foreign trade zone treatment

The provision also imposes a tax on floor stocks of cigarettes. Cigarettes manufactured in the United States or imported into the United States which are removed before January 1, 2008 and held on that date for sale by any person are subject to a floor stocks tax. The floor stocks tax is equal to the excess of the applicable tax under the new rates over the applicable tax at the present-law rates. The person holding cigarettes on January 1, 2008 to which the floor stocks tax applies is liable for the tax. Such person is allowed a $500 credit against the floor stocks tax. In addition, to the extent provided in regulations, no floor stocks tax is to be imposed on cigarettes held for retail sale on January 1, 2008 in a vending machine by any person. The Secretary may reduce a person's general $500 credit by the amount of vending machine cigarette taxes exempted for that person.

Notwithstanding any other provision of law, the floor stocks tax applies to an article located in a foreign trade zone on January 1, 2008, provided that internal revenue taxes have been determined, or customs duties have been liquidated, with respect to such article before such date, or such article is held on a tax-and-duty-paid basis on such date under the supervision of a customs officer.

For purposes of determining the floor stocks tax, component members of a "controlled group" (as modified) are treated as one taxpayer.[5] "Controlled group" for these purposes means a parent-subsidiary, brother-sister, or combined corporate group with more than 50-percent ownership with respect to either combined voting power or total value. Under regulations, similar principles may apply to a group of persons under common control where one or more persons are not a corporation.

The provision provides that the floor stocks tax shall be paid on or before April 14, 2008, in the manner prescribed by Treasury regulations. In general, all of the rules, including penalties, applicable with respect to taxes on tobacco products and cigarette papers and tubes apply to the floor stocks tax. The person who bore the ultimate burden of the floor stocks tax may be treated as the person entitled to a credit of refund of such tax.

EFFECTIVE DATE

The provision applies to articles removed after December 31, 2007.

B. Modify Definition of Roll-Your-Own Tobacco

(Sec. 1001 of the bill and sec. 5702 of the Code)

[5] Controlled group is defined in section 1563.

PRESENT LAW

Federal excise taxes are imposed upon tobacco products and cigarette papers and tubes.[6] Tobacco products are cigars, cigarettes, snuff, chewing tobacco, pipe tobacco, and roll-your-own tobacco. A "cigar" is any roll of tobacco wrapped in leaf tobacco or in any substance containing tobacco, other than any roll of tobacco which is a cigarette. A "cigarette" is (i) any roll of tobacco wrapped in paper or in any substance not containing tobacco; and (ii) any roll of tobacco wrapped in any substance containing tobacco which, because of its appearance, the type of tobacco used in the filler, or its packaging and labeling, is likely to be offered to, or purchased by, consumers as a cigarette. "Roll-your-own tobacco" is any tobacco, which because of its appearance, type, packaging, or labeling, is suitable for use and likely to be offered to, or purchased by, consumers as tobacco for making cigarettes. "Cigarette paper" is paper, or any other material except tobacco, prepared for use as a cigarette wrapper. A "cigarette tube" is cigarette paper made into a hollow cylinder for use in making cigarettes.[7]

Wrappers containing tobacco are not within the definition of cigarette papers or tubes because they contain tobacco. They are also not generally within the definition of roll-your-own tobacco because they are usually used to make cigars, not cigarettes. For the same reason, loose tobacco suitable for making roll-your-own cigars is not considered to be roll-your-own tobacco.

REASONS FOR CHANGE

The Committee understands that wrappers containing tobacco may be escaping taxation because such wrappers contain tobacco and are used to make cigars rather than cigarettes. Otherwise, such wrappers would be considered cigarette papers, cigarette tubes, or roll-your-own tobacco. The Committee further understands that loose tobacco used to make roll-your-own cigars may be escaping taxation because such tobacco is not used to make cigarettes. The Committee believes that these products are in the nature of tobacco products and should, therefore, be classified as roll-your-own tobacco in light of the equalized tax treatment of small cigarettes, small cigars, and roll-your-own tobacco.

EXPLANATION OF PROVISION

Under the provision, roll-your-own tobacco also includes any tobacco, which because of its appearance, type, packaging, or labeling, is suitable for use and likely to be offered to, or purchased by, consumers as tobacco for making cigars, or for use as wrappers for making cigars.

EFFECTIVE DATE

The provision applies to articles removed after December 31, 2007.

[6] Sec. 5701.
[7] Sec. 5702.

C. Exemption From Fuel Excise Tax for Use in Ambulances

(Sec. 1002 of the bill and secs. 4041 and 6427 of the Code)

PRESENT LAW

In general, Federal excise tax is imposed upon the removal of taxable fuel from a terminal or refinery, the entry of taxable fuel into the United States, and the sale of taxable fuel to, or use of taxable fuel by, any person unless tax was previously imposed.[8] Certain uses of fuel are exempt from tax. For example, fuel sold to a State or local government for the exclusive use of a State or local government is exempt. For another example, liquids sold for use in, or used in, helicopters or fixed wing aircraft for purposes of providing transportation for emergency medical services are exempt.[9] The ultimate purchaser of fuel used for such exempt purposes is entitled to a payment without interest from the Secretary equal to the aggregate amount of the tax imposed on such fuel.[10] A claim for such payment must ordinarily be filed on an annual basis; however, a claim may be filed as often as quarterly if at the close of any quarter of the taxable year of a claimant, the aggregate amount of tax owing to the claimant with respect to fuel is at least $750.[11]

REASONS FOR CHANGE

The Committee recognizes that fuel used in ambulances owned by a State or local government is exempt from Federal excise tax, and that fuel used in privately-owned aircraft for purposes of providing transportation for emergency medical services is exempt (subject to further restrictions in the case of fixed-wing aircraft). The Committee believes that it is appropriate to provide a similar exemption for fuel used in privately-owned ambulances for purposes of providing emergency medical services.

EXPLANATION OF PROVISION

Under the provision, any liquid sold for use in, or used in, any ambulance for purposes of providing transportation for emergency medical services is exempt from Federal excise tax. The ultimate purchaser of fuel used for such exempt purpose is entitled to a payment without interest from the Secretary equal to the aggregate amount of the tax imposed on such fuel. A claim for such payment must ordinarily be filed on an annual basis; however, a claim may be filed as often as quarterly if at the close of any quarter of the taxable year of a claimant, the aggregate amount of tax owing to the claimant with respect to fuel is at least $750.

The provision does not apply to any liquid used after December 31, 2012.

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[8] Secs. 4041(a)(1) and 4081(a)(1).

[9] Secs. 4041(l) and 4261(g). Fixed-wing aircraft must be equipped for and fully dedicated on that flight to acute care emergency medical services.

[10] Sec. 6427(d).

[11] Sec. 6427(i).

EFFECTIVE DATE

The provision applies to fuel used in transportation provided in calendar quarters beginning after the date of enactment.

III. VOTES OF THE COMMITTEE

In compliance with clause 3(b) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning votes of the Committee on Ways and Means in consideration of the bill, H.R. 3162, the "Children's Health and Medicare Protection Act of 2007."

The bill, H.R. 3162, as amended, was favorably reported by a roll call vote of 24 yeas to 17 nays (with a quorum being present). The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. RANGEL.....	x			Mr. MCCRERY.....		x	
Mr. STARK.....	x			Mr. HERGER.....		x	
Mr. LEVIN.....	x			Mr. CAMP.....		x	
Mr. MCDERMOTT...	x			Mr. RAMSTAD.....		x	
Mr. LEWIS (GA)...	x			Mr. JOHNSON.....		x	
Mr. NEAL.....	x			Mr. ENGLISH.....		x	
Mr. MCNULTY.....	x			Mr. WELLER.....		x	
Mr. TANNER.....	x			Mr. HULSHOF.....		x	
Mr. BECERRA.....	x			Mr. LEWIS (KY)...		x	
Mr. DOGGETT.....	x			Mr. BRADY.....		x	
Mr. POMEROY.....	x			Mr. REYNOLDS....		x	
Ms. TUBBS JONES...	x			Mr. RYAN.....		x	
Mr. THOMPSON.....	x			Mr. CANTOR.....		x	
Mr. LARSON.....	x			Mr. LINDER.....		x	
Mr. EMANUEL.....	x			Mr. NUNES.....		x	
Mr. BLUMENAUER.	x			Mr. TIBERI.....		x	
Mr. KIND.....	x			Mr. PORTER.....		x	
Mr. PASCRELL	x						
Ms. BERKLEY	x						
Mr. CROWLEY	x						
Mr. VAN HOLLEN	x						
Mr. MEEK	x						
Ms. SCHWARTZ	x						
Mr. DAVIS	x						

VOTES ON AMENDMENTS

A roll call vote was conducted on the following amendments. The votes were follows:

An amendment by Mr. Camp to strike section 421(b) (relating to employer plans) was defeated by a roll call vote of 17 yeas to 24 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. RANGEL.....		x		Mr. MCCRERY.....	x		
Mr. STARK.....		x		Mr. HERGER.....	x		
Mr. LEVIN.....		x		Mr. CAMP.....	x		
Mr. MCDERMOTT...		x		Mr. RAMSTAD.....	x		
Mr. LEWIS (GA)...		x		Mr. JOHNSON.....	x		
Mr. NEAL.....		x		Mr. ENGLISH.....	x		
Mr. MCNULTY.....		x		Mr. WELLER.....	x		
Mr. TANNER.....		x		Mr. HULSHOF.....	x		
Mr. BECERRA.....		x		Mr. LEWIS (KY)...	x		
Mr. DOGGETT.....		x		Mr. BRADY.....	x		
Mr. POMEROY.....		x		Mr. REYNOLDS....	x		
Ms. TUBBS JONES...		x		Mr. RYAN.....	x		
Mr. THOMPSON.....		x		Mr. CANTOR.....	x		
Mr. LARSON.....		x		Mr. LINDER.....	x		
Mr. EMANUEL.....		x		Mr. NUNES.....	x		
Mr. BLUMENAUER.		x		Mr. TIBERI.....	x		
Mr. KIND.....		x		Mr. PORTER.....	x		
Mr. PASCRELL		x					
Ms. BERKLEY		x					
Mr. CROWLEY		x					
Mr. VAN HOLLEN		x					
Mr. MEEK		x					
Ms. SCHWARTZ		x					
Mr. DAVIS		x					

An amendment by Mr. English giving the Secretary of Health and Human Services the authority to adjust individual county benchmarks to ensure that at least one Medicare Advantage plan is serving that particular county was defeated by a roll call vote of 17 yeas to 24 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. RANGEL.....		x		Mr. MCCRERY.....	x		
Mr. STARK.....		x		Mr. HERGER.....	x		
Mr. LEVIN.....		x		Mr. CAMP.....	x		
Mr. MCDERMOTT...		x		Mr. RAMSTAD.....	x		
Mr. LEWIS (GA)...		x		Mr. JOHNSON.....	x		
Mr. NEAL.....		x		Mr. ENGLISH.....	x		
Mr. MCNULTY.....		x		Mr. WELLER.....	x		
Mr. TANNER.....		x		Mr. HULSHOF.....	x		
Mr. BECERRA.....		x		Mr. LEWIS (KY)...	x		
Mr. DOGGETT.....		x		Mr. BRADY.....	x		
Mr. POMEROY.....		x		Mr. REYNOLDS....	x		
Ms. TUBBS JONES...		x		Mr. RYAN.....	x		
Mr. THOMPSON.....		x		Mr. CANTOR.....	x		
Mr. LARSON.....		x		Mr. LINDER.....	x		
Mr. EMANUEL.....		x		Mr. NUNES.....	x		
Mr. BLUMENAUER.		x		Mr. TIBERI.....	x		
Mr. KIND.....		x		Mr. PORTER.....	x		
Mr. PASCRELL		x					
Ms. BERKLEY		x					
Mr. CROWLEY		x					
Mr. VAN HOLLEN		x					
Mr. MEEK		x					
Ms. SCHWARTZ		x					
Mr. DAVIS		x					

An amendment by Mr. Weller to strike section 701 (relating to home health payments) was defeated by a roll call vote of 17 yeas to 24 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. RANGEL.....		x		Mr. MCCRERY.....	x		
Mr. STARK.....		x		Mr. HERGER.....	x		
Mr. LEVIN.....		x		Mr. CAMP.....	x		
Mr. MCDERMOTT...		x		Mr. RAMSTAD.....	x		
Mr. LEWIS (GA)...		x		Mr. JOHNSON.....	x		
Mr. NEAL.....		x		Mr. ENGLISH.....	x		
Mr. MCNULTY.....		x		Mr. WELLER.....	x		
Mr. TANNER.....		x		Mr. HULSHOF.....	x		
Mr. BECERRA.....		x		Mr. LEWIS (KY)...	x		
Mr. DOGGETT.....		x		Mr. BRADY.....	x		
Mr. POMEROY.....		x		Mr. REYNOLDS....	x		
Ms. TUBBS JONES...		x		Mr. RYAN.....	x		
Mr. THOMPSON.....		x		Mr. CANTOR.....	x		
Mr. LARSON.....		x		Mr. LINDER.....	x		
Mr. EMANUEL.....		x		Mr. NUNES.....	x		
Mr. BLUMENAUER.		x		Mr. TIBERI.....	x		
Mr. KIND.....		x		Mr. PORTER.....	x		
Mr. PASCRELL		x					
Ms. BERKLEY		x					
Mr. CROWLEY		x					
Mr. VAN HOLLEN		x					
Mr. MEEK		x					
Ms. SCHWARTZ		x					
Mr. DAVIS		x					

An amendment by Mr. Lewis of Kentucky to strike section 1001 was defeated by a roll call vote of 16 yeas to 24 nays, with one Member voting present. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. RANGEL.....		x		Mr. MCCRERY.....	x		
Mr. STARK.....		x		Mr. HERGER.....	x		
Mr. LEVIN.....		x		Mr. CAMP.....	x		
Mr. MCDERMOTT...		x		Mr. RAMSTAD.....		x	
Mr. LEWIS (GA)...		x		Mr. JOHNSON.....	x		
Mr. NEAL.....		x		Mr. ENGLISH.....	x		
Mr. MCNULTY.....		x		Mr. WELLER.....	x		
Mr. TANNER.....			x	Mr. HULSHOF.....	x		
Mr. BECERRA.....		x		Mr. LEWIS (KY)...	x		
Mr. DOGGETT.....		x		Mr. BRADY.....	x		
Mr. POMEROY.....		x		Mr. REYNOLDS....	x		
Ms. TUBBS JONES...		x		Mr. RYAN.....	x		
Mr. THOMPSON.....		x		Mr. CANTOR.....	x		
Mr. LARSON.....		x		Mr. LINDER.....	x		
Mr. EMANUEL.....		x		Mr. NUNES.....	x		
Mr. BLUMENAUER.		x		Mr. TIBERI.....	x		
Mr. KIND.....		x		Mr. PORTER.....	x		
Mr. PASCRELL		x					
Ms. BERKLEY		x					
Mr. CROWLEY		x					
Mr. VAN HOLLEN		x					
Mr. MEEK		x					
Ms. SCHWARTZ		x					
Mr. DAVIS		x					

An amendment by Mr. Brady to strike section 501 (relating to the inpatient hospital payment updates) was defeated by a roll call vote of 16 yeas to 24 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. RANGEL…….		x		Mr. MCCRERY…...	x		
Mr. STARK……		x		Mr. HERGER……..	x		
Mr. LEVIN…….		x		Mr. CAMP……...	x		
Mr. MCDERMOTT…		x		Mr. RAMSTAD…...	x		
Mr. LEWIS (GA)…		x		Mr. JOHNSON…...	x		
Mr. NEAL……..		x		Mr. ENGLISH…….	x		
Mr. MCNULTY……		x		Mr. WELLER……..	x		
Mr. TANNER…….		x		Mr. HULSHOF……			
Mr. BECERRA……...		x		Mr. LEWIS (KY)…	x		
Mr. DOGGETT……..		x		Mr. BRADY……	x		
Mr. POMEROY…….		x		Mr. REYNOLDS….	x		
Ms. TUBBS JONES...		x		Mr. RYAN……...	x		
Mr. THOMPSON…...		x		Mr. CANTOR……..	x		
Mr. LARSON…….		x		Mr. LINDER……...	x		
Mr. EMANUEL……..		x		Mr. NUNES…….	x		
Mr. BLUMENAUER.		x		Mr. TIBERI…….	x		
Mr. KIND……...		x		Mr. PORTER……...	x		
Mr. PASCRELL		x					
Ms. BERKLEY		x					
Mr. CROWLEY		x					
Mr. VAN HOLLEN		x					
Mr. MEEK		x					
Ms. SCHWARTZ		x					
Mr. DAVIS		x					

An amendment by Mr. Reynolds to put in place for 2008 and 2009 a 5 % increase to the rates under the Medicare ambulance fee schedule was defeated by a roll call vote of 16 yeas to 24 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. RANGEL…….		x		Mr. MCCRERY…...	x		
Mr. STARK……		x		Mr. HERGER……..	x		
Mr. LEVIN…….		x		Mr. CAMP……...	x		
Mr. MCDERMOTT…		x		Mr. RAMSTAD…...	x		
Mr. LEWIS (GA)…		x		Mr. JOHNSON…...	x		
Mr. NEAL……..		x		Mr. ENGLISH…….	x		
Mr. MCNULTY……			x	Mr. WELLER……..	x		
Mr. TANNER…….		x		Mr. HULSHOF……	x		
Mr. BECERRA……...		x		Mr. LEWIS (KY)…	x		
Mr. DOGGETT……..		x		Mr. BRADY……	x		
Mr. POMEROY…….		x		Mr. REYNOLDS….	x		
Ms. TUBBS JONES...		x		Mr. RYAN……...	x		
Mr. THOMPSON…...		x		Mr. CANTOR……..	x		
Mr. LARSON…….		x		Mr. LINDER……...	x		
Mr. EMANUEL……..		x		Mr. NUNES…….	x		
Mr. BLUMENAUER.		x		Mr. TIBERI…….	x		
Mr. KIND……...		x		Mr. PORTER……...	x		
Mr. PASCRELL		x					
Ms. BERKLEY		x					
Mr. CROWLEY		x					
Mr. VAN HOLLEN		x					
Mr. MEEK		x					
Ms. SCHWARTZ		x					
Mr. DAVIS		x					

An amendment by Mr. Ryan to strike section 902 (repeal of trigger provision) was defeated by a roll call vote of 17 yeas to 24 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. RANGEL.....		x		Mr. MCCRERY.....	x		
Mr. STARK.....		x		Mr. HERGER.....	x		
Mr. LEVIN.....		x		Mr. CAMP.....	x		
Mr. MCDERMOTT...		x		Mr. RAMSTAD.....	x		
Mr. LEWIS (GA)...		x		Mr. JOHNSON.....	x		
Mr. NEAL.....		x		Mr. ENGLISH.....	x		
Mr. MCNULTY.....		x		Mr. WELLER.....	x		
Mr. TANNER.....		x		Mr. HULSHOF.....	x		
Mr. BECERRA.....		x		Mr. LEWIS (KY)...	x		
Mr. DOGGETT.....		x		Mr. BRADY.....	x		
Mr. POMEROY.....		x		Mr. REYNOLDS....	x		
Ms. TUBBS JONES...		x		Mr. RYAN.....	x		
Mr. THOMPSON.....		x		Mr. CANTOR.....	x		
Mr. LARSON.....		x		Mr. LINDER.....	x		
Mr. EMANUEL.....		x		Mr. NUNES.....	x		
Mr. BLUMENAUER.		x		Mr. TIBERI.....	x		
Mr. KIND.....		x		Mr. PORTER.....	x		
Mr. PASCRELL		x					
Ms. BERKLEY		x					
Mr. CROWLEY		x					
Mr. VAN HOLLEN		x					
Mr. MEEK		x					
Ms. SCHWARTZ		x					
Mr. DAVIS		x					

An amendment by Mr. Tiberi to insert at the end of section 401 the following: (f) Limitation On Implementation. – Notwithstanding subsection (a), the amendments made by such subsection shall not apply to a plan under part C of title XVIII of the Social Security Act if at least 50 percent of the Medicare beneficiaries enrolled in such plan are minorities or have applicable incomes below 200 percent of the poverty line, was defeated by a roll call vote of 17 yeas to 24 nays. The vote was as follows.

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. RANGEL.....		x		Mr. MCCRERY.....	x		
Mr. STARK.....		x		Mr. HERGER.....	x		
Mr. LEVIN.....		x		Mr. CAMP.....	x		
Mr. MCDERMOTT...		x		Mr. RAMSTAD.....	x		
Mr. LEWIS (GA)...		x		Mr. JOHNSON.....	x		
Mr. NEAL.....		x		Mr. ENGLISH.....	x		
Mr. MCNULTY.....		x		Mr. WELLER.....	x		
Mr. TANNER.....		x		Mr. HULSHOF.....	x		
Mr. BECERRA.....		x		Mr. LEWIS (KY)...	x		
Mr. DOGGETT.....		x		Mr. BRADY.....	x		
Mr. POMEROY.....		x		Mr. REYNOLDS....	x		
Ms. TUBBS JONES...		x		Mr. RYAN.....	x		
Mr. THOMPSON.....		x		Mr. CANTOR.....	x		
Mr. LARSON.....		x		Mr. LINDER.....	x		
Mr. EMANUEL.....		x		Mr. NUNES.....	x		
Mr. BLUMENAUER.		x		Mr. TIBERI.....	x		
Mr. KIND.....		x		Mr. PORTER.....	x		
Mr. PASCRELL		x					
Ms. BERKLEY		x					
Mr. CROWLEY		x					
Mr. VAN HOLLEN		x					
Mr. MEEK		x					
Ms. SCHWARTZ		x					
Mr. DAVIS		x					

An amendment by Mr. English to strike section 506 (relating to the skilled nursing facility update) was defeated by a roll call vote of 17 yeas to 24 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. RANGEL…….		x		Mr. MCCRERY…...	x		
Mr. STARK……		x		Mr. HERGER……..	x		
Mr. LEVIN…….		x		Mr. CAMP……...	x		
Mr. MCDERMOTT…		x		Mr. RAMSTAD…...	x		
Mr. LEWIS (GA)…		x		Mr. JOHNSON….....	x		
Mr. NEAL……..		x		Mr. ENGLISH…….	x		
Mr. MCNULTY……		x		Mr. WELLER……..	x		
Mr. TANNER…….		x		Mr. HULSHOF……	x		
Mr. BECERRA……...		x		Mr. LEWIS (KY)…	x		
Mr. DOGGETT……..		x		Mr. BRADY……	x		
Mr. POMEROY…….		x		Mr. REYNOLDS….	x		
Ms. TUBBS JONES...		x		Mr. RYAN……...	x		
Mr. THOMPSON…...		x		Mr. CANTOR……..	x		
Mr. LARSON…….		x		Mr. LINDER……...	x		
Mr. EMANUEL……..		x		Mr. NUNES…….	x		
Mr. BLUMENAUER.		x		Mr. TIBERI…….	x		
Mr. KIND……...		x		Mr. PORTER……...	x		
Mr. PASCRELL		x					
Ms. BERKLEY		x					
Mr. CROWLEY		x					
Mr. VAN HOLLEN		x					
Mr. MEEK		x					
Ms. SCHWARTZ		x					
Mr. DAVIS		x					

An amendment by Mr. Nunes to strike section 608 (relating to rental and purchase of power-driven wheelchairs) was defeated by a roll call vote of 17 yeas to 24 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. RANGEL.....		x		Mr. MCCRERY.....	x		
Mr. STARK.....		x		Mr. HERGER.....	x		
Mr. LEVIN.....		x		Mr. CAMP.....	x		
Mr. MCDERMOTT...		x		Mr. RAMSTAD.....	x		
Mr. LEWIS (GA)...		x		Mr. JOHNSON.....	x		
Mr. NEAL.....		x		Mr. ENGLISH.....	x		
Mr. MCNULTY.....		x		Mr. WELLER.....	x		
Mr. TANNER.....		x		Mr. HULSHOF.....	x		
Mr. BECERRA.....		x		Mr. LEWIS (KY)...	x		
Mr. DOGGETT.....		x		Mr. BRADY.....	x		
Mr. POMEROY.....		x		Mr. REYNOLDS....	x		
Ms. TUBBS JONES...		x		Mr. RYAN.....	x		
Mr. THOMPSON.....		x		Mr. CANTOR.....	x		
Mr. LARSON.....		x		Mr. LINDER.....	x		
Mr. EMANUEL.....		x		Mr. NUNES.....	x		
Mr. BLUMENAUER.		x		Mr. TIBERI.....	x		
Mr. KIND.....		x		Mr. PORTER.....	x		
Mr. PASCRELL		x					
Ms. BERKLEY		x					
Mr. CROWLEY		x					
Mr. VAN HOLLEN		x					
Mr. MEEK		x					
Ms. SCHWARTZ		x					
Mr. DAVIS		x					

An amendment by Mr. Tiberi to strike section 213(a) (relating to administrative verification of income and resources under the part D low-income subsidy program) was defeated by a roll call vote of 17 yeas to 24 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. RANGEL.....		x		Mr. MCCRERY.....	x		
Mr. STARK.....		x		Mr. HERGER.....	x		
Mr. LEVIN.....		x		Mr. CAMP.....	x		
Mr. MCDERMOTT...		x		Mr. RAMSTAD.....	x		
Mr. LEWIS (GA)...		x		Mr. JOHNSON.....	x		
Mr. NEAL.....		x		Mr. ENGLISH.....	x		
Mr. MCNULTY.....		x		Mr. WELLER.....	x		
Mr. TANNER.....		x		Mr. HULSHOF.....	x		
Mr. BECERRA.....		x		Mr. LEWIS (KY)...	x		
Mr. DOGGETT.....		x		Mr. BRADY.....	x		
Mr. POMEROY.....		x		Mr. REYNOLDS....	x		
Ms. TUBBS JONES...		x		Mr. RYAN.....	x		
Mr. THOMPSON.....		x		Mr. CANTOR.....	x		
Mr. LARSON.....		x		Mr. LINDER.....	x		
Mr. EMANUEL.....		x		Mr. NUNES.....	x		
Mr. BLUMENAUER.		x		Mr. TIBERI.....	x		
Mr. KIND.....		x		Mr. PORTER.....	x		
Mr. PASCRELL		x					
Ms. BERKLEY		x					
Mr. CROWLEY		x					
Mr. VAN HOLLEN		x					
Mr. MEEK		x					
Ms. SCHWARTZ		x					
Mr. DAVIS		x					

An amendment by Mr. English to prevent an increase in the beneficiary Part B premium due to any increase in Part B spending under this bill was defeated by a roll call vote of 15 yeas to 26 nays. The vote was as follows:

Representatives	Yea	Nay	Present	Representative	Yea	Nay	Present
Mr. RANGEL.....		x		Mr. MCCRERY.....		x	
Mr. STARK.....		x		Mr. HERGER.....	x		
Mr. LEVIN.....		x		Mr. CAMP.....	x		
Mr. MCDERMOTT...		x		Mr. RAMSTAD.....	x		
Mr. LEWIS (GA)...		x		Mr. JOHNSON.....	x		
Mr. NEAL.....		x		Mr. ENGLISH.....	x		
Mr. MCNULTY.....		x		Mr. WELLER.....	x		
Mr. TANNER.....		x		Mr. HULSHOF.....	x		
Mr. BECERRA.....		x		Mr. LEWIS (KY)...	x		
Mr. DOGGETT.....		x		Mr. BRADY.....	x		
Mr. POMEROY.....		x		Mr. REYNOLDS....	x		
Ms. TUBBS JONES...		x		Mr. RYAN.....	x		
Mr. THOMPSON.....		x		Mr. CANTOR.....	x		
Mr. LARSON.....		x		Mr. LINDER.....		x	
Mr. EMANUEL.....		x		Mr. NUNES.....	x		
Mr. BLUMENAUER.		x		Mr. TIBERI.....	x		
Mr. KIND.....		x		Mr. PORTER.....	x		
Mr. PASCRELL		x					
Ms. BERKLEY		x					
Mr. CROWLEY		x					
Mr. VAN HOLLEN		x					
Mr. MEEK		x					
Ms. SCHWARTZ		x					
Mr. DAVIS		x					

IV. BUDGET EFFECTS OF THE BILL

A. Committee Estimate of Budgetary Effects

In compliance with clause 3(d)(2) of rule XIII of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the bill, H.R. 3162 as reported.

The effects of the bill on Federal budget receipts are presented in the cost estimate provided by the Congressional Budget Office and the revenue table from the Joint Committee on Taxation (see below).

B. Statement Regarding New Budget Authority and Tax Expenditures Budget Authority

In compliance with clause 3(c)(2) of rule XIII of the Rules of the House of Representatives, requiring a statement regarding new budget authority and tax expenditures budget authority, CBO estimates that enacting this legislation would increase the federal direct spending by $27.5 billion over the 2008–2012 period and by $132.6 billion over the 2008–2017 period.

C. Cost Estimate Prepared by the Congressional Budget Office

In compliance with clause 3(c)(3) of rule XIII of the Rules of the House of Representatives, requiring a cost estimate prepared by the Congressional Budget Office, the following statement by CBO is provided. CBO and JCT estimate that net revenues would increase under the bill by $28.9 billion over the next five years and $59.7 billion over the 10-year period.

U.S. Congress,
Congressional Budget Office,
Washington, DC, July 30, 2007.

Hon. Charles B. Rangel,
Chairman, Committee on Ways and Means,
House of Representatives, Washington, DC.

Dear Mr. Chairman: The Congressional Budget Office (CBO) and the Joint Committee on Taxation (JCT) have prepared the attached estimate for the Children's Health and Medicare Protection Act of 2007, as ordered reported by the Committee on Ways and Means on July 27, 2007.

CBO estimates that enacting this legislation would increase federal direct spending by $27.5 billion over the 2008–2012 period and by $132.6 billion over the 2008–2017 period. CBO and JCT estimate that net revenues would increase under the bill by $28.9 billion over the next five years and $59.7 billion over the 10-year period. (A portion of that increase would be in off-budget revenues: $0.8 billion for the 2008–2012 period and $2.4 billion over the 2008–2017 period.)

On balance, the spending and revenue changes would reduce federal deficits by $1.4 billion through 2012, but would increase federal deficits by $72.9 billion for the 2008–2017 period. The two attached tables provide estimates of year-by-year changes and a sum-

mary of the estimated change in enrollment of children under the State Children's Health Insurance Program (SCHIP) and Medicaid.

CBO and JCT have reviewed the bill and determined that it contains no intergovernmental mandates as defined in the Unfunded Mandates Reform Act (UMRA). The bill would affect the way states administer SCHIP and Medicaid, but because of the flexibility in those programs, the new requirements would not be intergovernmental mandates as defined in UMRA.

In general, state, local, and tribal governments would benefit from the continuation of existing SCHIP grants, the creation of new grant programs, and broader flexibility and options in some programs.

The bill also would give state insurance commissioners the power to regulate the marketing and enrollment practices of agents and brokers relating to Medicare Advantage, private plans, and prescription drug plans. Under current law, states are preempted from enforcing such standards.

The bill contains several mandates on the private sector, including provisions that would increase the federal excise tax on tobacco products, extend the number of months that Medicare would be secondary payer for patients with end-stage renal disease, and place further restrictions on the types of plans that Medigap issuers could sell to Medicare beneficiaries. CBO and JCT estimate that the direct cost of these mandates would significantly exceed the statutory threshold established under UMRA ($131 million in 2007, adjusted annually for inflation) in each of the first five years that the mandates are in effect.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contacts are Eric Rollins, Jeanne De Sa, and Tom Bradley.

Sincerely,

PETER R. ORSZAG,
Director.

Enclosure.

Table 1. Estimated Effect on Direct Spending and Revenues of H.R. 3162, the Children's Health and Medicare Protection Act, as Ordered Reported by the House Committee on Ways and Means on July 27, 2007

by fiscal year, in billions of dollars

		2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-2012	2008-2017
TITLE I -- CHILDREN'S HEALTH INSURANCE PROGRAM														
Subtitle A -- Funding														
101	New formula for SCHIP allotments	0.0	1.9	3.1	4.7	5.7	6.6	7.7	9.1	10.4	11.9	13.5	21.9	74.5
	Effect on Medicaid spending of sections 101 and 111	0.0	-0.3	0.8	2.4	3.5	4.2	4.4	4.5	4.8	5.0	5.3	10.6	34.5
102	Shorten availability of funds to 2 years	the effects of this provision are incorporated in section 101												
103	Modify redistribution of unspent funds	the effects of this provision are incorporated in section 101												
104	Allow spending of additional funds on Medicaid children	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
	Subtotal	**0.0**	**1.6**	**3.8**	**7.1**	**9.2**	**10.8**	**12.1**	**13.7**	**15.2**	**16.9**	**18.8**	**32.5**	**109.1**
Subtitle B -- Improving Enrollment and Retention of Eligible Children														
111	Bonus payments for enrollment of additional children	0.0	0.0	1.3	2.4	3.2	3.9	4.2	4.5	4.9	5.3	5.7	10.8	35.4
112	Allow use of eligibility findings from other programs	the effects of this provision are incorporated in sections 101 and 111												
113	Outreach procedures for children and pregnant women	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
114	Increase the match rate for translation services	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.4
	Subtotal	**0.0**	**0.0**	**1.3**	**2.4**	**3.3**	**3.9**	**4.2**	**4.6**	**4.9**	**5.4**	**5.8**	**10.9**	**35.8**
Subtitle C -- Coverage														
121	Require coverage of certain additional services	0.0	0.0	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.4	0.7	2.2
122	Revise benchmark benefit packages	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.3	0.9
123	Grace period for payment of premiums	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
	Subtotal	**0.0**	**0.1**	**0.1**	**0.2**	**0.3**	**0.3**	**0.3**	**0.4**	**0.4**	**0.5**	**0.5**	**1.1**	**3.2**
Subtitle D -- Populations														
131	State option to cover individuals through age 24	0.0	0.0	0.0	0.1	0.3	0.5	0.8	1.0	1.0	1.1	1.1	0.9	5.9
132	State option to cover certain legal immigrants	0.0	0.1	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.3	0.9	2.2
133	State option to cover pregnant women under SCHIP	0.0	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.3	0.3	0.7	1.9
134	Limitation on coverage of adults under SCHIP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Subtotal	**0.0**	**0.1**	**0.3**	**0.5**	**0.7**	**0.9**	**1.2**	**1.4**	**1.5**	**1.6**	**1.7**	**2.5**	**10.0**

Table 1. Estimated Effect on Direct Spending and Revenues of H.R. 3162, the Children's Health and Medicare Protection Act, as Ordered Reported by the House Committee on Ways and Means on July 27, 2007

by fiscal year, in billions of dollars

		2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-2012	2008-2017
Subtitle E -- Access														
141	Children's Access, Payment, and Equality Commission	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
142	Develop model interstate enrollment process	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
143	Revise requirement to document citizenship	0.0	0.3	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.2	0.2	0.8	1.9
144	Access to dental care for children	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
145	Prohibit new section 1938 demonstration projects	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.2
	Subtotal	**0.0**	**0.3**	**0.1**	**0.1**	**0.1**	**0.1**	**0.2**	**0.2**	**0.2**	**0.2**	**0.2**	**0.8**	**1.7**
Subtitle F -- Quality and Program Integrity														
151	Development of pediatric health quality measures	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
152	Apply certain Medicaid managed care rules to SCHIP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
153	Updated federal evaluation of SCHIP	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
154	IG / GAO access to records	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
155	Allow federal employees to call Title XXI program "CHIP"	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Subtotal	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	Total, Title I	**0.0**	**2.1**	**5.7**	**10.4**	**13.5**	**16.1**	**18.0**	**20.2**	**22.2**	**24.6**	**27.0**	**47.8**	**159.9**
TITLE II -- MEDICARE BENEFICIARY IMPROVEMENTS														
Subtitle A -- Improvements in Benefits														
201	Coverage and waiver of cost-sharing for preventive services.	0.0	0.1	0.2	0.2	0.3	0.3	0.4	0.4	0.4	0.5	0.6	1.1	3.4
202	Waiver of deductible for colorectal cancer screening tests regardless of coding, subsequent diagnosis, or ancillary tissue removal.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
203	Parity for mental health coinsurance.	0.0	0.3	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.5	0.6	2.2	4.7
	Subtotal	**0.0**	**0.4**	**0.6**	**0.7**	**0.8**	**0.8**	**0.8**	**0.9**	**0.9**	**1.0**	**1.2**	**3.3**	**8.2**
Subtitle B -- Assistance for Low Income Medicare Beneficiaries														
211	Increase asset limits for Medicare Savings Program and LIS program	0.0	0.0	0.2	0.6	1.0	1.1	1.7	2.0	2.4	3.0	3.2	2.9	15.0
212	Making QI program permanent and expanding eligibility.	0.0	0.4	0.5	0.6	0.7	0.9	1.0	1.1	1.2	1.3	1.4	3.0	8.9
213	Eliminating barriers to enrollment.	0.0	0.0	0.5	0.9	1.1	1.1	1.3	1.5	1.7	2.1	2.2	3.6	12.2
214	Eliminating application of estate recovery.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
215	Elimination of part D cost-sharing for certain individuals.	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.5
216	Exclude certain income and resources from LIS eligibility determinations	0.0	0.0	0.2	0.2	0.3	0.3	0.3	0.4	0.4	0.5	0.6	0.9	3.1
217	Cost-sharing protections for low-income subsidy-eligible individuals.	0.0	0.0	0.0	0.4	0.7	0.6	0.8	0.9	1.0	1.2	1.3	1.7	6.9
218	Intelligent assignment in enrollment.	0.0	0.0	0.0	-0.1	-0.2	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.4	-1.2
	Subtotal	**0.0**	**0.4**	**1.4**	**2.6**	**3.6**	**3.9**	**5.0**	**5.7**	**6.5**	**8.0**	**8.5**	**11.9**	**45.6**

Table 1. Estimated Effect on Direct Spending and Revenues of H.R. 3162, the Children's Health and Medicare Protection Act, as Ordered Reported by the House Committee on Ways and Means on July 27, 2007

by fiscal year, in billions of dollars

		2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-2012	2008-2017
Subtitle C -- Part D Beneficiary Improvements														
221	Count ADAP and IHS spending as true out-of-pocket spending	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.2
222	Permit mid-year changes in enrollment in certain situations	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
223	Extend Part D coverage to benzodiazepines	0.0	0.0	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.2	0.5	1.2
224	Permitting updating drug compendia under Part D using Part B update process.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
225	Codification of special protections for six protected drug classifications.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
226	Eliminate late enrollment penalties paid by LIS beneficiaries	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
227	Special enrollment period for subsidy eligible individuals.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Subtotal	**0.0**	**0.0**	**0.1**	**0.2**	**0.2**	**0.2**	**0.2**	**0.2**	**0.2**	**0.2**	**0.2**	**0.7**	**1.6**
Subtitle D -- Reducing Health Disparities														
231	Medicare data on race, ethnicity, and primary language.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
232	Ensuring effective communication in Medicare.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
233	Demonstration to promote access for Medicare beneficiaries with limited English proficiency by providing reimbursement for culturally and linguistically appropriate services.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
234	Demonstration to improve care to previously uninsured.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
235	Office of the Inspector General report on compliance with and enforcement of national standards on culturally and linguistically appropriate services.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
236	IOM report on impact of language access services.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
237	Definitions.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Subtotal	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
	Total, Title II	**0.0**	**0.8**	**2.2**	**3.5**	**4.6**	**4.9**	**6.0**	**6.8**	**7.6**	**9.2**	**9.8**	**15.9**	**55.3**
TITLE III -- PHYSICIANS' SERVICE PAYMENT REFORM														
301	Establishment of separate target growth rates for service categories.	0.0	3.3	6.8	5.1	2.5	3.4	6.8	11.7	17.5	21.5	24.1	21.1	102.7
302	Improving accuracy of relative values under the Medicare physician fee schedule.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
303	Feedback mechanism on practice patterns.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
304	Payments for efficient areas.	0.0	0.0	0.1	0.2	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.4	0.4
305	Recommendations on refining the physician fee schedule.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
306	Improved and expanded medical home demonstration project.	0.0	0.0	0.1	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.3
307	Repeal of Physician Assistance and Quality Initiative Fund.	0.0	-0.8	-0.4	-0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-1.4	-1.4
308	Adjustment to Medicare payment localities.	0.0	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2
309	Payment for imaging services.	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.4	-1.2
310	Repeal of Physicians Advisory Council.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total, Title III	**0.0**	**2.4**	**6.5**	**5.3**	**2.6**	**3.3**	**6.7**	**11.5**	**17.4**	**21.3**	**23.9**	**20.1**	**101.0**

Table 1. Estimated Effect on Direct Spending and Revenues of H.R. 3162, the Children's Health and Medicare Protection Act, as Ordered Reported by the House Committee on Ways and Means on July 27, 2007

by fiscal year, in billions of dollars

		2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-2012	2008-2017
TITLE IV -- MEDICARE ADVANTAGE REFORMS														
Subtitle A -- Payment Reform														
401	Equalizing payments between Medicare Advantage plans and fee-for-service Medicare.	0.0	0.0	-4.9	-11.1	-17.0	-17.4	-20.0	-19.8	-20.4	-23.5	-23.0	-50.4	-157.1
	Subtotal	**0.0**	**0.0**	**-4.9**	**-11.1**	**-17.0**	**-17.4**	**-20.0**	**-19.8**	**-20.4**	**-23.5**	**-23.0**	**-50.4**	**-157.1**
Subtitle B -- Beneficiary Protections														
411	NAIC development of marketing, advertising, and related protections.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
412	Limitation on out-of-pocket costs for individual health services.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
413	MA plan enrollment modifications.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
414	Information for beneficiaries on MA plan administrative costs.	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	0.0	-0.4
	Subtotal	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**-0.1**	**-0.1**	**0.0**	**-0.2**
Subtitle C -- Quality and Other Provisions														
421	Requiring all MA plans to meet equal standards.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
422	Development of new quality reporting measures on racial disparities.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
423	Strengthening audit authority.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
424	Improving risk adjustment for MA payments.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
425	Eliminating special treatment of private fee-for-service plans.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
426	Renaming of Medicare Advantage program.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Subtotal	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**
Subtitle D -- Extension of Authorities														
431	Extension and revision of authority for special needs plans (SNPs).	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
432	Extension and revision of authority for Medicare reasonable cost contracts.	0.0	0.0	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2
	Subtotal	**0.0**	**0.0**	**0.0**	**0.1**	**0.1**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.2**	**0.2**
	Total, Title IV	**0.0**	**0.0**	**-4.9**	**-11.0**	**-16.9**	**-17.4**	**-20.0**	**-19.8**	**-20.4**	**-23.5**	**-23.0**	**-50.2**	**-157.0**

Table 1. Estimated Effect on Direct Spending and Revenues of H.R. 3162, the Children's Health and Medicare Protection Act, as Ordered Reported by the House Committee on Ways and Means on July 27, 2007

by fiscal year, in billions of dollars

		2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-2012	2008-2017
TITLE V -- PROVISIONS RELATING TO MEDICARE PART A														
501	Inpatient hospital payment updates.	0.0	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.3	-0.3	-0.3	-0.4	-1.1	-2.7
502	Payment for inpatient rehabilitation facility (IRF) services.	0.0	-0.3	-0.5	-0.6	-0.6	-0.6	-0.7	-0.8	-0.8	-0.9	-1.0	-2.4	-6.6
503	Long-term care hospitals.	0.0	0.1	0.0	-0.2	-0.2	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.5	-1.3
504	Increasing the DSH adjustment cap.	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2
505	PPS-exempt cancer hospitals.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.3
506	Skilled nursing facility payment update.	0.0	-0.3	-0.5	-0.6	-0.6	-0.6	-0.7	-0.7	-0.8	-0.8	-0.9	-2.7	-6.5
507	Revocation of unique deeming authority of the Joint Commission for the Accreditation of Healthcare Organizations.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
508	Treatment of Medicare hospital reclassifications.	0.0	0.2	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.5	0.6
509	Medicare critical access hospital designations.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total, Title V	**0.0**	**-0.3**	**-0.9**	**-1.4**	**-1.6**	**-1.6**	**-1.8**	**-1.9**	**-2.0**	**-2.2**	**-2.4**	**-5.7**	**-15.9**
TITLE VI -- OTHER PROVISIONS RELATING TO MEDICARE PART B														
Subtitle A -- Payment and Coverage Improvements														
601	Payment for therapy services.	0.0	0.5	0.7	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.4	1.4
602	Medicare separate definition of outpatient speech-language pathology services.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1
603	Increased reimbursement rate for certified nurse-midwives.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
604	Adjustment in outpatient hospital fee schedule increase factor.	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.3	-0.8
605	Exception to 60-day limit on Medicare substitute billing arrangements in case of physicians ordered to active duty in the Armed Forces.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
606	Excluding clinical social worker services from coverage under the Medicare skilled nursing facility prospective payment system and consolidated payment.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
607	Coverage of marriage and family therapist services and mental health counselor services.	0.0	0.0	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.6
608	Rental and purchase of power-driven wheelchairs.	0.0	-0.3	-0.1	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.6	-0.9
609	Rental and purchase of oxygen equipment	0.0	0.0	0.0	-0.4	-0.6	-0.7	-0.8	-0.8	-0.8	-0.9	-0.9	-1.8	-6.0
610	Adjustment for Medicare mental health services.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
611	Extension of brachytherapy special rule.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
612	Payment for part B drugs.	0.0	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.2	-0.2	-0.3	-0.3	-0.7	-1.9
	Subtotal	**0.0**	**0.2**	**0.5**	**-0.4**	**-0.8**	**-0.9**	**-1.0**	**-1.1**	**-1.1**	**-1.2**	**-1.3**	**-1.6**	**-7.4**

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		2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-2012	2008-2017
Subtitle B -- Extension of Medicare Rural Access Protections														
621	2-year extension of floor on Medicare work geographic adjustment.	0.0	0.3	0.4	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.8	0.8
622	2-year extension of special treatment of certain physician pathology services under Medicare.	0.0	0.1	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2
623	2-year extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
624	2-year extension of Medicare incentive payment program for physician scarcity areas .	0.0	0.2	0.3	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.6	0.6
625	2-year extension of Medicare increase payments for ground ambulance services in rural areas.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
626	Extending hold harmless for small rural hospitals under the HOPD prospective payment system.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Subtotal	**0.0**	**0.5**	**0.9**	**0.3**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**1.7**	**1.7**
Subtitle C -- End Stage Renal Disease Program														
631	Chronic kidney disease demonstration projects.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
632	Medicare coverage of kidney disease patient education services.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
633	Required training for patient care dialysis technicians.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
634	MedPAC report on treatment modalities for patients with kidney failure.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
635	Adjustment for erythropoietin stimulating agents (ESAs).	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.3
636	Site neutral composite rate.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1
637	Development of ESRD bundling system and quality incentive payments.	0.0	0.0	0.0	0.0	0.0	-0.3	-0.4	-0.5	-0.6	-0.6	-0.7	-0.2	-3.1
638	MedPAC report on ESRD bundling system.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
639	OIG study and report on erythropoietin.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Subtotal	**0.0**	**0.0**	**0.0**	**-0.1**	**0.0**	**-0.3**	**-0.5**	**-0.5**	**-0.6**	**-0.7**	**-0.7**	**-0.4**	**-3.4**
Subtitle D -- Miscellaneous														
651	Limitation on exception to the prohibition on certain physician referrals for hospitals.	0.0	0.0	-0.1	-0.2	-0.2	-0.3	-0.3	-0.4	-0.5	-0.5	-0.6	-0.7	-2.9
	Subtotal	**0.0**	**0.0**	**-0.1**	**-0.2**	**-0.2**	**-0.3**	**-0.3**	**-0.4**	**-0.5**	**-0.5**	**-0.6**	**-0.7**	**-2.9**
	Total, Title VI	**0.0**	**0.7**	**1.3**	**-0.4**	**-1.0**	**-1.5**	**-1.8**	**-2.0**	**-2.2**	**-2.4**	**-2.7**	**-1.0**	**-12.0**

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TITLE VII -- PROVISIONS RELATING TO MEDICARE PARTS A AND B														
701	Home health payment update for 2008.	0.0	-0.3	-0.5	-0.6	-0.6	-0.7	-0.7	-0.8	-0.9	-1.0	-1.1	-2.6	-7.2
702	2-year extension of temporary Medicare payment increase for home health services furnished in a rural area.	0.0	0.1	0.2	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.3
703	Extension of Medicare secondary payer for beneficiaries with end stage renal disease for large group plans.	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.2	-0.2	-0.4	-1.2
704	Plan for Medicare payment adjustments for never events.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
705	Reinstatement of residency slots	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total, Title VII	**0.0**	**-0.2**	**-0.4**	**-0.6**	**-0.7**	**-0.8**	**-0.9**	**-1.0**	**-1.1**	**-1.2**	**-1.3**	**-2.7**	**-8.1**
TITLE VIII -- MEDICAID														
Subtitle A -- Protecting Existing Coverage														
801	Extend transitional Medicaid through 2009	0.0	0.3	0.8	0.5	0.0	0.0	0.0	0.0	0.0	0.0	0.0	1.6	1.6
802	State option to provide family planning services	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1	-0.1	-0.1	-0.1	-0.2	-0.4
803	Continue provision of adult day health services	0.0	0.2	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.2
804	Treatment of community spouses under HCB programs	0.0	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.2	0.5
805	Expand use of county-operated health systems in CA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	-0.1	-0.1
	Subtotal	**0.0**	**0.5**	**0.9**	**0.5**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**1.9**	**1.8**
Subtitle B -- Payments														
811	Additional payments to Puerto Rico and other territories	0.0	0.0	0.3	0.4	0.5	0.6	0.7	0.7	0.7	0.8	0.8	1.8	5.4
812	Increase brand rebate to 20.1%	0.0	-0.1	-0.3	-0.3	-0.3	-0.4	-0.4	-0.4	-0.5	-0.5	-0.5	-1.3	-3.5
813	Treatment of pension contributions in FMAP calculation	0.0	0.3	0.0	0.0	0.1	0.1	0.1	0.1	0.1	0.1	0.1	0.5	0.8
814	Prohibit Administration from restricting certain services	0.0	0.1	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
815	Additional DSH funds for Tennessee	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.2	0.3
816	Memphis Regional Medical Center	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Subtotal	**0.0**	**0.3**	**0.1**	**0.2**	**0.3**	**0.4**	**0.4**	**0.4**	**0.4**	**0.4**	**0.4**	**1.3**	**3.1**
Subtitle C -- Miscellaneous														
821	Demonstration project for employer buy-in of coverage	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.3
822	Fund NIH / IHS diabetes programs through 2009	0.0	0.0	0.1	0.2	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.3	0.3
823	Technical correction to DRA	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Subtotal	**0.0**	**0.0**	**0.1**	**0.2**	**0.1**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.0**	**0.4**	**0.6**
	Total, Title VIII	**0.0**	**0.8**	**1.1**	**0.9**	**0.4**	**0.4**	**0.4**	**0.4**	**0.4**	**0.4**	**0.4**	**3.5**	**5.5**

Table 1. Estimated Effect on Direct Spending and Revenues of H.R. 3162, the Children's Health and Medicare Protection Act, as Ordered Reported by the House Committee on Ways and Means on July 27, 2007

by fiscal year, in billions of dollars

		2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-2012	2008-2017
TITLE IX -- MISCELLANEOUS														
901	Medicare Payment Advisory Commission status.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
902	Repeal of trigger provision.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
903	Repeal of comparative cost adjustment (CCA) program.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
904	Comparative effectiveness research.	0.0	0.0	0.0	0.1	0.1	0.2	0.3	0.2	0.1	0.0	0.0	0.5	1.1
905	Implementation of Health information technology (IT) under Medicare.	0.0	0.0	0.0	0.0	0 0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
906	Development, reporting, and use of health care measures.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.1	0.1
907	Improvements to the Medigap program.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
908	Implementation funding	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total, Title IX	**0.0**	**0.1**	**0.1**	**0.1**	**0.2**	**0.2**	**0.3**	**0.2**	**0.1**	**0.0**	**0.0**	**0.6**	**1.2**
INTERACTIONS - - DIRECT SPENDING														
	Fee-for-service interactions	0.0	0.2	0.3	0.1	0.0	0.1	0.1	0.2	0.3	0.4	0.4	0.7	2.0
	Medicare Advantage interactions	0.0	0.0	1.9	1.1	0.1	0.3	1.2	2.5	4.2	5.2	5.9	3.4	22.3
	Premium interactions with fee-for-service provisions /1/	0.0	-0.8	-2.3	-1.5	-0.6	-0.7	-1.6	-3.0	-4.6	-5.8	-6.5	-5.9	-27.3
	Medicaid interactions with Medicare provisions	0.0	0.0	0.0	0.1	0.1	0.2	0.3	0.4	0.4	0.5	0.6	0.4	2.6
	TRICARE interaction with Medicare provisions	0.0	0.1	0.2	0.1	0.0	0.1	0.2	0.4	0.6	0.7	0.8	0.5	3.1
	Total, Interactions	**0.0**	**-0.5**	**0.0**	**-0.2**	**-0.2**	**0.0**	**0.2**	**0.5**	**0.8**	**1.0**	**1.2**	**-0.9**	**2.7**
TOTAL CHANGES IN DIRECT SPENDING		**0.0**	**5.8**	**10.6**	**6.6**	**0.8**	**3.7**	**7.1**	**15.0**	**22.9**	**27.2**	**32.9**	**27.5**	**132.6**

Table 1. Estimated Effect on Direct Spending and Revenues of H.R. 3162, the Children's Health and Medicare Protection Act, as Ordered Reported by the House Committee on Ways and Means on July 27, 2007

by fiscal year, in billions of dollars

		2007	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-2012	2008-2017
TITLES I-IX -- REVENUES														
904	Comparative effectiveness research. - - tax on issuers of private health insurance policies	0.0	0.0	0.0	0.0	0.3	0.3	0.3	0.3	0.3	0.3	0.3	0.6	2.0
	Revenue interactions with Title I and section 904													
	Income and Hospital Insurance (Part A) payroll taxes	0.0	0.0	0.1	0.1	0.1	0.1	0.2	0.2	0.2	0.2	0.3	0.5	1.5
	Social Security payroll taxes	0.0	0.1	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.4	0.8	2.4
TITLE X -- REVENUES														
1001	Increase in tax rates and modify certain definitions.	0.0	4.6	5.8	5.6	5.6	5.5	5.5	5.4	5.4	5.3	5.3	27.0	53.8
1002	Extend exemption from fuel excise tax for use in ambulance.	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0	0.0
	Total, Title X	0.0	4.6	5.8	5.6	5.5	5.5	5.5	5.4	5.4	5.3	5.3	27.0	53.8
	Subtotal, Changes in Revenues													
	On-budget	**0.0**	**4.6**	**5.8**	**5.7**	**6.0**	**5.9**	**5.9**	**5.9**	**5.9**	**5.8**	**5.8**	**28.1**	**57.3**
	Off-budget	0.0	0.1	0.1	0.2	0.2	0.2	0.2	0.3	0.3	0.3	0.4	0.8	2.4
	Total, Changes in Revenues	**0.0**	**4.7**	**6.0**	**5.9**	**6.2**	**6.1**	**6.1**	**6.2**	**6.2**	**6.2**	**6.2**	**28.9**	**59.7**
Memorandum: Change in Surplus or Deficit (Negative amounts increase deficit)														
	On-budget	**0.0**	**-1.2**	**-4.8**	**-0.9**	**5.2**	**2.3**	**-1.2**	**-9.1**	**-17.0**	**-21.4**	**-27.1**	**0.6**	**-75.3**
	Unified (on-budget and off-budget)	**0.0**	**-1.1**	**-4.6**	**-0.7**	**5.4**	**2.5**	**-1.0**	**-8.8**	**-16.7**	**-21.0**	**-26.7**	**1.4**	**-72.9**

NOTES:

1 Premium interactions for provisions in title IV are included in the estimates for those provisions. The estimate of the combined effect of fee-for-service and Medicare Advantage provisions on premium receipts would be:

0.0	-0.8	-1.5	0.1	1.6	1.8	1.0	-0.4	-2.0	-3.0	-3.5	1.2	-6.7

Table 2. CBO Estimate of Changes in SCHIP and Medicaid Enrollment of Children Under H.R. 3162, the Children's Health and Medicare Protection Act of 2007, as ordered reported by the Committee on Ways and Means on July 27, 2007

All figures are average monthly enrollment, in millions of individuals. Components may not sum to totals because of rounding.

	SCHIP /a/				Medicaid /b/				SCHIP/Medicaid total		
	Enrollees moved to SCHIP	Reduction in the uninsured	Reduction in other coverage /c/	Total	Enrollees moved to SCHIP	Reduction in the uninsured	Reduction in other coverage /c/	Total	Reduction in the uninsured	Reduction in other coverage /c/	Total
FISCAL YEAR 2012:											
CBO's baseline projections				3.3				25.0			28.3
Effect of providing funding to maintain current SCHIP programs	0.6	0.8	0.5	1.9	-0.6	n.a.	n.a.	-0.6	0.8	0.5	1.3
Effect of additional SCHIP funding and other provisions:											
Additional enrollment within existing eligibility groups /d/	n.a.	0.6	0.4	1.1	n.a.	2.9	0.7	3.6	3.5	1.1	4.7
Expansion of SCHIP and Medicaid eligibility to new populations	n.a.	0.5	0.5	1.0	n.a.	0.1	0.2	0.4	0.6	0.7	1.3
Subtotal	n.a.	1.1	0.9	2.0	n.a.	3.0	1.0	4.0	4.1	1.9	6.0
Total proposed changes	0.6	1.9	1.4	4.0	-0.6	3.0	1.0	3.3	4.9	2.4	7.3
Estimated enrollment under proposal				7.3				28.3			35.6

Notes:

/a/ The figures in this table include the program's adult enrollees, who account for less than 10 percent of total SCHIP enrollment.

/b/ The figures in this table do not include children who receive Medicaid because they are disabled.

/c/ "Other coverage" is largely private coverage, but also includes about 200,000 legal immigrant children who now receive coverage under state-funded programs.

/d/ For simplicity of display, the Medicaid figures in this line include the additional children enrolled as a side effect of expansions of SCHIP eligibility.

n.a. = not applicable

D. Macroeconomic Impact Analysis

In compliance with clause 3(h)(2) of rule XIII of the Rules of the House of Representatives, the following statement is made by the Joint Committee on Taxation with respect to the provisions of the bill amending the Internal Revenue Code of 1986: the effects of the bill on economic activity are so small as to be incalculable within the context of a model of the aggregate economy.

E. Pay-Go Rule

In compliance with clause 10 of rule XXI of the Rules of the House of Representatives, the following statement is made concerning the effects on the budget of the revenue provisions of the bill, H.R. 3162 as reported: the provisions of the bill affecting revenues have the following net effect on the deficit or surplus: (1) the bill reduces federal deficits by $1.4 billion over the fiscal year 2008–2012 period; and (2) the bill would increase the deficit or reduce the surplus by $72.9 billion over the fiscal year 2008–2017 period.

ESTIMATED REVENUE EFFECTS OF THE TAX PROVISIONS CONTAINED IN H.R. 3162, THE "CHILDREN'S HEALTH AND MEDICARE PROTECTION ACT OF 2007," AS REPORTED BY THE COMMITTEE ON WAYS AND MEANS

Fiscal Years 2008 - 2017

[Millions of Dollars]

Provision	Effective	2008	2009	2010	2011	2012	2013	2014	2015	2016	2017	2008-12	2008-17
II. Medicare Beneficiary Improvements													
A. Disclosure of tax return information for purposes of providing low-income subsidies under Medicare	dma DOE	*Negligible Revenue Effect*											
IX. Miscellaneous Provisions													
A. Tax on issuers of private health insurance policies and sponsors of self-insured health plans	10/1/10	---	---	---	285	285	285	285	285	285	285	570	1,995
X. Revenue Provisions													
A. Increase in excise tax rate to $.84 per pack of cigarettes and generally proportionate increases for other tobacco products and cigarette papers and tubes	ara 12/31/07	4,600	5,761	5,600	5,555	5,506	5,459	5,411	5,361	5,310	5,259	27,022	53,822
B. Modify definition of roll-your-own tobacco	ara 12/31/07	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	[1]	1	2
C. Extension of exemption from fuel excise tax for use in ambulances (sunset 12/31/12)	fuitpicqba DOE	-4	-6	-7	-7	-7	-2	---	---	---	---	-32	-34
Total of Revenue Provisions		**4,596**	**5,755**	**5,593**	**5,548**	**5,499**	**5,457**	**5,411**	**5,361**	**5,310**	**5,259**	**26,991**	**53,790**
NET TOTAL		**4,596**	**5,755**	**5,593**	**5,833**	**5,784**	**5,742**	**5,696**	**5,646**	**5,595**	**5,544**	**27,561**	**55,785**

Joint Committee on Taxation

NOTE: Details may not add to totals due to rounding.

Legend for "Effective" column:
ara = articles removed after
dma = disclosures made after
DOE = date of enactment
fuitpicqba = fuel used in transportation provided in calendar quarters beginning after

[1] Gain of less than $500,000.

V. OTHER MATTERS TO BE DISCUSSED UNDER THE RULES OF THE HOUSE

A. Committee Oversight Findings and Recommendations

With respect to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives (relating to oversight findings), the Committee advises that it is appropriate and timely to enact the provisions included in the bill as reported.

B. Statement of General Performance Goals and Objectives

With respect to clause 3(c)(1) of rule XIII of the Rules of the House of Representatives, the primary purpose of H.R. 3162 the "Children's Health and Medicare Protection Act of 2007" is to extend and improve the Children's Health Insurance Program, to improve beneficiary protections under Medicare, Medicaid and the CHIP program and for other purposes.

C. Constitutional Authority Statement

With respect to clause 3(d)(1) of rule XIII of the Rules of the House of Representatives (relating to Constitutional Authority), the Committee states that the Committee's Action in reporting this bill is derived from Article I of the Constitution, Section 8 ("The Congress shall have Power to lay and collect Taxes, Duties, Imposts and Excises..."), and from the 16th Amendment to the Constitution.

D. Information Relating to Unfunded Mandates

This information is provided in accordance with section 423 of the Unfunded Mandates Act of 1995 (P.L. 104–4).

The Committee has determined that the following provisions of the reported bill contain Federal private sector mandates within the meaning of Public Law No. 104–4, the Unfunded Mandates Reform Act of 1995: an increase in the excise tax rate on tobacco products and cigarette papers and tubes; taxes on certain health insurance policies; extending the number of months that Medicare would be secondary payer for patients with end-stage renal disease; and placing further restrictions on the types of plans that Medigap issuers could sell to Medicare beneficiaries.

CBO and JCT have reviewed the bill and determined that it does not impose any Federal intergovernmental mandates on State, local, or tribal governments within the meaning of Public Law No. 104–4, the Unfunded Mandates Reform Act of 1995.

The costs required to comply with each Federal private sector mandate generally are no greater than the aggregate estimated budget effects of the provision.

E. Applicability of House Rule XXI 5(b)

Clause 5 of rule XXI of the Rules of the House of Representatives provides, in part, that "a bill or joint resolution, amendment, or conference report, carrying a Federal income tax rate increase may not be considered as passed or agreed to unless so determined by a vote of not less than three-fifths of the Members voting, a quorum being present." The Committee has carefully reviewed the

provisions of the bill and states that the provisions of the bill do not involve any Federal income tax rate increases within the meaning of the rule.

F. Tax Complexity Analysis

Section 4022(b) of the Internal Revenue Service Reform and Restructuring Act of 1998 (the "IRS Reform Act") requires the Joint Committee on Taxation (in consultation with the Internal Revenue Service and the Department of the Treasury) to provide a tax complexity analysis. The complexity analysis is required for all legislation reported by the Senate Committee on Finance, the House Committee on Ways and Means, or any committee of conference if the legislation includes a provision that directly or indirectly amends the Internal Revenue Code and has widespread applicability to individuals or small businesses.

The staff of the Joint Committee on Taxation has determined that a complexity analysis is not required under section 4022(b) of the IRS Reform Act because the bill contains no provisions that amend the Code and that have "widespread applicability" to individuals or small businesses.

G. Limited Tax Benefits

Pursuant to clause 9 of rule XXI of the Rules of the House of Representatives, the Ways and Means Committee has determined that the bill as reported contains no congressional earmarks, limited tax benefits, or limited tariff benefits within the meaning of that rule.

VI. Changes in Existing Law Made by the Bill, as Reported

In compliance with clause 3(e) of rule XIII of the Rules of the House of Representatives, changes in existing law made by the bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

SOCIAL SECURITY ACT

* * * * * * *

TITLE XI—GENERAL PROVISIONS, PEER REVIEW, AND ADMINISTRATIVE SIMPLIFICATION

Part A—General Provisions

* * * * * * *

SEC. 1108. ADDITIONAL GRANTS TO PUERTO RICO, THE VIRGIN ISLANDS, GUAM, AND AMERICAN SAMOA; LIMITATION ON TOTAL PAYMENTS.

(a) * * *

* * * * * * *

(g) Medicaid Payments to Territories for Fiscal Year 1998 and Thereafter.—

(1) * * *

(2) FISCAL YEAR 1999 AND THEREAFTER.—Notwithstanding subsection (f) and subject to [paragraph (3)] *paragraphs (3) and (4)*, with respect to fiscal year 1999 and any fiscal year thereafter, the total amount certified by the Secretary under title XIX for payment to—

(A) * * *

* * * * * * *

(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.

(B) VIRGIN ISLANDS.—For the Virgin Islands, $5,000,000 for each of fiscal years 2009 through 2012.

(C) GUAM.—For Guam, $5,000,000 for each of fiscal years 2009 through 2012.

(D) NORTHERN MARIANA ISLANDS.—For the Northern Mariana Islands, $4,000,000 for each of fiscal years 2009 through 2012.

(E) AMERICAN SAMOA.—For American Samoa, $4,000,000 for each of fiscal years 2009 through 2012.

Such amounts shall not be taken into account in applying paragraph (2) for fiscal years 2009 through 2012 but shall be taken into account in applying such paragraph for fiscal year 2013 and subsequent fiscal years.

(5) EXCLUSION OF CERTAIN EXPENDITURES FROM PAYMENT LIMITS.—With respect to fiscal year 2008 and each fiscal year thereafter, if Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa qualify for a payment under subparagraph (A)(i) or (B) of section 1903(a)(3) for a calendar quarter of such fiscal year with respect to expenditures for improvements in data reporting systems described in such subparagraph, the limitation on expenditures under title XIX for such commonwealth or territory otherwise determined under subsection (f) and this subsection for such fiscal year shall be determined without regard to payment for such expenditures.

* * * * * * *

CRIMINAL PENALTIES FOR ACTS INVOLVING FEDERAL HEALTH CARE PROGRAMS

SEC. 1128B. (a) * * *

(b)(1) * * *

* * * * * * *

(3) Paragraphs (1) and (2) shall not apply to—

(A) * * *

* * * * * * *

(H) any remuneration between a federally qualified health center (or an entity controlled by such a health center) and an [MA] *Medicare Part C* organization pursuant to a written agreement described in section 1853(a)(4).

* * * * * * *

AUTHORITY TO WAIVE REQUIREMENTS DURING NATIONAL EMERGENCIES

SEC. 1135. (a) * * *

(b) SECRETARIAL AUTHORITY.—To the extent necessary to accomplish the purpose specified in subsection (a), the Secretary is authorized, subject to the provisions of this section, to temporarily waive or modify the application of, with respect to health care items and services furnished by a health care provider (or classes of health care providers) in any emergency area (or portion of such an area) during any portion of an emergency period, the requirements of titles XVIII, XIX, or XXI, or any regulation thereunder (and the requirements of this title other than this section, and regulations thereunder, insofar as they relate to such titles), pertaining to—

(1) * * *

* * * * * * *

(6) limitations on payments under section 1851(i) for health care items and services furnished to individuals enrolled in a [Medicare+Choice] *Medicare Part C* plan by health care professionals or facilities not included under such plan; and

* * * * * * *

Insofar as the Secretary exercises authority under paragraph (6) with respect to individuals enrolled in a [Medicare+Choice] *Medicare Part C* plan, to the extent possible given the circumstances, the Secretary shall reconcile payments made on behalf of such enrollees to ensure that the enrollees do not pay more than would be required had they received services from providers within the network of the plan and may reconcile payments to the organization offering the plan to ensure that such organization pays for services for which payment is included in the capitation payment it receives under part C of title XVIII. A waiver or modification provided for under paragraph (3) or (7) shall only be in effect if such actions are taken in a manner that does not discriminate among individuals on the basis of their source of payment or of their ability to pay, and, except in the case of a waiver or modification to which the fifth sentence of this subsection applies, shall be limited to a 72-hour period beginning upon implementation of a hospital disaster protocol. A waiver or modification under such paragraph (7) shall be withdrawn after such period and the provider shall comply with the requirements under such paragraph for any patient still under the care of the provider. If a public health emergency described in subsection (g)(1)(B) involves a pandemic infectious disease (such as pandemic influenza), the duration of a waiver or modification under paragraph (3) shall be determined in accordance with subsection (e) as such subsection applies to public health emergencies.

* * * * * * *

OUTREACH EFFORTS TO INCREASE AWARENESS OF THE AVAILABILITY OF MEDICARE COST-SHARING AND SUBSIDIES FOR LOW-INCOME INDIVIDUALS UNDER TITLE XVIII

SEC. 1144. (a) * * *

* * * * * * *

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

(1) DISTRIBUTION OF APPLICATIONS TO APPLICANTS FOR MEDICARE.—In the case of each individual applying for hospital insurance benefits under section 226 or 226A, the Commissioner shall provide the following:

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

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

(C) Information on how the individual may obtain assistance in completing such applications, including information on how the individual may contact the State health insurance assistance program (SHIP) for the State in which the individual is located.

The Commissioner shall make such application forms available at local offices of the Social Security Administration.

(2) TRAINING PERSONNEL IN ASSISTING IN COMPLETING APPLICATIONS.—The Commissioner shall provide training to those employees of the Social Security Administration who are involved in receiving applications for benefits described in paragraph (1) in assisting applicants in completing a medicare savings program application described in paragraph (1). Such employees who are so trained shall provide such assistance upon request.

(3) TRANSMITTAL OF COMPLETED APPLICATION.—If such an employee assists in completing such an application, the employee, with the consent of the applicant, shall transmit the completed application to the appropriate State medicaid agency for processing.

(4) COORDINATION WITH OUTREACH.—The Commissioner shall coordinate outreach activities under this subsection with outreach activities conducted by States in connection with the low-income subsidy program and the medicare savings program.

* * * * * * *

FUNCTIONS OF PEER REVIEW ORGANIZATIONS

SEC. 1154. (a) Any utilization and quality control peer review organization entering into a contract with the Secretary under this part must perform the following functions:

(1) The organization shall review some or all of the professional activities in the area, subject to the terms of the contract and subject to the requirements of subsection (d), of physicians and other health care practitioners and institutional

and noninstitutional providers of health care services in the provision of health care services and items for which payment may be made (in whole or in part) under title XVIII (including where payment is made for such services to eligible organizations pursuant to contracts under section 1876, to [Medicare Advantage] *Medicare Part C* organizations pursuant to contracts under part C, and to prescription drug sponsors pursuant to contracts under part D) for the purpose of determining whether—

(A) * * *

* * * * * * *

(17) The organization shall execute its responsibilities under subparagraphs (A) and (B) of paragraph (1) by offering to providers, practitioners, [Medicare Advantage] *Medicare Part C* organizations offering [Medicare Advantage] *Medicare Part C* plans under part C, and prescription drug sponsors offering prescription drug plans under part D quality improvement assistance pertaining to prescription drug therapy. For purposes of this part and title XVIII, the functions described in this paragraph shall be treated as a review function.

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TITLE XVIII—HEALTH INSURANCE FOR THE AGED AND DISABLED

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MEDICARE PAYMENT ADVISORY COMMISSION

SEC. 1805. (a) ESTABLISHMENT.—There is hereby established *as an agency of Congress* the Medicare Payment Advisory Commission (in this section referred to as the "Commission").

(b) DUTIES.—

(1) * * *

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(2) SPECIFIC TOPICS TO BE REVIEWED.—

(A) [MEDICARE+CHOICE] *MEDICARE PART C* PROGRAM.—Specifically, the Commission shall review, with respect to the [Medicare+Choice] *Medicare Part C* program under part C, the following:

(i) * * *

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(iii) The implications of risk selection both among [Medicare+Choice] *Medicare Part C* organizations and between the [Medicare+Choice] *Medicare Part C* option and the original medicare fee-for-service option.

(iv) The development and implementation of mechanisms to assure the quality of care for those enrolled with [Medicare+Choice] *Medicare Part C* organizations.

(v) The impact of the [Medicare+Choice] *Medicare Part C* program on access to care for medicare beneficiaries.

(vi) Other major issues in implementation and further development of the [Medicare+Choice] *Medicare Part C* program.

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PROVISIONS RELATING TO ADMINISTRATION

SEC. 1808. (a) COORDINATED ADMINISTRATION OF MEDICARE PRESCRIPTION DRUG AND [MEDICARE ADVANTAGE] *MEDICARE PART C* PROGRAMS.—

(1) * * *

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(c) MEDICARE BENEFICIARY OMBUDSMAN.—

(1) * * *

(2) DUTIES.—The Medicare Beneficiary Ombudsman shall—

(A) * * *

(B) provide assistance with respect to complaints, grievances, and requests referred to in subparagraph (A), including—

(i) assistance in collecting relevant information for such individuals, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, [MA] *Medicare Part C* organization, or the Secretary;

(ii) assistance to such individuals with any problems arising from disenrollment from an [MA] *Medicare Part C* plan under part C; and

* * * * * * *

(3) WORKING WITH HEALTH INSURANCE COUNSELING PROGRAMS.—To the extent possible, the Ombudsman shall work with health insurance counseling programs (receiving funding under section 4360 of Omnibus Budget Reconciliation Act of 1990) to facilitate the provision of information to individuals entitled to benefits under part A or enrolled under part B, or both regarding [MA] *Medicare Part C* plans and changes to those plans. Nothing in this paragraph shall preclude further collaboration between the Ombudsman and such programs.

PART A—HOSPITAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

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MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM

SEC. 1820. (a) * * *

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(c) MEDICARE RURAL HOSPITAL FLEXIBILITY PROGRAM DESCRIBED.—

(1) * * *

(2) STATE DESIGNATION OF FACILITIES.—

(A) * * *

(B) CRITERIA FOR DESIGNATION AS CRITICAL ACCESS HOSPITAL.—A State may designate a facility as a critical access hospital if the facility—

(i) is a hospital that is located in a county (or equivalent unit of local government) in a rural area (as defined in section 1886(d)(2)(D)) or is treated as being located in a rural area pursuant to section 1886(d)(8)(E), and that—

(I) is located more than a 35-mile drive ([or,] *or, in the case of a hospital that is located in the county seat of Butler, Alabama, a 32-mile drive, or,* in the case of mountainous terrain or in areas with only secondary roads available, a 15-mile drive) from a hospital, or another facility described in this subsection; or

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COMPARATIVE EFFECTIVENESS RESEARCH

SEC. 1822. (a) CENTER FOR COMPARATIVE EFFECTIVENESS RESEARCH ESTABLISHED.—

(1) IN GENERAL.—The Secretary shall establish within the Agency of Healthcare Research and Quality a Center for Comparative Effectiveness Research (in this section referred to as the "Center") to conduct, support, and synthesize research (including research conducted or supported under section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically.

(2) DUTIES.—The Center shall—

(A) conduct, support, and synthesize research relevant to the comparative clinical effectiveness of the full spectrum of health care treatments, including pharmaceuticals, medical devices, medical and surgical procedures, and other medical interventions;

(B) conduct and support systematic reviews of clinical research, including original research conducted subsequent to the date of the enactment of this section;

(C) use methodologies such as randomized controlled clinical trials as well as other various types of clinical research, such as observational studies;

(D) submit to the Comparative Effectiveness Research Commission, the Secretary, and Congress appropriate relevant reports described in subsection (d)(2);

(E) encourage, as appropriate, the development and use of clinical registries and the development of clinical effectiveness research data networks from electronic health records, post marketing drug and medical device surveillance efforts, and other forms of electronic health data; and

(F) not later than 180 days after the date of the enactment of this section, develop methodological standards to be used when conducting studies of comparative clinical effectiveness and value (and procedures for use of such stand-

ards) in order to help ensure accurate and effective comparisons and update such standards at least biennially.

(b) OVERSIGHT BY COMPARATIVE EFFECTIVENESS RESEARCH COMMISSION.—

(1) IN GENERAL.—The Secretary shall establish an independent Comparative Effectiveness Research Commission (in this section referred to as the "Commission") to oversee and evaluate the activities carried out by the Center under subsection (a) to ensure such activities result in highly credible research and information resulting from such research.

(2) DUTIES.—The Commission shall—

(A) determine national priorities for research described in subsection (a) and in making such determinations consult with patients and health care providers and payers;

(B) monitor the appropriateness of use of the CERTF described in subsection (f) with respect to the timely production of comparative effectiveness research determined to be a national priority under subparagraph (A);

(C) identify highly credible research methods and standards of evidence for such research to be considered by the Center;

(D) review and approve the methodological standards (and updates to such standards) developed by the Center under subsection (a)(2)(F);

(E) enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences shall conduct an evaluation and report on standards of evidence for such research;

(F) support forums to increase stakeholder awareness and permit stakeholder feedback on the efforts of the Agency of Healthcare Research and Quality to advance methods and standards that promote highly credible research;

(G) make recommendations for public data access policies of the Center that would allow for access of such data by the public while ensuring the information produced from research involved is timely and credible;

(H) appoint a clinical perspective advisory panel for each research priority determined under subparagraph (A), which shall frame the specific research inquiry to be examined with respect to such priority to ensure that the information produced from such research is clinically relevant to decisions made by clinicians and patients at the point of care;

(I) make recommendations for the priority for periodic reviews of previous comparative effectiveness research and studies conducted by the Center under subsection (a);

(J) routinely review processes of the Center with respect to such research to confirm that the information produced by such research is objective, credible, consistent with standards of evidence established under this section, and developed through a transparent process that includes consultations with appropriate stakeholders;

(K) at least annually, provide guidance or recommendations to health care providers and consumers for the use of

information on the comparative effectiveness of health care services by consumers, providers (as defined for purposes of regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996) and public and private purchasers;

(L) make recommendations for a strategy to disseminate the findings of research conducted and supported under this section that enables clinicians to improve performance, consumers to make more informed health care decisions, and payers to set medical policies that improve quality and value;

(M) provide for the public disclosure of relevant reports described in subsection (d)(2); and

(N) submit to Congress an annual report on the progress of the Center in achieving national priorities determined under subparagraph (A) for the provision of credible comparative effectiveness information produced from such research to all interested parties.

(3) COMPOSITION OF COMMISSION.—

(A) IN GENERAL.—The members of the Commission shall consist of—

(i) the Director of the Agency for Healthcare Research and Quality;

(ii) the Chief Medical Officer of the Centers for Medicare & Medicaid Services; and

(iii) up to 15 additional members who shall represent broad constituencies of stakeholders including clinicians, patients, researchers, third-party payers, consumers of Federal and State beneficiary programs.

(B) QUALIFICATIONS.—

(i) DIVERSE REPRESENTATION OF PERSPECTIVES.—The members of the Commission shall represent a broad range of perspectives and shall collectively have experience in the following areas:

(I) Epidemiology.

(II) Health services research.

(III) Bioethics.

(IV) Decision sciences.

(V) Economics.

(ii) DIVERSE REPRESENTATION OF HEALTH CARE COMMUNITY.—At least one member shall represent each of the following health care communities:

(I) Consumers.

(II) Practicing physicians, including surgeons.

(III) Employers.

(IV) Public payers.

(V) Insurance plans.

(VI) Clinical researchers who conduct research on behalf of pharmaceutical or device manufacturers.

(4) APPOINTMENT.—The Comptroller General of the United States, in consultation with the chairs of the committees of jurisdiction of the House of Representatives and the Senate, shall appoint the members of the Commission.

(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General of the United States shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship 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.

(9) COMPENSATION.—While serving on the business of the Commission (including traveltime), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Director of the Commission.

(10) 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.

(11) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Secretary, in consultation with the Comptroller General deems necessary to assure the efficient administration of the Commission, the Commission may—

(A) employ and fix the compensation of an Executive Director (subject to the approval of the Secretary, in consultation with the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

(B) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

(D) make advance, progress, and other payments which relate to the work of the Commission;

(E) provide transportation and subsistence for persons serving without compensation; and

(F) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

(12) POWERS.—

(A) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Executive Director, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

(B) DATA COLLECTION.—In order to carry out its functions, the Commission shall—

(i) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

(ii) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate, and

(iii) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

(C) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data of the Commission, immediately upon request.

(D) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the Comptroller General.

(c) RESEARCH REQUIREMENTS.—Any research conducted, supported, or synthesized under this section shall meet the following requirements:

(1) ENSURING TRANSPARENCY, CREDIBILITY, AND ACCESS.—

(A) The establishment of the agenda and conduct of the research shall be insulated from inappropriate political or stakeholder influence.

(B) Methods of conducting such research shall be scientifically based.

(C) All aspects of the prioritization of research, conduct of the research, and development of conclusions based on the research shall be transparent to all stakeholders.

(D) The process and methods for conducting such research shall be publicly documented and available to all stakeholders.

(E) Throughout the process of such research, the Center shall provide opportunities for all stakeholders involved to review and provide comment on the methods and findings of such research.

(2) USE OF CLINICAL PERSPECTIVE ADVISORY PANELS.—The research shall meet a national research priority determined under subsection (b)(2)(A) and shall examine the specific research in-

quiry framed by the clinical perspective advisory panel for the national research priority.

(3) STAKEHOLDER INPUT.—The priorities of the research, the research, and the dissemination of the research shall involve the consultation of patients, health care providers, and health care consumer representatives through transparent mechanisms recommended by the Commission.

(d) PUBLIC ACCESS TO COMPARATIVE EFFECTIVENESS INFORMATION.—

(1) IN GENERAL.—Not later than 90 days after receipt by the Center or Commission, as applicable, of a relevant report described in paragraph (2) made by the Center, Commission, or clinical perspective advisory panel under this section, appropriate information contained in such report shall be posted on the official public Internet site of the Center and of the Commission, as applicable.

(2) RELEVANT REPORTS DESCRIBED.—For purposes of this section, a relevant report is each of the following submitted by a grantee or contractor of the Center:

(A) An interim progress report.

(B) A draft final comparative effectiveness review.

(C) A final progress report on new research submitted for publication by a peer review journal.

(D) Stakeholder comments.

(E) A final report.

(3) ACCESS BY CONGRESS AND THE COMMISSION TO THE CENTER'S INFORMATION.—Congress and the Commission shall each have unrestricted access to all deliberations, records, and nonproprietary data of the Center, immediately upon request.

(e) DISSEMINATION AND INCORPORATION OF COMPARATIVE EFFECTIVENESS INFORMATION.—

(1) DISSEMINATION.—The Center shall provide for the dissemination of appropriate findings produced by research supported, conducted, or synthesized under this section to health care providers, patients, vendors of health information technology focused on clinical decision support, appropriate professional associations, and Federal and private health plans.

(2) INCORPORATION.—The Center shall assist users of health information technology focused on clinical decision support to promote the timely incorporation of the findings described in paragraph (1) into clinical practices and to promote the ease of use of such incorporation.

(f) REPORTS TO CONGRESS.—

(1) ANNUAL REPORTS.—Beginning not later than one year after the date of the enactment of this section, the Director of the Agency of Healthcare Research and Quality and the Commission shall submit to Congress an annual report on the activities of the Center and the Commission, as well as the research, conducted under this section.

(2) RECOMMENDATION FOR FAIR SHARE PER CAPITA AMOUNT FOR ALL-PAYER FINANCING.—Beginning not later than December 31, 2009, the Secretary shall submit to Congress an annual recommendation for a fair share per capita amount described in

subsection (c)(1) of section 9511 of the Internal Revenue Code of 1986 for purposes of funding the CERTF under such section.

(3) ANALYSIS AND REVIEW.—Not later than December 31, 2011, the Secretary, in consultation with the Commission, shall submit to Congress a report on all activities conducted or supported under this section as of such date. Such report shall include an evaluation of the return on investment resulting from such activities, the overall costs of such activities, and an analysis of the backlog of any research proposals approved by the Commission but not funded. Such report shall also address whether Congress should expand the responsibilities of the Center and of the Commission to include studies of the effectiveness of various aspects of the health care delivery system, including health plans and delivery models, such as health plan features, benefit designs and performance, and the ways in which health services are organized, managed, and delivered.

(g) COORDINATING COUNCIL FOR HEALTH SERVICES RESEARCH.—

(1) ESTABLISHMENT.—The Secretary shall establish a permanent council (in this section referred to as the "Council") for the purpose of—

(A) assisting the offices and agencies of the Department of Health and Human Services, the Department of Veterans Affairs, the Department of Defense, and any other Federal department or agency to coordinate the conduct or support of health services research; and

(B) advising the President and Congress on—

(i) the national health services research agenda;

(ii) strategies with respect to infrastructure needs of health services research; and

(iii) appropriate organizational expenditures in health services research by relevant Federal departments and agencies.

(2) MEMBERSHIP.—

(A) NUMBER AND APPOINTMENT.—The Council shall be composed of 20 members. One member shall be the Director of the Agency for Healthcare Research and Quality. The Director shall appoint the other members not later than 30 days after the enactment of this Act.

(B) TERMS.—

(i) IN GENERAL.—Except as provided in clause (ii), each member of the Council shall be appointed for a term of 4 years.

(ii) TERMS OF INITIAL APPOINTEES.—Of the members first appointed—

(I) 8 shall be appointed for a term of 4 years; and

(II) 7 shall be appointed for a term of 3 years.

(iii) VACANCIES.—Any vacancies shall not affect the power and duties of the Council and shall be filled in the same manner as the original appointment.

(C) QUALIFICATIONS.—

(i) IN GENERAL.—The members of the Council shall include one senior official from each of the following agencies:

(I) The Veterans Health Administration.

(II) The Department of Defense Military Health Care System.

(III) The Centers for Disease Control and Prevention.

(IV) The National Center for Health Statistics.

(V) The National Institutes of Health.

(VI) The Center for Medicare & Medicaid Services.

(VII) The Federal Employees Health Benefits Program.

(ii) NATIONAL, PHILANTHROPIC FOUNDATIONS.—The members of the Council shall include 4 senior leaders from major national, philanthropic foundations that fund and use health services research.

(iii) STAKEHOLDERS.—The remaining members of the Council shall be representatives of other stakeholders in health services research, including private purchasers, health plans, hospitals and other health facilities, and health consumer groups.

(3) ANNUAL REPORT.—The Council shall submit to Congress an annual report on the progress of the implementation of the national health services research agenda.

(h) FUNDING OF COMPARATIVE EFFECTIVENESS RESEARCH.—For fiscal year 2008 and each subsequent fiscal year, amounts in the Comparative Effectiveness Research Trust Fund (referred to in this section as the "CERTF") under section 9511 of the Internal Revenue Code of 1986 shall be available to the Secretary to carry out this section.

PART B—SUPPLEMENTARY MEDICAL INSURANCE BENEFITS FOR THE AGED AND DISABLED

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SCOPE OF BENEFITS

SEC. 1832. (a) The benefits provided to an individual by the insurance program established by this part shall consist of—

(1) * * *

(2) entitlement to have payment made on his behalf (subject to the provisions of this part) for—

(A) * * *

(B) medical and other health services (other than items described in subparagraph (G) or subparagraph (I)) furnished by a provider of services or by others under arrangement with them made by a provider of services, excluding—

(i) * * *

* * * * * * *

(v) marriage and family therapist services;

(vi) mental health counselor services;

(C) outpatient physical therapy services (other than services to which the second sentence of section 1861(p) applies) [and outpatient], *outpatient* occupational therapy

services (other than services to which such sentence applies through the operation of section 1861(g)), *and outpatient speech-language pathology services (other than services to which the second sentence of section 1861(p) applies through the application of section 1861(ll)(2))*;

* * * * * * *

PAYMENT OF BENEFITS

SEC. 1833. (a) Except as provided in section 1876, and subject to the succeeding provisions of this section, there shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for services with respect to which benefits are payable under this part, amounts equal to—

(1) in the case of services described in section 1832(a)(1)—80 percent of the reasonable charges for the services; except that (A) an organization which provides medical and other health services (or arranges for their availability) on a prepayment basis (and either is sponsored by a union or employer, or does not provide, or arrange for the provision of, any inpatient hospital services) may elect to be paid 80 percent of the reasonable cost of services for which payment may be made under this part on behalf of individuals enrolled in such organization in lieu of 80 percent of the reasonable charges for such services if the organization undertakes to charge such individuals no more than 20 percent of such reasonable cost plus any amounts payable by them as a result of subsection (b), (B) with respect to items and services described in section 1861(s)(10)(A), the amounts paid shall be 100 percent of the reasonable charges for such items and services, (C) with respect to expenses incurred for those physicians' services for which payment may be made under this part that are described in section 1862(a)(4), the amounts paid shall be subject to such limitations as may be prescribed by regulations, (D) with respect to clinical diagnostic laboratory tests for which payment is made under this part (i) on the basis of a fee schedule under subsection (h)(1) or section 1834(d)(1), the amount paid shall be equal to 80 percent (or 100 percent, in the case of such tests for which payment is made on an assignment-related basis) of the lesser of the amount determined under such fee schedule, the limitation amount for that test determined under subsection (h)(4)(B), or the amount of the charges billed for the tests, (ii) on the basis of a negotiated rate established under subsection (h)(6), the amount paid shall be equal to 100 percent of such negotiated rate, or (iii) on the basis of a rate established under a demonstration project under section 1847(e), the amount paid shall be equal to 100 percent of such rate, (E) with respect to services furnished to individuals who have been determined to have end stage renal disease, the amounts paid shall be determined subject to the provisions of section 1881, (F) with respect to clinical social worker services under section 1861(s)(2)(N), the amounts paid shall be 80 per-

cent 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 clause (L),

(G) with respect to facility services furnished in connection with a surgical procedure specified pursuant to subsection (i)(1)(A) and furnished to an individual in an ambulatory surgical center described in such subsection, for services furnished beginning with the implementation date of a revised payment system for such services in such facilities specified in subsection (i)(2)(D), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by the Secretary under such revised payment system,

(H) with respect to services of a certified registered nurse anesthetist under section 1861(s)(11), the amounts paid shall be 80 percent of the least of the actual charge, the prevailing charge that would be recognized (or, for services furnished on or after January 1, 1992, the fee schedule amount provided under section 1848) if the services had been performed by an anesthesiologist, or the fee schedule for such services established by the Secretary in accordance with subsection (l), (I) with respect to covered items (described in section 1834(a)(13)), the amounts paid shall be the amounts described in section 1834(a)(1), and (J) with respect to expenses incurred for radiologist services (as defined in section 1834(b)(6)), subject to section 1848, the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount provided under the fee schedule established under section 1834(b), (K) with respect to certified nurse-midwife services under section 1861(s)(2)(L), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph [(but in no event shall such fee schedule exceed 65 percent of the prevailing charge that would be allowed for the same service performed by a physician, or, for services furnished on or after January 1, 1992, 65 percent of the fee schedule amount provided under section 1848 for the same service performed by a physician)], (L) with respect to qualified psychologist services under section 1861(s)(2)(M), the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary for the purposes of this subparagraph, (M) with respect to prosthetic devices and orthotics and prosthetics (as defined in section 1834(h)(4)), the amounts paid shall be the amounts described in section 1834(h)(1), (N) with respect to expenses incurred for physicians' services (as defined in section 1848(j)(3)), the amounts paid shall be 80 percent of the payment basis determined under section 1848(a)(1), (O) with respect to services described in section 1861(s)(2)(K) (relating to services furnished by physician assistants, nurse practitioners, or clinic nurse specialists), the amounts paid shall be equal to 80 percent of (i) the lesser of the actual charge or 85 percent of the fee schedule amount provided under section 1848, or (ii) in the case of services as an assistant at surgery, the lesser of the actual charge or 85 percent of the amount that would otherwise be recognized if performed by a physician who is serving as an assistant at surgery, (P) with respect to surgical dressings, the amounts paid shall be

the amounts determined under section 1834(i), (Q) with respect to items or services for which fee schedules are established pursuant to section 1842(s), the amounts paid shall be 80 percent of the lesser of the actual charge or the fee schedule established in such section, (R) with respect to ambulance services, (i) the amounts paid shall be 80 percent of the lesser of the actual charge for the services or the amount determined by a fee schedule established by the Secretary under section 1834(l) and (ii) with respect to ambulance services described in section 1834(l)(8), the amounts paid shall be the amounts determined under section 1834(g) for outpatient critical access hospital services, (S) with respect to drugs and biologicals (including intravenous immune globulin (as defined in section 1861(zz))) not paid on a cost or prospective payment basis as otherwise provided in this part (other than items and services described in subparagraph (B)), the amounts paid shall be 80 percent of the lesser of the actual charge or the payment amount established in section 1842(o) (or, if applicable, under section 1847, 1847A, or 1847B), (T) with respect to medical nutrition therapy services (as defined in section 1861(vv)), the amount paid shall be ⟦80⟧ *100* percent of the lesser of the actual charge for the services or 85 percent of the amount determined under the fee schedule established under section 1848(b) for the same services if furnished by a physician, (U) with respect to facility fees described in section 1834(m)(2)(B), the amounts paid shall be 80 percent of the lesser of the actual charge or the amounts specified in such section, ⟦and⟧ (V) notwithstanding subparagraphs (I) (relating to durable medical equipment), (M) (relating to prosthetic devices and orthotics and prosthetics), and (Q) (relating to 1842(s) items), with respect to competitively priced items and services (described in section 1847(a)(2)) that are furnished in a competitive area, the amounts paid shall be the amounts described in section 1847(b)(5), *(W) with respect to additional preventive services (as defined in section 1861(ccc)(2)) and other preventive services for which a payment rate is not otherwise established under this section, the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under a fee schedule established by the Secretary for purposes of this clause, (X) with respect to marriage and family therapist services under section 1861(s)(2)(CC), 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), and (Y) with respect to mental health counselor services under section 1861(s)(2)(DD), 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)*;

(2) in the case of services described in section 1832(a)(2) (except those services described in subparagraphs (C), (D), (E), (F), (G), (H), and (I) of such section and unless otherwise specified in section 1881)—

(A) * * *

* * * * * * *

(F) with respect to a covered osteoporosis drug (as defined in section 1861(kk)) furnished by a home health

agency, 80 percent of the reasonable cost of such service, as determined under section 1861(v); [and]

(G) with respect to items and services described in section 1861(s)(10)(A), the lesser of—

(i) * * *

(ii) the customary charges with respect to such services, *and*

(H) with respect to additional preventive services (as defined in section 1861(ccc)(2)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(W);

(3) in the case of services described in section 1832(a)(2)(D)—

(A) * * *

(B) with respect to the services described in clause (ii) of section 1832(a)(2)(D) that are furnished to an individual enrolled with a [MA] *Medicare Part C* plan under part C pursuant to a written agreement described in section 1853(a)(4), the amount (if any) by which—

(i) * * *

* * * * * * *

(8) in the case of—

(A) outpatient physical therapy services [(which includes outpatient speech-language pathology services)], *outpatient speech-language pathology services,* and outpatient occupational therapy services furnished—

(i) * * *

* * * * * * *

(B) outpatient physical therapy services [(which includes outpatient speech-language pathology services)], *outpatient speech-language pathology services,* and outpatient occupational therapy services furnished—

(i) * * *

* * * * * * *

(b) Before applying subsection (a) with respect to expenses incurred by an individual during any calendar year, the total amount of the expenses incurred by such individual during such year (which would, except for this subsection, constitute incurred expenses from which benefits payable under subsection (a) are determinable) shall be reduced by a deductible of $75 for calendar years before 1991, $100 for 1991 through 2004, $110 for 2005, and for a subsequent year the amount of such deductible for the previous year increased by the annual percentage increase in the monthly actuarial rate under section 1839(a)(1) ending with such subsequent year (rounded to the nearest $1); except that (1) such total amount shall not include expenses incurred for [items and services described in section 1861(s)(10)(A)] *preventive services (as defined in section 1861(ccc)(1))*, (2) such deductible shall not apply with respect to home health services (other than a covered osteoporosis drug (as defined in section 1861(kk))), (3) such deductible shall not apply with respect to clinical diagnostic laboratory tests for which payment is made under this part (A) under subsection (a)(1)(D)(i) or (a)(2)(D)(i) on an assignment-related basis, or to a provider hav-

ing an agreement under section 1866, or (B) on the basis of a negotiated rate determined under subsection (h)(6), *and* (4) such deductible shall not apply to Federally qualified health center services[, (5) such deductible shall not apply with respect to screening mammography (as described in section 1861(jj)), (6) such deductible shall not apply with respect to screening pap smear and screening pelvic exam (as described in section 1861(nn)), (7) such deductible shall not apply with respect to ultrasound screening for abdominal aortic aneurysm (as defined in section 1861(bbb)), and (8) such deductible shall not apply with respect to colorectal cancer screening tests (as described in section 1861(pp)(1))]. The total amount of the expenses incurred by an individual as determined under the preceding sentence shall, after the reduction specified in such sentence, be further reduced by an amount equal to the expenses incurred for the first three pints of whole blood (or equivalent quantities of packed red blood cells, as defined under regulations) furnished to the individual during the calendar year, except that such deductible for such blood shall in accordance with regulations be appropriately reduced to the extent that there has been a replacement of such blood (or equivalent quantities of packed red blood cells, as so defined); and for such purposes blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual shall be deemed replaced when the institution or other person furnishing such blood (or such equivalent quantities of packed red blood cells, as so defined) is given one pint of blood for each pint of blood (or equivalent quantities of packed red blood cells, as so defined) furnished such individual with respect to which a deduction is made under this sentence. The deductible under the previous sentence for blood or blood cells furnished an individual in a year shall be reduced to the extent that a deductible has been imposed under section 1813(a)(2) to blood or blood cells furnished the individual in the year. *Clause (1) of the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code applied, of the establishment of a diagnosis as a result of the test, or of the removal of tissue or other matter or other procedure that is performed in connection with and as a result of the screening test.*

(c) Notwithstanding any other provision of this part, with respect to expenses incurred in any calendar year *before 2008* in connection with the treatment of mental, psychoneurotic, and personality disorders of an individual who is not an inpatient of a hospital at the time such expenses are incurred, there shall be considered as incurred expenses for purposes of subsections (a) and (b) only 62½ percent of such expenses. For purposes of this subsection, the term "treatment" does not include brief office visits (as defined by the Secretary) for the sole purpose of monitoring or changing drug prescriptions used in the treatment of such disorders or partial hospitalization services that are not directly provided by a physician.

* * * * * * *

(g)(1) Subject to paragraphs (4) and (5), in the case of physical therapy services of the type described in section 1861(p) *and speech-language pathology services of the type described in such section through the application of section 1861(ll)(2)*, but not described in section 1833(a)(8)(B), and physical therapy services *and speech-*

language pathology services of such type which are furnished by a physician or as incident to physicians' services, with respect to expenses incurred in any calendar year, no more than the amount specified in paragraph (2) for the year shall be considered as incurred expenses for purposes of subsections (a) and (b).

* * * * * * *

(5) With respect to expenses incurred during the period beginning on January 1, 2006, and ending on December 31, [2007] *2009*, for services, the Secretary shall implement a process under which an individual enrolled under this part may, upon request of the individual or a person on behalf of the individual, obtain an exception from the uniform dollar limitation specified in paragraph (2), for services described in paragraphs (1) and (3) if the provision of such services is determined to be medically necessary. Under such process, if the Secretary does not make a decision on such a request for an exception within 10 business days of the date of the Secretary's receipt of the request, the Secretary shall be deemed to have found the services to be medically necessary.

* * * * * * *

(t) PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.—

(1) AMOUNT OF PAYMENT.—

(A) * * *

(B) DEFINITION OF COVERED OPD SERVICES.—For purposes of this subsection, the term "covered OPD services"—

(i) * * *

* * * * * * *

(iv) does not include any therapy services described in subsection (a)(8) or ambulance services, for which payment is made under a fee schedule described in section 1834(k) or section 1834(l) and does not include [screening mammography (as defined in section 1861(jj)) and diagnostic mammography] *diagnostic mammography and preventive services (as defined in section 1861(ccc)(1))*.

* * * * * * *

(3) CALCULATION OF BASE AMOUNTS.—

(A) * * *

* * * * * * *

(C) CALCULATION OF CONVERSION FACTORS.—

(i) * * *

* * * * * * *

(iv) OPD FEE SCHEDULE INCREASE FACTOR.—For purposes of this subparagraph, subject to paragraph (17), the "OPD fee schedule increase factor" for services furnished in a year is equal to the market basket percentage increase applicable under section 1886(b)(3)(B)(iii) to hospital discharges occurring during the fiscal year ending in such year, reduced by 1 percentage point for such factor for services furnished

in each of 2000 and 2002 *and reduced by 0.25 percentage point for such factor for such services furnished in 2008*. In applying the previous sentence for years beginning with 2000, the Secretary may substitute for the market basket percentage increase an annual percentage increase that is computed and applied with respect to covered OPD services furnished in a year in the same manner as the market basket percentage increase is determined and applied to inpatient hospital services for discharges occurring in a fiscal year.

* * * * * * *

(7) TRANSITIONAL ADJUSTMENT TO LIMIT DECLINE IN PAYMENT.—

(A) * * *

* * * * * * *

(D) HOLD HARMLESS PROVISIONS.—

(i) TEMPORARY TREATMENT FOR CERTAIN RURAL HOSPITALS.—(I) * * *

(II) In the case of a hospital located in a rural area and that has not more than 100 beds and that is not a sole community hospital (as defined in section 1886(d)(5)(D)(iii)), for covered OPD services furnished on or after January 1, 2006, and before ⟦January 1, 2009⟧ *January 1, 2010*, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the applicable percentage of the amount of such difference. For purposes of the previous sentence, with respect to covered OPD services furnished during 2006, ⟦2007, or 2008,⟧ the applicable percentage shall be 95 percent, ⟦90 percent, and 85 percent, respectively.⟧ *and with respect to such services furnished after 2006 the applicable percentage shall be 90 percent.*

* * * * * * *

(16) MISCELLANEOUS PROVISIONS.—

(A) * * *

* * * * * * *

(C) PAYMENT FOR DEVICES OF BRACHYTHERAPY AT CHARGES ADJUSTED TO COST.—Notwithstanding the preceding provisions of this subsection, for a device of brachytherapy consisting of a seed or seeds (or radioactive source) furnished on or after January 1, 2004, and before January 1, ⟦2008⟧ *2009*, the payment basis for the device under this subsection shall be equal to the hospital's charges for each device furnished, adjusted to cost. Charges for such devices shall not be included in determining any outlier payment under this subsection.

* * * * * * *

(u) INCENTIVE PAYMENTS FOR PHYSICIAN SCARCITY AREAS.—

(1) IN GENERAL.—In the case of physicians' services furnished on or after January 1, 2005, and before January 1, [2008] *2010*—

(A) * * *

* * * * * * *

(v) INCENTIVE PAYMENTS FOR EFFICIENT AREAS.—

(1) IN GENERAL.—In the case of services furnished under the physician fee schedule under section 1848 on or after January 1, 2009, and before January 1, 2011, by a supplier that is paid under such fee schedule in an efficient area (as identified under paragraph (2)), in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid an amount equal to 5 percent of the payment amount for the services under this part.

(2) IDENTIFICATION OF EFFICIENT AREAS.—

(A) IN GENERAL.—Based upon available data, the Secretary shall identify those counties or equivalent areas in the United States in the lowest fifth percentile of utilization based on per capita spending for services provided in 2007 under this part and part A.

(B) IDENTIFICATION OF COUNTIES WHERE SERVICE IS FURNISHED.—For purposes of paying the additional amount specified in paragraph (1), if the Secretary uses the 5-digit postal ZIP Code where the service is furnished, the dominant county of the postal ZIP Code (as determined by the United States Postal Service, or otherwise) shall be used to determine whether the postal ZIP Code is in a county described in subparagraph (A).

(C) JUDICIAL REVIEW.— There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting—

(i) the identification of a county or other area under subparagraph (A); or

(ii) the assignment of a postal ZIP Code to a county or other area under subparagraph (B).

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

SPECIAL PAYMENT RULES FOR PARTICULAR ITEMS AND SERVICES

SEC. 1834. (a) PAYMENT FOR DURABLE MEDICAL EQUIPMENT.—

(1) * * *

* * * * * * *

(5) PAYMENT FOR OXYGEN AND OXYGEN EQUIPMENT.—

(A) * * *

* * * * * * *

(F) OWNERSHIP OF EQUIPMENT.—

(i) IN GENERAL.—[Payment] *Subject to clause (iii), payment* for oxygen equipment (including portable oxygen equipment) under this paragraph may not extend over a period of continuous use (as determined by the Secretary) of longer than [36 months] *18 months*.

(ii) OWNERSHIP.—

(I) TRANSFER OF TITLE.—On the first day that begins after the [36th continuous month] *18th continuous month* during which payment is made for the equipment under this paragraph, the supplier of the equipment shall transfer title to the equipment to the individual.

* * * * * * *

(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 "18 months" is deemed a reference to "36 months".

* * * * * * *

(7) PAYMENT FOR OTHER ITEMS OF DURABLE MEDICAL EQUIPMENT.—

(A) PAYMENT.—In the case of an item of durable medical equipment not described in paragraphs (2) through (6), the following rules shall apply:

(i) RENTAL.—

(I) IN GENERAL.—[Except as provided in clause (iii), payment] *Payment* for the item shall be made on a monthly basis for the rental of the item during the period of medical need (but payments under this clause may not extend over a period of continuous use (as determined by the Secretary) of longer than 13 months).

* * * * * * *

[(iii) PURCHASE AGREEMENT OPTION FOR POWER-DRIVEN WHEELCHAIRS.—In the case of a power-driven wheelchair, at the time the supplier furnishes the item, the supplier shall offer the individual the option to purchase the item, and payment for such item shall be made on a lump-sum basis if the individual exercises such option.]

[(iv)] *(iii)* MAINTENANCE AND SERVICING.—After the supplier transfers title to the item under clause (ii) [or in the case of a power-driven wheelchair for which a purchase agreement has been entered into under clause (iii)], maintenance and servicing payments shall, if the Secretary determines such payments are reasonable and necessary, be made (for parts and labor not covered by the supplier's or manufacturer's warranty, as determined by the Secretary to be appro-

priate for the particular type of durable medical equipment), and such payments shall be in an amount determined to be appropriate by the Secretary.

* * * * * * *

(C) REPLACEMENT OF ITEMS.—

(i) * * *

(ii) PAYMENT FOR REPLACEMENT ITEMS.—If the reasonable lifetime of such an item, as so established, has been reached during a continuous period of medical need, or the carrier determines that the item is lost or irreparably damaged, the patient may elect to have payment for an item serving as a replacement for such item made—

(I) * * *

(II) in the case of an item for which a purchase agreement has been entered into under subparagraph (A)(ii) [or (A)(iii)], in a lump-sum amount for the purchase of the item.

* * * * * * *

(20) IDENTIFICATION OF QUALITY STANDARDS.—

(A) * * *

(B) DESIGNATION OF INDEPENDENT ACCREDITATION ORGANIZATIONS.—Not later than the date that is 1 year after the date on which the Secretary implements the quality standards under subparagraph (A), notwithstanding [section 1865(b)] *section 1865(a)*, the Secretary shall designate and approve one or more independent accreditation organizations for purposes of such subparagraph.

* * * * * * *

(d) FREQUENCY LIMITS AND PAYMENT FOR COLORECTAL CANCER SCREENING TESTS.—

(1) * * *

(2) SCREENING FLEXIBLE SIGMOIDOSCOPIES.—

(A) * * *

* * * * * * *

(C) FACILITY PAYMENT LIMIT.—

(i) * * *

[(ii) LIMITATION ON COINSURANCE.—Notwithstanding any other provision of this title, in the case of a beneficiary who receives the services described in clause (i)—

[(I) in computing the amount of any applicable copayment, the computation of such coinsurance shall be based upon the fee schedule under which payment is made for the services, and

[(II) the amount of such coinsurance is equal to 25 percent of the payment amount under the fee schedule described in subclause (I).]

(ii) NO COINSURANCE.—In the case of a beneficiary who receives services described in clause (i), there shall be no coinsurance applied.

* * * * * * *

(3) SCREENING COLONOSCOPY.—

(A) * * *

* * * * * * *

(C) FACILITY PAYMENT LIMIT.—

(i) * * *

[(ii) LIMITATION ON COINSURANCE.—Notwithstanding any other provision of this title, in the case of a beneficiary who receives the services described in clause (i)—

[(I) in computing the amount of any applicable coinsurance, the computation of such coinsurance shall be based upon the fee schedule under which payment is made for the services, and

[(II) the amount of such coinsurance is equal to 25 percent of the payment amount under the fee schedule described in subclause (I).]

(ii) NO COINSURANCE.—In the case of a beneficiary who receives services described in clause (i), there shall be no coinsurance applied.

* * * * * * *

(l) ESTABLISHMENT OF FEE SCHEDULE FOR AMBULANCE SERVICES.—

(1) * * *

* * * * * * *

(13) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.—

(A) IN GENERAL.—After computing the rates with respect to ground ambulance services under the other applicable provisions of this subsection, in the case of such services [furnished on or after July 1, 2004, and before January 1, 2007,] for which the transportation originates in—

(i) a rural area described in paragraph (9) or in a rural census tract described in such paragraph, *for services furnished on or after July 1, 2004, and before January 1, 2007, and on or after January 1, 2008, and before January 1, 2010,* the fee schedule established under this section shall provide that the rate for the service otherwise established, after the application of any increase under paragraphs (11) and (12), shall be increased by 2 percent; and

(ii) an area not described in clause (i), *for services furnished on or after July 1, 2004, and before January 1, 2007,* the fee schedule established under this subsection shall provide that the rate for the service otherwise established, after the application of any increase under paragraph (11), shall be increased by 1 percent.

(B) APPLICATION OF INCREASED PAYMENTS [AFTER 2006] *FOR SUBSEQUENT PERIODS*.—The increased payments under *clauses (i) and (ii) of* subparagraph (A) shall not be taken into account in calculating payments for services furnished after the period specified [in such subparagraph] *in the respective clause*.

* * * * * * *

PROCEDURE FOR PAYMENT OF CLAIMS OF PROVIDERS OF SERVICES

SEC. 1835. (a) Except as provided in subsections (b), (c), and (e), payment for services described in section 1832(a)(2) furnished an individual may be made only to providers of services which are eligible therefor under section 1866(a), and only if—

(1) * * *

* * * * * * *

For purposes of this section, the term "provider of services" shall include a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) (or meets the requirements of such section through the operation of [section 1861(g)] *subsection (g) or (ll)(2) of section 1861*), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) (or meets the requirements of such section through the operation of [section 1861(g)] *subsection (g) or (ll)(2) of section 1861*), but only with respect to the furnishing of outpatient physical therapy services (as therein defined) or (through the operation of [section 1861(g)] *subsection (g) or (ll)(2) of section 1861*) with respect to the furnishing of outpatient occupational therapy services *or outpatient speech-language pathology services, respectively*.

To the extent provided by regulations, the certification and recertification requirements of paragraph (2) shall be deemed satisfied where, at a later date, a physician makes a certification of the kind provided in subparagraph (A) or (B) of paragraph (2) (whichever would have applied), but only where such certification is accompanied by such medical and other evidence as may be required by such regulations. With respect to the physician certification required by paragraph (2) for home health services furnished to any individual by a home health agency (other than an agency which is a governmental entity) and with respect to the establishment and review of a plan for such services, the Secretary shall prescribe regulations which shall become effective no later than July 1, 1981, and which prohibit a physician who has a significant ownership interest in, or a significant financial or contractual relationship with, such home health agency from performing such certification and from establishing or reviewing such plan, except that such prohibition shall not apply with respect to a home health agency which is a sole community home health agency (as determined by the Secretary). For purposes of the preceding sentence, service by a physician as an uncompensated officer or director of a home health agency shall not constitute having a significant ownership interest in, or a significant financial or contractual relationship with, such agency. For purposes of paragraph (2)(A), an individual shall be

considered to be "confined to his home" if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home", the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a State, or accredited, to furnish adult day-care services in the State shall not disqualify an individual from being considered to be "confined to his home". Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration.

* * * * * * *

AMOUNTS OF PREMIUMS

SEC. 1839. (a) * * *

* * * * * * *

(h) POTENTIAL APPLICATION OF COMPARATIVE COST ADJUSTMENT IN CCA AREAS.—

(1) IN GENERAL.—Certain individuals who are residing in a CCA area under section 1860C–1 who are not enrolled in an [MA] *Medicare Part C* plan under part C may be subject to a premium adjustment under subsection (f) of such section for months in which the CCA program under such section is in effect in such area.

* * * * * * *

PAYMENT OF PREMIUMS

SEC. 1840. (a) * * *

* * * * * * *

(i) In the case of an individual enrolled in a [Medicare+Choice] *Medicare Part C* plan, the Secretary shall provide for necessary adjustments of the monthly beneficiary premium to reflect 80 percent of any reduction elected under section 1854(f)(1)(E) and to reflect any credit provided under section 1854(b)(1)(C)(iv). To the extent to which the Secretary determines that such an adjustment is appropriate, with the concurrence of any agency responsible for the administration of such benefits, such premium adjustment may be provided directly, as an adjustment to any social security, railroad retirement, or civil service retirement benefits, or, in the case of an individual who receives medical assistance under title XIX for

medicare costs described in section 1905(p)(3)(A)(ii), as an adjustment to the amount otherwise owed by the State for such medical assistance.

* * * * * * *

PROVISIONS RELATING TO THE ADMINISTRATION OF PART B

SEC. 1842. (a) * * *
(b)
(2) * * *

* * * * * * *

(6) No payment under this part for a service provided to any individual shall (except as provided in section 1870) be made to anyone other than such individual or (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) the physician or other person who provided the service, except that (A) payment may be made (i) to the employer of such physician or other person if such physician or other person is required as a condition of his employment to turn over his fee for such service to his employer, or (ii) where the service was provided under a contractual arrangement between such physician or other person and an entity, to the entity if, under the contractual arrangement, the entity submits the bill for the service and the contractual arrangement meets such program integrity and other safeguards as the Secretary may determine to be appropriate, (B) payment may be made to an entity (i) which provides coverage of the services under a health benefits plan, but only to the extent that payment is not made under this part, (ii) which has paid the person who provided the service an amount (including the amount payable under this part) which that person has accepted as payment in full for the service, and (iii) to which the individual has agreed in writing that payment may be made under this part, (C) in the case of services described in clause (i) of section 1861(s)(2)(K), payment shall be made to either (i) the employer of the physician assistant involved, or (ii) with respect to a physician assistant who was the owner of a rural health clinic (as described in section 1861(aa)(2)) for a continuous period beginning prior to the date of the enactment of the Balanced Budget Act of 1997 and ending on the date that the Secretary determines such rural health clinic no longer meets the requirements of section 1861(aa)(2), payment may be made directly to the physician assistant, (D) payment may be made to a physician for physicians' services (and services furnished incident to such services) furnished by a second physician to patients of the first physician if (i) the first physician is unavailable to provide the services; (ii) the services are furnished pursuant to an arrangement between the two physicians that (I) is informal and reciprocal, or (II) involves per diem or other fee-for-time compensation for such services; (iii) the services are not provided by the second physician over a continuous period of more than 60 days *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*; and (iv) the claim form submitted to the medicare administrative contractor for such services includes the second physician's unique identifier (provided under the system established under

subsection (r)) and indicates that the claim meets the requirements of this subparagraph for payment to the first physician, (E) in the case of an item or service (other than services described in section 1888(e)(2)(A)(ii)) furnished by, or under arrangements made by, a skilled nursing facility to an individual who (at the time the item or service is furnished) is a resident of a skilled nursing facility, payment shall be made to the facility, (F) in the case of home health services (including medical supplies described in section 1861(m)(5), but excluding durable medical equipment to the extent provided for in such section) furnished to an individual who (at the time the item or service is furnished) is under a plan of care of a home health agency, payment shall be made to the agency (without regard to whether or not the item or service was furnished by the agency, by others under arrangement with them made by the agency, or when any other contracting or consulting arrangement, or otherwise), (G) in the case of services in a hospital or clinic to which section 1880(e) applies, payment shall be made to such hospital or clinic, and (H) in the case of services described in section 1861(aa)(3) that are furnished by a health care professional under contract with a Federally qualified health center, payment shall be made to the center. No payment which under the preceding sentence may be made directly to the physician or other person providing the service involved (pursuant to an assignment described in subparagraph (B)(ii) of paragraph (3)) shall be made to anyone else under a reassignment or power of attorney (except to an employer or entity as described in subparagraph (A) of such sentence); but nothing in this subsection shall be construed (i) to prevent the making of such a payment in accordance with an assignment from the individual to whom the service was provided or a reassignment from the physician or other person providing such service if such assignment or reassignment is made to a governmental agency or entity or is established by or pursuant to the order of a court of competent jurisdiction, or (ii) to preclude an agent of the physician or other person providing the service from receiving any such payment if (but only if) such agent does so pursuant to an agency agreement under which the compensation to be paid to the agent for his services for or in connection with the billing or collection of payments due such physician or other person under this title is unrelated (directly or indirectly) to the amount of such payments or the billings therefor, and is not dependent upon the actual collection of any such payment. For purposes of subparagraph (C) of the first sentence of this paragraph, an employment relationship may include any independent contractor arrangement, and employer status shall be determined in accordance with the law of the State in which the services described in such clause are performed.

* * * * * * *

(18)(A) * * *

* * * * * * *

(C) A practitioner described in this subparagraph is any of the following:

(i) * * *

* * * * * * *

(vii) A marriage and family therapist (as defined in section 1861(eee)(2)).

(viii) A mental health counselor (as defined in section 1861(fff)(1)).

* * * * * * *

USE OF AVERAGE SALES PRICE PAYMENT METHODOLOGY

SEC. 1847A. (a) * * *

(b) PAYMENT AMOUNT.—

(1) IN GENERAL.—Subject to *paragraph (6) and* subsections (d)(3)(C) and (e), the amount of payment determined under this section for the billing and payment code for a drug or biological (based on a minimum dosage unit) is, subject to applicable deductible and coinsurance—

(A) * * *

* * * * * * *

(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.

* * * * * * *

COMPETITIVE ACQUISITION OF OUTPATIENT DRUGS AND BIOLOGICALS

SEC. 1847B. (a) IMPLEMENTATION OF COMPETITIVE ACQUISITION.—

(1) IMPLEMENTATION OF PROGRAM.—

(A) IN GENERAL.—The Secretary shall establish and implement a competitive acquisition program under which—

(i) * * *

(ii) each physician is given the opportunity [annually] *on an ongoing basis* to elect to obtain drugs and biologicals under the program, rather than under section 1847A; and

(iii) each physician who elects to obtain drugs and biologicals under the program makes [an annual selection] *a selection (which may be changed on an annual basis)* under paragraph (5) of the contractor through which drugs and biologicals within a category of drugs and biologicals will be acquired and delivered to the physician under this part.

This section shall not apply in the case of a physician who elects section 1847A to apply. *An election and selection described in clauses (ii) and (iii) shall continue to be effective without the need for any periodic reelection or reapplication or selection.*

* * * * * * *

(E) PHYSICIAN OUTREACH AND EDUCATION.—The Secretary shall conduct a program of outreach to education physicians concerning the program and the ongoing oppor-

tunity of physicians to elect to obtain drugs and biologicals under the program.

* * * * * * *

(b) PROGRAM REQUIREMENTS.—

(1) * * *

* * * * * * *

(4) TERMS OF CONTRACTS.—

(A) * * *

* * * * * * *

(E) DIRECT DELIVERY OF DRUGS AND BIOLOGICALS TO PHYSICIANS.—Under the contract the contractor shall only supply competitively biddable drugs and biologicals directly to the selecting physicians and not directly to individuals, except under circumstances and settings where an individual currently receives a drug or biological in the individual's home or other non-physician office setting as the Secretary may provide. The contractor shall not deliver drugs and biologicals to a selecting physician except upon receipt of a prescription for such drugs and biologicals, and such necessary data as may be required by the Secretary to carry out this section. This section does not—

(i) require a physician to submit a prescription for each individual treatment; **[**or**]**

(ii) change a physician's flexibility in terms of writing a prescription for drugs or biologicals for a single treatment or a course of treatment**[**.**]***; or*

(iii) prevent a contractor from delivering drugs and biologicals to the site in which the drugs or biologicals will be administered.

* * * * * * *

PAYMENT FOR PHYSICIANS' SERVICES

SEC. 1848. (a) * * *

(b) ESTABLISHMENT OF FEE SCHEDULES.—

(1) * * *

* * * * * * *

(4) SPECIAL **[**RULE**]** *RULES* FOR IMAGING SERVICES.—

(A) **[**IN GENERAL**]** *LIMITATION*.—In the case of imaging services described in subparagraph (B) furnished on or after January 1, 2007, if—

(i) * * *

* * * * * * *

(B) IMAGING SERVICES DESCRIBED.—For purposes of **[**subparagraph (A)**]** *this paragraph*, imaging services described in this subparagraph are imaging and computer-assisted imaging services, including X-ray, ultrasound (including echocardiography), nuclear medicine (including positron emission tomography), magnetic resonance imaging, computed tomography, and fluoroscopy, but excluding diagnostic and screening mammography.

(C) PAYMENT ONLY FOR SERVICES PROVIDED IN ACCREDITED FACILITIES.—

(i) IN GENERAL.—In the case of imaging services that are diagnostic imaging services described in clause (ii), the payment amount for the technical component and the professional component of the services established for a year under the fee schedule described in paragraph (1) shall each be zero, unless the services are furnished at a diagnostic imaging services facility that meets the certificate requirement described in section 354(b)(1) of the Public Health Service Act, as applied under subsection (m). The previous sentence shall not apply with respect to the technical component if the imaging equipment meets certification standards and the professional component of a diagnostic imaging service that is furnished by a physician.

(ii) DIAGNOSTIC IMAGING SERVICES.—For purposes of clause (i) and subsection (m), the term "diagnostic imaging services" means all imaging modalities, including diagnostic magnetic resonance imaging ("MRI"), computed tomography ("CT"), positron emission tomography ("PET"), nuclear medicine procedures, x-rays, sonograms, ultrasounds, echocardiograms, and such emerging diagnostic imaging technologies as specified by the Secretary.

(D) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—In computing the number of practice expense relative value units under subsection (c)(2)(C)(ii) with respect to imaging services described in subparagraph (B), the Secretary shall adjust such number of units so it reflects a 75 percent (rather than 50 percent) presumed rate of utilization of imaging equipment.

(E) ADJUSTMENT IN TECHNICAL COMPONENT DISCOUNT ON SINGLE-SESSION IMAGING INVOLVING CONSECUTIVE BODY PARTS.—The Secretary shall increase the reduction in expenditures attributable to the multiple procedure payment reduction applicable to the technical component for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (42 CFR 405, et al.) from 25 percent to 50 percent.

(F) ADJUSTMENT IN ASSUMED INTEREST RATE FOR CAPITAL PURCHASES.—In computing the practice expense component for imaging services under this section, the Secretary shall change the interest rate assumption for capital purchases of imaging devices to reflect the prevailing rate in the market, but in no case higher than 11 percent.

(c) DETERMINATION OF RELATIVE VALUES FOR PHYSICIANS' SERVICES.—

(1) * * *

(2) DETERMINATION OF RELATIVE VALUES.—

(A) * * *

(B) PERIODIC REVIEW AND ADJUSTMENTS IN RELATIVE VALUES.—

(i) * * *

(ii) ADJUSTMENTS.—

(I) * * *

* * * * * * *

(III) ADJUSTMENT AUTHORITY FOR EFFICIENCY GAINS FOR NEW PROCEDURES.—In carrying out subclauses (I) and (II), the Secretary may apply a methodology, based on supporting evidence, under which there is imposed a reduction over a period of years in specified relative value units in the case of a new (or newer) procedure to take into account inherent efficiencies that are typically or likely to be gained during the period of initial increased application of the procedure.

* * * * * * *

(v) EXEMPTION OF CERTAIN REDUCED EXPENDITURES FROM BUDGET-NEUTRALITY CALCULATION.—The following reduced expenditures, as estimated by the Secretary, shall not be taken into account in applying clause (ii)(II):

(I) * * *

(II) OPD PAYMENT CAP *AND OTHER PROVISIONS* FOR IMAGING SERVICES.—Effective for fee schedules established beginning with 2007, reduced expenditures attributable to subsection (b)(4).

(III) REDUCTIONS IN WORK VALUE UNITS FOR SERVICES WITH ACCELERATED VOLUME GROWTH.—Effective January 1, 2009, reduced expenditures attributable to clause (vi).

(vi) AUTHORIZING REDUCTION IN WORK VALUE UNITS FOR SERVICES WITH ACCELERATED VOLUME GROWTH.—The Secretary may provide (without using existing processes the Secretary has established for review of relative value) for a reduction in the work value units for a particular physician's service if the annual rate of growth in the expenditures for such service for which payment is made under this part for individuals for 2006 or a subsequent year exceeds the average annual rate of growth in expenditures of all physicians' services for which payment is made under this part by more than 10 percentage points for such year.

(vii) CONSULTATION WITH EXPERT PANEL AND BASED ON CLINICAL EVIDENCE.—The Secretary shall exercise authority under clauses (ii)(III) and (vi) in consultation with the expert panel established under paragraph (7) and shall take into account clinical evidence supporting or refuting the merits of such accelerated growth.

* * * * * * *

(7) USE OF EXPERT PANEL TO IDENTIFY MISVALUED PHYSICIANS' SERVICES.—

(A) IN GENERAL.—The Secretary shall establish an expert panel (in this paragraph referred to as the "expert panel")—

(i) to identify, through data analysis, physicians' services for which the relative value under this subsection is potentially misvalued, particularly those services for which such relative value may be overvalued;

(ii) to assess whether those misvalued services warrant review using existing processes (referred to in paragraph (2)(J)(ii)) for the consideration of coding changes; and

(iii) to advise the Secretary concerning the exercise of authority under clauses (ii)(III) and (vi) of paragraph (2)(B).

(B) COMPOSITION OF PANEL.—The expert panel shall be appointed by the Secretary and composed of—

(i) members with expertise in medical economics and technology diffusion;

(ii) members with clinical expertise;

(iii) physicians, particularly physicians (such as a physician employed by the Veterans Administration or a physician who has a full time faculty appointment at a medical school) who are not directly affected by changes in the physician fee schedule under this section;

(iv) carrier medical directors; and

(v) representatives of private payor health plans.

(C) APPOINTMENT CONSIDERATIONS.—In appointing members to the expert panel, the Secretary shall assure racial and ethnic diversity on the panel and may consider appointing a liaison from organizations with experience in the consideration of coding changes to the panel.

(8) EXAMINATION OF SERVICES WITH SUBSTANTIAL CHANGES.—The Secretary, in consultation with the expert panel under paragraph (7), shall—

(A) conduct a five-year review of physicians' services in conjunction with the RUC 5-year review, particularly for services that have experienced substantial changes in length of stay, site of service, volume, practice expense, or other factors that may indicate changes in physician work;

(B) identify new services to determine if they are likely to experience a reduction in relative value over time and forward a list of the services so identified for such five-year review; and

(C) for physicians' services that are otherwise unreviewed under the process the Secretary has established, periodically review a sample of relative value units within different types of services to assess the accuracy of the relative values contained in the Medicare physician fee schedule.

(d) CONVERSION FACTORS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—**[**The conversion factor**]**

(i) APPLICATION OF SINGLE CONVERSION FACTOR.—Subject to clause (ii), the conversion factor for each year shall be the conversion factor established under this subsection for the previous year (or, in the case of

1992, specified in subparagraph (B)) adjusted by the update (established under paragraph (3)) for the year involved (for years before 2001) and, for years beginning with 2001, multiplied by the update (established under paragraph (4)) for the year involved.

(ii) APPLICATION OF MULTIPLE CONVERSION FACTORS BEGINNING WITH 2008.—

(I) IN GENERAL.—In applying clause (i) for years beginning with 2008, separate conversion factors shall be established for each service category of physicians' services (as defined in subsection (j)(5)) and any reference in this section to a conversion factor for such years shall be deemed to be a reference to the conversion factor for each of such categories.

(II) INITIAL CONVERSION FACTORS; SPECIAL RULE FOR ANESTHESIA SERVICES.— Such factors for 2008 shall be based upon the single conversion factor for 2007 multiplied by the update established under paragraph (8) for such category for 2008. In the case of the service category described in subsection (j)(5)(F) (relating to anesthesia services), the conversion factor for 2008 shall be based on the separate conversion factor specified in subparagraph (D) for 2007 multiplied by the update established under paragraph (8) for such category for 2008.

(III) UPDATING OF CONVERSION FACTORS.— Such factor for a service category for a subsequent year shall be based upon the conversion factor for such category for the previous year and adjusted by the update established for such category under paragraph (8) for the year involved.

* * * * * * *

(D) SPECIAL RULES FOR ANESTHESIA SERVICES.—The separate conversion factor for anesthesia services for a year *(before 2008)* shall be equal to 46 percent of the single conversion factor established for other physicians' services, except as adjusted for changes in work, practice expense, or malpractice relative value units.

(E) PUBLICATION AND DISSEMINATION OF INFORMATION.—The Secretary shall—

(i) * * *

(ii) make available to the Medicare Payment Advisory Commission and the public by March 1 of each year (beginning with 2000) an estimate of the sustainable *or target* growth rate and of the conversion factor which will apply to physicians' services for the succeeding year and data used in making such estimate.

* * * * * * *

(4) UPDATE FOR YEARS BEGINNING WITH 2001.—

(A) * * *

(B) UPDATE ADJUSTMENT FACTOR.—For purposes of subparagraph (A)(ii), subject to subparagraph (D) and para-

graphs (5) [and (6)], *(6), and (8)*, the "update adjustment factor" for a year is equal (as estimated by the Secretary) to the sum of the following:

(i) * * *

(ii) CUMULATIVE ADJUSTMENT COMPONENT.—An amount determined by—

(I) * * *

(II) dividing that difference by actual expenditures for such services for the prior year as increased by the sustainable *or target* growth rate under subsection (f) for the year for which the update adjustment factor is to be determined; and

* * * * * * *

(C) DETERMINATION OF ALLOWED EXPENDITURES.—For purposes of this paragraph:

(i) * * *

* * * * * * *

(iii) YEARS BEGINNING WITH 2000.—[The allowed] *Subject to paragraph (8)(B), the allowed* expenditures for a year (beginning with 2000) is equal to the allowed expenditures for physicians' services for the previous year, increased by the sustainable growth rate under subsection (f) for the year involved.

(D) RESTRICTION ON UPDATE ADJUSTMENT FACTOR.—[The update] *Subject to paragraph (8)(E), the update* adjustment factor determined under subparagraph (B) for a year may not be less than −0.07 or greater than 0.03.

* * * * * * *

(8) UPDATES FOR SERVICE CATEGORIES BEGINNING WITH 2008.—

(A) IN GENERAL.—In applying paragraph (4) for a year beginning with 2008, the following rules apply:

(i) APPLICATION OF SEPARATE UPDATE ADJUSTMENTS FOR EACH SERVICE CATEGORY.—Pursuant to paragraph (1)(A)(ii)(I), the update shall be made to the conversion factor for each service category (as defined in subsection (j)(5)) based upon an update adjustment factor for the respective category and year and the update adjustment factor shall be computed, for a year, separately for each service category.

(ii) COMPUTATION OF ALLOWED AND ACTUAL EXPENDITURES BASED ON SERVICE CATEGORIES.—In computing the prior year adjustment component and the cumulative adjustment component under clauses (i) and (ii) of paragraph (4)(B), the following rules apply:

(I) APPLICATION BASED ON SERVICE CATEGORIES.—The allowed expenditures and actual expenditures shall be the allowed and actual expenditures for the service category, as determined under subparagraph (B).

(II) LIMITATION TO PHYSICIAN FEE-SCHEDULE SERVICES.—Actual expenditures shall only take

into account expenditures for services furnished under the physician fee schedule.

(III) APPLICATION OF CATEGORY SPECIFIC TARGET GROWTH RATE.—The growth rate applied under clause (ii)(II) of such paragraph shall be the target growth rate for the service category involved under subsection (f)(5).

(IV) ALLOCATION OF CUMULATIVE OVERHANG.—There shall be substituted for the difference described in subparagraph (B)(ii)(I) of such paragraph the amount described in subparagraph (C)(i) for the service category involved.

(B) DETERMINATION OF ALLOWED EXPENDITURES.—In applying paragraph (4) for a year beginning with 2008, notwithstanding subparagraph (C)(iii) of such paragraph, the allowed expenditures for a service category for a year is an amount computed by the Secretary as follows:

(i) FOR 2008.—For 2008:

(I) TOTAL 2007 ALLOWED EXPENDITURES.—Compute the total allowed expenditures for services furnished under the physician fee schedule under such paragraph for 2007.

(II) INCREASE BY GROWTH RATE.—Increase the total under subclause (I) by the target growth rate for such category under subsection (f) for 2008.

(III) ALLOCATION TO SERVICE CATEGORY.—Multiply the increased total under subclause (II) by the overhang allocation factor for the service category (as defined in subparagraph (C)(iii)).

(ii) FOR SUBSEQUENT YEARS.—For a subsequent year, take the amount of allowed expenditures for such category for the preceding year (under clause (i) or this clause) and increase it by the target growth rate determined under subsection (f) for such category and year.

(C) COMPUTATION AND APPLICATION OF CUMULATIVE OVERHANG AMONG CATEGORIES.—

(i) IN GENERAL.—For purposes of applying paragraph (4)(B)(ii)(II) under clause (ii)(IV), the amount described in this clause for a year (beginning with 2008) is the sum of the following:

(I) PRE-2008 CUMULATIVE OVERHANG.—The amount of the pre-2008 cumulative excess spending (as defined in clause (ii)) multiplied by the overhang allocation factor for the service category (under clause (iii)).

(II) POST-2007 CUMULATIVE AMOUNTS.—For a year beginning with 2009, the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services (as determined under paragraph (4)(C)) in the service category from January 1, 2008, through the end of the prior year and 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.

(e) GEOGRAPHIC ADJUSTMENT FACTORS.—

(1) ESTABLISHMENT OF GEOGRAPHIC INDICES.—

(A) * * *

* * * * * * *

(E) FLOOR AT 1.0 ON WORK GEOGRAPHIC INDEX.—After calculating the work geographic index in subparagraph (A)(iii), for purposes of payment for services furnished on or after January 1, 2004, and before January 1, [2008] *2010*, the Secretary shall increase the work geographic index to 1.00 for any locality for which such work geographic index is less than 1.00.

* * * * * * *

(6) FEE SCHEDULE GEOGRAPHIC AREAS.—

(A) IN GENERAL.—

(i) REVISION.—Subject to clause (ii), for services furnished on or after January 1, 2008, the Secretary shall revise the fee schedule areas used for payment under this section applicable to the State of California using the county-based geographic adjustment factor as specified in option 3 (table 9) in the proposed rule for the 2008 physician fee schedule published at 72 Fed. Reg. 38,122 (July 12, 2007).

(ii) TRANSITION.—For services furnished during the period beginning January 1, 2008, and ending December 31, 2010, after calculating the work, practice expense, and malpractice geographic indices described in clauses (i), (ii), and (iii) of paragraph (1)(A) that would otherwise apply, the Secretary shall increase any such

geographic index for any county in California that is lower than the geographic index used for payment for services under this section as of December 31, 2007, in such county to such geographic index level.

(B) SUBSEQUENT REVISIONS.—

(i) TIMING.—Not later than January 1, 2011, the Secretary shall review and make revisions to fee schedule areas in all States for which more than one fee schedule area is used for payment of services under this section. The Secretary may revise fee schedule areas in States in which a single fee schedule area is used for payment for services under this section using the same methodology applied in the previous sentence.

(ii) LINK WITH GEOGRAPHIC INDEX DATA REVISION.—The revision described in clause (i) shall be made effective concurrently with the application of the periodic review of geographic adjustment factors required under paragraph (1)(C) for 2011 and subsequent periods.

(f) SUSTAINABLE GROWTH RATE*; TARGET GROWTH RATE*.—

(1) PUBLICATION.—The Secretary shall cause to have published in the Federal Register not later than—

(A) November 1, 2000, the sustainable growth rate for 2000 and 2001; [and]

(B) November 1 of each succeeding year *before 2008* the sustainable growth rate for such succeeding year and each of the preceding 2 years[.]*; and*

(C) November 1 of each succeeding year the target growth rate for such succeeding year and each of the 2 preceding years.

(2) SPECIFICATION OF GROWTH RATE.—The sustainable growth rate for all physicians' services for a fiscal year (beginning with fiscal year 1998 and ending with fiscal year 2000) and a year beginning with 2000 *and ending with 2007* shall be equal to the product of—

(A) * * *

(B) 1 plus the Secretary's estimate of the percentage change (divided by 100) in the average number of individuals enrolled under this part (other than [Medicare+Choice] *Medicare Part C* plan enrollees) from the previous applicable period to the applicable period involved,

* * * * * * *

(4) DEFINITIONS.—In this subsection:

(A) SERVICES INCLUDED IN PHYSICIANS' SERVICES.—The term "physicians' services" includes other items and services (such as clinical diagnostic laboratory tests and radiology services), specified by the Secretary, that are commonly performed or furnished by a physician or in a physician's office, but does not include services furnished to a [Medicare+Choice] *Medicare Part C* plan enrollee.

(B) [MEDICARE+CHOICE] *MEDICARE PART C* PLAN ENROLLEE.—The term "[Medicare+Choice] *Medicare Part C* plan enrollee" means, with respect to a fiscal year, an individual enrolled under this part who has elected to receive

benefits under this title for the fiscal year through a [Medicare+Choice] *Medicare Part C* plan offered under part C, and also includes an individual who is receiving benefits under this part through enrollment with an eligible organization with a risk-sharing contract under section 1876.

* * * * * * *

(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 computing the sustainable growth rate except for the following:

(A) The reference in paragraphs (2)(A) and (2)(D) to "all physicians' services" is deemed a reference to the physicians' services included in such category but shall not take into account items and services included in physicians' services through the operation of paragraph (4)(A).

(B) The factor described in paragraph (2)(C) for the service category described in subsection (j)(5)(A) shall be increased by 0.03.

(C) A national coverage determination (as defined in section 1869(f)(1)(B)) shall be treated as a change in regulation described in paragraph (2)(D).

* * * * * * *

(j) DEFINITIONS.—In this section:

(1) * * *

* * * * * * *

(3) PHYSICIANS' SERVICES.—The term "physicians' services" includes items and services described in paragraphs (1), (2)(A), (2)(D), (2)(G), (2)(P) (with respect to services described in subparagraphs (A) and (C) of section 1861(oo)(2)), (2)(R) (with respect to services described in suparagraphs (B), (C), and (D) of section 1861(pp)(1)), (2)(S), (2)(W), (2)(AA), *(2)(DD),* (3), (4), (13), (14) (with respect to services described in section 1861(nn)(2)), and (15) of section 1861(s) (other than clinical diagnostic laboratory tests and, except for purposes of subsection (a)(3), (g), and (h) such other items and services as the Secretary may specify).

* * * * * * *

(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 the

recommendations of the United States Preventive Services Task Force).

(B) Evaluation and management services not described in subparagraph (A).

(C) Imaging services (as defined in subsection (b)(4)(B)) and diagnostic tests (other than clinical diagnostic laboratory tests) not described in subparagraph (A).

(D) Procedures that are subject (under regulations promulgated to carry out this section) to a 10-day or 90-day global period (in this paragraph referred to as "major procedures"), except that the Secretary may reclassify as minor procedures under subparagraph (F) any procedures that would otherwise be included in this category if the Secretary determines that such procedures are not major procedures.

(E) Anesthesia services that are paid on the basis of the separate conversion factor for anesthesia services determined under subsection (d)(1)(D).

(F) Minor procedures and any other physicians' services that are not described in a preceding subparagraph.

* * * * * * *

[(l) PHYSICIAN ASSISTANCE AND QUALITY INITIATIVE FUND.—

[(1) ESTABLISHMENT.—The Secretary shall establish under this subsection a Physician Assistance and Quality Initiative Fund (in this subsection referred to as the "Fund") which shall be available to the Secretary for physician payment and quality improvement initiatives, which may include application of an adjustment to the update of the conversion factor under subsection (d).

[(2) FUNDING.—

[(A) AMOUNT AVAILABLE.—There shall be available to the Fund for expenditures an amount equal to $1,350,000,000.

[(B) TIMELY OBLIGATION OF ALL AVAILABLE FUNDS FOR SERVICES FURNISHED DURING 2008.—The Secretary shall provide for expenditures from the Fund in a manner designed to provide (to the maximum extent feasible) for the obligation of the entire amount specified in subparagraph (A) for payment with respect to physicians' services furnished during 2008.

[(C) PAYMENT FROM TRUST FUND.—The amount specified in subparagraph (A) shall be available to the Fund, as expenditures are made from the Fund, from the Federal Supplementary Medical Insurance Trust Fund under section 1841.

[(D) FUNDING LIMITATION.—Amounts in the Fund shall be available in advance of appropriations in accordance with subparagraph (B) but only if the total amount obligated from the Fund does not exceed the amount available to the Fund under subparagraph (A). The Secretary may obligate funds from the Fund only if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services and the appropriate budget officer certify) that there are available in the Fund sufficient

amounts to cover all such obligations incurred consistent with the previous sentence.

[(E) CONSTRUCTION.—In the case that expenditures from the Fund are applied to, or otherwise affect, a conversion factor under subsection (d) for a year, the conversion factor under such subsection shall be computed for a subsequent year as if such application or effect had never occurred.]

(m) CERTIFICATION OF FACILITIES THAT FURNISH DIAGNOSTIC IMAGING SERVICES.—

(1) IN GENERAL.—For purposes of subsection (b)(4)(C)(i), except as provided under paragraphs (2) through (8), the provisions of section 354 of the Public Health Service Act (as in effect as of June 1, 2007), relating to the certification of mammography facilities, shall apply, with respect to the provision of diagnostic imaging services (as defined in subsection (b)(4)(C)(ii)) and to a diagnostic imaging services facility defined in paragraph (8) (and to the process of accrediting such facilities) in the same manner that such provisions apply, with respect to the provision of mammograms and to a facility defined in subsection (a)(3) of such section (and to the process of accrediting such mammography facilities).

(2) TERMINOLOGY AND REFERENCES.—For purposes of applying section 354 of the Public Health Service Act under paragraph (1)—

(A) any reference to "mammography", or "breast imaging" is deemed a reference to "diagnostic imaging services (as defined in section 1848(b)(4)(C)(ii) of the Social Security Act)";

(B) any reference to a mammogram or film is deemed a reference to an image, as defined in paragraph (8);

(C) any reference to "mammography facility" or to a "facility" under such section 354 is deemed a reference to a diagnostic imaging services facility, as defined in paragraph (8);

(D) any reference to radiological equipment used to image the breast is deemed a reference to medical imaging equipment used to provide diagnostic imaging services;

(E) any reference to radiological procedures or radiological is deemed a reference to medical imaging services, as defined in paragraph (8) or medical imaging, respectively;

(F) any reference to an inspection (as defined in subsection (a)(4) of such section) or inspector is deemed a reference to an audit (as defined in paragraph (8)) or auditor, respectively;

(G) any reference to a medical physicist (as described in subsection (f)(1)(E) of such section) is deemed to include a reference to a magnetic resonance scientist or the appropriate qualified expert as determined by the accrediting body;

(H) in applying subsection (d)(1)(A)(i) of such section, the reference to "type of each x-ray machine, image receptor, and processor" is deemed a reference to "type of imaging equipment";

(I) in applying subsection (d)(1)(B) of such section, the reference that "the person or agent submits to the Secretary" is deemed a reference that "the person or agent submits to the Secretary, through the appropriate accreditation body";

(J) in applying subsection (d)(1)(B)(i) of such section, the reference to standards established by the Secretary is deemed a reference to standards established by an accreditation body and approved by the Secretary;

(K) in applying subsection (e) of such section, relating to an accreditation body—

(i) in paragraph (1)(A), the reference to "may" is deemed a reference to "shall";

(ii) in paragraph (1)(B)(i)(II), the reference to "a random sample of clinical images from such facilities" is deemed a reference to "a statistically significant random sample of clinical images from a statistically significant random sample of facilities";

(iii) in paragraph (3)(A) of such section—

(I) the reference to "paragraph (1)(B)" in such subsection is deemed to be a reference to "paragraph (1)(B) and subsection (f)"; and

(II) the reference to the "Secretary" is deemed a reference to "an accreditation body, with the approval of the Secretary"; and

(iv) in paragraph (6)(B), the reference to the Committee on Labor and Human Resources of the Senate is deemed to be the Committee on Finance of the Senate and the reference to the Committee on Energy and Commerce of the House of Representatives is deemed to include a reference to the Committee on Ways and Means of the House of Representatives;

(L) in applying subsection (f), relating to quality standards—

(i) each reference to standards established by the Secretary is deemed a reference to standards established by an accreditation body involved and approved by the Secretary under subsection (d)(1)(B)(i) of such section;

(ii) in paragraph (1)(A), the reference to "radiation dose" is deemed a reference to "radiation dose, as appropriate";

(iii) in paragraph (1)(B), the reference to "radiological standards" is deemed a reference to "medical imaging standards, as appropriate";

(iv) in paragraphs (1)(D)(ii) and (1)(E)(iii), the reference to "the Secretary" is deemed a reference to "an accreditation body with the approval of the Secretary";

(v) in each of subclauses (III) and (IV) of paragraph (1)(G)(ii), each reference to "patient" is deemed a reference to "patient, if requested by the patient"; and

(M) in applying subsection (g), relating to inspections—

(i) each reference to the "Secretary or State or local agency acting on behalf of the Secretary" is deemed to include a reference to an accreditation body involved;

(ii) in the first sentence of paragraph (1)(F), the reference to "annual inspections required under this paragraph" is deemed a reference to "the audits carried out in facilities at least every three years from the date of initial accreditation under this paragraph"; and

(iii) in the second sentence of paragraph (1)(F), the reference to "inspections carried out under this paragraph" is deemed a reference to "audits conducted under this paragraph during the previous year".

(3) DATES AND PERIODS.—For purposes of paragraph (1), in applying section 354 of the Public Health Service Act, the following applies:

(A) IN GENERAL.—Except as provided in subparagraph (B)—

(i) any reference to "October 1, 1994" shall be deemed a reference to "January 1, 2010";

(ii) the reference to "the date of the enactment of this section" in each of subsections (e)(1)(D) and (f)(1)(E)(iii) is deemed to be a reference to "the date of the enactment of the Children's Health and Medicare Protection Act of 2007";

(iii) the reference to "annually" in subsection (g)(1)(E) is deemed a reference to "every three years";

(iv) the reference to "October 1, 1996" in subsection (l) is deemed to be a reference to "January 1, 2011";

(v) the reference to "October 1, 1999" in subsection (n)(3)(H) is deemed to be a reference to "January 1, 2012"; and

(vi) the reference to "October 1, 1993" in the matter following paragraph (3)(J) of subsection (n) is deemed to be a reference "January 1, 2010".

(B) ULTRASOUND SERVICES.—With respect to diagnostic imaging services that are ultrasounds—

(i) any reference to "October 1, 1994" shall be deemed a reference to "January 1, 2012";

(ii) the reference to "the date of the enactment of this section" in subsection (f)(1)(E)(iii) is deemed to be a reference to "7 years after the date of the enactment of the Children's Health and Medicare Protection Act of 2007";

(iii) the reference to "October 1, 1996" in subsection (l) is deemed to be a reference to "January 1, 2013";

(4) PROVISIONS NOT APPLICABLE.—For purposes of paragraph (1), in applying section 354 of the Public Health Service Act, the following provision shall not apply:

(A) Subsections (e) and (f) of such section, in so far as the respective subsection imposes any requirement for a physician to be certified, accredited, or otherwise meet requirements, with respect to the provision of any diagnostic imaging services, as a condition of payment under subsection (b)(4)(C)(i), with respect to the professional or technical component, for such service.

(B) Subsection (e)(1)(B)(iv) of such section, insofar as it applies to a facility with respect to the provision of ultrasounds.

(C) Subsection (e)(1)(B)(v).

(D) Subsection (f)(1)(H) of such section, relating to standards for special techniques for mammograms of patients with breast implants.

(E) Subsection (g)(6) of such section, relating to an inspection demonstration program.

(F) Subsection (n)(3)(G) of such section, relating to the national advisory committee.

(G) Subsection (p) of such section, relating to breast cancer screening surveillance research grants.

(H) Paragraphs (1)(B) and (2) of subsection (r) of such section, related to funding.

(5) ACCREDITATION BODIES.—For purposes of paragraph (1), in applying section 354(e)(1) of the Public Health Service, the following shall apply:

(A) APPROVAL OF TWO ACCREDITATION BODIES FOR EACH TREATMENT MODALITY.—In the case that there is more than one accreditation body for a treatment modality that qualifies for approval under this subsection, the Secretary shall approve at least two accreditation bodies for such treatment modality.

(B) ADDITIONAL ACCREDITATION BODY STANDARDS.—In addition to the standards described in subparagraph (B) of such section for accreditation bodies, the Secretary shall establish standards that require—

(i) the timely integration of new technology by accreditation bodies for purposes of accrediting facilities under this subsection; and

(ii) the accreditation body involved to evaluate the annual medical physicist survey (or annual medical survey of another appropriate qualified expert chosen by the accreditation body) of a facility upon onsite review of such facility.

(6) ADDITIONAL QUALITY STANDARDS.—For purposes of paragraph (1), in applying subsection (f)(1) of section 354 of the Public Health Service—

(A) the quality standards under such subsection shall, with respect to a facility include—

(i) standards for qualifications of medical personnel who are not physicians and who perform diagnostic imaging services at the facility that require such personnel to ensure that individuals, prior to performing medical imaging, demonstrate compliance with the standards established under subsection (a) through successful completion of certification by a nationally recognized professional organization, licensure, completion of an examination, pertinent coursework or degree program, verified pertinent experience, or through other ways determined appropriate by an accreditation body (with the approval of the Secretary, or through some combination thereof);

(ii) standards requiring the facility to maintain records of the credentials of physicians and other medical personnel described in clause (i);

(iii) standards for qualifications and responsibilities of medical directors and other personnel with supervising roles at the facility;

(iv) standards that require the facility has procedures to ensure the safety of patients of the facility; and

(v) standards for the establishment of a quality control program at the facility to be implemented as described in subparagraph (E) of such subsection;

(B) the quality standards described in subparagraph (B) of such subsection shall be deemed to include standards that require the establishment and maintenance of a quality assurance and quality control program at each facility that is adequate and appropriate to ensure the reliability, clarity, and accuracy of the technical quality of diagnostic images produced at such facilities; and

(C) the quality standard described in subparagraph (C) of such subsection, relating to a requirement for personnel who perform specified services, shall include in such requirement that such personnel must meet continuing medical education standards as specified by an accreditation body (with the approval of the Secretary) and update such standards at least once every three years.

(7) ADDITIONAL REQUIREMENTS.—Notwithstanding any provision of section 354 of the Public Health Service Act, the following shall apply to the accreditation process under this subsection for purposes of subsection (b)(4)(C)(i):

(A) Any diagnostic imaging services facility accredited before January 1, 2010 (or January 1, 2012 in the case of ultrasounds), by an accrediting body approved by the Secretary shall be deemed a facility accredited by an approved accreditation body for purposes of such subsection as of such date if the facility submits to the Secretary proof of such accreditation by transmittal of the certificate of accreditation, including by electronic means.

(B) The Secretary may require the accreditation under this subsection of an emerging technology used in the provision of a diagnostic imaging service as a condition of payment under subsection (b)(4)(C)(i) for such service at such time as the Secretary determines there is sufficient empirical and scientific information to properly carry out the accreditation process for such technology.

(8) DEFINITIONS.—For purposes of this subsection:

(A) AUDIT.—The term "audit" means an onsite evaluation, with respect to a diagnostic imaging services facility, by the Secretary, State or local agency on behalf of the Secretary, or accreditation body approved under this subsection that includes the following:

(i) Equipment verification.

(ii) Evaluation of policies and procedures for compliance with accreditation requirements.

(iii) Evaluation of personnel qualifications and credentialing.

(iv) Evaluation of the technical quality of images.

(v) Evaluation of patient reports.

(vi) Evaluation of peer-review mechanisms and other quality assurance activities.

(vii) Evaluation of quality control procedures, results, and follow-up actions.

(viii) Evaluation of medical physicists (or other appropriate professionals chosen by the accreditation body) and magnetic resonance scientist surveys.

(ix) Evaluation of consumer complaint mechanisms.

(x) Provision of recommendations for improvement based on findings with respect to clauses (i) through (ix).

(B) DIAGNOSTIC IMAGING SERVICES FACILITY.—The term "diagnostic imaging services facility" has the meaning given the term "facility" in section 354(a)(3) of the Public Health Service Act (42 U.S.C. 263b(a)(3)) subject to the reference changes specified in paragraph (2), but does not include any facility that does not furnish diagnostic imaging services for which payment may be made under this section.

(C) IMAGE.—The term "image" means the portrayal of internal structures of the human body for the purpose of detecting and determining the presence or extent of disease or injury and may be produced through various techniques or modalities, including radiant energy or ionizing radiation and ultrasound and magnetic resonance. Such term does not include image guided procedures.

(D) MEDICAL IMAGING SERVICE.—The term "medical imaging service" means a service that involves the science of an image.

PART C—[MEDICARE+CHOICE] *MEDICARE PART C* PROGRAM

ELIGIBILITY, ELECTION, AND ENROLLMENT

SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS THROUGH [MEDICARE+CHOICE] *MEDICARE PART C* PLANS.—

(1) IN GENERAL.—Subject to the provisions of this section, each [Medicare+Choice] *Medicare Part C* eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits (other than qualified prescription drug benefits) under this title—

(A) * * *

(B) through enrollment in a [Medicare+Choice] *Medicare Part C* plan under this part,

* * * * * * *

(2) TYPES OF [MEDICARE+CHOICE] *MEDICARE PART C* PLANS THAT MAY BE AVAILABLE.—A [Medicare+Choice] *Medicare Part C* plan may be any of the following types of plans of health insurance:

(A) COORDINATED CARE PLANS (INCLUDING REGIONAL PLANS).—

(i) IN GENERAL.—Coordinated care plans which provide health care services, including but not limited to health maintenance organization plans (with or without point of service options), plans offered by provider-sponsored organizations (as defined in section 1855(d)), and regional or local preferred provider organization plans (including [MA] *Medicare Part C* regional plans).

(ii) SPECIALIZED [MA] *MEDICARE PART C* PLANS FOR SPECIAL NEEDS INDIVIDUALS.—Specialized [MA] *Medicare Part C* plans for special needs individuals (as defined in section 1859(b)(6)) may be any type of coordinated care plan.

(B) COMBINATION OF MSA PLAN AND CONTRIBUTIONS TO [MEDICARE+CHOICE] *MEDICARE PART C* MSA.—An MSA plan, as defined in section 1859(b)(3), and a contribution into a [Medicare+Choice] *Medicare Part C* medical savings account (MSA).

(C) PRIVATE FEE-FOR-SERVICE PLANS.—A [Medicare+Choice] *Medicare Part C* private fee-for-service plan, as defined in section 1859(b)(2).

(3) [MEDICARE+CHOICE] *MEDICARE PART C* ELIGIBLE INDIVIDUAL.—

(A) IN GENERAL.—In this title, subject to subparagraph (B), the term "[Medicare+Choice] *Medicare Part C* eligible individual" means an individual who is entitled to benefits under part A and enrolled under part B.

(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—Such term shall not include an individual medically determined to have end-stage renal disease, except that—

(i) an individual who develops end-stage renal disease while enrolled in a [Medicare+Choice] *Medicare Part C* plan may continue to be enrolled in that plan; and

(ii) in the case of such an individual who is enrolled in a [Medicare+Choice] *Medicare Part C* plan under clause (i) (or subsequently under this clause), if the enrollment is discontinued under circumstances described in subsection (e)(4)(A), then the individual will be treated as a "[Medicare+Choice] *Medicare Part C* eligible individual" for purposes of electing to continue enrollment in another [Medicare+Choice] *Medicare Part C* plan.

(b) SPECIAL RULES.—

(1) RESIDENCE REQUIREMENT.—

(A) * * *

(B) CONTINUATION OF ENROLLMENT PERMITTED.—Pursuant to rules specified by the Secretary, the Secretary shall provide thatan [MA] *Medicare Part C* local plan may offer to all individuals residing in a geographic area the option to continue enrollment in the plan, notwithstanding that the individual no longer resides in the service area of the

plan, so long as the plan provides that individuals exercising this option have, as part of the benefits under the original medicare fee-for-service program option, reasonable access within that geographic area to the full range of basic benefits, subject to reasonable cost sharing liability in obtaining such benefits.

(C) CONTINUATION OF ENROLLMENT PERMITTED WHERE SERVICE CHANGED.—Notwithstanding subparagraph (A) and in addition to subparagraph (B), if a [Medicare+Choice] *Medicare Part C* organization eliminates from its service area a [Medicare+Choice] *Medicare Part C* payment area that was previously within its service area, the organization may elect to offer individuals residing in all or portions of the affected area who would otherwise be ineligible to continue enrollment the option to continue enrollment in an [MA] *Medicare Part C* local plan it offers so long as—

(i) * * *

(ii) there is no other [Medicare+Choice] *Medicare Part C* plan offered in the area in which the enrollee resides at the time of the organization's election.

* * * * * * *

(c) PROCESS FOR EXERCISING CHOICE.—

(1) * * *

(2) COORDINATION THROUGH MEDICARE+CHOICE ORGANIZATIONS.—

(A) ENROLLMENT.—Such process shall permit an individual who wishes to elect a [Medicare+Choice] *Medicare Part C* plan offered by a [Medicare+Choice] *Medicare Part C* organization to make such election through the filing of an appropriate election form with the organization.

(B) DISENROLLMENT.—Such process shall permit an individual, who has elected a [Medicare+Choice] *Medicare Part C* plan offered by a [Medicare+Choice] *Medicare Part C* organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

(3) DEFAULT.—

(A) INITIAL ELECTION.—

(i) * * *

(ii) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary may establish procedures under which an individual who is enrolled in a health plan (other than [Medicare+Choice] *Medicare Part C* plan) offered by a [Medicare+Choice] *Medicare Part C* organization at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the [Medicare+Choice] *Medicare Part C* plan offered by the organization (or, if the organization offers more than one such plan, such plan or plans as the Secretary identifies under such procedures).

(B) CONTINUING PERIODS.—An individual who has made (or is deemed to have made) an election under this section

is considered to have continued to make such election until such time as—

(i) * * *

(ii) the [Medicare+Choice] *Medicare Part C* plan with respect to which such election is in effect is discontinued or, subject to subsection (b)(1)(B), no longer serves the area in which the individual resides.

(d) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—

(1) * * *

(2) PROVISION OF NOTICE.—

(A) OPEN SEASON NOTIFICATION.—At least 15 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each Medicare+Choice eligible individual residing in an area the following:

(i) * * *

(ii) LIST OF PLANS AND COMPARISON OF PLAN OPTIONS.—A list identifying the [Medicare+Choice] *Medicare Part C* plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans. Such information shall be presented in a comparative form.

* * * * * * *

(B) NOTIFICATION TO NEWLY ELIGIBLE MEDICARE+CHOICE ELIGIBLE INDIVIDUALS.—To the extent practicable, the Secretary shall, not later than 30 days before the beginning of the initial [Medicare+Choice] *Medicare Part C* enrollment period for an individual described in subsection (e)(1), mail to the individual the information described in subparagraph (A).

* * * * * * *

(D) PERIODIC UPDATING.—The information described in subparagraph (A) shall be updated on at least an annual basis to reflect changes in the availability of [Medicare+Choice] *Medicare Part C* plans and the benefits and [Medicare+Choice] *Medicare Part C* monthly basic and supplemental beneficiary premiums for such plans.

(3) GENERAL INFORMATION.—General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

(A) * * *

* * * * * * *

(C) RIGHTS.—A general description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program and the [Medicare+Choice] *Medicare Part C* program and the right to be protected against discrimination based on health status-related factors under section 1852(b).

* * * * * * *

(E) POTENTIAL FOR CONTRACT TERMINATION.—The fact that a [Medicare+Choice] *Medicare Part C* organization may terminate its contract, refuse to renew its contract, or reduce the service area included in its contract, under this part, and the effect of such a termination, nonrenewal, or service area reduction may have on individuals enrolled with the [Medicare+Choice] *Medicare Part C* plan under this part.

(F) CATASTROPHIC COVERAGE AND SINGLE DEDUCTIBLE.—In the case of an [MA] *Medicare Part C* regional plan, a description of the catastrophic coverage and single deductible applicable under the plan.

(4) INFORMATION COMPARING PLAN OPTIONS.—Information under this paragraph, with respect to a [Medicare+Choice] *Medicare Part C* plan for a year, shall include the following:

(A) BENEFITS.—The benefits covered under the plan, including the following:

(i) * * *

(iv) In the case of an MSA plan, differences in cost sharing, premiums, and balance billing under such a plan compared to under other [Medicare+Choice] *Medicare Part C* plans.

(v) In the case of a Medicare+Choice private fee-for-service plan, differences in cost sharing, premiums, and balance billing under such a plan compared to under other [Medicare+Choice] *Medicare Part C* plans.

* * * * * * *

(5) MAINTAINING A TOLL-FREE NUMBER AND INTERNET SITE.—The Secretary shall maintain a toll-free number for inquiries regarding [Medicare+Choice] *Medicare Part C* options and the operation of this part in all areas in which [Medicare+Choice] *Medicare Part C* plans are offered and an Internet site through which individuals may electronically obtain information on such options and [Medicare+Choice] *Medicare Part C* plans.

* * * * * * *

(7) PROVISION OF INFORMATION.—A [Medicare+Choice] *Medicare Part C* organization shall provide the Secretary with such information on the organization and each [Medicare+Choice] *Medicare Part C* plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

* * * * * * *

(e) COVERAGE ELECTION PERIODS.—

(1) INITIAL CHOICE UPON ELIGIBILITY TO MAKE ELECTION IF [MEDICARE+CHOICE] *MEDICARE PART C* PLANS AVAILABLE TO INDIVIDUAL.—If, at the time an individual first becomes entitled to benefits under part A and enrolled under part B, there is one or more [Medicare+Choice] *Medicare Part C* plans offered in the area in which the individual resides, the individual shall make the election under this section during a period specified by the Secretary such that if the individual elects a

[Medicare+Choice] *Medicare Part C* plan during the period, coverage under the plan becomes effective as of the first date on which the individual may receive such coverage. If any portion of an individual's initial enrollment period under part B occurs after the end of the annual, coordinated election period described in paragraph (3)(B)(iii), the initial enrollment period under this part shall further extend through the end of the individual's initial enrollment period under part B.

(2) OPEN ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—Subject to paragraph (5)—

(A) * * *

* * * * * * *

(C) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 3 MONTHS IN SUBSEQUENT YEARS.—

(i) IN GENERAL.—Subject to clauses (ii) and (iii) and subparagraph (D), at any time during the first 3 months of a year after 2006, or, if the individual first becomes a [Medicare+Choice] *Medicare Part C* eligible individual during a year after 2006, during the first 3 months of such year in which the individual is a [Medicare+Choice] *Medicare Part C* eligible individual, a [Medicare+Choice] *Medicare Part C* eligible individual may change the election under subsection (a)(1).

* * * * * * *

(iii) LIMITATION ON EXERCISE OF RIGHT WITH RESPECT TO PRESCRIPTION DRUG COVERAGE.—Effective for plan years beginning on or after January 1, 2006, in applying clause (i) (and clause (i) of subparagraph (B)) in the case of an individual who—

(I) is enrolled in an [MA] *Medicare Part C* plan that does provide qualified prescription drug coverage, the individual may exercise the right under such clause only with respect to coverage under the original fee-for-service plan or coverage under another [MA] *Medicare Part C* plan that does not provide such coverage and may not exercise such right to obtain coverage under an MA–PD plan or under a prescription drug plan under part D; or

(II) is enrolled in an MA–PD plan, the individual may exercise the right under such clause only with respect to coverage under another MA–PD plan (and not an [MA] *Medicare Part C* plan that does not provide qualified prescription drug coverage) or under the original fee-for-service plan and coverage under a prescription drug plan under part D.

(D) CONTINUOUS OPEN ENROLLMENT FOR INSTITUTIONALIZED INDIVIDUALS*, FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS, AND QUALIFIED MEDICARE BENEFICIARIES*.—At any time after 2005 in the case of a [Medicare+Choice] *Medicare Part C* eligible individual who is institutionalized (as defined by the Secretary)*, a full-benefit dual eligible indi-*

vidual (as defined in section 1935(c)(6)), or a qualified medicare beneficiary (as defined in section 1905(p)(1)), the individual may elect under subsection (a)(1)—

(i) to enroll *or disenroll* in a [Medicare+Choice] *Medicare Part C* plan; or

(ii) to change the [Medicare+Choice] *Medicare Part C* plan in which the individual is enrolled.

(E) LIMITED CONTINUOUS OPEN ENROLLMENT OF ORIGINAL FEE-FOR-SERVICE ENROLLEES IN [MEDICARE ADVANTAGE] *Medicare Part C* NON-PRESCRIPTION DRUG PLANS.—

(i) IN GENERAL.—On any date during 2007 or 2008 on which a [Medicare Advantage] *Medicare Part C* eligible individual is an unenrolled fee-for-service individual (as defined in clause (ii)), the individual may elect under subsection (a)(1) to enroll in a [Medicare Advantage] *Medicare Part C* plan that is not an MA–PD plan.

(ii) UNENROLLED FEE-FOR-SERVICE INDIVIDUAL DEFINED.—In this subparagraph, the term "unenrolled fee-for-service individual" means, with respect to a date, a [Medicare Advantage] *Medicare Part C* eligible individual who—

(I) * * *

(II) is not enrolled in an [MA] *Medicare Part C* plan on such date; and

(III) as of such date is not otherwise eligible to elect to enroll in an [MA] *Medicare Part C* plan.

(3) ANNUAL, COORDINATED ELECTION PERIOD.—

(A) * * *

* * * * * * *

(C) MEDICARE+CHOICE HEALTH INFORMATION FAIRS.—During the fall season of each year (beginning with 1999) and during the period described in subparagraph (B)(iii), in conjunction with the annual coordinated election period defined in subparagraph (B), the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform [Medicare+Choice] *Medicare Part C* eligible individuals about [Medicare+Choice] *Medicare Part C* plans and the election process provided under this section.

(D) SPECIAL INFORMATION CAMPAIGNS.—During November 1998 the Secretary shall provide for an educational and publicity campaign to inform [Medicare+Choice] *Medicare Part C* eligible individuals about the availability of [Medicare+Choice] *Medicare Part C* plans, and eligible organizations with risk-sharing contracts under section 1876, offered in different areas and the election process provided under this section. During the period described in subparagraph (B)(iii), the Secretary shall provide for an educational and publicity campaign to inform [MA] *Medicare Part C* eligible individuals about the availability of [MA] *Medicare Part C* plans (including MA–PD plans) offered in different areas and the election process provided under this section.

(4) SPECIAL ELECTION PERIODS.—Effective as of January 1, 2006, an individual may discontinue an election of a [Medicare+Choice] *Medicare Part C* plan offered by a [Medicare+Choice] *Medicare Part C* organization other than during an annual, coordinated election period and make a new election under this section if—

(A) * * *

* * * * * * *

(C) the individual demonstrates (in accordance with guidelines established by the Secretary) that—

(i) * * *

(ii) the organization (or an agent or other entity acting on the organization's behalf) materially misrepresented the plan's provisions in marketing the plan to the individual; [or]

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

(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; or

[(D)] *(F)* the individual meets such other exceptional conditions as the Secretary may provide*, taking into account the health or well-being of the individual*.

Effective as of January 1, 2006, an individual who, upon first becoming eligible for benefits under part A at age 65, enrolls in a [Medicare+Choice] *Medicare Part C* plan under this part, the individual may discontinue the election of such plan, and elect coverage under the original fee-for-service plan, at any time during the 12-month period beginning on the effective date of such enrollment.

* * * * * * *

(7) NO AUTO-ENROLLMENT OF MEDICAID BENEFICIARIES.—In no case may the Secretary provide for the enrollment in a MA plan of a Medicare Advantage eligible individual who is eligible to receive medical assistance under title XIX as a full-benefit dual eligible individual or a qualified medicare beneficiary, without the affirmative application of such individual (or authorized representative of the individual) to be enrolled in such plan.

* * * * * * *

(h) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—

(1) * * *

* * * * * * *

(6) STANDARD DEFINITIONS OF BENEFITS AND FORMATS FOR USE IN MARKETING MATERIALS.—

(A) IN GENERAL.—Not later than January 1, 2010, the Secretary, in consultation with the National Association of Insurance Commissioners and a working group of the type described in section 1852(m)(7)(E), shall develop standard

descriptions and definitions for benefits under this title for use in marketing material distributed by Medicare Part C organizations and formats for including such descriptions in such marketing material.

(B) REQUIRED USE OF STANDARD DEFINITIONS.— For plan years beginning on or after January 1, 2011, the Secretary shall disapprove the distribution of marketing material under paragraph (1)(B) if such marketing material does not use, without modification, the applicable descriptions and formats specified under subparagraph (A).

* * * * * * *

(j) PUBLICATION OF MEDICAL LOSS RATIOS AND OTHER COST-RELATED INFORMATION.—

(1) IN GENERAL.—The Secretary shall publish, not later than October 1 of each year (beginning with 2009), for each Medicare Part C plan contract, the following:

(A) The medical loss ratio of the plan in the previous year.

(B) The per enrollee payment under this part to the plan, as adjusted to reflect a risk score (based on factors described in section 1853(a)(1)(C)(i)) of 1.0.

(C) The average risk score (as so based).

(2) SUBMISSION OF DATA.—

(A) IN GENERAL.—Each Medicare Part C organization shall submit to the Secretary, in a form and manner specified by the Secretary, data necessary for the Secretary to publish the information described in paragraph (1) on a timely basis, including the information described in paragraph (3).

(B) DATA FOR 2008 AND 2009.—The data submitted under subparagraph (A) for 2008 and for 2009 shall be consistent in content with the data reported as part of the Medicare Part C plan bid in June 2007 for 2008.

(C) MEDICAL LOSS RATIO DATA.—The data to be submitted under subparagraph (A) relating to medical loss ratio for a year—

(i) shall be submitted not later than June 1 of the following year; and

(ii) beginning with 2010, shall be submitted based on the standardized elements and definitions developed under paragraph (4).

(D) AUDITED DATA.—Data submitted under this paragraph shall be data that has been audited by an independent third party auditor.

(3) MLR INFORMATION.—The information described in this paragraph with respect to a Medicare Part C plan for a year is as follows:

(A) The costs for the plan in the previous year for each of the following:

(i) Total medical expenses, separately indicated for benefits for the original medicare fee-for-service program option and for supplemental benefits.

(ii) Non-medical expenses, shown separately for each of the following categories of expenses:

(I) Marketing and sales.
(II) Direct administration.
(III) Indirect administration.
(IV) Net cost of private reinsurance.

(B) Gain or loss margin.

(C) Total revenue requirement, computed as the total of medical and nonmedical expenses and gain or loss margin, multiplied by the gain or loss margin.

(D) Percent of revenue ratio, computed as the total revenue requirement expressed as a percentage of revenue.

(4) DEVELOPMENT OF DATA REPORTING STANDARDS.—

(A) IN GENERAL.—The Secretary shall develop and implement standardized data elements and definitions for reporting under this subsection, for contract years beginning with 2010, of data necessary for the calculation of the medical loss ratio for Medicare Part C plans. Not later than December 31, 2008, the Secretary shall publish a report describing the elements and definitions so developed.

(B) CONSULTATION.—The Secretary shall consult with representatives of Medicare Part C organizations, experts on health plan accounting systems, and representatives of the National Association of Insurance Commissioners, in the development of such data elements and definitions.

(5) MEDICAL LOSS RATIO DEFINED.—For purposes of this part, the term "medical loss ratio" means, with respect to an MA plan for a year, the ratio of—

(A) the aggregate benefits (excluding nonmedical expenses described in paragraph (3)(A)(ii)) paid under the plan for the year, to

(B) the aggregate amount of premiums (including basic and supplemental beneficiary premiums) and payments made under sections 1853 and 1860D–15) collected for the plan and year.

Such ratio shall be computed without regard to whether the benefits or premiums are for required or supplemental benefits under the plan.

(k) PUBLICATION OF ENROLLMENT AND OTHER INFORMATION.—

(1) MONTHLY PUBLICATION OF PLAN-SPECIFIC ENROLLMENT DATA.—The Secretary shall publish (on the public website of the Centers for Medicare & Medicaid Services or otherwise) not later than 30 days after the end of each month (beginning with January 2008) on the actual enrollment in each Medicare Part C plan by contract and by county.

(2) AVAILABILITY OF OTHER INFORMATION.—The Secretary shall make publicly available data and other information in a format that may be readily used for analysis of the Medicare Part C program under this part and will contribute to the understanding of the organization and operation of such program.

BENEFITS AND BENEFICIARY PROTECTIONS

SEC. 1852. (a) BASIC BENEFITS.—

(1) REQUIREMENT.—

(A) IN GENERAL.—Except as provided in section 1859(b)(3) for MSA plans and except as provided in para-

graph (6) for [MA] *Medicare Part C* regional plans, each [Medicare+Choice] *Medicare Part C* plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI, benefits under the original medicare fee-for-service program option (and, for plan years before 2006, additional benefits required under section 1854(f)(1)(A)) *with cost-sharing that is no greater (and may be less) than the cost-sharing that would otherwise be imposed under such program option*.

(B) BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION DEFINED.—

(i) IN GENERAL.—For purposes of this part, the term "benefits under the original medicare fee-for-service program option" means those items and services (other than hospice care) for which benefits are available under parts A and B to individuals entitled to benefits under part A and enrolled under part B, with cost-sharing for those services as required under parts A and B [or an actuarially equivalent level of cost-sharing as determined in this part].

[(ii) SPECIAL RULE FOR REGIONAL PLANS.—In the case of an MA regional plan in determining an actuarially equivalent level of cost-sharing with respect to benefits under the original medicare fee-for-service program option, there shall only be taken into account, with respect to the application of section 1858(b)(2), such expenses only with respect to subparagraph (A) of such section.]

(ii) PERMITTING USE OF FLAT COPAYMENT OR PER DIEM RATE.—Nothing in clause (i) shall be construed as prohibiting a Medicare part C plan from using a flat copayment or per diem rate, in lieu of the cost-sharing that would be imposed under part A or B, so long as the amount of the cost-sharing imposed does not exceed the amount of the cost-sharing that would be imposed under the respective part if the individual were not enrolled in a plan under this part.

* * * * * * *

(6) SPECIAL BENEFIT RULES FOR REGIONAL PLANS.—In the case of an MA plan that is an MA regional plan, benefits under the plan shall include the benefits described in paragraphs (1) and (2) of section 1858(b).

(7) LIMITATION ON COST-SHARING FOR DUAL ELIGIBLES AND QUALIFIED MEDICARE BENEFICIARIES.—In the case of a individual who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)) or a qualified medicare beneficiary (as defined in section 1905(p)(1)) who is enrolled in a Medicare Part C plan, the plan may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under this title and title XIX if the individual were not enrolled with such plan.

(b) ANTIDISCRIMINATION.—

(1) BENEFICIARIES.—

(A) IN GENERAL.—A [Medicare+Choice] *Medicare Part C* organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act. The Secretary shall not approve a plan of an organization if the Secretary determines that the design of the plan and its benefits are likely to substantially discourage enrollment by certain [MA] *Medicare Part C* eligible individuals with the organization.

(B) CONSTRUCTION.—Subparagraph (A) shall not be construed as requiring a [Medicare+Choice] *Medicare Part C* organization to enroll individuals who are determined to have end-stage renal disease, except as provided under section 1851(a)(3)(B).

(2) PROVIDERS.—A [Medicare+Choice] *Medicare Part C* organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

* * * * * * *

(e) QUALITY IMPROVEMENT PROGRAM.—

(1) IN GENERAL.—Each [MA] *Medicare Part C program* organization shall have an ongoing quality improvement program for the purpose of improving the quality of care provided to enrollees in each [MA] *Medicare Part C program* plan offered by such organization [(other than an MA private fee-for-service plan or an MSA plan)].

(2) CHRONIC CARE IMPROVEMENT PROGRAMS.—As part of the quality improvement program under paragraph (1), each [MA] *Medicare Part C* organization shall have a chronic care improvement program. Each chronic care improvement program shall have a method for monitoring and identifying enrollees with multiple or sufficiently severe chronic conditions that meet criteria established by the organization for participation under the program.

(3) DATA.—

(A) COLLECTION, ANALYSIS, AND REPORTING.—

(i) IN GENERAL.—Except as provided in clauses (ii) and (iii) with respect to plans described in such clauses and subject to subparagraph (B), as part of the quality improvement program under paragraph (1), each [MA] *Medicare Part C* organization shall provide for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality. *In the case of a specialized Medicare Part C plan for special needs individuals described in paragraph (2) or (3) of section 1859(f), the*

organization shall provide for the reporting on quality measures developed for the plan under subparagraph (D)(iii).

(ii) APPLICATION TO MA REGIONAL PLANS.—The Secretary shall establish as appropriate by regulation requirements for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality for [MA] *Medicare Part C* organizations with respect to [MA] *Medicare Part C* regional plans. Such requirements may not exceed the requirements under this subparagraph with respect to [MA] *Medicare Part C* local plans that are preferred provider organization plans.

(iii) APPLICATION TO PREFERRED PROVIDER ORGANIZATIONS.—Clause (i) shall apply to [MA] *Medicare Part C* organizations with respect to [MA] *Medicare Part C* local plans that are preferred provider organization plans only insofar as services are furnished by providers or services, physicians, and other health care practitioners and suppliers that have contracts with such organization to furnish services under such plans.

(iv) DEFINITION OF PREFERRED PROVIDER ORGANIZATION PLAN.—In this subparagraph, the term "preferred provider organization plan" means an [MA] *Medicare Part C* plan that—

(I) * * *

* * * * * * *

(B) LIMITATIONS.—

(i) TYPES OF DATA.—[The Secretary] *Subject to subparagraph (D), the Secretary* shall not collect under subparagraph (A) data on quality, outcomes, and beneficiary satisfaction to facilitate consumer choice and program administration other than the types of data that were collected by the Secretary as of November 1, 2003.

(ii) CHANGES IN TYPES OF DATA.—Subject to [subclause (iii)] *clause (iii) and subparagraph (C)*, the Secretary may only change the types of data that are required to be submitted under subparagraph (A) after submitting to Congress a report on the reasons for such changes that was prepared in consultation with [MA] *Medicare Part C* organizations and private accrediting bodies.

* * * * * * *

(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 sub-

mitted for Medicare Part C plans that are preferred provider organization plans for that year.

(ii) APPLICATION OF SAME MEASURES AS COORDINATED CARE PLANS BEGINNING IN CONTRACT YEAR 2010.—For a contract year beginning with 2010, a 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 such contract year Medicare Part C plans described in section 1851(a)(2)(A)(i) for contract year such contract year.

(D) ADDITIONAL QUALITY REPORTING MEASURES.—

(i) IN GENERAL.—The Secretary shall develop by October 1, 2009, quality measures for Medicare Part C plans that measure disparities in the amount and quality of health services provided to racial and ethnic minorities.

(ii) DATA TO MEASURE RACIAL AND ETHNIC DISPARITIES IN THE AMOUNT AND QUALITY OF CARE PROVIDED TO ENROLLEES.—The Secretary shall provide for Medicare Part C organizations to submit data under this paragraph, including data similar to those submitted for other quality measures, that permits analysis of disparities among racial and ethnic minorities in health services, quality of care, and health status among Medicare Part C plan enrollees for use in submitting the reports under paragraph (5).

(iii) SPECIFICATION OF ADDITIONAL QUALITY MEASUREMENTS FOR SPECIALIZED PART C PLANS.—For implementation for plan years beginning not later than January 1, 2010, the Secretary shall develop new quality measures appropriate to meeting the needs of—

(I) beneficiaries enrolled in specialized Medicare Part C plans for special needs individuals (described in section 1859(b)(6)(A)(ii)(I)) that serve predominantly individuals who are dual-eligible individuals eligible for medical assistance under title XIX by measuring the special needs for care of individuals who are both Medicare and Medicaid beneficiaries; and

(II) beneficiaries enrolled in specialized Medicare Part C plans for special needs individuals (described in section 1859(b)(6)(A)(ii)(II)) that serve predominantly institutionalized individuals by measuring the special needs for care of individuals who are a resident in long-term care institution.

(4) TREATMENT OF ACCREDITATION.—

(A) * * *

* * * * * * *

(C) TIMELY ACTION ON APPLICATIONS.—The Secretary shall determine, within 210 days after the date the Secretary receives an application by a private accrediting organization and using the criteria specified in [section

1865(b)(2)] *section 1865(a)(2)*, whether the process of the private accrediting organization meets the requirements with respect to any specific clause in subparagraph (B) with respect to which the application is made. The Secretary may not deny such an application on the basis that it seeks to meet the requirements with respect to only one, or more than one, such specific clause.

* * * * * * *

(5) REPORT TO CONGRESS.—

(A) IN GENERAL.—Not later than 2 years after the date of the enactment of this paragraph, and biennially thereafter, the Secretary shall submit to Congress a report regarding how quality assurance programs conducted under this subsection measure and report on disparities in the amount and quality of health care services furnished to racial and ethnic minorities.

(B) CONTENTS OF REPORT.—Each such report shall include the following:

(i) A description of the means by which such programs focus on such racial and ethnic minorities.

(ii) An evaluation of the impact of such programs on eliminating health disparities and on improving health outcomes, continuity and coordination of care, management of chronic conditions, and consumer satisfaction.

(iii) Recommendations on ways to reduce clinical outcome disparities among racial and ethnic minorities.

(iv) Data for each MA plan from HEDIS and other source reporting the disparities in the amount and quality of health services furnished to racial and ethnic minorities.

* * * * * * *

(j) RULES REGARDING PROVIDER PARTICIPATION.—

(1) PROCEDURES.—Insofar as a [Medicare+Choice] *Medicare Part C* organization offers benefits under a [Medicare+Choice] *Medicare Part C* plan through agreements with physicians, the organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under such a plan. Such procedures shall include—

(A) * * *

* * * * * * *

(2) CONSULTATION IN MEDICAL POLICIES.—A [Medicare+Choice] *Medicare Part C* organization shall consult with physicians who have entered into participation agreements with the organization regarding the organization's medical policy, quality, and medical management procedures.

(3) PROHIBITING INTERFERENCE WITH PROVIDER ADVICE TO ENROLLEES.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (C), a [Medicare+Choice] *Medicare Part C* organization (in relation to an individual enrolled under a

[Medicare+Choice] *Medicare Part C* plan offered by the organization under this part) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

(B) CONSCIENCE PROTECTION.—Subparagraph (A) shall not be construed as requiring a [Medicare+Choice] *Medicare Part C* plan to provide, reimburse for, or provide coverage of a counseling or referral service if the [Medicare+Choice] *Medicare Part C* organization offering the plan—

(i) * * *

(ii) in the manner and through the written instrumentalities such [Medicare+Choice] *Medicare Part C* organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization or plan adopts a change in policy regarding such a counseling or referral service.

* * * * * * *

(D) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this paragraph, the term "health care professional" means a physician (as defined in section 1861(r)) or other health care professional if coverage for the professional's services is provided under the [Medicare+Choice] *Medicare Part C* plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

(4) LIMITATIONS ON PHYSICIAN INCENTIVE PLANS.—

(A) IN GENERAL.—No [Medicare+Choice] *Medicare Part C* organization may operate any physician incentive plan (as defined in subparagraph (B)) unless the organization provides assurances satisfactory to the Secretary that the following requirements are met:

(i) * * *

* * * * * * *

(B) PHYSICIAN INCENTIVE PLAN DEFINED.—In this paragraph, the term "physician incentive plan" means any compensation arrangement between a [Medicare+Choice] *Medicare Part C* organization and a physician or physician

group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization under this part.

(5) LIMITATION ON PROVIDER INDEMNIFICATION.—A [Medicare+Choice] *Medicare Part C* organization may not provide (directly or indirectly) for a health care professional, provider of services, or other entity providing health care services (or group of such professionals, providers, or entities) to indemnify the organization against any liability resulting from a civil action brought for any damage caused to an enrollee with a Medicare+Choice plan of the organization under this part by the organization's denial of medically necessary care.

(6) SPECIAL RULES FOR [MEDICARE+CHOICE] *MEDICARE PART C* PRIVATE FEE-FOR-SERVICE PLANS.—For purposes of applying this part (including subsection (k)(1)) and section 1866(a)(1)(O), a hospital (or other provider of services), a physician or other health care professional, or other entity furnishing health care services is treated as having an agreement or contract in effect with a [Medicare+Choice] *Medicare Part C* organization (with respect to an individual enrolled in a [Medicare+Choice] *Medicare Part C* private fee-for-service plan it offers), if—

(A) * * *

* * * * * * *

The previous sentence shall only apply in the absence of an explicit agreement between such a provider, professional, or other entity and the [Medicare+Choice] *Medicare Part C* organization.

(7) PROMOTION OF E-PRESCRIBING BY [MA] *MEDICARE PART C* PLANS.—

(A) * * *

* * * * * * *

(k) TREATMENT OF SERVICES FURNISHED BY CERTAIN PROVIDERS.—

(1) * * *

(2) APPLICATION TO [MEDICARE+CHOICE] *MEDICARE PART C* PRIVATE FEE-FOR-SERVICE PLANS.—

(A) BALANCE BILLING LIMITS UNDER [MEDICARE+CHOICE] *MEDICARE PART C* PRIVATE FEE-FOR-SERVICE PLANS IN CASE OF CONTRACT PROVIDERS.—

(i) IN GENERAL.—In the case of an individual enrolled in a [Medicare+Choice] *Medicare Part C* private fee-for-service plan under this part, a physician, provider of services, or other entity that has a contract (including through the operation of subsection (j)(6)) establishing a payment rate for services furnished to the enrollee shall accept as payment in full for covered services under this title that are furnished to such an individual an amount not to exceed (including any deductibles, coinsurance, copayments, or balance billing otherwise permitted under the plan) an amount

equal to [115 percent] *100 percent* of such payment rate.

* * * * * * *

(C) INFORMATION ON BENEFICIARY LIABILITY.—

(i) IN GENERAL.—Each [Medicare+Choice] *Medicare Part C* organization that offers a [Medicare+Choice] *Medicare Part C* private fee-for-service plan shall provide that enrollees under the plan who are furnished services for which payment is sought under the plan are provided an appropriate explanation of benefits (consistent with that provided under parts A and B and, if applicable, under medicare supplemental policies) that includes a clear statement of the amount of the enrollee's liability [(including any liability for balance billing consistent with this subsection)] with respect to payments for such services.

* * * * * * *

(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 and brokers in selling plans, including defining and prohibiting cold calls, unsolicited door-to-door sales, cross-selling, and co-branding.

(B) SPECIAL CONSIDERATIONS.—The model regulations shall specifically address the marketing—

(i) of plans to full benefit dual-eligible individuals and qualified medicare beneficiaries;

(ii) of plans to populations with limited English proficiency;

(iii) of plans to beneficiaries in senior living facilities; and

(iv) of plans at educational events.

(3) ENROLLMENT GUIDELINES.—

(A) IN GENERAL.—The model regulations shall address the disclosures Medicare private plans, agents, and brokers must make when enrolling beneficiaries, and a process—

(i) for affirmative beneficiary sign off before enrollment in a plan; and

(ii) in the case of Medicare Part C plans, for plans to conduct a beneficiary call-back to confirm beneficiary sign off and enrollment.

(B) SPECIFIC CONSIDERATIONS.—The model regulations shall specially address beneficiary understanding of the Medicare plan through required disclosure (or beneficiary verification) of each of the following:

(i) The type of Medicare private plan involved.

(ii) Attributes of the plan, including premiums, cost sharing, formularies (if applicable), benefits, and provider access limitations in the plan.

(iii) Comparative quality of the plan.

(iv) The fact that plan attributes may change annually.

(4) APPOINTMENT, CERTIFICATION AND TRAINING OF AGENTS AND BROKERS.—The model regulations shall establish procedures and requirements for appointment, certification (and periodic recertification), and training of agents and brokers that market or sell Medicare private plans consistent with existing State appointment and certification procedures and with this paragraph.

(5) AGENT AND BROKER COMMISSIONS.—

(A) IN GENERAL.—The model regulations shall establish standards for fair and appropriate commissions for agents and brokers consistent with this paragraph.

(B) LIMITATION ON TYPES OF COMMISSION.—The model regulations shall specifically prohibit the following:

(i) Differential commissions—

(I) for Medicare Part C plans based on the type of Medicare private plan; or

(II) prescription drug plans under part D based on the type of prescription drug plan.

(ii) Commissions in the first year that are more than 200 percent of subsequent year commissions.

(iii) The payment of extra bonuses or incentives (such as trips, gifts, and other non-commission cash payments).

(C) AGENT DISCLOSURE.—In developing the model regulations, the NAIC shall consider requiring agents and brokers to disclose commissions to a beneficiary upon request of the beneficiary before enrollment.

(D) PREVENTION OF FRAUD.—The model regulations shall consider the opportunity for fraud and abuse and beneficiary steering in setting standards under this paragraph and shall provide for the ability of State commissioners to investigate commission structures.

(6) MARKET CONDUCT.—

(A) IN GENERAL.—The model regulations shall establish standards for the market conduct of organizations offering Medicare private plans, and of agents and brokers selling such plans, and for State review of plan market conduct.

(B) MATTERS TO BE INCLUDED.—Such standards shall include standards for—

(i) timely payment of claims;

(ii) beneficiary complaint reporting and disclosure; and

(iii) State reporting of market conduct violations and sanctions.

(7) IMPLEMENTATION.—

(A) PUBLICATION OF NAIC MODEL REGULATIONS.—If the model regulations are submitted on a timely basis under paragraph (1)—

(i) the Secretary shall publish them in the Federal Register upon receipt and request public comment on the issue of whether such regulations are consistent with the requirements established in this subsection for such regulations;

(ii) not later than 6 months after the date of such publication, the Secretary shall determine whether such regulations are so consistent with such requirements and shall publish notice of such determination in the Federal Register; and

(iii) if the Secretary makes the determination under clause (ii) that such regulations are consistent with such requirements, in the notice published under clause (ii) the Secretary shall publish notice of adoption of such model regulations as constituting the marketing and enrollment standards adopted under this subsection to be applied under this title; and

(iv) if the Secretary makes the determination under such clause that such regulations are not consistent with such requirements, the procedures of clauses (ii) and (iii) of subparagraph (B) shall apply (in relation to the notice published under clause (ii)), in the same manner as such clauses would apply in the case of publication of a notice under subparagraph (B)(i).

(B) NO MODEL REGULATIONS.—If the model regulations are not submitted on a timely basis under paragraph (1)—

(i) the Secretary shall publish notice of such fact in the Federal Register;

(ii) not later than 6 months after the date of publication of such notice, the Secretary shall propose regulations that provide for marketing and enrollment standards that incorporate the requirements of this subsection for the model regulations and request public comments on such proposed regulations; and

(iii) not later than 6 months after the date of publication of such proposed regulations, the Secretary shall publish final regulations that shall constitute the marketing and enrollment standards adopted under this subsection to be applied under this title.

(C) REFERENCES TO MARKETING AND ENROLLMENT STANDARDS.—In this title, a reference to marketing and enrollment standards adopted under this subsection is deemed a reference to the regulations constituting such standards adopted under subparagraph (A) or (B), as the case may be.

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

(i) In the case of components that relate predominantly to operations in relation to Medicare private plans, the effective date shall be for plan years beginning on or after such date (not later than 1 year after the date of promulgation of the standards) as the Secretary specifies.

(ii) In the case of other components, the effective date shall be such date, not later than 1 year after the date of promulgation of the standards, as the Secretary specifies.

(E) CONSULTATION.— In promulgating marketing and enrollment standards under this paragraph, the NAIC or Secretary shall consult with a working group composed of representatives of issuers of Medicare private plans, consumer groups, medicare beneficiaries, State Health Insurance Assistance Programs, and other qualified individuals. Such representatives shall be selected in a manner so as to assure balanced representation among the interested groups.

(8) ENFORCEMENT.—

(A) IN GENERAL.—Any Medicare private plan that violates marketing and enrollment standards is subject to sanctions under section 1857(g).24 (B) STATE RESPONSIBILITIES.—Nothing in this subsection or section 1857(g) shall prohibit States from imposing sanctions against Medicare private plans, agents, or brokers for violations of the marketing and enrollment standards adopted under section 1852(m). States shall have the sole authority to regulate agents and brokers.

(9) MEDICARE PRIVATE PLAN DEFINED.—In this subsection, the term "Medicare private plan" means a Medicare Part C plan and a prescription drug plan under part D.

PAYMENTS TO [MEDICARE+CHOICE] *MEDICARE PART C* ORGANIZATIONS

SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—

(1) MONTHLY PAYMENTS.—

(A) IN GENERAL.—Under a contract under section 1857 and subject to subsections (e), (g), and (i) and section 1859(e)(4), the Secretary shall make monthly payments under this section in advance to each Medicare+Choice organization, with respect to coverage of an individual under this part in a [Medicare+Choice] *Medicare Part C* payment area for a month, in an amount determined as follows:

(i) * * *

* * * * * * *

(B) PAYMENT AMOUNT FOR ORIGINAL FEE-FOR-SERVICE BENEFITS BEGINNING WITH 2006.—

(i) PAYMENT OF BID FOR PLANS WITH BIDS BELOW BENCHMARK.—In the case of a plan for which there are average per capita monthly savings described in section 1854(b)(3)(C) or 1854(b)(4)(C), as the case may be, the amount specified in this subparagraph is equal to the unadjusted [MA] *Medicare Part C* statutory non-drug monthly bid amount, adjusted under subparagraph (C) and (if applicable) under subparagraphs (F) and (G), plus the amount (if any) of any rebate under subparagraph (E).

(ii) PAYMENT OF BENCHMARK FOR PLANS WITH BIDS AT OR ABOVE BENCHMARK.—In the case of a plan for which there are no average per capita monthly savings described in section 1854(b)(3)(C) or 1854(b)(4)(C), as the case may be, the amount specified in this subparagraph is equal to the [MA] *Medicare Part C* area-specific non-drug monthly benchmark amount, adjusted under subparagraph (C) and (if applicable) under subparagraphs (F) and (G).

(iii) PAYMENT OF BENCHMARK FOR MSA PLANS.—Notwithstanding clauses (i) and (ii), in the case of an MSA plan, the amount specified in this subparagraph is equal to the [MA] *Medicare Part C* area-specific non-drug monthly benchmark amount, adjusted under subparagraph (C).

(C) DEMOGRAPHIC ADJUSTMENT, INCLUDING ADJUSTMENT FOR HEALTH STATUS.—

(i) * * *

(ii) APPLICATION DURING PHASE-OUT OF BUDGET NEUTRALITY FACTOR.—For 2006 through 2010:

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

* * * * * * *

(D) SEPARATE PAYMENT FOR FEDERAL DRUG SUBSIDIES.—In the case of an enrollee in an MA–PD plan, the [MA] *Medicare Part C* organization offering such plan also receives—

(i) * * *

* * * * * * *

(F) ADJUSTMENT FOR INTRA-AREA VARIATIONS.—

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

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

(G) ADJUSTMENT RELATING TO RISK ADJUSTMENT.—The Secretary shall adjust payments with respect to [MA] *Medicare Part C* plans as necessary to ensure that—

(i) * * *

(I) * * *

(II) the [MA] *Medicare Part C* monthly basic beneficiary premium under section 1854(b)(2)(A); equals

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

(H) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment to a [Medicare+Choice] *Medicare Part C* organization with respect to classes of individuals determined to have end-stage renal disease and enrolled in a [Medicare+Choice] *Medicare Part C* plan of the organization. Such rates of payment shall be actuarially equivalent to rates that would have been paid with respect to other enrollees in the [MA] *Medicare Part C* payment area (or such other area as specified by the Secretary) under the provisions of this section as in effect before the date of the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. In accordance with regulations, the Secretary shall provide for the application of the seventh sentence of section 1881(b)(7) to payments under this section covering the provision of renal dialysis treatment in the same manner as such sentence applies to composite rate payments described in such sentence. In establishing such rates, the Secretary shall provide for appropriate adjustments to increase each rate to reflect the demonstration rate (including the risk adjustment methodology associated with such rate) of the social health maintenance organization end-stage renal disease capitation demonstrations (es-

tablished by section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993), and shall compute such rates by taking into account such factors as renal treatment modality, age, and the underlying cause of the end-stage renal disease. The Secretary may apply the competitive bidding methodology provided for in this section, with appropriate adjustments to account for the risk adjustment methodology applied to end stage renal disease payments.

(2) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—

(A) * * *

(B) SPECIAL RULE FOR CERTAIN ENROLLEES.—

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

* * * * * * *

(3) ESTABLISHMENT OF RISK ADJUSTMENT FACTORS.—

(A) * * *

(B) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require [Medicare+Choice] *Medicare Part C* organizations (and eligible organizations with risk-sharing contracts under section 1876) to submit data regarding inpatient hospital services for periods beginning on or after July 1, 1997, and data regarding other services and other information as the Secretary deems necessary for periods beginning on or after July 1, 1998. The Secretary may not require an organization to submit such data before January 1, 1998.

(C) INITIAL IMPLEMENTATION.—

(i) * * *

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

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

* * * * * * *

(4) PAYMENT RULE FOR FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—If an individual who is enrolled with an [MA] *Medicare Part C* plan under this part receives a service from a federally

qualified health center that has a written agreement with the [MA] *Medicare Part C* organization that offers such plan for providing such a service (including any agreement required under section 1857(e)(3))—

(A) * * *

* * * * * * *

(b) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—

(1) ANNUAL ANNOUNCEMENTS.—

(A) FOR 2005.—The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), not later than the second Monday in May of 2004, with respect to each [MA] *Medicare Part C* payment area, the following:

(i) [MA] *MEDICARE PART C* CAPITATION RATES.—The annual [MA] *Medicare Part C* capitation rate for each [MA] *Medicare Part C* payment area for 2005.

* * * * * * *

(B) FOR 2006 AND SUBSEQUENT YEARS.—For a year after 2005—

(i) INITIAL ANNOUNCEMENT.—The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), not later than the first Monday in April before the calendar year concerned, with respect to each [MA] *Medicare Part C* payment area, the following:

(I) [MA] *MEDICARE PART C* CAPITATION RATES; [MA] *MEDICARE PART C* LOCAL AREA BENCHMARK.—The annual [MA] *Medicare Part C* capitation rate for each [MA] *Medicare Part C* payment area for the year.

* * * * * * *

(ii) REGIONAL BENCHMARK ANNOUNCEMENT.—The Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties), on a timely basis before the calendar year concerned, with respect to each [MA] *Medicare Part C* region and each [MA] *Medicare Part C* regional plan for which a bid was submitted under section 1854, the [MA] *Medicare Part C* region-specific non-drug monthly benchmark amount for that region for the year involved.

* * * * * * *

(2) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under paragraph (1) for a year, the Secretary shall provide for notice to [Medicare+Choice] *Medicare Part C* organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement and shall provide such organizations an opportunity to comment on such proposed changes.

* * * * * * *

(4) CONTINUED COMPUTATION AND PUBLICATION OF COUNTY-SPECIFIC PER CAPITA FEE-FOR-SERVICE EXPENDITURE INFORMATION.—The Secretary, through the Chief Actuary of the Centers for Medicare & Medicaid Services, shall provide for the computation and publication, on an annual basis beginning with 2001 at the time of publication of the annual [Medicare+Choice] *Medicare Part C* capitation rates under paragraph (1), of the following information for the original medicare fee-for-service program under parts A and B (exclusive of individuals eligible for coverage under section 226A) for each [Medicare+Choice] *Medicare Part C* payment area for the second calendar year ending before the date of publication:

(A) * * *

* * * * * * *

* * * * * * *

(c) CALCULATION OF ANNUAL [MEDICARE+CHOICE] *MEDICARE PART C* CAPITATION RATES.—

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

(A) BLENDED CAPITATION RATE.—For a year before 2005, the sum of—

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

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

* * * * * * *

(B) MINIMUM AMOUNT.—12 multiplied by the following amount:

(i) * * *

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

* * * * * * *

(iv) For 2002, 2003, and 2004, the minimum amount specified in this clause (or clause (iii)) for the preceding year increased by the national per capita [Medicare+Choice] *Medicare Part C* growth percent-

age, described in paragraph (6)(A) for that succeeding year.

(C) MINIMUM PERCENTAGE INCREASE.—

(i) For 1998, 102 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the [Medicare+Choice] *Medicare Part C* payment area.

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

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

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

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

(I) 102 percent of the annual [MA] *Medicare Part C* capitation rate under this paragraph for the area for the previous year; or

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

(D) 100 PERCENT OF FEE-FOR-SERVICE COSTS.—

(i) IN GENERAL.—For each year specified in clause (ii), the adjusted average per capita cost for the year involved, determined under section 1876(a)(4) and adjusted as appropriate for the purpose of risk adjustment, for the [MA] *Medicare Part C* payment area for individuals who are not enrolled in an [MA] *Medicare Part C* plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1886(h) *and costs attributable to payments under section 1886(d)(5)(B)*.

(ii) PERIODIC REBASING.—The provisions of clause (i) shall apply for 2004 and for subsequent years *(before 2009)* as the Secretary shall specify (but not less than once every 3 years) *and for each year beginning with 2009*.

* * * * * * *

(3) ANNUAL AREA-SPECIFIC MEDICARE+CHOICE CAPITATION RATE.—

(A) IN GENERAL.—For purposes of paragraph (1)(A), subject to subparagraphs (B) and (E), the annual area-specific [Medicare+Choice] *Medicare Part C* capitation rate for a Medicare+Choice payment area—

(i) for 1998 is, subject to subparagraph (D), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area, increased by the national per capita [Medicare+Choice] *Medicare Part C* growth percentage for 1998 (described in paragraph (6)(A)); or

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

(B) REMOVAL OF MEDICAL EDUCATION FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—

(i) IN GENERAL.—In determining the area-specific [Medicare+Choice] *Medicare Part C* capitation rate under subparagraph (A) for a year (beginning with 1998), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to exclude from the rate the applicable percent (specified in clause (ii)) of the payment adjustments described in subparagraph (C).

* * * * * * *

(D) TREATMENT OF AREAS WITH HIGHLY VARIABLE PAYMENT RATES.—In the case of a [Medicare+Choice] *Medicare Part C* payment area for which the annual per capita rate of payment determined under section 1876(a)(1)(C) for 1997 varies by more than 20 percent from such rate for 1996, for purposes of this subsection the Secretary may substitute for such rate for 1997 a rate that is more representative of the costs of the enrollees in the area.

(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific [MA] *Medicare Part C* capitation rate under subparagraph (A) for a year (beginning with 2004), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.

(4) INPUT-PRICE-ADJUSTED ANNUAL NATIONAL MEDICARE+CHOICE CAPITATION RATE.—

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

(i) the national standardized annual [Medicare+Choice] *Medicare Part C* capitation rate (determined under subparagraph (B)) for the year,

* * * * * * *

(B) NATIONAL STANDARDIZED ANNUAL MEDICARE+CHOICE CAPITATION RATE.—In subparagraph (A)(i), the "national standardized annual [Medicare+Choice] *Medicare Part C* capitation rate" for a year is equal to—

(i) the sum (for all [Medicare+Choice] *Medicare Part C* payment areas) of the product of—

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

* * * * * * *

(6) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE DEFINED.—

(A) IN GENERAL.—In this part, the "national per capita [Medicare+Choice] *Medicare Part C* growth percentage" for a year is the percentage determined by the Secretary, by March 1st before the beginning of the year involved, to reflect the Secretary's estimate of the projected per capita rate of growth in expenditures under this title for an individual entitled to benefits under part A and enrolled under part B, reduced by the number of percentage points specified in subparagraph (B) for the year. Separate determinations may be made for aged enrollees, disabled enrollees, and enrollees with end-stage renal disease.

* * * * * * *

(C) ADJUSTMENT FOR OVER OR UNDER PROJECTION OF NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE.—Beginning with rates calculated for 1999, before computing rates for a year as described in paragraph (1), the Secretary shall adjust all area-specific and national [Medicare+Choice] *Medicare Part C* capitation rates (and beginning in 2000, the minimum amount) for the previous year for the differences between the projections of the national per capita [Medicare+Choice] *Medicare Part C* growth percentage for that year and previous years and the current estimate of such percentage for such years, except that for purposes of paragraph (1)(C)(v)(II), no such adjustment shall be made for a year before 2004.

(7) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If the Secretary makes a determination with respect to coverage under this title or there is a change in benefits required to be provided under this part that the Secretary projects will result in a significant increase in the costs to [Medicare+Choice] *Medicare Part C* of providing benefits under contracts under this part (for periods after any period described in section 1852(a)(5)), the Secretary shall adjust appropriately the payments to such organizations under this part. Such projection and adjustment shall be based on an analysis by the Chief Actuary of the Cen-

ters for Medicare & Medicaid Services of the actuarial costs associated with the new benefits.

(d) [MA] *MEDICARE PART C* PAYMENT AREA; [MA] *MEDICARE PART C* LOCAL AREA; [MA] *MEDICARE PART C* REGION DEFINED.—

(1) [MA] *MEDICARE PART C* PAYMENT AREA.—In this part, except as provided in this subsection, the term "[MA] *Medicare Part C* payment area" means—

(A) with respect to an [MA] *Medicare Part C* local plan, an MA local area (as defined in paragraph (2)); and

(B) with respect to an [MA] *Medicare Part C* regional plan, an [MA] *Medicare Part C* region (as established under section 1858(a)(2)).

(2) [MA] *MEDICARE PART C* LOCAL AREA.—The term "[MA] *Medicare Part C* local area" means a county or equivalent area specified by the Secretary.

(3) RULE FOR ESRD BENEFICIARIES.—In the case of individuals who are determined to have end stage renal disease, the [Medicare+Choice] *Medicare Part C* payment area shall be a State or such other payment area as the Secretary specifies.

(4) GEOGRAPHIC ADJUSTMENT.—

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

(i) to a single statewide [Medicare+Choice] *Medicare Part C* payment area,

* * * * * * *

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

* * * * * * *

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

(C) METROPOLITAN BASED SYSTEM.—The metropolitan based system described in this subparagraph is one in which—

(i) all the portions of each metropolitan statistical area in the State or in the case of a consolidated metropolitan statistical area, all of the portions of each

primary metropolitan statistical area within the consolidated area within the State, are treated as a single [Medicare+Choice] *Medicare Part C* payment area, and

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

* * * * * * *

(e) SPECIAL RULES FOR INDIVIDUALS ELECTING MSA PLANS.—

(1) IN GENERAL.—If the amount of the [Medicare+Choice] *Medicare Part C* monthly MSA premium (as defined in section 1854(b)(2)(C)) for an MSA plan for a year is less than 1/12 of the annual [Medicare+Choice] *Medicare Part C* capitation rate applied under this section for the area and year involved, the Secretary shall deposit an amount equal to 100 percent of such difference in a [Medicare+Choice] *Medicare Part C* MSA established (and, if applicable, designated) by the individual under paragraph (2).

(2) ESTABLISHMENT AND DESIGNATION OF [MEDICARE+CHOICE] *MEDICARE PART C* MEDICAL SAVINGS ACCOUNT AS REQUIREMENT FOR PAYMENT OF CONTRIBUTION.—In the case of an individual who has elected coverage under an MSA plan, no payment shall be made under paragraph (1) on behalf of an individual for a month unless the individual—

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

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

* * * * * * *

(3) LUMP-SUM DEPOSIT OF MEDICAL SAVINGS ACCOUNT CONTRIBUTION.—In the case of an individual electing an MSA plan effective beginning with a month in a year, the amount of the contribution to the [Medicare+Choice] *Medicare Part C* MSA on behalf of the individual for that month and all successive months in the year shall be deposited during that first month. In the case of a termination of such an election as of a month before the end of a year, the Secretary shall provide for a procedure for the recovery of deposits attributable to the remaining months in the year.

(f) PAYMENTS FROM TRUST FUNDS.—The payment to a [Medicare+Choice] *Medicare Part C* organization under this section for individuals enrolled under this part with the organization and payments to a Medicare+Choice MSA under subsection (e)(1) shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under part A and under part B represents of the actuarial value of the total benefits under this title. Payments to [MA]

Medicare Part C organizations for statutory drug benefits provided under this title are made from the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund. Monthly payments otherwise payable under this section for October 2000 shall be paid on the first business day of such month. Monthly payments otherwise payable under this section for October 2001 shall be paid on the last business day of September 2001. Monthly payments otherwise payable under this section for October 2006 shall be paid on the first business day of October 2006.

(g) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)), a rehabilitation hospital described in section 1886(d)(1)(B)(ii) or a distinct part rehabilitation unit described in the matter following clause (v) of section 1886(d)(1)(B), or a long-term care hospital (described in section 1886(d)(1)(B)(iv)) as of the effective date of the individual's—

(1) election under this part of a [Medicare+Choice] *Medicare Part C* plan offered by a [Medicare+Choice] *Medicare Part C* organization—

(A) payment for such services until the date of the individual's discharge shall be made under this title through the [Medicare+Choice] *Medicare Part C* plan or the original medicare fee-for-service program option described in section 1851(a)(1)(A) (as the case may be) elected before the election with such organization,

* * * * * * *

(2) termination of election with respect to a [Medicare+Choice] *Medicare Part C* organization under this part—

(A) * * *

(B) payment for such services during the stay shall not be made under section 1886(d) or other payment provision under this title for inpatient services for the type of facility, hospital, or unit involved, described in the matter preceding paragraph (1), as the case may be, or by any succeeding [Medicare+Choice] *Medicare Part C* organization, and

* * * * * * *

(h) SPECIAL RULE FOR HOSPICE CARE.—

(1) INFORMATION.—A contract under this part shall require the [Medicare+Choice] *Medicare Part C* organization to inform each individual enrolled under this part with a [Medicare+Choice] *Medicare Part C* plan offered by the organization about the availability of hospice care if—

(A) * * *

* * * * * * *

(2) PAYMENT.—If an individual who is enrolled with a [Medicare+Choice] *Medicare Part C* organization under this part makes an election under section 1812(d)(1) to receive hospice care from a particular hospice program—

(A) * * *

(B) payment for other services for which the individual is eligible notwithstanding the individual's election of hospice care under section 1812(d)(1), including services not related to the individual's terminal illness, shall be made by the Secretary to the [Medicare+Choice] *Medicare Part C* organization or the provider or supplier of the service instead of payments calculated under subsection (a); and

(C) the Secretary shall continue to make monthly payments to the [Medicare+Choice] *Medicare Part C* organization in an amount equal to the value of the additional benefits required under section 1854(f)(1)(A).

(i) NEW ENTRY BONUS.—

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

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

* * * * * * *

(2) PERIOD OF APPLICATION.—Paragraph (1) shall only apply to payment for [Medicare+Choice] *Medicare Part C* plans which are first offered in a [Medicare+Choice] *Medicare Part C* payment area during the 2-year period beginning on January 1, 2000.

(3) LIMITATION TO ORGANIZATION OFFERING FIRST PLAN IN AN AREA.—Paragraph (1) shall only apply to payment to the first [Medicare+Choice] *Medicare Part C* organization that offers a [Medicare+Choice] *Medicare Part C* plan in each [Medicare+Choice] *Medicare Part C* payment area, except that if more than one such organization first offers such a plan in an area on the same date, paragraph (1) shall apply to payment for such organizations.

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

(5) OFFERED DEFINED.—In this subsection, the term "offered" means, with respect to a [Medicare+Choice] *Medicare Part C* plan as of a date, that a [Medicare+Choice] *Medicare Part C* eligible individual may enroll with the plan on that date, regardless of when the enrollment takes effect or when the individual obtains benefits under the plan.

(j) COMPUTATION OF BENCHMARK AMOUNTS.—For purposes of this part, the term "[MA] *Medicare Part C* area-specific non-drug monthly benchmark amount" means for a month in a year—

(1) with respect to—

(A) a service area that is entirely within an [MA] *Medicare Part C* local area, subject to section 1860C–1(d)(2)(A), an amount equal to 1/12 of the annual [MA] *Medicare Part C* capitation rate under section 1853(c)(1) (or, [beginning with 2007] *for 2007 and 2008*, 1/12 of the applicable amount determined under subsection (k)(1)*, or, beginning with 2009, 1/12 of the blended benchmark amount determined under subsection (l)(1)*) for the area for the year, adjusted as appropriate (for years before 2007) for the purpose of risk adjustment; or

(B) a service area that includes more than one [MA] *Medicare Part C* local area, an amount equal to the average of the amounts described in subparagraph (A) for each such local [MA] *Medicare Part C* area, weighted by the projected number of enrollees in the plan residing in the respective local [MA] *Medicare Part C* areas (as used by the plan for purposes of the bid and disclosed to the Secretary under section 1854(a)(6)(A)(iii)), adjusted as appropriate (for years before 2007) for the purpose of risk adjustment; or

(2) with respect to an [MA] *Medicare Part C* region for a month in a year, the [MA] *Medicare Part C* region-specific non-drug monthly benchmark amount, as defined in section 1858(f) for the region for the year.

(k) DETERMINATION OF APPLICABLE AMOUNT FOR PURPOSES OF CALCULATING THE BENCHMARK AMOUNTS.—

(1) * * *

(2) PHASE-OUT OF BUDGET NEUTRALITY FACTOR.—

(A) * * *

(B) PERCENT DETERMINED.—

(i) * * *

* * * * * * *

(iv) REQUIREMENTS.—In estimating the amounts under the previous clauses, the Secretary shall—

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

* * * * * * *

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

(IV) as necessary, adjust the risk scores for late data submitted by [Medicare Advantage] *Medicare Part C* organizations;

* * * * * * *

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

* * * * * * *

(l) DETERMINATION OF BLENDED BENCHMARK AMOUNT.—

(1) IN GENERAL.—For purposes of subsection (j), subject to paragraphs (2) and (3), the term "blended benchmark amount" means for an area—

(A) for 2009 the sum of—

(i) ⅔ of the applicable amount (as defined in subsection (k)(1)) for the area and year; and

(ii) ⅓ of the amount specified in subsection (c)(1)(D)(i) for the area and year;

(B) for 2010 the sum of—

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

(ii) ⅔ of the amount specified in subsection (c)(1)(D)(i) for the area and year; and

(C) for a subsequent year the amount specified in subsection (c)(1)(D)(i) for the area and year.

(2) FEE-FOR-SERVICE PAYMENT FLOOR.—In no case shall the blended benchmark amount for an area and year be less than the amount specified in subsection (c)(1)(D)(i) for the area and year.

(3) EXCEPTION FOR PACE PLANS.—This subsection shall not apply to payments to a PACE program under section 1894.

PREMIUMS AND BID AMOUNTS

SEC. 1854. (a) SUBMISSION OF PROPOSED PREMIUMS, BID AMOUNTS, AND RELATED INFORMATION.—

(1) IN GENERAL.—

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

(i) * * *

* * * * * * *

(B) BENEFICIARY REBATE INFORMATION.—In the case of a plan required to provide a monthly rebate under subsection (b)(1)(C) for a year, the [MA] *Medicare Part C* organization offering the plan shall submit to the Secretary, in such form and manner and at such time as the Secretary specifies, information on—

(i) * * *

(ii) the [MA] *Medicare Part C* monthly prescription drug beneficiary premium (if any) and the [MA] *Medicare Part C* monthly supplemental beneficiary premium (if any).

(C) PAPERWORK REDUCTION FOR OFFERING OF MA REGIONAL PLANS NATIONALLY OR IN MULTI-REGION AREAS.—The Secretary shall establish requirements for information submission under this subsection in a manner that promotes the offering of [MA] *Medicare Part C* regional plans in more than one region (including all regions) through the filing of consolidated information.

(2) INFORMATION REQUIRED FOR COORDINATED CARE PLANS BEFORE 2006.—For a [Medicare+Choice] *Medicare Part C* plan described in section 1851(a)(2)(A), the information described in this paragraph is as follows:

(A) BASIC (AND ADDITIONAL) BENEFITS.—For benefits described in section 1852(a)(1)(A) for a year before 2006—

(i) * * *

(ii) the [Medicare+Choice] *Medicare Part C* monthly basic beneficiary premium (as defined in subsection (b)(2)(A));

* * * * * * *

(B) SUPPLEMENTAL BENEFITS.—For benefits described in section 1852(a)(3)—

(i) * * *

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

* * * * * * *

(3) REQUIREMENTS FOR MSA PLANS.—For an MSA plan described, the information for any year in this paragraph is as follows:

(A) BASIC (AND ADDITIONAL) BENEFITS.—For benefits described in section 1852(a)(1)(A), the amount of the [Medicare+Choice] *Medicare Part C* monthly MSA premium.

(B) SUPPLEMENTAL BENEFITS.—For benefits described in section 1852(a)(3), the amount of the [Medicare+Choice] *Medicare Part C* monthly supplementary beneficiary premium.

(4) REQUIREMENTS FOR PRIVATE FEE-FOR-SERVICE PLANS BEFORE 2006.—For a [Medicare+Choice] *Medicare Part C* plan described in section 1851(a)(2)(C) for benefits described in section 1852(a)(1)(A) for a year before 2006, the information described in this paragraph is as follows:

(A) BASIC (AND ADDITIONAL) BENEFITS.—For benefits described in section 1852(a)(1)(A)—

(i) * * *

(ii) the amount of the [Medicare+Choice] *Medicare Part C* monthly basic beneficiary premium;

* * * * * * *

(B) SUPPLEMENTAL BENEFITS.—For benefits described in section 1852(a)(3), the amount of the [Medicare+Choice] *Medicare Part C* monthly supplemental beneficiary premium (as defined in subsection (b)(2)(B)).

(5) REVIEW.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall review the adjusted community rates, the amounts of the basic and supplemental premiums, and values filed under paragraphs (2) and (4) of this subsection and shall approve or disapprove such rates, amounts, and values so submitted. The Chief Actuary of the Centers for Medicare & Medicaid Services shall review the actuarial assumptions and data used by the [Medicare+Choice] *Medicare Part C* organization with respect to such rates, amounts, and values so submitted to determine the appropriateness of such assumptions and data.

(B) EXCEPTION.—The Secretary shall not review, approve, or disapprove the amounts submitted under paragraph (3) or, in the case of an [MA] *Medicare Part C* private fee-for-service plan, subparagraphs (A)(ii) and (B) of paragraph (4).

(6) SUBMISSION OF BID AMOUNTS BY [MA] *MEDICARE PART C* ORGANIZATIONS BEGINNING IN 2006.—

(A) INFORMATION TO BE SUBMITTED.—For an [MA] *Medicare Part C* plan (other than an MSA plan) for a plan year beginning on or after January 1, 2006, the information described in this subparagraph is as follows:

(i) * * *

* * * * * * *

(iii) The actuarial basis for determining the amount under clause (i) and the proportions described in clause (ii) and such additional information as the Secretary may require to verify such actuarial bases and the projected number of enrollees in each [MA] *Medicare Part C* local area.

* * * * * * *

In the case of a specialized [MA] *Medicare Part C* plan for special needs individuals, the information described in this subparagraph is such information as the Secretary shall specify.

(B) ACCEPTANCE AND NEGOTIATION OF BID AMOUNTS.—

(i) AUTHORITY.—Subject to [clauses (iii) and (iv)] *clause (iii)*, the Secretary has the authority to negotiate regarding monthly bid amounts submitted under subparagraph (A) (and the proportions described in subparagraph (A)(ii)), including supplemental benefits provided under subsection (b)(1)(C)(ii)(I) and in exercising such authority the Secretary shall have authority similar to the authority of the Director of the Office of Personnel Management with respect to health benefits plans under chapter 89 of title 5, United States Code.

* * * * * * *

(iii) NONINTERFERENCE.—In order to promote competition under this part and part D and in carrying out such parts, the Secretary may not require any [MA] *Medicare Part C* organization to contract with a

particular hospital, physician, or other entity or individual to furnish items and services under this title or require a particular price structure for payment under such a contract to the extent consistent with the Secretary's authority under this part.

[(iv) EXCEPTION.—In the case of a plan described in section 1851(a)(2)(C), the provisions of clauses (i) and (ii) shall not apply and the provisions of paragraph (5)(B), prohibiting the review, approval, or disapproval of amounts described in such paragraph, shall apply to the negotiation and rejection of the monthly bid amounts and the proportions referred to in subparagraph (A).]

(b) MONTHLY PREMIUM CHARGED.—

(1) IN GENERAL.—

(A) RULE FOR OTHER THAN MSA PLANS.—Subject to the rebate under subparagraph (C), the monthly amount (if any) of the premium charged to an individual enrolled in a [Medicare+Choice] *Medicare Part C* plan (other than an MSA plan) offered by a [Medicare+Choice] *Medicare Part C* organization shall be equal to the sum of the [Medicare+Choice] *Medicare Part C* monthly basic beneficiary premium, the [Medicare+Choice] *Medicare Part C* monthly supplementary beneficiary premium (if any), and, if the plan provides qualified prescription drug coverage, the [MA] *Medicare Part C* monthly prescription drug beneficiary premium.

(B) MSA PLANS.—The monthly amount of the premium charged to an individual enrolled in an MSA plan offered by a [Medicare+Choice] *Medicare Part C* organization shall be equal to the [Medicare+Choice] *Medicare Part C* monthly supplemental beneficiary premium (if any).

(C) BENEFICIARY REBATE RULE.—

(i) REQUIREMENT.—The [MA] *Medicare Part C* plan shall provide to the enrollee a monthly rebate equal to 75 percent of the average per capita savings (if any) described in paragraph (3)(C) or (4)(C), as applicable to the plan and year involved.

(ii) FORM OF REBATE.—A rebate required under this subparagraph shall be provided through the application of the amount of the rebate toward one or more of the following:

(I) * * *

(II) PAYMENT FOR PREMIUM FOR PRESCRIPTION DRUG COVERAGE.—Crediting toward the [MA] *Medicare Part C* monthly prescription drug beneficiary premium.

* * * * * * *

(iv) APPLICATION OF PART B PREMIUM REDUCTION.—Insofar as an [MA] *Medicare Part C* organization elects to provide a rebate under this subparagraph under a plan as a credit toward the part B premium under clause (ii)(III), the Secretary shall apply such credit to reduce the premium under section 1839 of

each enrollee in such plan as provided in section 1840(i).

(2) PREMIUM AND BID TERMINOLOGY DEFINED.—For purposes of this part:

(A) [MA] *MEDICARE PART C* MONTHLY BASIC BENEFICIARY PREMIUM.—The term "[MA] *Medicare Part C* monthly basic beneficiary premium" means, with respect to an [MA] *Medicare Part C* plan—

(i) * * *

(ii) described in section 1853(a)(1)(B)(ii), the amount (if any) by which the unadjusted [MA] *Medicare Part C* statutory non-drug monthly bid amount (as defined in subparagraph (E)) exceeds the applicable unadjusted [MA] *Medicare Part C* area-specific non-drug monthly benchmark amount (as defined in section 1853(j)).

(B) [MA] *MEDICARE PART C* MONTHLY PRESCRIPTION DRUG BENEFICIARY PREMIUM.—The term "[MA] *Medicare Part C* monthly prescription drug beneficiary premium" means, with respect to an [MA] *Medicare Part C* plan, the base beneficiary premium (as determined under section 1860D–13(a)(2) and as adjusted under section 1860D–13(a)(1)(B)), less the amount of rebate credited toward such amount under section 1854(b)(1)(C)(ii)(II).

(C) [MA] *MEDICARE PART C* MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The term "[MA] *Medicare Part C* monthly supplemental beneficiary premium" means, with respect to an [MA] *Medicare Part C* plan, the portion of the aggregate monthly bid amount submitted under clause (i) of subsection (a)(6)(A) for the year that is attributable under clause (ii)(III) of such subsection to the provision of supplemental health care benefits, less the amount of rebate credited toward such portion under section 1854(b)(1)(C)(ii)(I).

(D) MEDICARE+CHOICE MONTHLY MSA PREMIUM.—The term "[Medicare+Choice] *Medicare Part C* monthly MSA premium" means, with respect to a [Medicare+Choice] *Medicare Part C* plan, the amount of such premium filed under subsection (a)(3)(A) for the plan.

(E) UNADJUSTED MA STATUTORY NON-DRUG MONTHLY BID AMOUNT.—The term "unadjusted [MA] *Medicare Part C* statutory non-drug monthly bid amount" means the portion of the bid amount submitted under clause (i) of subsection (a)(6)(A) for the year that is attributable under clause (ii)(I) of such subsection to the provision of benefits under the original medicare fee-for-service program option (as defined in section 1852(a)(1)(B)).

(3) COMPUTATION OF AVERAGE PER CAPITA MONTHLY SAVINGS FOR LOCAL PLANS.—For purposes of paragraph (1)(C)(i), the average per capita monthly savings referred to in such paragraph for an [MA] *Medicare Part C* local plan and year is computed as follows:

(A) DETERMINATION OF STATEWIDE AVERAGE RISK ADJUSTMENT FOR LOCAL PLANS.—

(i) IN GENERAL.—Subject to clause (iii), the Secretary shall determine, at the same time rates are promulgated under section 1853(b)(1) (beginning with 2006) for each State, the average of the risk adjustment factors to be applied under section 1853(a)(1)(C) to payment for enrollees in that State for [MA] *Medicare Part C* local plans.

(ii) TREATMENT OF STATES FOR FIRST YEAR IN WHICH LOCAL PLAN OFFERED.—In the case of a State in which no [MA] *Medicare Part C* local plan was offered in the previous year, the Secretary shall estimate such average. In making such estimate, the Secretary may use average risk adjustment factors applied to comparable States or applied on a national basis.

* * * * * * *

(B) DETERMINATION OF RISK ADJUSTED BENCHMARK AND RISK-ADJUSTED BID FOR LOCAL PLANS.—For each [MA] *Medicare Part C* plan offered in a local area in a State, the Secretary shall—

(i) adjust the applicable [MA] *Medicare Part C* area-specific non-drug monthly benchmark amount (as defined in section 1853(j)(1)) for the area by the average risk adjustment factor computed under subparagraph (A); and

(ii) adjust the unadjusted [MA] *Medicare Part C* statutory non-drug monthly bid amount by such applicable average risk adjustment factor.

(C) DETERMINATION OF AVERAGE PER CAPITA MONTHLY SAVINGS.—The average per capita monthly savings described in this subparagraph for an [MA] *Medicare Part C* local plan is equal to the amount (if any) by which—

(i) * * *

* * * * * * *

(4) COMPUTATION OF AVERAGE PER CAPITA MONTHLY SAVINGS FOR REGIONAL PLANS.—For purposes of paragraph (1)(C)(i), the average per capita monthly savings referred to in such paragraph for an [MA] *Medicare Part C* regional plan and year is computed as follows:

(A) DETERMINATION OF REGIONWIDE AVERAGE RISK ADJUSTMENT FOR REGIONAL PLANS.—

(i) IN GENERAL.—The Secretary shall determine, at the same time rates are promulgated under section 1853(b)(1) (beginning with 2006) for each [MA] *Medicare Part C* region the average of the risk adjustment factors to be applied under section 1853(a)(1)(C) to payment for enrollees in that region for [MA] *Medicare Part C* regional plans.

(ii) TREATMENT OF REGIONS FOR FIRST YEAR IN WHICH REGIONAL PLAN OFFERED.—In the case of an [MA] *Medicare Part C* region in which no [MA] *Medicare Part C* regional plan was offered in the previous year, the Secretary shall estimate such average. In making such estimate, the Secretary may use aver-

age risk adjustment factors applied to comparable regions or applied on a national basis.

(iii) AUTHORITY TO DETERMINE RISK ADJUSTMENT FOR AREAS OTHER THAN REGIONS.—The Secretary may provide for the determination and application of risk adjustment factors under this subparagraph on the basis of areas other than [MA] *Medicare Part C* regions or on a plan-specific basis.

(B) DETERMINATION OF RISK-ADJUSTED BENCHMARK AND RISK-ADJUSTED BID FOR REGIONAL PLANS.—For each [MA] *Medicare Part C* regional plan offered in a region, the Secretary shall—

(i) adjust the applicable [MA] *Medicare Part C* area-specific non-drug monthly benchmark amount (as defined in section 1853(j)(2)) for the region by the average risk adjustment factor computed under subparagraph (A); and

(ii) adjust the unadjusted [MA] *Medicare Part C* statutory non-drug monthly bid amount by such applicable average risk adjustment factor.

(C) DETERMINATION OF AVERAGE PER CAPITA MONTHLY SAVINGS.—The average per capita monthly savings described in this subparagraph for an [MA] *Medicare Part C* regional plan is equal to the amount (if any) by which—

(i) * * *

* * * * * * *

(c) UNIFORM PREMIUM AND BID AMOUNTS.—Except as permitted under section 1857(i), the [MA] *Medicare Part C* monthly bid amount submitted under subsection (a)(6), the amounts of the [MA] *Medicare Part C* monthly basic, prescription drug, and supplemental beneficiary premiums, and the [MA] *Medicare Part C* monthly MSA premium charged under subsection (b) of an [MA] *Medicare Part C* organization under this part may not vary among individuals enrolled in the plan.

(d) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—

(1) IN GENERAL.—Each [Medicare+Choice] *Medicare Part C* organization shall permit the payment of [Medicare+Choice] *Medicare Part C* monthly basic, prescription drug, and supplemental beneficiary premiums on a monthly basis, may terminate election of individuals for a [Medicare+Choice] *Medicare Part C* plan for failure to make premium payments only in accordance with section 1851(g)(3)(B)(i), and may not provide for cash or other monetary rebates as an inducement for enrollment or otherwise.

(2) BENEFICIARY'S OPTION OF PAYMENT THROUGH WITHHOLDING FROM SOCIAL SECURITY PAYMENT OR USE OF ELECTRONIC FUNDS TRANSFER MECHANISM.—In accordance with regulations, an [MA] *Medicare Part C* organization shall permit each enrollee, at the enrollee's option, to make payment of premiums (if any) under this part to the organization through—

(A) * * *

* * * * * * *

All premium payments that are withheld under subparagraph (A) shall be credited to the appropriate Trust Fund (or Account thereof), as specified by the Secretary, under this title and shall be paid to the [MA] *Medicare Part C* organization involved. No charge may be imposed under an [MA] *Medicare Part C* plan with respect to the election of the payment option described in subparagraph (A). The Secretary shall consult with the Commissioner of Social Security and the Secretary of the Treasury regarding methods for allocating premiums withheld under subparagraph (A) among the appropriate Trust Funds and Account.

(3) INFORMATION NECESSARY FOR COLLECTION.—In order to carry out paragraph (2)(A) with respect to an enrollee who has elected such paragraph to apply, the Secretary shall transmit to the Commissioner of Social Security—

(A) * * *

* * * * * * *

(4) CONSOLIDATED MONTHLY BENEFICIARY PREMIUM.—In the case of an enrollee in an [MA] *Medicare Part C* plan, the Secretary shall provide a mechanism for the consolidation of—

(A) the [MA] *Medicare Part C* monthly basic beneficiary premium (if any);

(B) the [MA] *Medicare Part C* monthly supplemental beneficiary premium (if any); and

(C) the [MA] *Medicare Part C* monthly prescription drug beneficiary premium (if any).

(e) LIMITATION ON ENROLLEE LIABILITY.—

(1) FOR BASIC AND ADDITIONAL BENEFITS BEFORE 2006.—For periods before 2006, in no event may—

(A) the [Medicare+Choice] *Medicare Part C* monthly basic beneficiary premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with a [Medicare+Choice] *Medicare Part C* plan described in section 1851(a)(2)(A) of an organization with respect to required benefits described in section 1852(a)(1)(A) and additional benefits (if any) required under subsection (f)(1)(A) for a year, exceed

(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to benefits under part A and enrolled under part B if they were not members of a [Medicare+Choice] *Medicare Part C* organization for the year.

(2) FOR SUPPLEMENTAL BENEFITS BEFORE 2006.—For periods before 2006, if the [Medicare+Choice] *Medicare Part C* organization provides to its members enrolled under this part in a [Medicare+Choice] *Medicare Part C* plan described in section 1851(a)(2)(A) with respect to supplemental benefits described in section 1852(a)(3), the sum of the [Medicare+Choice] *Medicare Part C* monthly supplemental beneficiary premium (multiplied by 12) charged and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such ben-

efits may not exceed the adjusted community rate for such benefits (as defined in subsection (f)(3)).

(3) DETERMINATION ON OTHER BASIS.—If the Secretary determines that adequate data are not available to determine the actuarial value under paragraph (1)(A), (2), or (4) the Secretary may determine such amount with respect to all individuals in same geographic area, the State, or in the United States, eligible to enroll in the [Medicare+Choice] *Medicare Part C* plan involved under this part or on the basis of other appropriate data.

(4) SPECIAL RULE FOR PRIVATE FEE-FOR-SERVICE PLANS AND FOR BASIC BENEFITS BEGINNING IN 2006.—With respect to a [Medicare+Choice] *Medicare Part C* private fee-for-service plan (other than a plan that is an MSA plan) and for periods beginning with 2006, with respect to an [MA] *Medicare Part C* plan described in section 1851(a)(2)(A), in no event may—

(A) * * *

(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable with respect to such benefits on average to individuals entitled to benefits under part A and enrolled under part B if they were not members of a [Medicare+Choice] *Medicare Part C* organization for the year.

(f) REQUIREMENT FOR ADDITIONAL BENEFITS BEFORE 2006.—

(1) REQUIREMENT.—

(A) IN GENERAL.—For years before 2006, each [Medicare+Choice] *Medicare Part C* organization (in relation to a [Medicare+Choice] *Medicare Part C* plan, other than an MSA plan, it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan for a contract year, subject to the succeeding provisions of this subsection, the organization shall provide to individuals such additional benefits (as the organization may specify) in a value which the Secretary determines is at least equal to the adjusted excess amount (as defined in subparagraph (C)).

* * * * * * *

(E) PREMIUM REDUCTIONS.—

(i) IN GENERAL.—Subject to clause (ii), as part of providing any additional benefits required under subparagraph (A), a [Medicare+Choice] *Medicare Part C* organization may elect a reduction in its payments under section 1853(a)(1)(A) with respect to a [Medicare+Choice] *Medicare Part C* plan and the Secretary shall apply such reduction to reduce the premium under section 1839 of each enrollee in such plan as provided in section 1840(i).

(ii) AMOUNT OF REDUCTION.—The amount of the reduction under clause (i) with respect to any enrollee in a [Medicare+Choice] *Medicare Part C* plan—

(I) * * *

(II) shall apply uniformly to each enrollee of the [Medicare+Choice] *Medicare Part C* plan to which such reduction applies.

(F) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a [Medicare+Choice] *Medicare Part C* organization from providing supplemental benefits (described in section 1852(a)(3)) that are in addition to the health care benefits otherwise required to be provided under this paragraph and from imposing a premium for such supplemental benefits.

(2) STABILIZATION FUND.—A [Medicare+Choice] *Medicare Part C* organization may provide that a part of the value of an excess amount described in paragraph (1) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to stabilize and prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of the amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the [Medicare+Choice] *Medicare Part C* plan of the organization in accordance with such paragraph prior to the end of such periods, shall revert for the use of such trust funds.

(3) ADJUSTED COMMUNITY RATE.—For purposes of this subsection, subject to paragraph (4), the term "adjusted community rate" for a service or services means, at the election of a [Medicare+Choice] *Medicare Part C* organization, either—

(A) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a [Medicare+Choice] *Medicare Part C* plan under this part if the rate of payment were determined under a "community rating system" (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)), or

* * * * * * *

but adjusted for differences between the utilization characteristics of the individuals electing coverage under this part and the utilization characteristics of the other enrollees with the plan (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals selecting other [Medicare+Choice] *Medicare Part C* coverage, or [Medicare+Choice] *Medicare Part C* eligible individuals in the area, in the State, or in the United States, eligible to elect [Medicare+Choice] *Medicare Part C* coverage under this part and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

* * * * * * *

(g) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to payments to [Medicare+Choice] *Medicare Part C* organizations under section 1853 or premiums paid to such organizations under this part.

(h) PERMITTING USE OF SEGMENTS OF SERVICE AREAS.—The Secretary shall permit a [Medicare+Choice] *Medicare Part C* organization to elect to apply the provisions of this section uniformly to separate segments of a service area (rather than uniformly to an entire service area) as long as such segments are composed of one or more [Medicare+Choice] *Medicare Part C* payment areas.

ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR MEDICARE+CHOICE ORGANIZATIONS; PROVIDER-SPONSORED ORGANIZATIONS

SEC. 1855. (a) ORGANIZED AND LICENSED UNDER STATE LAW.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), a [Medicare+Choice] *Medicare Part C* organization shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a [Medicare+Choice] *Medicare Part C* plan.

(2) SPECIAL EXCEPTION FOR PROVIDER-SPONSORED ORGANIZATIONS.—

(A) IN GENERAL.—In the case of a provider-sponsored organization that seeks to offer a [Medicare+Choice] *Medicare Part C* plan in a State, the Secretary shall waive the requirement of paragraph (1) that the organization be licensed in that State if—

(i) * * *

* * * * * * *

(C) DENIAL OF APPLICATION BASED ON DISCRIMINATORY TREATMENT.—The ground for approval of such a waiver application described in this subparagraph is that the State has denied such a licensing application and—

(i) * * *

(ii) the State requires the organization, as a condition of licensure, to offer any product or plan other than a [Medicare+Choice] *Medicare Part C* plan.

* * * * * * *

(G) APPLICATION AND ENFORCEMENT OF STATE CONSUMER PROTECTION AND QUALITY STANDARDS.—

(i) IN GENERAL.—A waiver granted under this paragraph to an organization with respect to licensing under State law is conditioned upon the organization's compliance with all consumer protection and quality standards insofar as such standards—

(I) * * *

(II) are generally applicable to other [Medicare+Choice] *Medicare Part C* organizations and plans in the State; and

* * * * * * *

(ii) INCORPORATION INTO CONTRACT.—In the case of such a waiver granted to an organization with respect to a State, the Secretary shall incorporate the requirement that the organization (and [Medicare+Choice] *Medicare Part C* plans it offers) comply with standards

under clause (i) as part of the contract between the Secretary and the organization under section 1857.

(iii) ENFORCEMENT.—In the case of such a waiver granted to an organization with respect to a State, the Secretary may enter into an agreement with the State under which the State agrees to provide for monitoring and enforcement activities with respect to compliance of such an organization and its [Medicare+Choice] *Medicare Part C* plans with such standards. Such monitoring and enforcement shall be conducted by the State in the same manner as the State enforces such standards with respect to other [Medicare+Choice] *Medicare Part C* organizations and plans, without discrimination based on the type of organization to which the standards apply. Such an agreement shall specify or establish mechanisms by which compliance activities are undertaken, while not lengthening the time required to review and process applications for waivers under this paragraph.

* * * * * * *

(b) ASSUMPTION OF FULL FINANCIAL RISK.—The [Medicare+Choice] *Medicare Part C* organization shall assume full financial risk on a prospective basis for the provision of the health care services for which benefits are required to be provided under section 1852(a)(1), except that the organization—

(1) * * *

* * * * * * *

(c) CERTIFICATION OF PROVISION AGAINST RISK OF INSOLVENCY FOR UNLICENSED PSOS.—

(1) IN GENERAL.—Each [Medicare+Choice] *Medicare Part C* organization that is a provider-sponsored organization, that is not licensed by a State under subsection (a), and for which a waiver application has been approved under subsection (a)(2), shall meet standards established under section 1856(a) relating to the financial solvency and capital adequacy of the organization.

* * * * * * *

ESTABLISHMENT OF STANDARDS

SEC. 1856. (a) ESTABLISHMENT OF SOLVENCY STANDARDS FOR PROVIDER-SPONSORED ORGANIZATIONS.—

(1) ESTABLISHMENT.—

(A) * * *

* * * * * * *

(C) ENROLLEE PROTECTION AGAINST INSOLVENCY.—Such standards shall include provisions to prevent enrollees from being held liable to any person or entity for the [Medicare+Choice] *Medicare Part C* organization's debts in the event of the organization's insolvency.

* * * * * * *

(b) ESTABLISHMENT OF OTHER STANDARDS.—

(1) IN GENERAL.—The Secretary shall establish by regulation other standards (not described in subsection (a)) for [Medicare+Choice] *Medicare Part C* organizations and plans consistent with, and to carry out, this part. The Secretary shall publish such regulations by June 1, 1998. In order to carry out this requirement in a timely manner, the Secretary may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

* * * * * * *

(3) RELATION TO STATE LAWS.—The standards established under this part shall supersede any State law or regulation [(other than State licensing laws or State laws relating to plan solvency)] *(other than State laws relating to licensing or plan solvency and State laws or regulations adopting the marketing and enrollment standards adopted under section 1852(m))* with respect to [MA] *Medicare Part C* plans which are offered by [MA] *Medicare Part C* organizations under this part.

(4) PROHIBITION OF MIDYEAR IMPLEMENTATION OF SIGNIFICANT NEW REGULATORY REQUIREMENTS.—The Secretary may not implement, other than at the beginning of a calendar year, regulations under this section that impose new, significant regulatory requirements on a [Medicare+Choice] *Medicare Part C* organization or plan.

* * * * * * *

CONTRACTS WITH [MEDICARE+CHOICE] *MEDICARE PART C* ORGANIZATIONS

PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—

SEC. 1857. (a) IN GENERAL.—The Secretary shall not permit the election under section 1851 of a [Medicare+Choice] *Medicare Part C* plan offered by a [Medicare+Choice] *Medicare Part C* organization under this part, and no payment shall be made under section 1853 to an organization, unless the Secretary has entered into a contract under this section with the organization with respect to the offering of such plan. Such a contract with an organization may cover more than 1 [Medicare+Choice] *Medicare Part C* plan. Such contract shall provide that the organization agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

(b) MINIMUM ENROLLMENT REQUIREMENTS.—

(1) IN GENERAL.—Subject to paragraph (2), the Secretary may not enter into a contract under this section with a [Medicare+Choice] *Medicare Part C* organization unless the organization has—

(A) * * *

* * * * * * *

(2) APPLICATION TO MSA PLANS.—In applying paragraph (1) in the case of a [Medicare+Choice] *Medicare Part C* organization that is offering an MSA plan, paragraph (1) shall be applied by substituting covered lives for individuals.

* * * * * * *

(c) CONTRACT PERIOD AND EFFECTIVENESS.—

(1) * * *

* * * * * * *

(4) PREVIOUS TERMINATIONS.—

(A) IN GENERAL.—The Secretary may not enter into a contract with a [Medicare+Choice] *Medicare Part C* organization if a previous contract with that organization under this section was terminated at the request of the organization within the preceding 2-year period, except as provided in subparagraph (B) and except in such other circumstances which warrant special consideration, as determined by the Secretary.

(B) EARLIER RE-ENTRY PERMITTED WHERE CHANGE IN PAYMENT POLICY.—Subparagraph (A) shall not apply with respect to the offering by a [Medicare+Choice] *Medicare Part C* organization of a [Medicare+Choice] *Medicare Part C* plan in a [Medicare+Choice] *Medicare Part C* payment area if during the 6-month period beginning on the date the organization notified the Secretary of the intention to terminate the most recent previous contract, there was a legislative change enacted (or a regulatory change adopted) that has the effect of increasing payment amounts under section 1853 for that [Medicare+Choice] *Medicare Part C* payment area.

* * * * * * *

(d) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—

(1) PERIODIC AUDITING.—The Secretary shall provide for the annual auditing of the financial records (including data relating to medicare utilization and costs, including allowable costs under section 1858(c)*), and data submitted with respect to risk adjustment under section 1853(a)(3)* of at least one-third of the [Medicare+Choice] *Medicare Part C* organizations offering [Medicare+Choice] *Medicare Part C* plans under this part. The Comptroller General shall monitor auditing activities conducted under this subsection.

(2) INSPECTION AND AUDIT.—Each contract under this section shall provide that the Secretary, or any person or organization designated by the Secretary—

(A) * * *

(B) shall have the right to audit and inspect any books and records of the [Medicare+Choice] *Medicare Part C* organization that pertain (i) to the ability of the organization to bear the risk of potential financial losses, [or (ii)] *(ii)* to services performed or determinations of amounts payable under the contract*, or (iii) to compliance with the requirements of subsection (e)(4) and the extent to which administrative costs comply with the applicable requirements for such costs under the Federal Acquisition Regulation*.

* * * * * * *

(4) DISCLOSURE.—

(A) IN GENERAL.—Each [Medicare+Choice] *Medicare Part C* organization shall, in accordance with regulations of the Secretary, report to the Secretary financial information which shall include the following:

(i) * * *

* * * * * * *

(B) PARTY IN INTEREST DEFINED.—For the purposes of this paragraph, the term "party in interest" means—

(i) any director, officer, partner, or employee responsible for management or administration of a [Medicare+Choice] *Medicare Part C* organization, any person who is directly or indirectly the beneficial owner of more than 5 percent of the equity of the organization, any person who is the beneficial owner of a mortgage, deed of trust, note, or other interest secured by, and valuing more than 5 percent of the organization, and, in the case of a [Medicare+Choice] *Medicare Part C* organization organized as a nonprofit corporation, an incorporator or member of such corporation under applicable State corporation law;

* * * * * * *

(C) ACCESS TO INFORMATION.—Each [Medicare+Choice] *Medicare Part C* organization shall make the information reported pursuant to subparagraph (A) available to its enrollees upon reasonable request.

* * * * * * *

(7) MARKETING AND ADVERTISING STANDARDS.—The contract shall require the organization to meet all standards adopted under section 1852(m) (including those enforced by the State involved pursuant to section 1856(b)(3)) relating to marketing and advertising conduct.

(e) ADDITIONAL CONTRACT TERMS.—

(1) * * *

(2) COST-SHARING IN ENROLLMENT-RELATED COSTS.—

(A) * * *

(B) AUTHORIZATION.—The Secretary is authorized to charge a fee to each [Medicare+Choice] *Medicare Part C* organization with a contract under this part and each PDP sponsor with a contract under part D that is equal to the organization' or sponsor's pro rata share (as determined by the Secretary) of the aggregate amount of fees which the Secretary is directed to collect in a fiscal year. Any amounts collected shall be available without further appropriation to the Secretary for the purpose of carrying out section 1851 (relating to enrollment and dissemination of information), section 1860D-1(c), and section 4360 of the Omnibus Budget Reconciliation Act of 1990 (relating to the health insurance counseling and assistance program). *Of the amounts so collected, no less than $55,000,000 for fiscal year 2009, $65,000,000 for fiscal year 2010, $75,000,000 for fiscal year 2011, and $85,000,000 for fiscal year 2012 and each succeeding fiscal year shall be used to support Medi-*

care Part C and Part D counseling and assistance provided by State Health Insurance Assistance Programs.

(C) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for the purposes described in subparagraph (B) for each fiscal year beginning with fiscal year 2001 and ending with fiscal year 2005 an amount equal to $100,000,000, [and] for each fiscal year beginning with fiscal year 2006 [an amount equal to $200,000,000] *and ending with fiscal year 2008 an amount equal to $200,000,000, for fiscal year 2009 an amount equal to $255,000,000, for fiscal year 2010 an amount equal to $265,000,000, for fiscal year 2011 an amount equal to $275,000,000, and for fiscal year 2012 and each succeeding fiscal year an amount equal to $285,000,000*, reduced by the amount of fees authorized to be collected under this paragraph and section 1860D–12(b)(3)(D) for the fiscal year. *The amounts in excess of $200,000,000 in any fiscal year shall be used to support State Health Insurance Assistance Programs under subparagraph (B) and the remaining amount used to support activities related to enrollment and dissemination of information.*

(D) LIMITATION.—In any fiscal year the fees collected by the Secretary under subparagraph (B) shall not exceed the lesser of—

(i) * * *

(ii)(I) * * *

* * * * * * *

(IV) the [Medicare+Choice] *Medicare Part C* portion (as defined in subparagraph (E)) of $100,000,000 in fiscal year 2001 and each succeeding fiscal year before fiscal year 2006; [and]

(V) the applicable portion (as defined in subparagraph (F)) of $200,000,000 in fiscal year 2006 and each succeeding fiscal year[.] *before fiscal year 2009; and*

(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.

(E) MEDICARE+CHOICE PORTION DEFINED.—In this paragraph, the term "Medicare+Choice portion" means, for a fiscal year, the ratio, as estimated by the Secretary, of—

(i) the average number of individuals enrolled in Medicare+Choice plans during the fiscal year, to

* * * * * * *

(F) APPLICABLE PORTION DEFINED.—In this paragraph, the term "applicable portion" means, for a fiscal year—

(i) with respect to MA organizations, the Secretary's estimate of the total proportion of expenditures under this title that are attributable to expenditures made under this part (including payments under part D that are made to such organizations); or

* * * * * * *

(3) AGREEMENTS WITH FEDERALLY QUALIFIED HEALTH CENTERS.—

(A) PAYMENT LEVELS AND AMOUNTS.—A contract under this section with an MA organization shall require the organization to provide, in any written agreement described in section 1853(a)(4) between the organization and a federally qualified health center, for a level and amount of payment to the federally qualified health center for services provided by such health center that is not less than the level and amount of payment that the plan would make for such services if the services had been furnished by a entity providing similar services that was not a federally qualified health center.

* * * * * * *

(4) REQUIREMENT FOR MINIMUM MEDICAL LOSS RATIO.—If the Secretary determines for a contract year (beginning with 2010) that an MA plan has failed to have a medical loss ratio (as defined in section 1851(j)(4)) of at least .85—

(A) for that contract year, the Secretary shall reduce the blended benchmark amount under subsection (l) for the second succeeding contract year by the numer of percentage points by which such loss ratio was less than 85 percent;

(B) for 3 consecutive contract years, the Secretary shall not permit the enrollment of new enrollees under the plan for coverage during the second succeeding contract year; and

(C) the Secretary shall terminate the plan contract if the plan fails to have such a medical loss ratio for 5 consecutive contract years.

(5) ENFORCEMENT OF AUDITS AND DEFICIENCIES.—

(A) INFORMATION IN CONTRACT.—The Secretary shall require that each contract with a Medicare Part C organization under this section shall include terms that inform the organization of the provisions in subsection (d).

(B) ENFORCEMENT AUTHORITY.—The Secretary is authorized, in connection with conducting audits and other activities under subsection (d), to take such actions, including pursuit of financial recoveries, necessary to address deficiencies identified in such audits or other activities.

(f) PROMPT PAYMENT BY [MEDICARE+CHOICE] *MEDICARE PART C* ORGANIZATION.—

(1) REQUIREMENT.—A contract under this part shall require a [Medicare+Choice] *Medicare Part C* organization to provide prompt payment (consistent with the provisions of sections 1816(c)(2) and 1842(c)(2)) of claims submitted for services and supplies furnished to enrollees pursuant to the contract, if the services or supplies are not furnished under a contract between the organization and the provider or supplier (or in the case of a [Medicare+Choice] *Medicare Part C* private fee-for-service plan, if a claim is submitted to such organization by an enrollee).

(2) SECRETARY'S OPTION TO BYPASS NONCOMPLYING ORGANIZATION.—In the case of a [Medicare+Choice] *Medicare Part C* eligible organization which the Secretary determines, after notice

and opportunity for a hearing, has failed to make payments of amounts in compliance with paragraph (1), the Secretary may provide for direct payment of the amounts owed to providers and suppliers (or, in the case of a [Medicare+Choice] *Medicare Part C* private fee-for-service plan, amounts owed to the enrollees) for covered services and supplies furnished to individuals enrolled under this part under the contract. If the Secretary provides for the direct payments, the Secretary shall provide for an appropriate reduction in the amount of payments otherwise made to the organization under this part to reflect the amount of the Secretary's payments (and the Secretary's costs in making the payments).

(g) INTERMEDIATE SANCTIONS.—

(1) IN GENERAL.—If the Secretary determines that a [Medicare+Choice] *Medicare Part C* organization with a contract under this section—

(A) * * *

(B) imposes premiums on individuals enrolled under this part in excess of the amount of the [Medicare+Choice] *Medicare Part C* monthly basic and supplemental beneficiary premiums permitted under section 1854;

* * * * * * *

(F) fails to comply with the applicable requirements of section 1852(j)(3) or 1852(k)(2)(A)(ii); [or]

* * * * * * *

(H) fails substantially to provide language services to limited English proficient beneficiaries enrolled in the plan that are required under law; and

(I) violates marketing and enrollment standards adopted under section 1852(m);

the Secretary may provide, in addition to any other remedies authorized by law, for any of the remedies described in paragraph (2).

(2) REMEDIES.—The remedies described in this paragraph are—

(A) civil money penalties of not more than [$25,000] *$50,000* for each determination under paragraph (1) or, with respect to a determination under subparagraph (D) or (E)(i) of such paragraph, of not more than [$100,000] *$200,000* for each such determination, plus, with respect to a determination under paragraph (1)(B), double the excess amount charged in violation of such paragraph (and the excess amount charged shall be deducted from the penalty and returned to the individual concerned), and plus, with respect to a determination under paragraph (1)(D), [$15,000] *$30,000* for each individual not enrolled as a result of the practice involved,

* * * * * * *

(3) OTHER INTERMEDIATE SANCTIONS.—In the case of a [Medicare+Choice] *Medicare Part C* organization for which the Secretary makes a determination under subsection (c)(2) the

basis of which is not described in paragraph (1), the Secretary may apply the following intermediate sanctions:

(A) Civil money penalties of not more than [$25,000] *$50,000* for each determination under subsection (c)(2) if the deficiency that is the basis of the determination has directly adversely affected (or has the substantial likelihood of adversely affecting) an individual covered under the organization's contract.

(B) Civil money penalties of not more than [$10,000] *$20,000* for each week beginning after the initiation of civil money penalty procedures by the Secretary during which the deficiency that is the basis of a determination under subsection (c)(2) exists.

* * * * * * *

(D) Civil monetary penalties of not more than [$100,000] *$200,000*, or such higher amount as the Secretary may establish by regulation, where the finding under subsection (c)(2)(A) is based on the organization's termination of its contract under this section other than at a time and in a manner provided for under subsection (a).

* * * * * * *

(h) PROCEDURES FOR TERMINATION.—

(1) IN GENERAL.—The Secretary may terminate a contract with a [Medicare+Choice] *Medicare Part C* organization under this section in accordance with formal investigation and compliance procedures established by the Secretary under which—

(A) * * *

* * * * * * *

(i) [MEDICARE+CHOICE] *MEDICARE PART C* PROGRAM COMPATIBILITY WITH EMPLOYER OR UNION GROUP HEALTH PLANS.—

(1) CONTRACTS WITH MA ORGANIZATIONS.—To facilitate the offering of [Medicare+Choice] *Medicare Part C* plans under contracts between [Medicare+Choice] *Medicare Part C* organizations and employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof) to furnish benefits to the entity's employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations, the Secretary may waive or modify requirements *that were in effect before the date of the enactment of the Children's Health and Medicare Protection Act of 2007* that hinder the design of, the offering of, or the enrollment in such [Medicare+Choice] *Medicare Part C* plans.

(2) EMPLOYER SPONSORED MA PLANS.—To facilitate the offering of [MA] *Medicare Part C* plans by employers, labor organizations, or the trustees of a fund established by one or more employers or labor organizations (or combination thereof) to furnish benefits to the entity's employees, former employees (or combination thereof) or members or former members (or combination thereof) of the labor organizations, the Secretary may waive or modify requirements *that were in effect before the date of the enactment of the Children's Health and Medicare Protec-*

tion Act of 2007 that hinder the design of, the offering of, or the enrollment in such [MA] *Medicare Part C* plans*, but only if 90 percent of the Medicare part C eligible individuals enrolled under such plan reside in a county in which the Medicare Part C organization offers a Medicare Part C local plan*. Notwithstanding section 1851(g), an [MA] *Medicare Part C* plan described in the previous sentence may restrict the enrollment of individuals under this part to individuals who are beneficiaries and participants in such plan.

(j) DISCLOSURE OF MARKET AND ADVERTISING CONTRACT VIOLATIONS AND IMPOSED SANCTIONS.—For years beginning with 2009, the Secretary shall post on its public website for the Medicare program an annual report that—

(1) lists each MA organization for which the Secretary made during the year a determination under subsection (c)(2) the basis of which is described in paragraph (1)(E); and

(2) that describes any applicable sanctions under subsection (g) applied to such organization pursuant to such determination.

SPECIAL RULES FOR MA REGIONAL PLANS

SEC. 1858. (a) REGIONAL SERVICE AREA; ESTABLISHMENT OF [MA] *MEDICARE PART C* REGIONS.—

(1) COVERAGE OF ENTIRE [MA] *MEDICARE PART C* REGION.—The service area for an [MA] *Medicare Part C* regional plan shall consist of an entire [MA] *Medicare Part C* region established under paragraph (2) and the provisions of section 1854(h) shall not apply to such a plan.

(2) ESTABLISHMENT OF [MA] *MEDICARE PART C* REGIONS.—

(A) [MA] *MEDICARE PART C* REGION.—For purposes of this title, the term "[MA] *Medicare Part C* region" means such a region within the 50 States and the District of Columbia as established by the Secretary under this paragraph.

(B) ESTABLISHMENT.—

(i) INITIAL ESTABLISHMENT.—Not later than January 1, 2005, the Secretary shall first establish and publish [MA] *Medicare Part C* regions.

(ii) PERIODIC REVIEW AND REVISION OF SERVICE AREAS.—The Secretary may periodically review [MA] *Medicare Part C* regions under this paragraph and, based on such review, may revise such regions if the Secretary determines such revision to be appropriate.

(C) REQUIREMENTS FOR MA REGIONS.—The Secretary shall establish, and may revise, [MA] *Medicare Part C* regions under this paragraph in a manner consistent with the following:

(i) * * *

(ii) MAXIMIZING AVAILABILITY OF PLANS.—The regions shall maximize the availability of [MA] *Medicare Part C* regional plans to all [MA] *Medicare Part C* eligible individuals without regard to health status, especially those residing in rural areas.

(D) MARKET SURVEY AND ANALYSIS.—Before establishing [MA] *Medicare Part C* regions, the Secretary shall conduct a market survey and analysis, including an examination of current insurance markets, to determine how the regions should be established.

(3) NATIONAL PLAN.—Nothing in this subsection shall be construed as preventing an [MA] *Medicare Part C* regional plan from being offered in more than one [MA] *Medicare Part C* region (including all regions).

(b) APPLICATION OF SINGLE DEDUCTIBLE AND CATASTROPHIC LIMIT ON OUT-OF-POCKET EXPENSES.—An [MA] *Medicare Part C* regional plan shall include the following:

(1) * * *

* * * * * * *

(c) PORTION OF TOTAL PAYMENTS TO AN ORGANIZATION SUBJECT TO RISK FOR 2006 AND 2007.—

(1) APPLICATION OF RISK CORRIDORS.—

(A) IN GENERAL.—This subsection shall only apply to [MA] *Medicare Part C* regional plans offered during 2006 or 2007.

(B) NOTIFICATION OF ALLOWABLE COSTS UNDER THE PLAN.—In the case of an [MA] *Medicare Part C* organization that offers an [MA] *Medicare Part C* regional plan in an [MA] *Medicare Part C* region in 2006 or 2007, the organization shall notify the Secretary, before such date in the succeeding year as the Secretary specifies, of—

(i) * * *

* * * * * * *

(C) ALLOWABLE COSTS DEFINED.—For purposes of this subsection, the term "allowable costs" means, with respect to an [MA] *Medicare Part C* regional plan for a year, the total amount of costs described in subparagraph (B) for the plan and year, reduced by the portion of such costs attributable to administrative expenses incurred in providing the benefits described in such subparagraph.

* * * * * * *

(D) TARGET AMOUNT DESCRIBED.—For purposes of this paragraph, the term "target amount" means, with respect to an [MA] *Medicare Part C* regional plan offered by an organization in a year, an amount equal to—

(i) * * *

* * * * * * *

(3) DISCLOSURE OF INFORMATION.—

(A) IN GENERAL.—Each contract under this part shall provide—

(i) that an [MA] *Medicare Part C* organization offering an [MA] *Medicare Part C* regional plan shall provide the Secretary with such information as the Secretary determines is necessary to carry out this subsection; and

* * * * * * *

(d) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS.—

(1) IN GENERAL.—In the case of an [MA] *Medicare Part C* organization that is offering an [MA] *Medicare Part C* regional plan in an [MA] *Medicare Part C* region and—

(A) * * *

* * * * * * *

(2) SELECTION OF APPROPRIATE STATE.—In applying paragraph (1) in the case of an [MA] *Medicare Part C* organization that meets the requirements of section 1855(a)(1) with respect to more than one State in a region, the organization shall select, in a manner specified by the Secretary among such States, one State the rules of which shall apply in the case of the States described in paragraph (1)(B).

[(e) STABILIZATION FUND.—

[(1) ESTABLISHMENT.—The Secretary shall establish under this subsection an MA Regional Plan Stabilization Fund (in this subsection referred to as the "Fund") which shall be available for two purposes:

[(A) PLAN ENTRY.—To provide incentives to have MA regional plans offered in each MA region under paragraph (3).

[(B) PLAN RETENTION.—To provide incentives to retain MA regional plans in certain MA regions with below-national-average MA market penetration under paragraph (4).

[(2) FUNDING.—

[(A) INITIAL FUNDING.—

[(i) IN GENERAL.—There shall be available to the Fund, for expenditures from the Fund during the period beginning on January 1, 2012, and ending on December 31, 2013, a total of $3,500,000,000.

[(ii) PAYMENT FROM TRUST FUNDS.—Such amount shall be available to the Fund, as expenditures are made from the Fund, from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in the proportion specified in section 1853(f).

[(B) ADDITIONAL FUNDING FROM SAVINGS.—

[(i) IN GENERAL.—There shall also be made available to the Fund, 50 percent of savings described in clause (ii).

[(ii) SAVINGS.—The savings described in this clause are 25 percent of the average per capita savings described in section 1854(b)(4)(C) for which monthly rebates are provided under section 1854(b)(1)(C) in the fiscal year involved that are attributable to MA regional plans.

[(iii) AVAILABILITY.—Funds made available under this subparagraph shall be transferred into a special account in the Treasury from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in the proportion specified in section 1853(f) on a monthly basis.

[(C) OBLIGATIONS.—Amounts in the Fund shall be available in advance of appropriations to MA regional plans in qualifying MA regions only in accordance with paragraph (5).

[(D) ORDERING.—Expenditures from the Fund shall first be made from amounts made available under subparagraph (A).

[(3) PLAN ENTRY FUNDING.—

[(A) IN GENERAL.—Funding is available under this paragraph for a year only as follows:

[(i) NATIONAL PLAN.—For a national bonus payment described in subparagraph (B) for the offering by a single MA organization of an MA regional plan in each MA region in the year, but only if there was not such a plan offered in each such region in the previous year. Funding under this clause is only available with respect to any individual MA organization for a single year, but may be made available to more than one such organization in the same year.

[(ii) REGIONAL PLANS.—Subject to clause (iii), for an increased amount under subparagraph (C) for an MA regional plan offered in an MA region which did not have any MA regional plan offered in the prior year.

[(iii) LIMITATION ON REGIONAL PLAN FUNDING IN CASE OF NATIONAL PLAN.—In no case shall there be any payment adjustment under subparagraph (C) for a year for which a national payment adjustment is made under subparagraph (B).

[(B) NATIONAL BONUS PAYMENT.—The national bonus payment under this subparagraph shall—

[(i) be available to an MA organization only if the organization offers MA regional plans in every MA region;

[(ii) be available with respect to all MA regional plans of the organization regardless of whether any other MA regional plan is offered in any region; and

[(iii) subject to amounts available under paragraph (5) for a year, be equal to 3 percent of the benchmark amount otherwise applicable for each MA regional plan offered by the organization.

[(C) REGIONAL PAYMENT ADJUSTMENT.—

[(i) IN GENERAL.—The increased amount under this subparagraph for an MA regional plan in an MA region for a year shall be an amount, determined by the Secretary, based on the bid submitted for such plan (or plans) and shall be available to all MA regional plans offered in such region and year. Such amount may be based on the mean, mode, or median, or other measure of such bids and may vary from region to region. The Secretary may not limit the number of plans or bids in a region.

[(ii) MULTI-YEAR FUNDING.—

[(I) IN GENERAL.—Subject to amounts available under paragraph (5), funding under this subpara-

graph shall be available for a period determined by the Secretary.

[(II) REPORT.—If the Secretary determines that funding will be provided for a second consecutive year with respect to an MA region, the Secretary shall submit to the Congress a report that describes the underlying market dynamics in the region and that includes recommendations concerning changes in the payment methodology otherwise provided for MA regional plans under this part.

[(iii) APPLICATION TO ALL PLANS IN A REGION.—Funding under this subparagraph with respect to an MA region shall be made available with respect to all MA regional plans offered in the region.

[(iv) LIMITATION ON AVAILABILITY OF PLAN RETENTION FUNDING IN NEXT YEAR.—If an increased amount is made available under this subparagraph with respect to an MA region for a period determined by the Secretary under clause (ii)(I), in no case shall funding be available under paragraph (4) with respect to MA regional plans offered in the region in the year following such period.

[(D) APPLICATION.—Any additional payment under this paragraph provided for an MA regional plan for a year shall be treated as if it were an addition to the benchmark amount otherwise applicable to such plan and year, but shall not be taken into account in the computation of any benchmark amount for any subsequent year.

[(4) PLAN RETENTION FUNDING.—

[(A) IN GENERAL.—Funding is available under this paragraph for a year with respect to MA regional plans offered in an MA region for the increased amount specified in subparagraph (B) but only if the region meets the requirements of subparagraphs (C) and (E).

[(B) PAYMENT INCREASE.—The increased amount under this subparagraph for an MA regional plan in an MA region for a year shall be an amount, determined by the Secretary, that does not exceed the greater of—

[(i) 3 percent of the benchmark amount applicable in the region; or

[(ii) such amount as (when added to the benchmark amount applicable to the region) will result in the ratio of—

[(I) such additional amount plus the benchmark amount computed under section 1854(b)(4)(B)(i) for the region and year, to the adjusted average per capita cost for the region and year, as estimated by the Secretary under section 1876(a)(4) and adjusted as appropriate for the purpose of risk adjustment; being equal to

[(II) the weighted average of such benchmark amounts for all the regions and such year, to the average per capita cost for the United States and

such year, as estimated by the Secretary under section 1876(a)(4) and adjusted as appropriate for the purpose of risk adjustment.

[(C) REGIONAL REQUIREMENTS.—The requirements of this subparagraph for an MA region for a year are as follows:

[(i) NOTIFICATION OF PLAN EXIT.—The Secretary has received notice (in such form and manner as the Secretary specifies) before a year that one or more MA regional plans that were offered in the region in the previous year will not be offered in the succeeding year.

[(ii) REGIONAL PLANS AVAILABLE FROM FEWER THAN 2 MA ORGANIZATIONS IN THE REGION.—The Secretary determines that if the plans referred to in clause (i) are not offered in the year, fewer than 2 MA organizations will be offering MA regional plans in the region in the year involved.

[(iii) PERCENTAGE ENROLLMENT IN MA REGIONAL PLANS BELOW NATIONAL AVERAGE.—For the previous year, the Secretary determines that the average percentage of MA eligible individuals residing in the region who are enrolled in MA regional plans is less than the average percentage of such individuals in the United States enrolled in such plans.

[(D) APPLICATION.—Any additional payment under this paragraph provided for an MA regional plan for a year shall be treated as if it were an addition to the benchmark amount otherwise applicable to such plan and year, but shall not be taken into account in the computation of any benchmark amount for any subsequent year.

[(E) 2-CONSECUTIVE-YEAR LIMITATION.—

[(i) IN GENERAL.—In no case shall any funding be available under this paragraph in an MA region in a period of consecutive years that exceeds 2 years.

[(ii) REPORT.—If the Secretary determines that funding will be provided under this paragraph for a second consecutive year with respect to an MA region, the Secretary shall submit to the Congress a report that describes the underlying market dynamics in the region and that includes recommendations concerning changes in the payment methodology otherwise provided for MA regional plans under this part.

[(5) FUNDING LIMITATION.—

[(A) IN GENERAL.—The total amount expended from the Fund as a result of the application of this subsection through the end of a calendar year may not exceed the amount available to the Fund as of the first day of such year. For purposes of this subsection, amounts that are expended under this title insofar as such amounts would not have been expended but for the application of this subsection shall be counted as amounts expended as a result of such application.

[(B) APPLICATION OF LIMITATION.—The Secretary may obligate funds from the Fund for a year only if the Sec-

retary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services and the appropriate budget officer certify) that there are available in the Fund at the beginning of the year sufficient amounts to cover all such obligations incurred during the year consistent with subparagraph (A). The Secretary shall take such steps, in connection with computing additional payment amounts under paragraphs (3) and (4) and including limitations on enrollment in MA regional plans receiving such payments, as will ensure that sufficient funds are available to make such payments for the entire year. Funds shall only be made available from the Fund pursuant to an apportionment made in accordance with applicable procedures.

[(6) SECRETARY REPORTS.—Not later than April 1 of each year (beginning in 2008), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

[(A) a detailed description of—

[(i) the total amount expended as a result of the application of this subsection in the previous year compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

[(ii) the projections of the total amount that will be expended as a result of the application of this subsection in the year in which the report is submitted compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted;

[(iii) amounts remaining within the funding limitation specified in paragraph (5); and

[(iv) the steps that the Secretary will take under paragraph (5)(B) to ensure that the application of this subsection will not cause expenditures to exceed the amount available in the Fund; and

[(B) a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that the description provided under subparagraph (A) is reasonable, accurate, and based on generally accepted actuarial principles and methodologies.

[(7) BIENNIAL GAO REPORTS.—Not later than January 1 of 2009, 2011, 2013, and 2015, the Comptroller General of the United States shall submit to the Secretary and Congress a report on the application of additional payments under this subsection. Each report shall include—

[(A) an evaluation of—

[(i) the quality of care provided to individuals enrolled in MA regional plans for which additional payments were made under this subsection;

[(ii) the satisfaction of such individuals with benefits under such a plan;

[(iii) the costs to the medicare program for payments made to such plans; and

[(iv) any improvements in the delivery of health care services under such a plan;

[(B) a comparative analysis of the performance of MA regional plans receiving payments under this subsection with MA regional plans not receiving such payments; and

[(C) recommendations for such legislation or administrative action as the Comptroller General determines to be appropriate.]

(f) COMPUTATION OF APPLICABLE MA REGION-SPECIFIC NON-DRUG MONTHLY BENCHMARK AMOUNTS.—

(1) COMPUTATION FOR REGIONS.—For purposes of section 1853(j)(2) and this section, [subject to subsection (e),] the term "[MA] *Medicare Part C* region-specific non-drug monthly benchmark amount" means, with respect to an [MA] *Medicare Part C* region for a month in a year, the sum of the 2 components described in paragraph (2) for the region and year. The Secretary shall compute such benchmark amount for each [MA] *Medicare Part C* region before the beginning of each annual, coordinated election period under section 1851(e)(3)(B) for each year (beginning with 2006).

(2) 2 COMPONENTS.—For purposes of paragraph (1), the 2 components described in this paragraph for an [MA] *Medicare Part C* region and a year are the following:

(A) * * *

* * * * * * *

(3) STATUTORY REGION-SPECIFIC NON-DRUG AMOUNT.—For purposes of paragraph (2)(A)(i), the term "statutory region-specific non-drug amount" means, for an [MA] *Medicare Part C* region and year, an amount equal the sum (for each MA local area within the region) of the product of—

(A) [MA] *Medicare Part C* area-specific non-drug monthly benchmark amount under section 1853(j)(1)(A) for that area and year; and

(B) the number of [MA] *Medicare Part C* eligible individuals residing in the local area, divided by the total number of [MA] *Medicare Part C* eligible individuals residing in the region.

(4) COMPUTATION OF STATUTORY MARKET SHARE PERCENTAGE.—

(A) IN GENERAL.—The Secretary shall determine for each year a statutory national market share percentage that is equal to the proportion of [MA] *Medicare Part C* eligible individuals nationally who were not enrolled in an [MA] *Medicare Part C* plan during the reference month.

* * * * * * *

(5) DETERMINATION OF WEIGHTED AVERAGE MA BIDS FOR A REGION.—

(A) IN GENERAL.—For purposes of paragraph (2)(B)(i), the weighted average of plan bids for an MA region and a year is the sum, for [MA] *Medicare Part C* regional plans described in subparagraph (D) in the region and year, of the products (for each such plan) of the following:

(i) MONTHLY MA STATUTORY NON-DRUG BID AMOUNT.—The unadjusted [MA] *Medicare Part C* statutory non-drug monthly bid amount for the plan.

* * * * * * *

(B) PLAN'S SHARE OF MA ENROLLMENT IN REGION.—

(i) IN GENERAL.—Subject to the succeeding provisions of this subparagraph, the factor described in this subparagraph for a plan is equal to the number of individuals described in subparagraph (C) for such plan, divided by the total number of such individuals for all [MA] *Medicare Part C* regional plans described in subparagraph (D) for that region and year.

(ii) SINGLE PLAN RULE.—In the case of an [MA] *Medicare Part C* region in which only a single MA regional plan is being offered, the factor described in this subparagraph shall be equal to 1.

(iii) EQUAL DIVISION AMONG MULTIPLE PLANS IN YEAR IN WHICH PLANS ARE FIRST AVAILABLE.—In the case of an [MA] *Medicare Part C* region in the first year in which any MA regional plan is offered, if more than one [MA] *Medicare Part C* regional plan is offered in such year, the factor described in this subparagraph for a plan shall (as specified by the Secretary) be equal to—

(I) * * *

* * * * * * *

(C) COUNTING OF INDIVIDUALS.—For purposes of subparagraph (B)(i), the Secretary shall count for each [MA] *Medicare Part C* regional plan described in subparagraph (D) for an [MA] *Medicare Part C* region and year, the number of individuals who reside in the region and who were enrolled under such plan under this part during the reference month.

(D) PLANS COVERED.—For an [MA] *Medicare Part C* region and year, an [MA] *Medicare Part C* regional plan described in this subparagraph is an [MA] *Medicare Part C* regional plan that is offered in the region and year and was offered in the region in the reference month.

(g) ELECTION OF UNIFORM COVERAGE DETERMINATION.—Instead of applying section 1852(a)(2)(C) with respect to an [MA] *Medicare Part C* regional plan, the organization offering the plan may elect to have a local coverage determination for the entire [MA] *Medicare Part C* region be the local coverage determination applied for any part of such region (as selected by the organization).

(h) ASSURING NETWORK ADEQUACY.—

(1) IN GENERAL.—For purposes of enabling [MA] *Medicare Part C* organizations that offer [MA] *Medicare Part C* regional plans to meet applicable provider access requirements under section 1852 with respect to such plans, the Secretary may provide for payment under this section to an essential hospital that provides inpatient hospital services to enrollees in such a plan where the [MA] *Medicare Part C* organization offering the plan certifies to the Secretary that the organization was

unable to reach an agreement between the hospital and the organization regarding provision of such services under the plan. Such payment shall be available only if—

(A) * * *

* * * * * * *

(4) ESSENTIAL HOSPITAL.—In this subsection, the term "essential hospital" means, with respect to an [MA] *Medicare Part C* regional plan offered by an [MA] *Medicare Part C* organization, a subsection (d) hospital (as defined in section 1886(d)) that the Secretary determines, based upon an application filed by the organization with the Secretary, is necessary to meet the requirements referred to in paragraph (1) for such plan.

DEFINITIONS; MISCELLANEOUS PROVISIONS

SEC. 1859. (a) DEFINITIONS RELATING TO MEDICARE+CHOICE ORGANIZATIONS.—In this part—

(1) [MEDICARE+CHOICE] *MEDICARE PART C* organization.—The term "[Medicare+Choice] *Medicare Part C* organization" means a public or private entity that is certified under section 1856 as meeting the requirements and standards of this part for such an organization.

* * * * * * *

(b) DEFINITIONS RELATING TO [MEDICARE+CHOICE] *MEDICARE PART C* PLANS.—

(1) [MEDICARE+CHOICE] *MEDICARE PART C* PLAN.—The term "[Medicare+Choice] *Medicare Part C* plan" means health benefits coverage offered under a policy, contract, or plan by a [Medicare+Choice] *Medicare Part C* organization pursuant to and in accordance with a contract under section 1857.

(2) [MEDICARE+CHOICE] *MEDICARE PART C* PRIVATE FEE-FOR-SERVICE PLAN.—The term "[Medicare+Choice] *Medicare Part C* private fee-for-service plan" means a [Medicare+Choice] *Medicare Part C* plan that—

(A) * * *

* * * * * * *

(3) MSA PLAN.—

(A) IN GENERAL.—The term "MSA plan" means a [Medicare+Choice] *Medicare Part C* plan that—

(i) * * *

* * * * * * *

(B) DEDUCTIBLE.—The amount of annual deductible under an MSA plan—

(i) * * *

(ii) for a subsequent contract year shall be not more than the maximum amount of such deductible for the previous contract year under this subparagraph increased by the national per capita [Medicare+Choice] *Medicare Part C* growth percentage under section 1853(c)(6) for the year.

* * * * * * *

(4) [MA] *MEDICARE PART C* REGIONAL PLAN.—The term "[MA] *Medicare Part C* regional plan" means an [MA] *Medicare Part C* plan described in section 1851(a)(2)(A)(i)—

(A) * * *

* * * * * * *

(C) the service area of which is one or more entire [MA] *Medicare Part C* regions.

(5) [MA] *MEDICARE PART C* LOCAL PLAN.—The term "[MA] *Medicare Part C* local plan" means an [MA] *Medicare Part C* plan that is not an [MA] *Medicare Part C* regional plan.

(6) SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS.—

(A) IN GENERAL.—The term "specialized [MA] *Medicare Part C* plan for special needs individuals" means [an MA plan that exclusively serves special needs individuals (as defined in subparagraph (B)).] *an MA plan—*

(i) that serves special needs individuals (as defined in subparagraph (B));

(ii) as of January 1, 2009, either—

(I) at least 90 percent of the enrollees in which are described in subparagraph (B)(i), as determined under regulations in effect as of July 1, 2007; or

(II) at least 90 percent of the enrollees in which are described in subparagraph (B)(ii) and are full-benefit dual eligible individuals (as defined in section 1935(c)(6)) or qualified medicare beneficiaries (as defined in section 1905(p)(1)); and

(iii) as of January 1, 2009, meets the applicable requirements of paragraph (2) or (3) of subsection (f), as the case may be.

(B) SPECIAL NEEDS INDIVIDUAL.—The term "special needs individual" means an [MA] *Medicare Part C* eligible individual who—

(i) * * *

* * * * * * *

(iii) *only for contract years beginning before January 1, 2009,* meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized [MA] *Medicare Part C* plan described in subparagraph (A) for individuals with severe or disabling chronic conditions.

* * * * * * *

(c) OTHER REFERENCES TO OTHER TERMS.—

(1) [MEDICARE+CHOICE] *MEDICARE PART C* ELIGIBLE INDIVIDUAL.—The term "[Medicare+Choice] *Medicare Part C* eligible individual" is defined in section 1851(a)(3).

(2) [MEDICARE+CHOICE] *MEDICARE PART C* PAYMENT AREA.—The term "[Medicare+Choice] *Medicare Part C* payment area" is defined in section 1853(d).

(3) NATIONAL PER CAPITA [MEDICARE+CHOICE] *MEDICARE PART C* GROWTH PERCENTAGE.—The "national per capita

[Medicare+Choice] *Medicare Part C* growth percentage" is defined in section 1853(c)(6).

(4) [MEDICARE+CHOICE] *MEDICARE PART C* MONTHLY BASIC BENEFICIARY PREMIUM; [MEDICARE+CHOICE] *MEDICARE PART C* MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The terms "[Medicare+Choice] *Medicare Part C* monthly basic beneficiary premium" and "[Medicare+Choice] *Medicare Part C* monthly supplemental beneficiary premium" are defined in section 1854(a)(2).

(5) [MA] *MEDICARE PART C* LOCAL AREA.—The term "[MA] *Medicare Part C* local area" is defined in section 1853(d)(2).

(d) COORDINATED ACUTE AND LONG-TERM CARE BENEFITS UNDER A [MEDICARE+CHOICE] *MEDICARE PART C* PLAN.—Nothing in this part shall be construed as preventing a State from coordinating benefits under a medicaid plan under title XIX with those provided under a [Medicare+Choice] *Medicare Part C* plan in a manner that assures continuity of a full-range of acute care and long-term care services to poor elderly or disabled individuals eligible for benefits under this title and under such plan.

(e) RESTRICTION ON ENROLLMENT FOR CERTAIN [MEDICARE+CHOICE] *MEDICARE PART C* PLANS.—

(1) IN GENERAL.—In the case of a [Medicare+Choice] *Medicare Part C* religious fraternal benefit society plan described in paragraph (2), notwithstanding any other provision of this part to the contrary and in accordance with regulations of the Secretary, the society offering the plan may restrict the enrollment of individuals under this part to individuals who are members of the church, convention, or group described in paragraph (3)(B) with which the society is affiliated.

(2) [MEDICARE+CHOICE] *MEDICARE PART C* RELIGIOUS FRATERNAL BENEFIT SOCIETY PLAN DESCRIBED.—For purposes of this subsection, a [Medicare+Choice] *Medicare Part C* religious fraternal benefit society plan described in this paragraph is a [Medicare+Choice] *Medicare Part C* plan described in section 1851(a)(2) that—

(A) * * *

* * * * * * *

(3) RELIGIOUS FRATERNAL BENEFIT SOCIETY DEFINED.—For purposes of paragraph (2)(A), a "religious fraternal benefit society" described in this section is an organization that—

(A) * * *

* * * * * * *

(C) offers, in addition to a [Medicare+Choice] *Medicare Part C* religious fraternal benefit society plan, health coverage to individuals not entitled to benefits under this title who are members of such church, convention, or group; and

* * * * * * *

(4) PAYMENT ADJUSTMENT.—Under regulations of the Secretary, in the case of individuals enrolled under this part under a [Medicare+Choice] *Medicare Part C* religious fraternal benefit society plan described in paragraph (2), the Sec-

retary shall provide for such adjustment to the payment amounts otherwise established under section 1854 as may be appropriate to assure an appropriate payment level, taking into account the actuarial characteristics and experience of such individuals.

(f) [RESTRICTION ON ENROLLMENT FOR SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS] *REQUIREMENTS FOR ENROLLMENT IN PART C PLANS FOR SPECIAL NEEDS BENEFICIARIES.*—

(1) REQUIREMENTS FOR ENROLLMENT.—In the case of a specialized [MA] *Medicare Part C* plan for special needs individuals (as defined in subsection (b)(6)), notwithstanding any other provision of this part and in accordance with regulations of the Secretary and for periods before January 1, [2009] *2012*, the plan may restrict the enrollment of individuals under the plan to individuals who are within one or more classes of special needs individuals.

(2) ADDITIONAL REQUIREMENTS FOR INSTITUTIONAL SNPS.—In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(A)(ii)(I), the applicable requirements of this subsection are as follows:

(A) The plan has an agreement with the State that includes provisions regarding cooperation on the coordination of care for such individuals. Such agreement shall include a description of the manner that the State Medicaid program under title XIX will pay for the costs of services for individuals eligible under such title for medical assistance for acute care and long-term care services.

(B) The plan has a contract with long-term care facilities and other providers in the area sufficient to provide care for enrollees described in subsection (b)(6)(B)(i).

(C) The plan reports to the Secretary information on additional quality measures specified by the Secretary under section 1852(e)(3)(D)(iv)(I) for such plans.

(3) ADDITIONAL REQUIREMENTS FOR DUAL SNPS.—In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(A)(ii)(II), the applicable requirements of this subsection are as follows:

(A) The plan has an agreement with the State Medicaid agency that—

(i) includes provisions regarding cooperation on the coordination of the financing of care for such individuals;

(ii) includes a description of the manner that the State Medicaid program under title XIX will pay for the costs of cost-sharing and supplemental services for individuals enrolled in the plan eligible under such title for medical assistance for acute and long-term care services; and

(iii) effective January 1, 2011, provides for capitation payments to cover costs of supplemental benefits for individuals described in subsection (b)(6)(A)(ii)(II).

(B) The out-of-pocket costs for services under parts A and B that are charged to enrollees may not exceed the out-of-

pocket costs for same services permitted for such individuals under title XIX.

(C) The plan reports to the Secretary information on additional quality measures specified by the Secretary under section 1852(e)(3)(D)(iv)(II) for such plans.

* * * * * * *

[COMPARATIVE COST ADJUSTMENT (CCA) PROGRAM

[SEC. 1860C–1.

[(a) ESTABLISHMENT OF PROGRAM.—

[(1) IN GENERAL.—The Secretary shall establish a program under this section (in this section referred to as the "CCA program") for the application of comparative cost adjustment in CCA areas selected under this section.

[(2) DURATION.—The CCA program shall begin January 1, 2010, and shall extend over a period of 6 years, and end on December 31, 2015.

[(3) REPORT.—Upon the completion of the CCA program, the Secretary shall submit a report to Congress. Such report shall include the following, with respect to both this part and the original medicare fee-for-service program:

[(A) An evaluation of the financial impact of the CCA program.

[(B) An evaluation of changes in access to physicians and other health care providers.

[(C) Beneficiary satisfaction.

[(D) Recommendations regarding any extension or expansion of the CCA program.

[(b) REQUIREMENTS FOR SELECTION OF CCA AREAS.—

[(1) CCA AREA DEFINED.—

[(A) IN GENERAL.—For purposes of this section, the term "CCA area" means an MSA that meets the requirements of paragraph (2) and is selected by the Secretary under subsection (c).

[(B) MSA DEFINED.—For purposes of this section, the term "MSA" means a Metropolitan Statistical Area (or such similar area as the Secretary recognizes).

[(2) REQUIREMENTS FOR CCA AREAS.—The requirements of this paragraph for an MSA to be a CCA area are as follows:

[(A) MA ENROLLMENT REQUIREMENT.—For the reference month (as defined under section 1858(f)(4)(B)) with respect to 2010, at least 25 percent of the total number of MA eligible individuals who reside in the MSA were enrolled in an MA local plan described in section 1851(a)(2)(A)(i).

[(B) 2 PLAN REQUIREMENT.—There will be offered in the MSA during the annual, coordinated election period under section 1851(e)(3)(B) before the beginning of 2010 at least 2 MA local plans described in section 1851(a)(2)(A)(i) (in addition to the fee-for-service program under parts A and B), each offered by a different MA organization and each of which met the minimum enrollment requirements of paragraph (1) of section 1857(b) (as applied without regard to paragraph (3) thereof) as of the reference month.

[(c) SELECTION OF CCA AREAS.—

[(1) GENERAL SELECTION CRITERIA.—The Secretary shall select CCA areas from among those MSAs qualifying under subsection (b) in a manner that—

[(A) seeks to maximize the opportunity to test the application of comparative cost adjustment under this title;

[(B) does not seek to maximize the number of MA eligible individuals who reside in such areas; and

[(C) provides for geographic diversity consistent with the criteria specified in paragraph (2).

[(2) SELECTION CRITERIA.—With respect to the selection of MSAs that qualify to be CCA areas under subsection (b), the following rules apply, to the maximum extent feasible:

[(A) MAXIMUM NUMBER.—The number of such MSAs selected may not exceed the lesser of (i) 6, or (ii) 25 percent of the number of MSAs that meet the requirement of subsection (b)(2)(A).

[(B) ONE OF 4 LARGEST AREAS BY POPULATION.—At least one such qualifying MSA shall be selected from among the 4 such qualifying MSAs with the largest total population of MA eligible individuals.

[(C) ONE OF 4 AREAS WITH LOWEST POPULATION DENSITY.—At least one such qualifying MSA shall be selected from among the 4 such qualifying MSAs with the lowest population density (as measured by residents per square mile or similar measure of density).

[(D) MULTISTATE AREA.—At least one such qualifying MSA shall be selected that includes a multi-State area. Such an MSA may be an MSA described in subparagraph (B) or (C).

[(E) LIMITATION WITHIN SAME GEOGRAPHIC REGION.—No more than 2 such MSAs shall be selected that are, in whole or in part, within the same geographic region (as specified by the Secretary) of the United States.

[(F) PRIORITY TO AREAS NOT WITHIN CERTAIN DEMONSTRATION PROJECTS.—Priority shall be provided for those qualifying MSAs that do not have a demonstration project in effect as of the date of the enactment of this section for medicare preferred provider organization plans under this part.

[(d) APPLICATION OF COMPARATIVE COST ADJUSTMENT.—

[(1) IN GENERAL.—In the case of a CCA area for a year—

[(A) for purposes of applying this part with respect to payment for MA local plans, any reference to an MA area-specific non-drug monthly benchmark amount shall be treated as a reference to such benchmark computed as if the CCA area-specific non-drug monthly benchmark amount (as defined in subsection (e)(1)) were substituted for the amount described in section 1853(j)(1)(A) for the CCA area and year involved, as phased in under paragraph (3); and

[(B) with respect to months in the year for individuals residing in the CCA area who are not enrolled in an MA

plan, the amount of the monthly premium under section 1839 is subject to adjustment under subsection (f).

[(2) EXCLUSION OF MA LOCAL AREAS WITH FEWER THAN 2 ORGANIZATIONS OFFERING MA PLANS.—

[(A) IN GENERAL.—In no case shall an MA local area that is within an MSA be included as part of a CCA area unless for 2010 (and, except as provided in subparagraph (B), for a subsequent year) there is offered in each part of such MA local area at least 2 MA local plans described in section 1851(a)(2)(A)(i) each of which is offered by a different MA organization.

[(B) CONTINUATION.—If an MA local area meets the requirement of subparagraph (A) and is included in a CCA area for 2010, such local area shall continue to be included in such CCA area for a subsequent year notwithstanding that it no longer meets such requirement so long as there is at least one MA local plan described in section 1851(a)(2)(A)(i) that is offered in such local area.

[(3) PHASE-IN OF CCA BENCHMARK.—

[(A) IN GENERAL.—In applying this section for a year before 2013, paragraph (1)(A) shall be applied as if the phase-in fraction under subparagraph (B) of the CCA non-drug monthly benchmark amount for the year were substituted for such fraction of the MA area-specific non-drug monthly benchmark amount.

[(B) PHASE-IN FRACTION.—The phase-in fraction under this subparagraph is—

[(i) for 2010 ¼; and

[(ii) for a subsequent year is the phase-in fraction under this subparagraph for the previous year increased by ¼, but in no case more than 1.

[(e) COMPUTATION OF CCA BENCHMARK AMOUNT.—

[(1) CCA NON-DRUG MONTHLY BENCHMARK AMOUNT.—For purposes of this section, the term "CCA non-drug monthly benchmark amount" means, with respect to a CCA area for a month in a year, the sum of the 2 components described in paragraph (2) for the area and year. The Secretary shall compute such benchmark amount for each such CCA area before the beginning of each annual, coordinated election period under section 1851(e)(3)(B) for each year (beginning with 2010) in which the CCA area is so selected.

[(2) 2 COMPONENTS.—For purposes of paragraph (1), the 2 components described in this paragraph for a CCA area and a year are the following:

[(A) MA LOCAL COMPONENT.—The product of the following:

[(i) WEIGHTED AVERAGE OF MEDICARE ADVANTAGE PLAN BIDS IN AREA.—The weighted average of the plan bids for the area and year (as determined under paragraph (3)(A)).

[(ii) NON-FFS MARKET SHARE.—One minus the fee-for-service market share percentage, determined under paragraph (4) for the area and year.

[(B) FEE-FOR-SERVICE COMPONENT.—The product of the following:

[(i) FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG AMOUNT.—The fee-for-service area-specific non-drug amount (as defined in paragraph (5)) for the area and year.

[(ii) FEE-FOR-SERVICE MARKET SHARE.—The fee-for-service market share percentage, determined under paragraph (4) for the area and year.

[(3) DETERMINATION OF WEIGHTED AVERAGE MA BIDS FOR A CCA AREA.—

[(A) IN GENERAL.—For purposes of paragraph (2)(A)(i), the weighted average of plan bids for a CCA area and a year is, subject to subparagraph (D), the sum of the following products for MA local plans described in subparagraph (C) in the area and year:

[(i) MONTHLY MEDICARE ADVANTAGE STATUTORY NON-DRUG BID AMOUNT.—The accepted unadjusted MA statutory non-drug monthly bid amount.

[(ii) PLAN'S SHARE OF MEDICARE ADVANTAGE ENROLLMENT IN AREA.—The number of individuals described in subparagraph (B), divided by the total number of such individuals for all MA plans described in subparagraph (C) for that area and year.

[(B) COUNTING OF INDIVIDUALS.—The Secretary shall count, for each MA local plan described in subparagraph (C) for an area and year, the number of individuals who reside in the area and who were enrolled under such plan under this part during the reference month for that year.

[(C) EXCLUSION OF PLANS NOT OFFERED IN PREVIOUS YEAR.—For an area and year, the MA local plans described in this subparagraph are MA local plans described in section 1851(a)(2)(A)(i) that are offered in the area and year and were offered in the CCA area in the reference month.

[(D) COMPUTATION OF WEIGHTED AVERAGE OF PLAN BIDS.—In calculating the weighted average of plan bids for a CCA area under subparagraph (A)—

[(i) in the case of an MA local plan that has a service area only part of which is within such CCA area, the MA organization offering such plan shall submit a separate bid for such plan for the portion within such CCA area; and

[(ii) the Secretary shall adjust such separate bid (or, in the case of an MA local plan that has a service area entirely within such CCA area, the plan bid) as may be necessary to take into account differences between the service area of such plan within the CCA area and the entire CCA area and the distribution of plan enrollees of all MA local plans offered within the CCA area.

[(4) COMPUTATION OF FEE-FOR-SERVICE MARKET SHARE PERCENTAGE.—The Secretary shall determine, for a year and a CCA area, the proportion (in this subsection referred to as the "fee-for-service market share percentage") equal to—

[(A) the total number of MA eligible individuals residing in such area who during the reference month for the year were not enrolled in any MA plan; divided by

[(B) the sum of such number and the total number of MA eligible individuals residing in such area who during such reference month were enrolled in an MA local plan described in section 1851(a)(2)(A)(i),

or, if greater, such proportion determined for individuals nationally.

[(5) FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG AMOUNT.—

[(A) IN GENERAL.—For purposes of paragraph (2)(B)(i) and subsection (f)(2)(A), subject to subparagraph (C), the term "fee-for-service area-specific non-drug amount" means, for a CCA area and a year, the adjusted average per capita cost for such area and year involved, determined under section 1876(a)(4) and adjusted as appropriate for the purpose of risk adjustment for benefits under the original medicare fee-for-service program option for individuals entitled to benefits under part A and enrolled under part B who are not enrolled in an MA plan for the year, but adjusted to exclude costs attributable to payments under section 1886(h).

[(B) USE OF FULL RISK ADJUSTMENT TO STANDARDIZE FEE-FOR-SERVICE COSTS TO TYPICAL BENEFICIARY.—In determining the adjusted average per capita cost for an area and year under subparagraph (A), such costs shall be adjusted to fully take into account the demographic and health status risk factors established under section 1853(a)(1)(A)(iv) so that such per capita costs reflect the average costs for a typical beneficiary residing in the CCA area.

[(C) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the adjusted average per capita cost under subparagraph (A) for a year, such cost shall be adjusted to include the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Veterans Affairs or the Department of Defense.

[(f) PREMIUM ADJUSTMENT.—

[(1) APPLICATION.—

[(A) IN GENERAL.—Except as provided in subparagraph (B), in the case of an individual who is enrolled under part B, who resides in a CCA area, and who is not enrolled in an MA plan under this part, the monthly premium otherwise applied under part B (determined without regard to subsections (b), (f), and (i) of section 1839 or any adjustment under this subsection) shall be adjusted in accordance with paragraph (2), but only in the case of premiums for months during the period in which the CCA program under this section for such area is in effect.

[(B) NO PREMIUM ADJUSTMENT FOR SUBSIDY ELIGIBLE BENEFICIARIES.—No premium adjustment shall be made under this subsection for a premium for a month if the individual is determined to be a subsidy eligible individual (as defined in section 1860D–14(a)(3)(A)) for the month.

[(2) AMOUNT OF ADJUSTMENT.—

[(A) IN GENERAL.—Under this paragraph, subject to the exemption under paragraph (1)(B) and the limitation under subparagraph (B), if the fee-for-service area-specific non-drug amount (as defined in section (e)(5)) for a CCA area in which an individual resides for a month—

[(i) does not exceed the CCA non-drug monthly benchmark amount (as determined under subsection (e)(1)) for such area and month, the amount of the premium for the individual for the month shall be reduced, by an amount equal to 75 percent of the amount by which such CCA benchmark exceeds such fee-for-service area-specific non-drug amount; or

[(ii) exceeds such CCA non-drug benchmark, the amount of the premium for the individual for the month shall be adjusted to ensure, that—

[(I) the sum of the amount of the adjusted premium and the CCA non-drug benchmark for the area; is equal to

[(II) the sum of the unadjusted premium plus the amount of such fee-for-service area-specific non-drug amount for the area.

[(B) LIMITATION.—In no case shall the actual amount of an adjustment under subparagraph (A) for an area and month in a year result in an adjustment that exceeds the maximum adjustment permitted under subparagraph (C) for the area and year, or, if less, the maximum annual adjustment permitted under subparagraph (D) for the area and year.

[(C) PHASE-IN OF ADJUSTMENT.—The amount of an adjustment under subparagraph (A) for a CCA area and year may not exceed the product of the phase-in fraction for the year under subsection (d)(3)(B) multiplied by the amount of the adjustment otherwise computed under subparagraph (A) for the area and year, determined without regard to this subparagraph and subparagraph (D).

[(D) 5-PERCENT LIMITATION ON ADJUSTMENT.—The amount of the adjustment under this subsection for months in a year shall not exceed 5 percent of the amount of the monthly premium amount determined for months in the year under section 1839 without regard to subsections (b), (f), and (i) of such section and this subsection.]

PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

Subpart 1—Part D Eligible Individuals and Prescription Drug Benefits

ELIGIBILITY, ENROLLMENT, AND INFORMATION

SEC. 1860D–1. (a) PROVISION OF QUALIFIED PRESCRIPTION DRUG COVERAGE THROUGH ENROLLMENT IN PLANS.—

(1) IN GENERAL.—Subject to the succeeding provisions of this part, each part D eligible individual (as defined in paragraph (3)(A)) is entitled to obtain qualified prescription drug coverage (described in section 1860D–2(a)) as follows:

(A) FEE-FOR-SERVICE ENROLLEES MAY RECEIVE COVERAGE THROUGH A PRESCRIPTION DRUG PLAN.—A part D eligible individual who is not enrolled in an **[**MA**]** *Medicare Part C* plan may obtain qualified prescription drug coverage through enrollment in a prescription drug plan (as defined in section 1860D–41(a)(14)).

(B) MEDICARE ADVANTAGE ENROLLEES.—

(i) ENROLLEES IN A PLAN PROVIDING QUALIFIED PRESCRIPTION DRUG COVERAGE RECEIVE COVERAGE THROUGH THE PLAN.—A part D eligible individual who is enrolled in an MA–PD plan obtains such coverage through such plan.

(ii) LIMITATION ON ENROLLMENT OF MA PLAN ENROLLEES IN PRESCRIPTION DRUG PLANS.—Except as provided in clauses (iii) and (iv), a part D eligible individual who is enrolled in an **[**MA**]** *Medicare Part C* plan may not enroll in a prescription drug plan under this part.

(iii) PRIVATE FEE-FOR-SERVICE ENROLLEES IN MA PLANS NOT PROVIDING QUALIFIED PRESCRIPTION DRUG COVERAGE PERMITTED TO ENROLL IN A PRESCRIPTION DRUG PLAN.—A part D eligible individual who is enrolled in an **[**MA**]** *Medicare Part C* private fee-for-service plan (as defined in section 1859(b)(2)) that does not provide qualified prescription drug coverage may obtain qualified prescription drug coverage through enrollment in a prescription drug plan.

* * * * * * *

(3) DEFINITIONS.—For purposes of this part:

(A) * * *

(B) **[**MA**]** *MEDICARE PART C* PLAN.—The term "**[**MA**]** *Medicare Part C* plan" has the meaning given such term in section 1859(b)(1).

(C) MA–PD PLAN.—The term "MA–PD plan" means an **[**MA**]** *Medicare Part C* plan that provides qualified prescription drug coverage.

(b) ENROLLMENT PROCESS FOR PRESCRIPTION DRUG PLANS.—

(1) ESTABLISHMENT OF PROCESS.—

(A) IN GENERAL.—The Secretary shall establish a process for the enrollment, disenrollment, termination, and change

of enrollment of part D eligible individuals in prescription drug plans consistent with this subsection.

(B) APPLICATION OF MA RULES.—In establishing such process, the Secretary shall use rules similar to (and coordinated with) the rules for enrollment, disenrollment, termination, and change of enrollment with an MA–PD plan under the following provisions of section 1851:

(i) * * *

* * * * * * *

(iii) COVERAGE ELECTION PERIODS.—Subject to paragraphs (2) and (3) of this subsection, section 1851(e) (other than subparagraphs (B), (C), and (E) of [paragraph (2) and] *paragraph (2),* the second sentence of paragraph (4)*, and paragraph (7),* of such section), relating to coverage election periods, including initial periods, annual coordinated election periods, special election periods, and election periods for exceptional circumstances.

* * * * * * *

(C) SPECIAL RULE.—The process established under subparagraph (A) shall include, in the case of a part D eligible individual who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)) who has failed to enroll in a prescription drug plan or an MA–PD plan, for the enrollment in a prescription drug plan that has a monthly beneficiary premium that does not exceed the premium assistance available under section 1860D–14(a)(1)(A)). If there is more than one such plan available, the Secretary shall enroll such an individual*, subject to subparagraph (D),* on a random basis among all such plans in the PDP region. Nothing in the previous sentence shall prevent such an individual from declining or changing such enrollment.

* * * * * * *

(D) INTELLIGENT ASSIGNMENT.—In the case of any auto-enrollment under subparagraph (C), no part D eligible individual described in such subparagraph shall be enrolled in a prescription drug plan which does not meet the following requirements:

(i) FORMULARY.—The plan has a formulary that covers at least—

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

(II) 95 percent of the 100 most commonly prescribed non-duplicative brand name covered part D drugs for such population.

(ii) PHARMACY NETWORK.—The plan has a network of pharmacies that substantially exceeds the minimum requirements for prescription drug plans in the State

and that provides access in areas where lower income individuals reside.

(iii) QUALITY.—

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

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

(iv) LOW COST.—The total cost under this title of providing prescription drug coverage under the plan consistent with the previous clauses of this subparagraph is among the lowest 25th percentile of prescription drug plans under this part in the State.

In the case that no plan meets the requirements under clauses (i) through (iv), the Secretary shall implement this subparagraph to the greatest extent possible with the goal of protecting beneficiary access to drugs without increasing the cost relative to the enrollment process under subparagraph (C) as in existence before the date of the enactment of this subparagraph.

(E) SPECIAL RULE FOR SUBSIDY ELIGIBLE INDIVIDUALS.—The process established under subparagraph (A) shall include, in the case of an applicable subsidy eligible individual (as defined in clause (ii) of paragraph (3)(F)) who fails to enroll in a prescription drug plan or an MA–PD plan during the special enrollment period described in clause (iii) of such paragraph applicable to such individual, a process for the facilitated enrollment of the individual in the prescription drug plan or MA–PD plan that is most appropriate for such individual (as determined by the Secretary). Nothing in the previous sentence shall prevent an individual described in such sentence from declining enrollment in a plan determined appropriate by the Secretary (or in the program under this part) or from changing such enrollment.

* * * * * * *

(3) ADDITIONAL SPECIAL ENROLLMENT PERIODS.—The Secretary shall establish special enrollment periods, including the following:

(A) * * *

* * * * * * *

(F) CHANGE IN FORMULARY RESULTING IN INCREASE IN COST-SHARING.—

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

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

(G) ELIGIBILITY FOR LOW-INCOME SUBSIDY.—

(i) IN GENERAL.—In the case of an applicable subsidy eligible individual (as defined in clause (ii)), the special enrollment period described in clause (iii).

(ii) APPLICABLE SUBSIDY ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this subparagraph, the term "applicable subsidy eligible individual" means a part D eligible individual who is determined under subparagraph (B) of section 1860D–14(a)(3) to be a subsidy eligible individual (as defined in subparagraph (A) of such section), and includes such an individual who was enrolled in a prescription drug plan or an MA–PD plan on the date of such determination.

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

* * * * * * *

(d) APPLICATION OF MARKETING AND ENROLLMENT STANDARDS.—The marketing and enrollment standards adopted under section 1852(m) shall apply to prescription drug plans (and sponsors of such plans) in the same manner as they apply to Medicare Part C plans and organizations offering such plans.

PRESCRIPTION DRUG BENEFITS

SEC. 1860D–2. (a) * * *

(b) STANDARD PRESCRIPTION DRUG COVERAGE.—For purposes of this part and part C, the term "standard prescription drug coverage" means coverage of covered part D drugs that meets the following requirements:

(1) * * *

* * * * * * *

(2) BENEFIT STRUCTURE.—

(A) * * *

(B) USE OF TIERS.—Nothing in this part shall be construed as preventing a PDP sponsor or an [MA] *Medicare Part C* organization from applying tiered copayments under a plan, so long as such tiered copayments are consistent with subparagraph (A)(ii).

* * * * * * *

(4) PROTECTION AGAINST HIGH OUT-OF-POCKET EXPENDITURES.—

(A) * * *

* * * * * * *

(D) INFORMATION REGARDING THIRD-PARTY REIMBURSEMENT.—

(i) PROCEDURES FOR EXCHANGING INFORMATION.—In order to accurately apply the requirements of subparagraph (C)(ii), the Secretary is authorized to establish procedures, in coordination with the Secretary of the Treasury and the Secretary of Labor—

(I) * * *

(II) for alerting the PDP sponsors and **[**MA**]** *Medicare Part C* organizations that offer the prescription drug plans and MA–PD plans in which such individuals are enrolled about such reimbursement arrangements.

(ii) AUTHORITY TO REQUEST INFORMATION FROM ENROLLEES.—A PDP sponsor or an **[**MA**]** *Medicare Part C* organization may periodically ask part D eligible individuals enrolled in a prescription drug plan or an MA–PD plan offered by the sponsor or organization whether such individuals have or expect to receive such third-party reimbursement. A material misrepresentation of the information described in the preceding sentence by an individual (as defined in standards set by the Secretary and determined through a process established by the Secretary) shall constitute grounds for termination of enrollment in any plan under section 1851(g)(3)(B) (and as applied under this part under section 1860D–1(b)(1)(B)(v)) for a period specified by the Secretary.

(5) CONSTRUCTION.—Nothing in this part shall be construed as preventing a PDP sponsor or an **[**MA**]** *Medicare Part C* organization offering an MA–PD plan from reducing to zero the cost-sharing otherwise applicable to preferred or generic drugs.

* * * * * * *

(4) PROTECTION AGAINST HIGH OUT-OF-POCKET EXPENDITURES.—

(A) * * *

* * * * * * *

(C) APPLICATION.—In applying subparagraph (A)—

(i) incurred costs shall only include costs incurred with respect to covered part D drugs for the annual deductible described in paragraph (1), for cost-sharing described in paragraph (2), and for amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3), but does not include any costs incurred for covered part D drugs which are not included (or treated as being included) in the plan's formulary; **[**and**]**

(ii) **[**such costs shall be treated as incurred only if**]** *subject to clause (iii), such costs shall be treated as incurred only if* they are paid by the part D eligible individual (or by another person, such as a family member, on behalf of the individual)**[**, under section 1860D–14, or under a State Pharmaceutical Assist-

ance Program] and the part D eligible individual (or other person) is not reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement (other than under such section or such a Program) for such costs[.]*; and*

(iii) such costs shall be treated as incurred and shall not be considered to be reimbursed under clause (ii) if such costs are borne or paid—

(I) under section 1860D–14;

(II) under a State Pharmaceutical Assistance Program;

(III) by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act); or

(IV) under an AIDS Drug Assistance Program under part B of title XXVI of the Public Health Service Act.

(d) ACCESS TO NEGOTIATED PRICES.—

(1) ACCESS.—

(A) IN GENERAL.—Under qualified prescription drug coverage offered by a PDP sponsor offering a prescription drug plan or an [MA] *Medicare Part C* organization offering an MA–PD plan, the sponsor or organization shall provide enrollees with access to negotiated prices used for payment for covered part D drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of a deductible or other cost-sharing or an initial coverage limit (described in subsection (b)(3)).

* * * * * * *

(3) AUDITS.—To protect against fraud and abuse and to ensure proper disclosures and accounting under this part and in accordance with section 1857(d)(2)(B) (as applied under section 1860D–12(b)(3)(C)), the Secretary may conduct periodic audits, directly or through contracts, of the financial statements and records of PDP sponsors with respect to prescription drug plans and [MA] *Medicare Part C* organizations with respect to MA–PD plans.

* * * * * * *

(e) COVERED PART D DRUG DEFINED.—

(1) * * *

(2) EXCLUSIONS.—

(A) IN GENERAL.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than [subparagraph (E)] *subparagraphs (E) and (J)* of such section (relating to smoking cessation agents *and benzodiazepines, respectively*), or under section 1927(d)(3), as such sections were in effect on the date of the enactment of this part. Such term also does not include a drug when used for the treatment of sexual or erectile dysfunction, unless such drug were used to treat a condi-

tion, other than sexual or erectile dysfunction, for which the drug has been approved by the Food and Drug Administration.

* * * * * * *

ACCESS TO A CHOICE OF QUALIFIED PRESCRIPTION DRUG COVERAGE

SEC. 1860D–3. (a) ASSURING ACCESS TO A CHOICE OF COVERAGE.—

(1) * * *

* * * * * * *

(3) QUALIFYING PLAN DEFINED.—For purposes of this section, the term "qualifying plan" means—

(A) * * *

(B) an MA–PD plan described in section 1851(a)(2)(A)(i) that provides—

(i) * * *

(ii) qualified prescription drug coverage that provides supplemental prescription drug coverage so long as there is no **[**MA**]** *Medicare Part C* monthly supplemental beneficiary premium applied under the plan, due to the application of a credit against such premium of a rebate under section 1854(b)(1)(C).

* * * * * * *

BENEFICIARY PROTECTIONS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE

SEC. 1860D–4. (a) * * *

(b) ACCESS TO COVERED PART D DRUGS.—

(1) * * *

* * * * * * *

(3) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If a PDP sponsor of a prescription drug plan uses a formulary (including the use of tiered cost-sharing), the following requirements must be met:

(A) * * *

* * * * * * *

(C) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES AND CLASSES.—

(i) IN GENERAL.—The formulary must include drugs within each therapeutic category and class of covered part D drugs, although*, except as provided in subparagraph (G),* not necessarily all drugs within such categories and classes.

* * * * * * *

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

* * * * * * *

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

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

(I) Anticonvulsants.

(II) Antineoplastics.

(III) Antiretrovirals.

(IV) Antidepressants.

(V) Antipsychotics.

(VI) Immunosuppresessants.

(ii) USE OF UTILIZATION MANAGEMENT TOOLS.—A PDP sponsor of a prescription drug plan may use prior authorization or step therapy for the initiation of medications within one of the classifications specified in clause (i) but only when approved by the Secretary, except that such prior authorization or step therapy may not be used in the case of antiretrovirals and in the case of individuals who already are stabilized on a drug treatment regimen.

* * * * * * *

(e) ELECTRONIC PRESCRIPTION PROGRAM.—

(1) * * *

* * * * * * *

(4) DEVELOPMENT, PROMULGATION, AND MODIFICATION OF STANDARDS.—

(A) * * *

* * * * * * *

(C) PILOT PROJECT TO TEST INITIAL STANDARDS.—

(i) * * *

* * * * * * *

(iii) VOLUNTARY PARTICIPATION OF PHYSICIANS AND PHARMACIES.—In order to conduct the pilot project under clause (i), the Secretary shall enter into agreements with physicians, physician groups, pharmacies, hospitals, PDP sponsors, [MA] *Medicare Part C* organizations, and other appropriate entities under which health care professionals electronically transmit prescriptions to dispensing pharmacies and pharmacists in accordance with such standards.

* * * * * * *

(6) ESTABLISHMENT OF SAFE HARBOR.—The Secretary, in consultation with the Attorney General, shall promulgate regulations that provide for a safe harbor from sanctions under paragraphs (1) and (2) of section 1128B(b) and an exception to the prohibition under subsection (a)(1) of section 1877 with respect to the provision of nonmonetary remuneration (in the form of hardware, software, or information technology and training services) necessary and used solely to receive and transmit electronic prescription information in accordance with the standards promulgated under this subsection—

(A) * * *

* * * * * * *

(C) in the case of a PDP sponsor or [MA] *Medicare Part C* organization, by the sponsor or organization to pharmacists and pharmacies participating in the network of such sponsor or organization, and to prescribing health care professionals.

* * * * * * *

(g) COVERAGE DETERMINATIONS AND RECONSIDERATIONS.—

(1) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—A PDP sponsor shall meet the requirements of paragraphs (1) through (3) of section 1852(g) with respect to covered benefits under the prescription drug plan it offers under this part in the same manner as such requirements apply to an [MA] *Medicare Part C* organization with respect to benefits it offers under an [MA] *Medicare Part C* plan under part C.

* * * * * * *

(h) APPEALS.—

(1) IN GENERAL.—Subject to paragraph (2), a PDP sponsor shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to benefits (including a determination related to the application of tiered cost-sharing described in subsection (g)(2)) in a manner similar (as determined by the Secretary) to the manner such requirements apply to an [MA] *Medicare Part C* organization with respect to benefits under the original medicare fee-for-service program option it offers under an [MA] *Medicare Part C* plan under part C. In applying this paragraph only the part D eligible individual shall be entitled to bring such an appeal.

* * * * * * *

(i) PRIVACY, CONFIDENTIALITY, AND ACCURACY OF ENROLLEE RECORDS.—The provisions of section 1852(h) shall apply to a PDP sponsor and prescription drug plan in the same manner as it applies to an [MA] *Medicare Part C* organization and an MA plan.

* * * * * * *

(j) TREATMENT OF ACCREDITATION.—Subparagraph (A) of section 1852(e)(4) (relating to treatment of accreditation) shall apply to a PDP sponsor under this part with respect to the following requirements, in the same manner as it applies to an [MA] *Medicare Part C* organization with respect to the requirements in subparagraph (B) (other than clause (vii) thereof) of such section:

(1) * * *

* * * * * * *

PDP REGIONS; SUBMISSION OF BIDS; PLAN APPROVAL

SEC. 1860D–11. (a) ESTABLISHMENT OF PDP REGIONS; SERVICE AREAS.—

(1) * * *

(2) ESTABLISHMENT OF PDP REGIONS.—

(A) IN GENERAL.—The Secretary shall establish, and may revise, PDP regions in a manner that is consistent with the requirements for the establishment and revision of [MA] *Medicare Part C* regions under subparagraphs (B) and (C) of section 1858(a)(2).

(B) RELATION TO [MA] *MEDICARE PART C* REGIONS.—To the extent practicable, PDP regions shall be the same as [MA] *Medicare Part C* regions under section 1858(a)(2). The Secretary may establish PDP regions which are not the same as [MA] *Medicare Part C* regions if the Secretary determines that the establishment of different regions under this part would improve access to benefits under this part.

* * * * * * *

(b) SUBMISSION OF BIDS, PREMIUMS, AND RELATED INFORMATION.—

(1) IN GENERAL.—A PDP sponsor shall submit to the Secretary information described in paragraph (2) with respect to each prescription drug plan it offers. Such information shall be submitted at the same time and in a similar manner to the manner in which information described in paragraph (6) of section 1854(a) is submitted by an [MA] *Medicare Part C* organization under paragraph (1) of such section.

* * * * * * *

(g) GUARANTEEING ACCESS TO COVERAGE.—

(1) * * *

* * * * * * *

(2) ELIGIBLE FALLBACK ENTITY.—For purposes of this section, the term "eligible fallback entity" means, with respect to all fallback service areas in a PDP region for a contract period, an entity that—

(A) * * *

* * * * * * *

For purposes of subparagraph (B), an entity shall be treated as submitting a bid with respect to a prescription drug plan if the entity is acting as a subcontractor of a PDP sponsor that is offering such a plan. The previous sentence shall not apply to entities that are subcontractors of an [MA] *Medicare Part C* organization except insofar as such organization is acting as a PDP sponsor with respect to a prescription drug plan.

* * * * * * *

REQUIREMENTS FOR AND CONTRACTS WITH PRESCRIPTION DRUG PLAN (PDP) SPONSORS

SEC. 1860D–12. (a) * * *

* * * * * * *

(g) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES; RELATION TO STATE LAWS.—The provisions of sections 1854(g) and 1856(b)(3) shall apply with respect to PDP sponsors and prescription drug plans under this part in the same manner as such sec-

tions apply to [MA] *Medicare Part C* organizations and MA plans under part C.

* * * * * * *

PREMIUMS; LATE ENROLLMENT PENALTY

SEC. 1860D–13. (a) MONTHLY BENEFICIARY PREMIUM.—

(1) * * *

* * * * * * *

(4) COMPUTATION OF NATIONAL AVERAGE MONTHLY BID AMOUNT.—

(A) IN GENERAL.—For each year (beginning with 2006) the Secretary shall compute a national average monthly bid amount equal to the average of the standardized bid amounts (as defined in paragraph (5)) for each prescription drug plan and for each MA–PD plan described in section 1851(a)(2)(A)(i). Such average does not take into account the bids submitted for MSA plans, [MA] *Medicare Part C* private fee-for-service plan, and specialized MA plans for special needs individuals, PACE programs under section 1894 (pursuant to section 1860D–21(f)), and under reasonable cost reimbursement contracts under section 1876(h) (pursuant to section 1860D–21(e)).

* * * * * * *

(c) COLLECTION OF MONTHLY BENEFICIARY PREMIUMS.—

(1) * * *

(2) CREDITING OF LATE ENROLLMENT PENALTY.—

(A) PORTION ATTRIBUTABLE TO INCREASED ACTUARIAL COSTS.—With respect to late enrollment penalties imposed under subsection (b), the Secretary shall specify the portion of such a penalty that the Secretary estimates is attributable to increased actuarial costs assumed by the PDP sponsor or [MA] *Medicare Part C* organization (and not taken into account through risk adjustment provided under section 1860D–15(c)(1) or through reinsurance payments under section 1860D–15(b)) as a result of such late enrollment.

(B) COLLECTION THROUGH WITHHOLDING.—In the case of a late enrollment penalty that is collected from a part D eligible individual in the manner described in section 1854(d)(2)(A), the Secretary shall provide that only the portion of such penalty estimated under subparagraph (A) shall be paid to the PDP sponsor or [MA] organization offering the part D plan in which the individual is enrolled.

(C) COLLECTION BY PLAN.—In the case of a late enrollment penalty that is collected from a part D eligible individual in a manner other than the manner described in section 1854(d)(2)(A), the Secretary shall establish procedures for reducing payments otherwise made to the PDP sponsor or [MA] *Medicare Part C* organization by an amount equal to the amount of such penalty less the portion of such penalty estimated under subparagraph (A).

* * * * * * *

Subpart 2—Prescription Drug Plans; PDP Sponsors; Financing

* * * * * * *

PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS

SEC. 1860D–14.

(a) INCOME-RELATED SUBSIDIES FOR INDIVIDUALS WITH INCOME UP TO 150 PERCENT OF POVERTY LINE.—

(1) INDIVIDUALS WITH INCOME BELOW 135 PERCENT OF POVERTY LINE.—In the case of a subsidy eligible individual (as defined in paragraph (3)) who is determined to have income that is below 135 percent of the poverty line applicable to a family of the size involved and who meets the resources requirement described in paragraph (3)(D) *(or, beginning with 2009, paragraph (3)(E))* or who is covered under this paragraph under paragraph (3)(B)(i), the individual is entitled under this section to the following:

(A) FULL PREMIUM SUBSIDY.—An income-related premium subsidy equal to—

(i) * * *

[(ii) 80 percent of any late enrollment penalties imposed under section 1860D–13(b) for the first 60 months in which such penalties are imposed for that individual, and 100 percent of any such penalties for any subsequent month.**]**

(ii) 100 percent of any late enrollment penalties imposed under section 1860D–13(b) for such individual.

* * * * * * *

(D) REDUCTION IN COST-SHARING BELOW OUT-OF-POCKET THRESHOLD.—

(i) **[**INSTITUTIONALIZED INDIVIDUALS.—In**]** *ELIMINATION OF COST-SHARING FOR CERTAIN FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—*

(I) INSTITUTIONALIZED INDIVIDUALS.—In the case of an individual who is a full-benefit dual eligible individual and who is an institutionalized individual or couple (as defined in section 1902(q)(1)(B)), the elimination of any beneficiary coinsurance 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)).

(II) CERTAIN OTHER INDIVIDUALS.—In the case of an individual who is a full-benefit dual eligible individual and with respect to whom there has been a determination that but for the provision of home and community based care (whether under section 1915 or under a waiver under section 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

coinsurance 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)).

* * * * * * *

(iv) OVERALL LIMITATION ON COST-SHARING.—In the case of all such individuals, a limitation on aggregate cost-sharing under this part for a year not to exceed 2.5 percent of income.

* * * * * * *

(2) OTHER INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF POVERTY LINE.—In the case of a subsidy eligible individual who is not described in paragraph (1), the individual is entitled under this section to the following:

(A) SLIDING SCALE PREMIUM SUBSIDY.—An income-related premium subsidy *equal to (i) an amount* determined on a linear sliding scale ranging from 100 percent of the amount described in ❚paragraph (1)(A)❚ *clause (i) of paragraph (1)(A)* for individuals with incomes at or below 135 percent of such level to 0 percent of such amount for individuals with incomes at 150 percent of such level*, plus (ii) 100 percent of the amount described in clause (ii) of such paragraph for such individual*.

* * * * * * *

(F) OVERALL LIMITATION ON COST-SHARING.—A limitation on aggregate cost-sharing under this part for a year not to exceed 2.5 percent of income.

(3) DETERMINATION OF ELIGIBILITY.—

(A) SUBSIDY ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this part, subject to subparagraph (F), the term "subsidy eligible individual" means a part D eligible individual who—

(i) * * *

* * * * * * *

(iii) meets the resources requirement described in subparagraph ❚(D) or❚ (E).

* * * * * * *

(C) INCOME DETERMINATIONS.—For purposes of applying this section—

(i) in the case of a part D eligible individual who is not treated as a subsidy eligible individual under subparagraph (B)(v), income shall be determined in the manner described in section 1905(p)(1)(B), without regard to the application of section 1902(r)(2) *and except that support and maintenance furnished in kind shall not be counted as income*; and

* * * * * * *

(D) RESOURCE STANDARD APPLIED TO FULL LOW-INCOME SUBSIDY TO BE BASED ON THREE TIMES SSI RESOURCE STANDARD.—The resources requirement of this subparagraph is that an individual's resources (as determined

under section 1613 for purposes of the supplemental security income program *subject to the additional exclusions provided under subparagraph (G)*) do not exceed—

(i) * * *

* * * * * * *

(E) ALTERNATIVE RESOURCE STANDARD.—

(i) IN GENERAL.—The resources requirement of this subparagraph is that an individual's resources (as determined under section 1613 for purposes of the supplemental security income program *subject to the additional exclusions provided under subparagraph (G)*) do not exceed—

(I) for 2006, $10,000 (or $20,000 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**]**

(II) for a subsequent year *(before 2009)* the dollar amounts specified in this subclause (or subclause (I)) for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year**[**.**]***;*

(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)).

* * * * * * *

(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.

(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).

(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 sub-

paragraphs (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) PREMIUM SUBSIDY AMOUNT.—

(1) * * *

(2) LOW-INCOME BENCHMARK PREMIUM AMOUNT DEFINED.—

(A) * * *

(B) PREMIUM AMOUNTS DESCRIBED.—The premium amounts described in this subparagraph are, in the case of—

(i) * * *

* * * * * * *

(iii) an MA–PD plan, the portion of the [MA] *Medicare Part C* monthly prescription drug beneficiary premium that is attributable to basic prescription drug benefits (described in section 1852(a)(6)(B)(ii)).

(c) ADMINISTRATION OF SUBSIDY PROGRAM.—

(1) IN GENERAL.—The Secretary shall provide a process whereby, in the case of a part D eligible individual who is determined to be a subsidy eligible individual and who is enrolled in a prescription drug plan or is enrolled in an MA–PD plan—

(A) the Secretary provides for a notification of the PDP sponsor or the [MA] *Medicare Part C* organization offering the plan involved that the individual is eligible for a subsidy and the amount of the subsidy under subsection (a);

* * * * * * *

PART E—MISCELLANEOUS PROVISIONS

DEFINITIONS OF SERVICES, INSTITUTIONS, ETC.

SEC. 1861. For purposes of this title—

Spell of Illness

(a) * * *

* * * * * * *

Hospital

(e) The term "hospital" (except for purposes of sections 1814(d), 1814(f), and 1835(b), subsection (a)(2) of this section, paragraph (7) of this subsection, and subsection (i) of this section) means an institution which—

(1) * * *

* * * * * * *

For purposes of subsection (a)(2), such term includes any institution which meets the requirements of paragraph (1) of this subsection. For purposes of sections 1814(d) and 1835(b) (including determination of whether an individual received inpatient hospital

services or diagnostic services for purposes of such sections), section 1814(f)(2), and subsection (i) of this section, such term includes any institution which (i) meets the requirements of paragraphs (5) and (7) of this subsection, (ii) is not primarily engaged in providing the services described in section 1861(j)(1)(A) and (iii) is primarily engaged in providing, by or under the supervision of individuals referred to in paragraph (1) of section 1861(r), to inpatients diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or rehabilitation services for the rehabilitation of injured, disabled, or sick persons. For purposes of section 1814(f)(1), such term includes an institution which (i) is a hospital for purposes of sections 1814(d), 1814(f)(2), and 1835(b) ❙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 (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*. Notwithstanding the preceding provisions of this subsection, such term shall not, except for purposes of subsection (a)(2), include any institution which is primarily for the care and treatment of mental diseases unless it is a psychiatric hospital (as defined in subsection (f)). The term "hospital" also includes a religious nonmedical health care institution (as defined in subsection (ss)(1)), but only with respect to items and services ordinarily furnished by such institution to inpatients, and payment may be made with respect to services provided by or in such an institution only to such extent and under such conditions, limitations, and requirements (in addition to or in lieu of the conditions, limitations, and requirements otherwise applicable) as may be provided in regulations consistent with section 1821. For provisions deeming certain requirements of this subsection to be met in the case of accredited institutions, see section 1865. The term "hospital" also includes a facility of fifty beds or less which is located in an area determined by the Secretary to meet the definition relating to a rural area described in subparagraph (A) of paragraph (5) of this subsection and which meets the other requirements of this subsection, except that—

(A) * * *

* * * * * * *

Outpatient Physical Therapy Services

(p) The term "outpatient physical therapy services" means physical therapy services furnished by a provider of services, a clinic, rehabilitation agency, or a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient—

(1) * * *

* * * * * * *

The term "outpatient physical therapy services" also includes physical therapy services furnished an individual by a physical therapist (in his office or in such individual's home) who meets licensing and other standards prescribed by the Secretary in regulations, otherwise than under an arrangement with and under the supervision of a provider of services, clinic, rehabilitation agency, or public health agency, if the furnishing of such services meets such conditions relating to health and safety as the Secretary may find necessary. In addition, such term includes physical therapy services which meet the requirements of the first sentence of this subsection except that they are furnished to an individual as an inpatient of a hospital or extended care facility. **[**The term "outpatient physical therapy services" also includes speech-language pathology services furnished by a provider of services, a clinic, rehabilitation agency, or by a public health agency, or by others under an arrangement with, and under the supervision of, such provider, clinic, rehabilitation agency, or public health agency to an individual as an outpatient, subject to the conditions prescribed in this subsection.**]** Nothing in this subsection shall be construed as requiring, with respect to outpatients who are not entitled to benefits under this title, a physical therapist to provide outpatient physical therapy services only to outpatients who are under the care of a physician or pursuant to a plan of care established by a physician. The Secretary may waive the requirement of a surety bond under paragraph (4)(A)(v) in the case of a clinic or agency that provides a comparable surety bond under State law.

* * * * * * *

Medical and Other Health Services

(s) The term "medical and other health services" means any of the following items or services:

(1) * * *

(2)(A) * * *

* * * * * * *

(D) outpatient physical therapy services*, outpatient speech-language pathology services,* and outpatient occupational therapy services;

* * * * * * *

(Z) intravenous immune globulin for the treatment of primary immune deficiency diseases in the home (as defined in subsection (zz)); **[**and**]**

(AA) ultrasound screening for abdominal aortic aneurysm (as defined in subsection (bbb)) for an individual—

(i) * * *

* * * * * * *

(iii) who—

(I) * * *

(II) manifests risk factors included in a beneficiary category recommended for screening by the United

States Preventive Services Task Force regarding abdominal aortic aneurysms;

(BB) additional preventive services (described in subsection (ccc)(1)(M));

(CC) marriage and family therapist services (as defined in subsection (eee));

(DD) mental health counselor services (as defined in subsection (fff)(2)); and

(EE) kidney disease education services (as defined in subsection (ggg));

* * * * * * *

Rural Health Clinic Services and Federally Qualified Health Center Services

(aa)(1) The term "rural health clinic services" means —

(A) * * *

* * * * * * *

(B) such services furnished by a physician assistant or a nurse practitioner (as defined in paragraph (5)), by a clinical psychologist (as defined by the Secretary) [or by a clinical social worker (as defined in subsection (hh)(1)),], *by a clinical social worker (as defined in subsection (hh)(1)), by a marriage and family therapist (as defined in subsection (eee)(2)), or a mental health counselor (as defined in subsection (fff)(1)),* and such services and supplies furnished as an incident to his service as would otherwise be covered if furnished by a physician or as an incident to a physician's service, and

* * * * * * *

Discharge Planning Process

(ee)(1) * * *

* * * * * * *

(3) With respect to a discharge plan for an individual who is enrolled with a [Medicare+Choice] *Medicare Part C* organization under a [Medicare+Choice] *Medicare Part C* plan and is furnished inpatient hospital services by a hospital under a contract with the organization—

(A) * * *

* * * * * * *

Clinical Social Worker; Clinical Social Worker Services

(hh)(1) * * *

(2) The term "clinical social worker services" means services performed by a clinical social worker (as defined in paragraph (1)) for the diagnosis and treatment of mental illnesses (other than services furnished to an inpatient of a hospital [and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation]) which the clinical social worker is legally authorized to perform under State law (or the State regulatory mechanism provided by

State law) of the State in which such services are performed as would otherwise be covered if furnished by a physician or as an incident to a physician's professional service.

* * * * * * *

Speech-Language Pathology Services; Audiology Services

(ll)(1) * * *

(2) The term "outpatient speech-language pathology services" has the meaning given the term "outpatient physical therapy services" in subsection (p), except that in applying such subsection—

(A) "speech-language pathology" shall be substituted for "physical therapy" each place it appears; and

(B) "speech-language pathologist" shall be substituted for "physical therapist" each place it appears.

[(2)**]** *(3)* The term "audiology services" means such hearing and balance assessment services furnished by a qualified audiologist as the audiologist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law), as would otherwise be covered if furnished by a physician.

[(3)**]** *(4)* In this subsection:

(A) * * *

* * * * * * *

Initial Preventive Physical Examination

(ww)(1) * * *

(2) The screening and other preventive services described in this paragraph include the following:

(A) * * *

* * * * * * *

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

* * * * * * *

Preventive Services

(ccc)(1) The term "preventive services" means the following:

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

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

(C) Diabetes outpatient self-management training services (as defined in subsection (qq)).

(D) Screening for glaucoma for certain individuals (as described in subsection (s)(2)(U)).

(E) Medical nutrition therapy services for certain individuals (as described in subsection (s)(2)(V)).

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

(G) Cardiovascular screening blood tests (as defined in subsection (xx)(1)).

(H) Diabetes screening tests (as defined in subsection described in subsection (s)(2)(Y)).

(I) Ultrasound screening for abdominal aortic aneurysm for certain individuals (as described in described in subsection (s)(2)(AA)).

(J) Pneumococcal and influenza vaccine and their administration (as described in subsection (s)(10)(A)).

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

(L) Screening mammography (as defined in subsection (jj)).

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

(N) Bone mass measurement (as defined in subsection (rr)).

(O) Additional preventive services (as determined under paragraph (2)).

(2)(A) The term "additional preventive services" means items and services, including mental health services, not described in subparagraphs (A) through (N) of paragraph (1) that the Secretary determines to be reasonable and necessary for the prevention or early detection of an illness or disability.

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

(i) take into account evidence-based recommendations by the United States Preventive Services Task Force and other appropriate organizations; and

(ii) use the process for making national coverage determinations (as defined in section 1869(f)(1)(B)) under this title.

Long-Term Care Hospital

(ddd) The term "long-term care hospital" means an institution which—

(1) is primarily engaged in providing inpatient services, by or under the supervision of a physician, to Medicare beneficiaries whose medically complex conditions require a long hospital stay and programs of care provided by a long-term care hospital;

(2) has an average inpatient length of stay (as determined by the Secretary) for Medicare beneficiaries of greater than 25 days, or as otherwise defined in section 1886(d)(1)(B)(iv);

(3) satisfies the requirements of subsection (e);

(4) meets the following facility criteria:

(A) the institution has a patient review process, documented in the patient medical record, that screens patients prior to admission for appropriateness of admission to a long-term care hospital, validates within 48 hours of admission that patients meet admission criteria for long-term care hospitals, regularly evaluates patients throughout their stay for continuation of care in a long-term care hospital, and assesses the available discharge options when patients no longer meet such continued stay criteria;

(B) the institution has active physician involvement with patients during their treatment through an organized medical staff, physician-directed treatment with physician onsite availability on a daily basis to review patient 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(n).

Marriage and Family Therapist Services

(eee)(1) The term "marriage and family therapist services" means services performed by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses, which the marriage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed, provided such services are covered under this title, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

(2) The term "marriage and family therapist" means an individual who—

(A) possesses a master's or doctoral degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law;

(B) after obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and

(C) is licensed or certified as a marriage and family therapist in the State in which marriage and family therapist services are performed.

Mental Health Counselor; Mental Health Counselor Services

(fff)(1) The term "mental health counselor" means an individual who—

(A) possesses a master's or doctor's degree which qualifies the individual for licensure or certification for the practice of mental health counseling in the State in which the services are performed;

(B) after obtaining such a degree has performed at least 2 years of supervised mental health counselor practice; and

(C) is licensed or certified as a mental health counselor or professional counselor by the State in which the services are performed.

(2) The term "mental health counselor services" means services performed by a mental health counselor (as defined in paragraph (1)) for the diagnosis and treatment of mental illnesses which the mental health counselor is legally authorized to perform under State

law (or the State regulatory mechanism provided by the State law) of the State in which such services are performed, provided such services are covered under this title, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

Kidney Disease Education Services

(ggg)(1) The term "kidney disease education services" means educational services that are—

(A) furnished to an individual with stage IV chronic kidney disease who, according to accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant;

(B) furnished, upon the referral of the physician managing the individual's kidney condition, by a qualified person (as defined in paragraph (2)); and

(C) designed—

(i) to provide comprehensive information (consistent with the standards developed under paragraph (3)) regarding—

(I) the management of comorbidities, including for purposes of delaying the need for dialysis;

(II) the prevention of uremic complications; and

(III) each option for renal replacement therapy (including hemodialysis and peritoneal dialysis at home and in-center as well as vascular access options and transplantation);

(ii) to ensure that the individual has the opportunity to actively participate in the choice of therapy; and

(iii) to be tailored to meet the needs of the individual involved.

(2) The term "qualified person" means a physician, physician assistant, nurse practitioner, or clinical nurse 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).

(6) No individual shall be eligible to be provided more than 6 sessions of kidney disease education services under this title.

* * * * * * *

EXCLUSIONS FROM COVERAGE AND MEDICARE AS SECONDARY PAYER

SEC. 1862. (a) Notwithstanding any other provision of this title, no payment may be made under part A or part B for any expenses incurred for items or services—

(1)(A) * * *

* * * * * * *

(M) in the case of a diabetes screening test (as defined in section 1861(yy)(1)), which is performed more frequently than is covered under section 1861(yy)(3), [and]

(N) in the case of ultrasound screening for abdominal aortic aneurysm which is performed more frequently than is provided for under section 1861(s)(2)(AA)[;], *and*

(O) in the case of kidney disease education services (as defined in section 1861(ggg)), which are furnished in excess of the number of sessions covered under such section;

* * * * * * *

(20) in the case of [outpatient occupational therapy services or outpatient physical therapy services] *outpatient physical therapy services, outpatient speech-language pathology services, or outpatient occupational therapy services* furnished as an incident to a physician's professional services (as described in section 1861(s)(2)(A)), that do not meet the standards and conditions (other than any licensing requirement specified by the Secretary) under the second sentence of section 1861(p) (or under such sentence through the operation of [section 1861(g)] *subsection (g) or (ll)(2) of section 1861*) as such standards and conditions would apply to such therapy services if furnished by a therapist;

(21) where such expenses are for home health services (including medical supplies described in section 1861(m)(5), but excluding durable medical equipment to the extent provided for in such section) furnished to an individual who is under a plan of care of the home health agency if the claim for payment for such services is not submitted by the agency; [or]

(22) subject to subsection (h), for which a claim is submitted other than in an electronic form specified by the Secretary[.]*; or*

(23) where such expenses are for renal dialysis services (as defined in subparagraph (B) of section 1881(b)(14)) for which payment is made under such section (other than under subparagraph (E) of such section) unless such payment is made under such section to a provider of services or a renal dialysis facility for such services.

* * * * * * *

(b) MEDICARE AS SECONDARY PAYER.—

(1) REQUIREMENTS OF GROUP HEALTH PLANS.—

(A) * * *

* * * * * * *

[(C) INDIVIDUALS WITH END STAGE RENAL DISEASE.—A group health plan (as defined in subparagraph (A)(v))—]

(C) INDIVIDUALS WITH END STAGE RENAL DISEASE.—

(i) IN GENERAL.—A group health plan (as defined in subparagraph (A)(v))—

[(i)] *(I)* may not take into account that an individual is entitled to or eligible for benefits under this title under section 226A during the 12-month period which begins with the first month in which the individual becomes entitled to benefits under part A under the provisions of section 226A, or, if earlier, the first month in which the individual would have been entitled to benefits under such part under the provisions of section 226A if the individual had filed an application for such benefits; and

[(ii)] *(II)* may not differentiate in the benefits it provides between individuals having end stage renal disease and other individuals covered by such plan on the basis of the existence of end stage renal disease, the need for renal dialysis, or in any other manner;

except that [clause (ii)] *subclause (II)* shall not prohibit a plan from paying benefits secondary to this title when an individual is entitled to or eligible for benefits under this title under section 226A after the end of the 12-month period described in [clause (i)] *subclause (I)*. Effective for items and services furnished on or after February 1, 1991, and before the date of enactment of the Balanced Budget Act of 1997 (with respect to periods beginning on or after February 1, 1990), this subparagraph shall be applied by substituting "18-month" for "12-month" each place it appears. [Effective for items] *Subject to clause (ii), effective for items* and services furnished on or after the date of enactment of the Balanced Budget Act of 1997, (with respect to periods beginning on or after the date that is 18 months prior to such date), [clauses (i) and (ii)] *subclauses (I) and (II)* shall be applied by substituting "30-month" for "12-month" each place it appears.

(ii) SPECIAL RULE FOR LARGE GROUP PLANS.—In applying clause (i) to a large group health plan (as defined in subparagraph (B)(iii)). effective for items and services furnished on or after January 1, 2008, (with respect to periods beginning on or after the date that is 30 months prior to January 1, 2008), subclauses (I) and (II) of such clause shall be applied by substituting "42-month" for "12-month" each place it appears.

* * * * * * *

USE OF STATE AGENCIES TO DETERMINE COMPLIANCE BY PROVIDERS OF SERVICES WITH CONDITIONS OF PARTICIPATION

SEC. 1864. (a) * * *

* * * * * * *

(c) The Secretary is authorized to enter into an agreement with any State under which the appropriate State or local agency which performs the certification function described in subsection (a) will survey, on a selective sample basis (or where the Secretary finds that a survey is appropriate because of substantial allegations of the existence of a significant deficiency or deficiencies which would, if found to be present, adversely affect health and safety of patients), provider entities that, ⟦pursuant to subsection (a) or (b)(1) of section 1865⟧ *pursuant to section 1865(a)(1)*, are treated as meeting the conditions or requirements of this title. The Secretary shall pay for such services in the manner prescribed in subsection (b).

* * * * * * *

EFFECT OF ACCREDITATION

SEC. 1865. ⟦(a) Except as provided in subsection (b) and the second sentence of section 1863, if—

⟦(1) an institution is accredited as a hospital by the Joint Commission on Accreditation of Hospitals, and

⟦(2)(A) such institution authorizes the Commission to release to the Secretary upon his request (or such State agency as the Secretary may designate) a copy of the most current accreditation survey of such institution made by such Commission, together with any other information directly related to the survey as the Secretary may require (including corrective action plans),

⟦(B) such Commission releases such a copy and any such information to the Secretary,

then, such institution shall be deemed to meet the requirements of the numbered paragraphs of section 1861(e); except—

⟦(3) paragraph (6) thereof, and

⟦(4) any standard, promulgated by the Secretary pursuant to paragraph (9) thereof, which is higher than the requirements prescribed for accreditation by such Commission.

If such Commission, as a condition for accreditation of a hospital, requires a utilization review plan (or imposes another requirement which serves substantially the same purpose), requires a discharge planning process (or imposes another requirement which serves substantially the same purpose), or imposes a standard which the Secretary determines is at least equivalent to the standard promulgated by the Secretary as described in paragraph (4) of this subsection, the Secretary is authorized to find that all institutions so accredited by such Commission comply also with clause (A) or (B) of section 1861(e)(6) or the standard described in such paragraph (4), as the case may be.⟧

⟦(b)⟧ *(a)*(1) ⟦In addition, if⟧ *If* the Secretary finds that accreditation of a provider entity (as defined in paragraph (4)) by the American Osteopathic Association or any other national accreditation body demonstrates that all of the applicable conditions or require-

ments of this title (other than the requirements of section 1834(j) or the conditions and requirements under section 1881(b)) are met or exceeded—

(A) * * *

* * * * * * *

[(c)**]** *(b)* The Secretary may not disclose any accreditation survey (other than a survey with respect to a home health agency) made and **[**released to him by the Joint Commission on Accreditation of Hospitals,**]** *released to the Secretary by* the American Osteopathic Association**[**,**]** or any other national accreditation body, of an entity accredited by such body, except that the Secretary may disclose such a survey and information related to such a survey to the extent such survey and information relate to an enforcement action taken by the Secretary.

[(d)**]** *(c)* Notwithstanding any other provision of this title, if the Secretary finds that a provider entity has significant deficiencies (as defined in regulations pertaining to health and safety), the entity shall, after the date of notice of such finding to the entity and for such period as may be prescribed in regulations, be deemed not to meet the conditions or requirements the entity has been treated as meeting **[**pursuant to subsection (a) or (b)(1)**]** *pursuant to subsection (a)(1)*.

[(e)**]** *(d)* For provisions relating to validation surveys of entities that are treated as meeting applicable conditions or requirements of this title **[**pursuant to subsection (a) or (b)(1)**]** *pursuant to subsection (a)(1)*, see section 1864(c).

AGREEMENTS WITH PROVIDERS OF SERVICES; ENROLLMENT PROCESSES

SEC. 1866. (a)(1) Any provider of services (except a fund designated for purposes of section 1814(g) and section 1835(e)) shall be qualified to participate under this title and shall be eligible for payments under this title if it files with the Secretary an agreement—

(A) * * *

* * * * * * *

(O) to accept as payment in full for services that are covered under this title and are furnished to any individual enrolled with a **[**Medicare+Choice**]** *Medicare Part C* organization under part C, with a PACE provider under section 1894 or 1934, or with an eligible organization with a risk-sharing contract under section 1876, under section 1876(i)(2)(A) (as in effect before February 1, 1985), under section 402(a) of the Social Security Amendments of 1967, or under section 222(a) of the Social Security Amendments of 1972, which does not have a contract (or, in the case of a PACE provider, contract or other agreement) establishing payment amounts for services furnished to members of the organization or PACE program eligible individuals enrolled with the PACE provider, the amounts that would be made as a payment in full under this title (less any payments under sections 1886(d)(11) and 1886(h)(3)(D)) if the individuals were not so enrolled,

* * * * * * *

(e) For purposes of this section, the term "provider of services" shall include—

(1) a clinic, rehabilitation agency, or public health agency if, in the case of a clinic or rehabilitation agency, such clinic or agency meets the requirements of section 1861(p)(4)(A) (or meets the requirements of such section through the operation of [section 1861(g)] *subsection (g) or (ll)(2) of section 1861*), or if, in the case of a public health agency, such agency meets the requirements of section 1861(p)(4)(B) (or meets the requirements of such section through the operation of [section 1861(g)] *subsection (g) or (ll)(2) of section 1861*), but only with respect to the furnishing of outpatient physical therapy services (as therein [defined) or] *defined),* (through the operation of section 1861(g)) with respect to the furnishing of outpatient occupational therapy services*, or (through the operation of section 1861(ll)(2)) with respect to the furnishing of outpatient speech-language pathology*; and

* * * * * * *

(f)(1) For purposes of subsection (a)(1)(Q) and sections 1819(c)(2)(E), 1833(s), 1855(i), 1876(c)(8), and 1891(a)(6), the requirement of this subsection is that a provider of services, [Medicare+Choice] *Medicare Part C* organization, or prepaid or eligible organization (as the case may be) maintain written policies and procedures with respect to all adult individuals receiving medical care by or through the provider or organization—

(A) * * *

* * * * * * *

(2) The written information described in paragraph (1)(A) shall be provided to an adult individual—

(A) * * *

* * * * * * *

(E) in the case of an eligible organization (as defined in section 1876(b)) or an organization provided payments under section 1833(a)(1)(A) or a [Medicare+Choice] *Medicare Part C* organization, at the time of enrollment of the individual with the organization.

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PROVISIONS FOR ADMINISTRATION OF DEMONSTRATION PROGRAM

SEC. 1866B. (a) GENERAL ADMINISTRATIVE AUTHORITY.—

(1) BENEFICIARY ELIGIBILITY.—Except as otherwise provided by the Secretary, an individual shall only be eligible to receive benefits under the program under section 1866A (in this section referred to as the "demonstration program") if such individual—

(A) * * *

(B) is not enrolled in a [Medicare+Choice] *Medicare Part C* plan under part C, an eligible organization under a contract under section 1876 (or a similar organization operating under a demonstration project authority), an or-

ganization with an agreement under section 1833(a)(1)(A), or a PACE program under section 1894.

* * * * * * *

HEALTH CARE QUALITY DEMONSTRATION PROGRAM

SEC. 1866C. (a) DEFINITIONS.—In this section:

(1) BENEFICIARY.—The term "beneficiary" means an individual who is entitled to benefits under part A and enrolled under part B, including any individual who is enrolled in a [Medicare Advantage] *Medicare Part C* plan under part C.

* * * * * * *

(c) ADMINISTRATION BY CONTRACT.—

(1) * * *

* * * * * * *

(3) BENEFITS.—A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include modifications to the package of benefits available under the original medicare fee-for-service program under parts A and B or the package of benefits available through a [Medicare Advantage] *Medicare Part C* plan under part C. The criteria employed under the demonstration program under this section to evaluate outcomes and determine best practice guidelines and incentives shall not be used as a basis for the denial of medicare benefits under the demonstration program to patients against their wishes (or if the patient is incompetent, against the wishes of the patient's surrogate) on the basis of the patient's age or expected length of life or of the patient's present or predicted disability, degree of medical dependency, or quality of life.

* * * * * * *

PRACTICING PHYSICIANS ADVISORY COUNCIL; COUNCIL FOR TECHNOLOGY AND INNOVATION

SEC. 1868. (a) PRACTICING PHYSICIANS ADVISORY COUNCIL.—(1) * * *

(2) The Council shall meet [once during each calendar quarter] *once each year (and at such other times as the Secretary may specify)* to discuss certain proposed changes in regulations and carrier manual instructions related to physician services identified by the Secretary. To the extent feasible and consistent with statutory deadlines, such consultation shall occur before the publication of such proposed changes.

* * * * * * *

DETERMINATIONS; APPEALS

SEC. 1869. (a) * * *

* * * * * * *

(c) CONDUCT OF RECONSIDERATIONS BY INDEPENDENT CONTRACTORS.—

(1) * * *

* * * * * * *

(3) REQUIREMENTS.—Any qualified independent contractor entering into a contract with the Secretary under this subsection shall meet all of the following requirements:

(A) * * *

* * * * * * *

(G) DISSEMINATION OF DECISIONS ON RECONSIDERATIONS.—Each qualified independent contractor shall make available all decisions with respect to reconsiderations of such qualified independent contractors to fiscal intermediaries (under section 1816), carriers (under section 1842), peer review organizations (under part B of title XI), [Medicare+Choice] *Medicare Part C* organizations offering [Medicare+Choice] *Medicare Part C* plans under part C, other entities under contract with the Secretary to make initial determinations under part A or part B or title XI, and to the public. The Secretary shall establish a methodology under which qualified independent contractors shall carry out this subparagraph.

* * * * * * *

STUDIES AND RECOMMENDATIONS

SEC. 1875. (a) * * *

(b) The Secretary shall make a continuing study of the operation and administration of this title (including a validation of the accreditation process of [the Joint Commission on Accreditation of Hospitals,] *national accreditation bodies under section 1865(a)* the operation and administration of health maintenance organizations authorized by section 226 of the Social Security Amendments of 1972, the experiments and demonstration projects authorized by section 402 of the Social Security Amendments of 1967 and the experiments and demonstration projects authorized by section 222(a) of the Social Security Amendments of 1972), and shall transmit to the Congress annually a report concerning the operation of such programs.

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PAYMENTS TO HEALTH MAINTENANCE ORGANIZATIONS AND COMPETITIVE MEDICAL PLANS

SEC. 1876. (a) * * *

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(h)(1) * * *

* * * * * * *

(5)(A) Any reasonable cost reimbursement contract with an eligible organization under this subsection that is extended or renewed on or after the date of enactment of the Children's Health and Medicare Protection Act of 2007 shall provide that the provisions of the Medicare Part C program described in subparagraph (B) shall apply to such organization and such contract

in a substantially similar manner as such provisions apply to Medicare Part C organizations and Medicare Part C plans under part C.

(B) The provisions described in this subparagraph are as follows:

(i) Section 1851(h) (relating to the approval of marketing material and application forms).

(ii) Section 1852(e) (relating to the requirement of having an ongoing quality improvement program and treatment of accreditation in the same manner as such provisions apply to Medicare Part C local plans that are preferred provider organization plans).

(iii) Section 1852(f) (relating to grievance mechanisms).

(iv) Section 1852(g) (relating to coverage determinations, reconsiderations, and appeals).

(v) Section 1852(j)(4) (relating to limitations on physician incentive plans).

(vi) Section 1854(c) (relating to the requirement of uniform premiums among individuals enrolled in the plan).

(vii) Section 1854(g) (relating to restrictions on imposition of premium taxes with respect to payments to organizations).

(viii) Section 1856(b)(3) (relating to relation to State laws).

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

[(5)**]** *(6)*(A) * * *

* * * * * * *

(C)(i) * * *

(ii) For any period beginning on or after **[**January 1, 2008**]** *January 1, 2011*, a reasonable cost reimbursement contract under this subsection may not be extended or renewed for a service area insofar as such area during the entire previous year was within the service area of—

(I) 2 or more **[**MA**]** *Medicare Part C* regional plans described in clause (iii); or

(II) 2 or more **[**MA**]** *Medicare Part C* local plans described in clause (iii).

(k)(1) Except as provided in paragraph (2)—

(A) on or after the date standards for **[**Medicare+Choice**]** *Medicare Part C* organizations and plans are first established under section 1856(b)(1), the Secretary shall not enter into any risk-sharing contract under this section with an eligible organization; and

* * * * * * *

(4) The following requirements shall apply to eligible organizations with risk-sharing contracts under this section in the same manner as they apply to **[**Medicare+Choice**]** *Medicare Part C* organizations under part C:

(A) * * *

* * * * * * *

LIMITATION ON CERTAIN PHYSICIAN REFERRALS

SEC. 1877. (a) * * *

(b) GENERAL EXCEPTIONS TO BOTH OWNERSHIP AND COMPENSATION ARRANGEMENT PROHIBITIONS.—Subsection (a)(1) shall not apply in the following cases:

(1) * * *

* * * * * * *

(3) PREPAID PLANS.—In the case of services furnished by an organization—

(A) * * *

* * * * * * *

(E) that is a **[**Medicare+Choice**]** *Medicare Part C* organization under part C that is offering a coordinated care plan described in section 1851(a)(2)(A) to an individual enrolled with the organization.

* * * * * * *

(d) ADDITIONAL EXCEPTIONS RELATED ONLY TO OWNERSHIP OR INVESTMENT PROHIBITION.—The following, if not otherwise excepted under subsection (b), shall not be considered to be an ownership or investment interest described in subsection (a)(2)(A):

(1) * * *

(2) RURAL PROVIDERS.—In the case of designated health services furnished in a rural area (as defined in section 1886(d)(2)(D)) by an entity, if—

(A) substantially all of the designated health services furnished by the entity are furnished to individuals residing in such a rural area; **[**and**]**

(B) effective for the 18-month period beginning on the date of the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the entity is not a specialty hospital (as defined in subsection (h)(7))**[**.**]***; and*

(C) if the entity is a hospital, the hospital meets the requirements of paragraph (3)(D).

(3) HOSPITAL OWNERSHIP.—In the case of designated health services provided by a hospital (other than a hospital described in paragraph (1)) if—

(A) * * *

(B) effective for the 18-month period beginning on the date of the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the hospital is not a specialty hospital (as defined in subsection (h)(7)); **[**and**]**

(C) the ownership or investment interest is in the hospital itself (and not merely in a subdivision of the hospital)**[**.**]***; and*

(D) the hospital meets the requirements described in subsection (i)(1) not later than 18 months after the date of the enactment of this subparagraph.

* * * * * * *

(i) REQUIREMENTS FOR HOSPITALS TO QUALIFY FOR HOSPITAL EXCEPTION TO OWNERSHIP OR INVESTMENT PROHIBITION.—

(1) REQUIREMENTS DESCRIBED.—For purposes of paragraphs subsection (d)(3)(D), the requirements described in this paragraph for a hospital are as follows:

(A) PROVIDER AGREEMENT.—The hospital had a provider agreement under section 1866 in effect on July 24, 2007.

(B) PROHIBITION OF EXPANSION OF FACILITY CAPACITY.—The number of operating rooms and beds of the hospital at any time on or after the date of the enactment of this subsection are no greater than the number of operating rooms and beds as of such date.

(C) PREVENTING CONFLICTS OF INTEREST.—

(i) The hospital submits to the Secretary an annual report containing a detailed description of—

(I) the identity of each physician owner and any other owners of the hospital; and

(II) the nature and extent of all ownership interests in the hospital.

(ii) The hospital has procedures in place to require that any referring physician owner discloses to the patient being referred, by a time that permits the patient to make a meaningful decision regarding the receipt of care, as determined by the Secretary—

(I) the ownership interest of such referring physician in the hospital; and

(II) if applicable, any such ownership interest of the treating physician.

(iii) The hospital does not condition any physician ownership interests either directly or indirectly on the physician owner making or influencing referrals to the hospital or otherwise generating business for the hospital.

(D) ENSURING BONA FIDE INVESTMENT.—

(i) Physician owners in the aggregate do not own more than 40 percent of the total value of the investment interests held in the hospital or in an entity whose assets include the hospital.

(ii) The investment interest of any individual physician owner does not exceed 2 percent of the total value of the investment interests held in the hospital or in an entity whose assets include the hospital.

(iii) Any ownership or investment interests that the hospital offers to a physician owner are not offered on more favorable terms than the terms offered to a person who is not a physician owner.

(iv) The hospital does not directly or indirectly provide loans or financing for any physician owner investments in the hospital.

(v) The hospital does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any individual physician owner or group of physician owners that is related to acquiring any ownership interest in the hospital.

(vi) Investment returns are distributed to investors in the hospital in an amount that is directly proportional to the investment of capital by the physician owner in the hospital.

(vii) Physician owners do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other investors in the hospital or located near the premises of the hospital.

(viii) The hospital does not offer a physician owner the opportunity to purchase or lease any property under the control of the hospital or any other investor in the hospital on more favorable terms than the terms offered to an individual who is not a physician owner.

(E) PATIENT SAFETY.—

(i) Insofar as the hospital admits a patient and does not have any physician available on the premises to provide services during all hours in which the hospital is providing services to such patient, before admitting the patient—

(I) the hospital discloses such fact to a patient; and

(II) following such disclosure, the hospital receives from the patient a signed acknowledgment that the patient understands such fact.

(ii) The hospital has the capacity to—

(I) provide assessment and initial treatment for patients; and

(II) refer and transfer patients to hospitals with the capability to treat the needs of the patient involved.

(2) PUBLICATION OF INFORMATION REPORTED.—The Secretary shall publish, and update on an annual basis, the information submitted by hospitals under paragraph (1)(C)(i) on the public Internet website of the Centers for Medicare & Medicaid Services.

(3) COLLECTION OF OWNERSHIP AND INVESTMENT INFORMATION.—For purposes of clauses (i) and (ii) of paragraph (1)(D), the Secretary shall collect physician ownership and investment information for each hospital as it existed on the date of the enactment of this subsection.

(4) PHYSICIAN OWNER DEFINED.—For purposes of this subsection, the term "physician owner" means a physician (or an immediate family member of such physician) with a direct or an indirect ownership interest in the hospital.

* * * * * * *

MEDICARE COVERAGE FOR END STAGE RENAL DISEASE PATIENTS

SEC. 1881. (a) * * *

(b)(1) * * *

* * * * * * *

(12)(A) [In lieu of payment] *Subject to paragraph (14), in lieu of payment* under paragraph (7) beginning with services furnished on January 1, 2005, the Secretary shall establish a basic case-mix adjusted prospective payment system for dialysis services furnished by providers of services and renal dialysis facilities in a year to individuals in a facility and to such individuals at home. The case-mix under such system shall be for a limited number of patient characteristics. *Under such system the payment rate for dialysis services furnished on or after January 1, 2008, by providers of such services for hospital-based facilities shall be the same as the payment rate (computed without regard to this sentence) for such services furnished by renal dialysis facilities that are not hospital-based, except that in applying the geographic index under subparagraph (D) to hospital-based facilities, the labor share shall be based on the labor share otherwise applied for such facilities.*

* * * * * * *

(F) Beginning with 2006, the Secretary shall annually increase the basic case-mix adjusted payment amounts established under this paragraph, by an amount determined by—

(i) * * *

* * * * * * *

Except as provided in subparagraph (G), nothing in this paragraph *or paragraph (14)* shall be construed as providing for an update to the composite rate component of the basic case-mix adjusted system under subparagraph (B) *or under the system under paragraph (14)*.

* * * * * * *

(H) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of the case-mix system, relative weights, payment amounts, the geographic adjustment factor, or the update for the system established under this paragraph *or paragraph (14)*, or the determination of the difference between medicare payment amounts and acquisition costs for separately billed drugs and biologicals (including erythropoietin) under this paragraph and paragraph (13) *or, under paragraph (14), the identification of renal dialysis services included in the bundled payment, the adjustment for outliers, the identification of facilities to which the phase-in may apply, and the determination of payment amounts under subparagraph (A) under such paragraph, and the application of paragraph (13)(C)(iii)*.

(13)(A) [The payment amounts] *Subject to paragraph (14), the payment amounts* under this title for separately billed drugs and biologicals furnished in a year, beginning with 2004, are as follows:

(i) * * *

* * * * * * *

(iii) [For such drugs] *Subject to subparagraph (C), for such drugs* and biologicals (including erythropoietin) furnished in

2006 and subsequent years, such acquisition cost or the amount determined under section 1847A for the drug or biological, as the Secretary may specify.

(B)[(i)] Drugs and biologicals (including erythropoietin) which were separately billed under this subsection on the day before the date of the enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 shall continue to be separately billed on and after such date*, subject to paragraph (14)*.

[(ii) Nothing in this paragraph, section 1842(o), section 1847A, or section 1847B shall be construed as requiring or authorizing the bundling of payment for drugs and biologicals into the basic case-mix adjusted payment system under this paragraph.]

(C)(i) The payment amounts under this title for erythropoietin furnished during 2008 or 2009 to an individual with end stage renal disease by a large dialysis facility (as defined in subparagraph (D)) (whether to individuals in the facility or at home), in an amount equal to $8.75 per thousand units (rounded to the nearest 100 units) or, if less, 102 percent of the average sales price (as determined under section 1847A) for such drug or biological.

(ii) The payment amounts under this title for darbepoetin alfa furnished during 2008 or 2009 to an individual with end stage renal disease by a large dialysis facility (as defined in clause (iii)) (whether to individuals in the facility or at home), in an amount equal to $2.92 per microgram or, if less, 102 percent of the average sales price (as determined under section 1847A) for such drug or biological.

(iii) For purposes of this subparagraph, the term "large dialysis facility" means a provider of services or renal dialysis facility that is owned or managed by a corporate entity that, as of July 24, 2007, owns or manages 300 or more such providers or facilities, and includes a successor to such a corporate entity.

(14)(A) Subject to subparagraph (E), for services furnished on or after January 1, 2010, the Secretary shall implement a payment system under which a single payment is made under this title for renal dialysis services (as defined in subparagraph (B)) in lieu of any other payment (including a payment adjustment under paragraph (12)(B)(ii)) for such services and items furnished pursuant to paragraph (4). In implementing the system the Secretary shall ensure that the estimated total amount of payments under this title for 2010 for renal dialysis services shall equal 96 percent of the estimated amount of payments for such services, including payments under paragraph (12)(B)(ii), that would have been made if such system had not been implemented.

(B) For purposes of this paragraph, the term "renal dialysis services" includes—

(i) items and services included in the composite rate for renal dialysis services as of December 31, 2009;

(ii) erythropoietin stimulating agents furnished to individuals with end stage renal disease;

(iii) other drugs and biologicals and diagnostic laboratory tests, that the Secretary identifies as commonly used in the treatment of such patients and for which payment was (before the application of this paragraph) made separately under this title, and any oral equivalent form of such drugs

and biologicals or of drugs and biologicals described in clause (ii); and

(iv) home dialysis training for which payment was (before the application of this paragraph) made separately under this section.

Such term does not include vaccines.

(C) The system under this paragraph may provide for payment on the basis of services furnished during a week or month or such other appropriate unit of payment as the Secretary specifies.

(D) Such system—

(i) shall include a payment adjustment based on case mix that may take into account patient weight, body mass index, comorbidities, length of time on dialysis, age, race, ethnicity, and other appropriate factors;

(ii) shall include a payment adjustment for high cost outliers due to unusual variations in the type or amount of medically necessary care, including variations in the amount of erythropoietin stimulating agents necessary for anemia management; and

(iii) may include such other payment adjustments as the Secretary determines appropriate, such as a payment adjustment—

(I) by a geographic index, such as the index referred to in paragraph (12)(D), as the Secretary determines to be appropriate;

(II) for pediatric providers of services and renal dialysis facilities;

(III) for low volume providers of services and renal dialysis facilities;

(IV) for providers of services or renal dialysis facilities located in rural areas; and

(V) for providers of services or renal dialysis facilities that are not large dialysis facilities.

(E) The Secretary may provide for a phase-in of the payment system described in subparagraph (A) for services furnished by a provider of services or renal dialysis facility described in any of subclauses (II) through (V) of subparagraph (D)(iii), but such payment system shall be fully implemented for services furnished in the case of any such provider or facility on or after January 1, 2013.

(F) The Secretary shall apply the annual increase that would otherwise apply under subparagraph (F) of paragraph (12) to payment amounts established under such paragraph (if this paragraph did not apply) in an appropriate manner under this paragraph.

* * * * * * *

(h)(1) Except as provided in paragraph (2), a provider of services or a renal dialysis facility may not use, for more than 12 months during 2009, or for any period beginning on January 1, 2010, any individual as a patient care dialysis technician unless the individual—

(A) has completed a training program in the care and treatment of an individual with chronic kidney failure who is undergoing dialysis treatment; and

(B) has been certified by a nationally recognized certification entity for dialysis technicians.

(2)(A) A provider of services or a renal dialysis facility may permit an individual enrolled in a training program described in paragraph (1)(A) to serve as a patient care dialysis technician while they are so enrolled.

(B) The requirements described in subparagraphs (A), (B), and (C) of paragraph (1) do not apply to an individual who has performed dialysis-related services for at least 5 years.

(3) For purposes of paragraph (1), if, since the most recent completion by an individual of a training program described in paragraph (1)(A), there has been a period of 24 consecutive months during which the individual has not furnished dialysis-related services for monetary compensation, such individual shall be required to complete a new training program or become recertified as described in paragraph (1)(B).

(4) A provider of services or a renal dialysis facility shall provide such regular performance review and regular in-service education as assures that individuals serving as patient care dialysis technicians for the provider or facility are competent to perform dialysis-related services.

(i) QUALITY INCENTIVE PAYMENTS IN THE END-STAGE RENAL DISEASE PROGRAM.—

(1) QUALITY INCENTIVE PAYMENTS FOR SERVICES FURNISHED IN 2008, 2009, AND 2010.—

(A) IN GENERAL.—With respect to renal dialysis services furnished during a performance period (as defined in subparagraph (B)) by a provider of services or renal dialysis facility that the Secretary determines meets the applicable performance standard for the period under subparagraph (C) and reports on measures for 2009 and 2010 under subparagraph (D) for such services, in addition to the amount otherwise paid under this section, subject to subparagraph (G), there also shall be paid to the provider or facility an amount equal to the applicable percentage (specified in subparagraph (E) for the period) of the Secretary's estimate (based on claims submitted not later than two months after the end of the performance period) of the amount specified in subparagraph (F) for such period.

(B) PERFORMANCE PERIOD.—In this paragraph, the term "performance period" means each of the following:

(i) The period beginning on July 1, 2008, and ending on December 31, 2008.

(ii) 2009.

(iii) 2010.

(C) PERFORMANCE STANDARD.—

(i) 2008.—For the performance period occurring in 2008, the applicable performance standards for a provider or facility under this subparagraph are—

(I) 92 percent or more of individuals with end stage renal disease receiving erythopoetin stimulating agents who have an average hematocrit of 33.0 percent or more; and

(II) less than a percentage, specified by the Secretary, of individuals with end stage renal disease

receiving erythopoetin stimulating agents who have an average hematocrit of 39.0 percent or more.

(ii) 2009 AND 2010.—For the 2009 and 2010 performance periods, the applicable performance standard for a provider or facility under this subparagraph is successful performance (relative to national average) on—

(I) such measures of anemia management as the Secretary shall specify, including measures of hemoglobin levels or hematocrit levels for erythropoietin stimulating agents that are consistent with the labeling for dosage of erythropoietin stimulating agents approved by the Food and Drug Administration for treatment of anemia in patients with end stage renal disease, taking into account variations in hemoglobin ranges or hematocrit levels of patients; and

(II) such other measures, relating to subjects described in subparagraph (D)(i), as the Secretary may specify.

(D) REPORTING PERFORMANCE MEASURES.—The performance measures under this subparagraph to be reported shall include—

(i) such measures as the Secretary specifies, before the beginning of the performance period involved and taking into account measures endorsed by the National Quality Forum, including, to the extent feasible measures on—

(I) iron management;

(II) dialysis adequacy; and

(III) vascular access, including for maximizing the placement of arterial venous fistula; and

(ii) to the extent feasible, such measure (or measures) of patient satisfaction as the Secretary shall specify.

The provider or facility submitting information on such measures shall attest to the completeness and accuracy of such information.

(E) APPLICABLE PERCENTAGE.—The applicable percentage specified in this subparagraph for—

(i) the performance period occurring in 2008, is 1.0 percent;

(ii) the 2009 performance period, is 2.0 percent; and

(iii) the 2010 performance period, is 3.0 percent.

In the case of any performance period which is less than an entire year, the applicable percentage specified in this subparagraph shall be multiplied by the ratio of the number of months in the year to the number of months in such performance period. In the case of 2010, the applicable percentage specified in this subparagraph shall be multiplied by the Secretary's estimate of the ratio of the aggregate payment amount described in subparagraph (F)(i) that would apply in 2010 if paragraph (14) did not apply, to the aggregate payment base under subparagraph (F)(ii) for 2010.

(F) PAYMENT BASE.—The payment base described in this subparagraph for a provider or facility is—

(i) for performance periods before 2010, the payment amount determined under paragraph (12) for services furnished by the provider or facility during the performance period, including the drug payment adjustment described in subparagraph (B)(ii) of such paragraph; and

(ii) for the 2010 performance period is the amount determined under paragraph (14) for services furnished by the provider or facility during the period.

(G) LIMITATION ON FUNDING.—

(i) IN GENERAL.—If the Secretary determines that the total payments under this paragraph for a performance period is projected to exceed the dollar amount specified in clause (ii) for such period, the Secretary shall reduce, in a pro rata manner, the amount of such payments for each provider or facility for such period to eliminate any such projected excess for the period.

(ii) DOLLAR AMOUNT.—The dollar amount specified in this clause—

(I) for the performance period occurring in 2008, is $50,000,000;

(II) for the 2009 performance period is $100,000,000; and

(III) for the 2010 performance period is $150,000,000.

(H) FORM OF PAYMENT.—The payment under this paragraph shall be in the form of a single consolidated payment.

(2) QUALITY INCENTIVE PAYMENTS FOR FACILITIES AND PROVIDERS FOR 2011.—

(A) INCREASED PAYMENT.—For 2011, in the case of a provider or facility that, for the performance period (as defined in subparagraph (B))—

(i) meets (or exceeds) the performance standard for anemia management specified in paragraph (1)(C)(ii)(I);

(ii) has substantially improved performance or exceeds a performance standard (as determined under subparagraph (E)); and

(iii) reports measures specified in paragraph (1)(D), with respect to renal dialysis services furnished by the provider or facility during the quality bonus payment period (as specified in subparagraph (C)) the payment amount otherwise made to such provider or facility under subsection (b)(14) shall be increased, subject to subparagraph (F), by the applicable percentage specified in subparagraph (D). Payment amounts under paragraph (1) shall not be counted for purposes of applying the previous sentence.

(B) PERFORMANCE PERIOD.—In this paragraph, the term "performance period" means a multi-month period specified by the Secretary.

(C) QUALITY BONUS PAYMENT PERIOD.—In this paragraph, the term "quality bonus payment period" means, with respect to a performance period, a multi-month period

beginning on January 1, 2011, specified by the Secretary that begins at least 3 months (but not more than 9 months) after the end of the performance period.

(D) APPLICABLE PERCENTAGE.—The applicable percentage specified in this subparagraph is a percentage, not to exceed the 4.0 percent, specified by the Secretary consistent with subparagraph (F). Such percentage may vary based on the level of performance and improvement. The applicable percentage specified in this subparagraph shall be multiplied by the ratio applied under the third sentence of paragraph (1)(E) for 2010.

(E) PERFORMANCE STANDARD.—Based on performance of a provider of services or a renal dialysis facility on performance measures described in paragraph (1)(D) for a performance period, the Secretary shall determine a composite score for such period.

(F) LIMITATION ON FUNDING.—If the Secretary determines that the total amount to be paid under this paragraph for a quality bonus payment period is projected to exceed $200,000,000, the Secretary shall reduce, in a uniform manner, the applicable percentage otherwise applied under subparagraph (D) for services furnished during the period to eliminate any such projected excess.

(3) APPLICATION.—

(A) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement by program instruction or otherwise this subsection.

(B) LIMITATIONS ON REVIEW.—

(i) IN GENERAL.—There shall be no administrative or judicial review under section 1869 or 1878 or otherwise of—

(I) the determination of performance measures and standards under this subsection;

(II) the determination of successful reporting, including a determination of composite scores; and

(III) the determination of the quality incentive payments made under this subsection.

(ii) TREATMENT OF DETERMINATIONS.—A determination under this subparagraph shall not be treated as a determination for purposes of section 1869.

(4) TECHNICAL ASSISTANCE.—The Secretary shall identify or establish an appropriately skilled group or organization, such as the ESRD Networks, to provide technical assistance to consistently low-performing facilities or providers that are in the bottom quintile.

(5) PUBLIC REPORTING.—

(A) ANNUAL NOTICE.—The Secretary shall provide an annual written notification to each individual who is receiving renal dialysis services from a provider of services or renal dialysis facility that—

(i) informs such individual of the composite scores described in subparagraph (A) and other relevant quality measures with respect to providers of services or renal dialysis facilities in the local area;

(ii) compares such scores and measures to the average local and national scores and measures; and

(iii) provides information on how to access additional information on quality of such services furnished and options for alternative providers and facilities.

(B) CERTIFICATES.—The Secretary shall provide certificates to facilities and providers who provide services to individuals with end-stage renal disease under this title to display in patient areas. The certificate shall indicate the composite score obtained by the facility or provider under the quality initiative.

(C) WEB-BASED QUALITY LIST.—The Secretary shall establish a web-based list of facilities and providers who furnish renal dialysis services under this section that indicates their composite score of each provider and facility.

(6) RECOMMENDATIONS FOR REPORTING AND QUALITY INCENTIVE INTITIATIVE FOR PHYSICIANS.—The Secretary shall develop recommendations for applying quality incentive payments under this subsection to physicians who receive the monthly capitated payment under this title. Such recommendations shall include the following:

(A) Recommendations to include pediatric specific measures for physicians with at least 50 percent of their patients with end stage renal disease being individuals under 18 years of age.

(B) Recommendations on how to structure quality incentive payments for physicians who demonstrate improvements in quality or who attain quality standards, as specified by the Secretary.

(7) REPORTS.—

(A) INITIAL REPORT.—Not later than January 1, 2013, the Secretary shall submit to Congress a report on the implementation of the bundled payment system under subsection (b)(14) and the quality initiative under this subsection. Such report shall include the following information:

(i) A comparison of the aggregate payments under subsection (b)(14) for items and services to the cost of such items and services.

(ii) The changes in utilization rates for erythropoietin stimulating agents.

(iii) The mode of administering such agents, including information on the proportion of such individuals receiving such agents intravenously as compared to subcutaneously.

(iv) The frequency of dialysis.

(v) Other differences in practice patterns, such as the adoption of new technology, different modes of practice, and variations in use of drugs other than drugs described in clause (iii).

(vi) The performance of facilities and providers under paragraph (2).

(vii) Other recommendations for legislative and administrative actions determined appropriate by the Secretary.

(B) SUBSEQUENT REPORT.—Not later than January 1, 2015, the Secretary shall submit to Congress a report that contains the information described in each of clauses (ii) through (vii) of subparagraph (A) and a comparison of the results of the payment system under subsection (b)(14) for renal dialysis services furnished during the 2-year period beginning on January 1, 2013, and the results of such payment system for such services furnished during the previous two-year period.

CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES

SEC. 1882. (a) * * *

* * * * * * *

(d)(1) * * *

* * * * * * *

(3)(A)(i) It is unlawful for a person to sell or issue to an individual entitled to benefits under part A or enrolled under part B of this title (including an individual electing a [Medicare+Choice] *Medicare Part C* plan under section 1851)—

(I) * * *

(II) in the case of an individual not electing a [Medicare+Choice] *Medicare Part C* plan, a medicare supplemental policy with knowledge that the individual is entitled to benefits under another medicare supplemental policy or in the case of an individual electing a [Medicare+Choice] *Medicare Part C* plan, a medicare supplemental policy with knowledge that the policy duplicates health benefits to which the individual is otherwise entitled under the [Medicare+Choice] *Medicare Part C* plan or under another medicare supplemental policy, or

* * * * * * *

(B)(i) It is unlawful for a person to issue or sell a medicare supplemental policy to an individual entitled to benefits under part A or enrolled under part B, whether directly, through the mail, or otherwise, unless—

(I) the person obtains from the individual, as part of the application for the issuance or purchase and on a form described in clause (II), a written statement signed by the individual stating, to the best of the individual's knowledge, what health insurance policies (including any [Medicare+Choice] *Medicare Part C* plan) the individual has, from what source, and whether the individual is entitled to any medical assistance under title XIX, whether as a qualified medicare beneficiary or otherwise, and

* * * * * * *

(g)(1) For purposes of this section, a medicare supplemental policy is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this title, which provides reimbursement for expenses incurred for services and items for which payment may be made under this title but which are not reimbursable by reason of the

applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this title; but does not include a prescription drug plan under part D or a [Medicare+Choice] *Medicare Part C* plan or any such policy or plan of one or more employers or labor organizations, or of the trustees of a fund established by one or more employers or labor organizations (or combination thereof), for employees or former employees (or combination thereof) or for members or former members (or combination thereof) of the labor organizations and does not include a policy or plan of an eligible organization (as defined in section 1876(b)) if the policy or plan provides benefits pursuant to a contract under section 1876 or an approved demonstration project described in section 603(c) of the Social Security Amendments of 1983, section 2355 of the Deficit Reduction Act of 1984, or section 9412(b) of the Omnibus Budget Reconciliation Act of 1986, or a policy or plan of an organization if the policy or plan provides benefits pursuant to an agreement under section 1833(a)(1)(A). For purposes of this section, the term "policy" includes a certificate issued under such policy.

* * * * * * *

(o) The requirements of this subsection are as follows:

(1) Each medicare supplemental policy shall provide for coverage of a group of benefits consistent with subsections [(p), (v), and (w)] *(p) and (v)*.

* * * * * * *

(4) In addition to the requirement of paragraph (2), the issuer of the policy must make available to the individual at least medicare supplemental policies with benefit packages classified as "C" or "F".

* * * * * * *

(s)(1) * * *

* * * * * * *

(3)(A) * * *

(B) An individual described in this subparagraph is an individual described in any of the following clauses:

(i) * * *

(ii) The individual is enrolled with a [Medicare+Choice] *Medicare Part C* organization under a [Medicare+Choice] *Medicare Part C* plan under part C, and there are circumstances permitting discontinuance of the individual's election of the plan under the first sentence of section 1851(e)(4) or the individual is 65 years of age or older and is enrolled with a PACE provider under section 1894, and there are circumstances that would permit the discontinuance of the individual's enrollment with such provider under circumstances that are similar to the circumstances that would permit discontinuance of the individual's election under the first sentence of such section if such individual were enrolled in a [Medicare+Choice] *Medicare Part C* plan.

* * * * * * *

(v) The individual—

(I) * * *

(II) subsequently terminates such enrollment and enrolls, for the first time, with any [Medicare+Choice] *Medicare Part C* organization under a [Medicare+Choice] *Medicare Part C* plan under part C, any eligible organization under a contract under section 1876, any similar organization operating under demonstration project authority, any PACE provider under section 1894, or any policy described in subsection (t), and

(III) the subsequent enrollment under subclause (II) is terminated by the enrollee during any period within the first [12 months] *24 months* of such enrollment (during which the enrollee is permitted to terminate such subsequent enrollment under section 1851(e)).

(vi) The individual, upon first becoming eligible for benefits under part A at age 65, enrolls in a [Medicare+Choice] *Medicare Part C* plan under part C or in a PACE program under section 1894, and disenrolls from such plan or such program by not later than [12 months] *24 months* after the effective date of such enrollment.

* * * * * * *

(F)(i) Subject to clause (ii), for purposes of this paragraph—

(I) in the case of an individual described in subparagraph (B)(v) (or deemed to be so described, pursuant to this subparagraph) whose enrollment with an organization or provider described in subclause (II) of such subparagraph is involuntarily terminated within the first [12 months] *24 months* of such enrollment, and who, without an intervening enrollment, enrolls with another such organization or provider, such subsequent enrollment shall be deemed to be an initial enrollment described in such subparagraph; and

(II) in the case of an individual described in clause (vi) of subparagraph (B) (or deemed to be so described, pursuant to this subparagraph) whose enrollment with a plan or in a program described in such clause is involuntarily terminated within the first [12 months] *24 months* of such enrollment, and who, without an intervening enrollment, enrolls in another such plan or program, such subsequent enrollment shall be deemed to be an initial enrollment described in such clause.

* * * * * * *

(u)(1) It is unlawful for a person to sell or issue a policy described in paragraph (2) to an individual with knowledge that the individual has in effect under section 1851 an election of an MSA plan or a [Medicare+Choice] *Medicare Part C* private fee-for-service plan.

* * * * * * *

(v) RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.—

(1) * * *

* * * * * * *

(3) AVAILABILITY OF SUBSTITUTE POLICIES WITH GUARANTEED ISSUE.—

(A) IN GENERAL.—The issuer of a medicare supplemental policy—

(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as "A", "B", "C", or "F" (including the benefit package classified as "F" with a high deductible feature, as described in subsection (p)(11)), under the standards established under subsection (p)(2), [or a benefit package described in subparagraph (A) or (B) of subsection (w)(2)] and that is offered and is available for issuance to new enrollees by such issuer;

* * * * * * *

(w) DEVELOPMENT OF NEW STANDARDS FOR MEDICARE SUPPLEMENTAL [POLICIES.—

[(1) IN GENERAL.—The Secretary] *POLICIES.—The Secretary* shall request the National Association of Insurance Commissioners to review and revise the standards for benefit packages under subsection (p)(1), taking into account the changes in benefits resulting from enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 and to otherwise update standards to reflect other changes in law included in such Act. [Such revision shall incorporate the inclusion of the 2 benefit packages described in paragraph (2).] Such revisions shall be made consistent with the rules applicable under subsection (p)(1)(E) with the reference to the "1991 NAIC Model Regulation" deemed a reference to the NAIC Model Regulation as published in the Federal Register on December 4, 1998, and as subsequently updated by the National Association of Insurance Commissioners to reflect previous changes in law (and subsection (v)) and the reference to "date of enactment of this subsection" deemed a reference to the date of enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. To the extent practicable, such revision shall provide for the implementation of revised standards for benefit packages as of January 1, 2006.

[(2) NEW BENEFIT PACKAGES.—The benefit packages described in this paragraph are the following (notwithstanding any other provision of this section relating to a core benefit package):

[(A) FIRST NEW BENEFIT PACKAGE.—A benefit package consisting of the following:

[(i) Subject to clause (ii), coverage of 50 percent of the cost-sharing otherwise applicable under parts A and B, except there shall be no coverage of the part B deductible and coverage of 100 percent of any cost-sharing otherwise applicable for preventive benefits.

[(ii) Coverage for all hospital inpatient coinsurance and 365 extra lifetime days of coverage of inpatient hospital services (as in the current core benefit package).

[(iii) A limitation on annual out-of-pocket expenditures under parts A and B to $4,000 in 2006 (or, in a subsequent year, to such limitation for the previous

year increased by an appropriate inflation adjustment specified by the Secretary).

[(B) SECOND NEW BENEFIT PACKAGE.—A benefit package consisting of the benefit package described in subparagraph (A), except as follows:

[(i) Substitute "75 percent" for "50 percent" in clause (i) of such subparagraph.

[(ii) Substitute "$2,000" for "$4,000" in clause (iii) of such subparagraph.]

* * * * * * *

PAYMENT TO HOSPITALS FOR INPATIENT HOSPITAL SERVICES

SEC. 1886. (a) * * *

(b)(1) * * *

(2)(A) * * *

* * * * * * *

(E)(i) * * *

(ii) For purposes of clause (i), each of the following shall be treated as a separate class of hospital:

(I) * * *

* * * * * * *

(III) Hospitals described in clause (vi) of such subsection.

(3)(A) * * *

(B)(i) For purposes of subsection (d) and subsection (j) for discharges occurring during a fiscal year, the "applicable percentage increase" shall be—

(I) * * *

* * * * * * *

(XIX) for each of fiscal years 2004 through 2006, subject to clause (vii), the market basket percentage increase for hospitals in all areas; [and]

(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

[(XX)] *(XXII)* for each subsequent fiscal year, subject to clause (viii), the market basket percentage increase for hospitals in all areas.

(ii) For purposes of subparagraphs (A) and (E), the "applicable percentage increase" for 12-month cost reporting periods beginning during—

(I) * * *

* * * * * * *

(VII) for fiscal years 1999 through 2002, is the applicable update factor specified under clause (vi) for the fiscal year, [and]

(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

[(VIII)] *(X)* subsequent fiscal years is the market basket percentage increase.

(F)(i) * * *

* * * * * * *

(iii) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

(I) * * *

* * * * * * *

(VI) Hospitals described in clause (vi) of such subsection.

(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 reporting periods beginning before October 1, 1999, that is within a class of hospital described in clause (iii) (other than subclause (IV), relating to long-term care hospitals, and that requests the Secretary (in a form and manner specified by the Secretary) to effect a rebasing under this clause for the hospital, the Secretary may compute the target amount for the hospital's 12-month cost reporting period beginning during fiscal year 2008 as an amount equal to the average described in clause (ii) but determined as if any reference in such clause to "the date of the enactment of this subparagraph" were a reference to "the date of the enactment of this clause".

(G)(i) * * *

(ii) In clause (i), a "qualified long-term care hospital" means, with respect to a cost reporting period, a hospital described in clause (iv) *or (vi)* of subsection (d)(1)(B) during each of the 2 cost reporting periods for which the Secretary has the most recent settled cost reports as of the date of the enactment of this subparagraph for each of which—

(I) * * *

* * * * * * *

(H)(i) In the case of a hospital or unit that is within a class of hospital described in clause (iv) *or (vi)*, for a cost reporting period beginning during fiscal years 1998 through 2002, the target amount for such a hospital or unit may not exceed the amount as updated up to or for such cost reporting period under clause (ii).

(ii)(I) In the case of a hospital or unit that is within a class of hospital described in clause (iv) *or (vi)*, the Secretary shall estimate the 75th percentile of the target amounts for such hospitals within such class for cost reporting periods ending during fiscal year 1996, as adjusted under clause (iii).

* * * * * * *

(iv) For purposes of this subparagraph, each of the following shall be treated as a separate class of hospital:

(I) * * *

* * * * * * *

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

* * * * * * *

(J) For cost reporting periods beginning during fiscal year 2001, for a hospital described in [subsection (d)(1)(B)(iv)] *clause (iv) or (vi) of subsection (d)(1)(B)*—

(i) * * *

* * * * * * *

(7)(A) * * *

(B) For purposes of this paragraph, each of the following shall be treated as a separate class of hospital:

(i) * * *

* * * * * * *

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

(d)(1)(A) * * *

(B) As used in this section, the term "subsection (d) hospital" means a hospital located in one of the fifty States or the District of Columbia other than—

(i) * * *

* * * * * * *

[(iv)(I)] *(iv)* a hospital which has an average inpatient length of stay (as determined by the Secretary) of greater than 25 days, [or]

(v)(I) a hospital that the Secretary has classified, at any time on or before December 31, 1990, (or, in the case of a hospital that, as of the date of the enactment of this clause, is located in a State operating a demonstration project under section 1814(b), on or before December 31, 1991) for purposes of applying exceptions and adjustments to payment amounts under this subsection, as a hospital involved extensively in treatment for or research on cancer,

(II) a hospital that was recognized as a comprehensive cancer center or clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, that is located in a State which, as of December 19, 1989, was not operating a demonstration project under section 1814(b), that applied and was denied, on or before December 31, 1990, for classification as a hospital involved extensively in treatment for or research on cancer under this clause (as in effect on the day before the date of the enactment of this subclause), that as of the date of the enactment of this subclause, is licensed for less than 50 acute care beds, and that demonstrates for the 4-year period ending on December 31, 1996, that at least 50 percent of its total discharges have a principal finding of neoplastic disease, as defined in subparagraph (E), [or]

(III) a hospital that was recognized as a clinical cancer research center by the National Cancer Institute of the National Institutes of Health as of February 18, 1998, that has never been reimbursed for inpatient hospital services pursuant to a reimbursement system under a demonstration project under section 1814(b), that is a freestanding facility organized primarily for treatment of and research on cancer and is not a unit of another hospital, that as of the date of the enactment of this subclause, is licensed for 162 acute care beds, and that

demonstrates for the 4-year period ending on June 30, 1999, that at least 50 percent of its total discharges have a principal finding of neoplastic disease, as defined in subparagraph (E)**[**;**]***, or*

(IV) a hospital that is a nonprofit corporation, the sole member of which is affiliated with a university that has been the recipient of a cancer center support grant from the National Cancer Institute of the National Institutes of Health, and which sole member (or its predecessors or such university) was recognized as a comprehensive cancer center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, if the hospital's articles of incorporation specify that at least 50 percent of its total discharges have a principal finding of neoplastic disease (as defined in subparagraph (E)) and if, of December 31, 2005, the hospital was licensed for less than 150 acute care beds, or

(V) a hospital (aa) that the Secretary has determined to be, at any time on or before December 31, 2011, a hospital involved extensively in treatment for, or research on, cancer, (bb) that is (as of the date of such determination) a free-standing facility, (cc) for which the hospital's predecessor provider entity was University Hospitals of Cleveland with medicare provider number 36–0137;

[(II)**]** *(vi)* a hospital that first received payment under this subsection in 1986 which has an average inpatient length of stay (as determined by the Secretary) of greater than 20 days and that has 80 percent or more of its annual medicare inpatient discharges with a principal diagnosis that reflects a finding of neoplastic disease in the 12-month cost reporting period ending in fiscal year 1997**[**, or**]***;*

(vii) a hospital that—

(I) is located in a State which ranks (according to the National Cancer Institute's statistics published in May of 2005) among the top ten States in the incidence of non-Hodgkins lymphoma, ovarian cancer, thyroid cancer, and cervical cancer and among the top ten States with the highest death rate for breast cancer and uterine cancer;

(II) is located in a State that as of December 31, 2006, had only one center under section 414 of the Public Health Service Act that has been designated by the National Cancer Institute as a comprehensive center currently serving all 21 counties in the most densely populated State in the nation (U.S. Census estimate for 2005: 8,717,925 persons; 1,134.5 persons per square mile), serving more than 70,000 patient visits annually;

(III) as of December 31, 2006, served as the teaching and clinical care, research and training hospital for the Center described in subclause (II), providing significant financial and operational support to such Center;

(IV) as of December 31, 2006, served as a core and essential element in such Center which conducts more than 130 clinical trial activities, national cooperative group studies, investigator-initiated and peer review studies and has re-

ceived as of 2005 at least $93,000,000 in research grant awards;

(V) as of December 31, 2006, can demonstrate that it has been a unique and an integral component of such Center since such Center's inception;

(VI) as of December 31, 2006, includes dedicated patient care units organized primarily for the treatment of and research on cancer with approximately 125 beds, 75 percent of which are dedicated to cancer patients, and contains a radiation oncology department as well as specialized emergency services for oncology patients;

(VII) as of December 31, 2004, is identified as the focus of the Center's inpatient activities in the Center's application as a NCI-designated comprehensive cancer center and shares the NCI comprehensive cancer designation with the Center; and

(VIII) as of December 31, 2006, has been recognized with a certificate of approval with commendation by the American College of Surgeons Commission on Cancer;

and, in accordance with regulations of the Secretary, does not include a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital (as defined by the Secretary). A hospital that was classified by the Secretary on or before September 30, 1995, as a hospital described in clause (iv) *(as in effect as of such date)* shall continue to be so classified *(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)* notwithstanding that it is located in the same building as, or on the same campus as, another hospital.

* * * * * * *

(E) For purposes of ⟦subclauses (II) and (III)⟧ *subclauses (II), (III), and (IV)* of subparagraph (B)(v) *and subparagraph (B)(vi)* only, the term "principal finding of neoplastic disease" means the condition established after study to be chiefly responsible for occasioning the admission of a patient to a hospital, except that only discharges with ICD–9–CM principal diagnosis codes of 140 through 239, V58.0, V58.1, V66.1, V66.2, or 990 will be considered to reflect such a principal diagnosis.

* * * * * * *

(5)(A) * * *

* * * * * * *

(F)(i) * * *

* * * * * * *

(xiv)(I) * * *

(II) Under subclause (I), the disproportionate share adjustment percentage shall not exceed ⟦12 percent⟧ *the percent specified in subclause (III)* for a hospital that is not classified as a rural referral center under subparagraph (C) or, in the case of discharges occurring on or after October 1, 2006, as a medicare-dependent, small rural hospital under subparagraph (G)(iv).

(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.

* * * * * * *

(8)(A) * * *

* * * * * * *

(C)(i) * * *

* * * * * * *

(v) Notwithstanding the previous provisions of this subparagraph, in the case that the application of subparagraph (B) or a decision of the Medicare Geographic Classification Review Board or the Secretary under paragraph (10) results in the redesignation of a rural hospital that is classified as a rural referral center under paragraph (5)(C) and sole community hospital under paragraph (5)(D)(iii) and that has at least 250 beds to an urban area that is in a non-location State, for which the combined average hourly wage of all hospitals located in such area is less than the combined average hourly wage of all hospitals located in the rural area of such State, and which was not reclassified under section 508 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, the wage index applicable to such hospital may not be less than the area wage index otherwise applicable to a hospital located in the rural area in the non-location State (or, if the non-location State has no rural area, the minimum wage index that the Secretary establishes for such State). For purposes of this clause, the term "non-location State" means, with respect to a hospital, a State other than the State in which the hospital is located.

[(v)**]** *(vi)* This subparagraph shall apply with respect to discharges occurring in a fiscal year only if the Secretary uses a method for making adjustments to the DRG prospective payment rate for area differences in hospital wage levels under paragraph (3)(E) for the fiscal year that is based on the use of Metropolitan Statistical Area classifications.

* * * * * * *

(11) ADDITIONAL PAYMENTS FOR MANAGED CARE ENROLLEES.—

(A) * * *

(B) APPLICABLE DISCHARGE.—For purposes of this paragraph, the term "applicable discharge" means the discharge of any individual who is enrolled under a risk-sharing contract with an eligible organization under section 1876 and who is entitled to benefits under part A or any individual who is enrolled with a **[**Medicare+Choice**]** *Medicare Part C* organization under part C.

* * * * * * *

(h) PAYMENTS FOR DIRECT GRADUATE MEDICAL EDUCATION COSTS.—

(1) * * *

* * * * * * *

(3) HOSPITAL PAYMENT AMOUNT PER RESIDENT.—

(A) * * *

* * * * * * *

(D) PAYMENT FOR MANAGED CARE ENROLLEES.—

(i) IN GENERAL.—For portions of cost reporting periods occurring on or after January 1, 1998, the Secretary shall provide for an additional payment amount under this subsection for services furnished to individuals who are enrolled under a risk-sharing contract with an eligible organization under section 1876 and who are entitled to part A or with a [Medicare+Choice] *Medicare Part C* organization under part C. The amount of such a payment shall equal, subject to clause (iii), the applicable percentage of the product of—

* * * * * * *

(4) DETERMINATION OF FULL-TIME-EQUIVALENT RESIDENTS.—

(A) * * *

* * * * * * *

(H) SPECIAL RULES FOR APPLICATION OF SUBPARAGRAPHS (F) AND (G).—

(i) * * *

* * * * * * *

(v) INCREASE IN RESIDENT LIMIT DUE TO CLOSURE OF OTHER HOSPITALS.—If one or more hospitals with approved medical residency training programs, which are located within the same metropolitan division of the core based statistical area as of January 1, 2001, closed, the Secretary shall increase by not more than 10 (subject to the limitation set forth in the last sentence of this clause) the otherwise applicable resident limit under subparagraph (F) for each hospital within the same metropolitan division of the core based statistical area that meets all the following criteria:

(I) The hospital is described in subsection (d)(5)(F)(i).

(II) The hospital instituted a medical residency training program in internal medicine that was accredited by the American Osteopathic Association on or after January 1, 2004.

(III) The hospital had a provider number and a resident limit as of January 1, 2000, and remained open as of October 1, 2007.

(IV) The hospital did not receive an increase in its resident limit under paragraph (7)(B).

In no event may the resident limit for any hospital be increased above 50 through application of this clause and in no event may the total of the residency positions added by this clause for all hospitals exceed 10.

* * * * * * *

(7) REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.—

(A) * * *

* * * * * * *

(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.

[(D)] *(E)* JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, with respect to determinations made under this paragraph.

* * * * * * *

(j) PROSPECTIVE PAYMENT FOR INPATIENT REHABILITATION SERVICES.—

(1) * * *

* * * * * * *

(3) PAYMENT RATE.—

(A) * * *

* * * * * * *

(C) INCREASE FACTOR.—For purposes of this subsection for payment units in each fiscal year (beginning with fiscal year 2001), the Secretary shall establish an increase factor. Such factor shall be based on an appropriate percentage increase in a market basket of goods and services comprising services for which payment is made under this subsection, which may be the market basket percentage increase described in subsection (b)(3)(B)(iii). *The increase factor to be applied under this subparagraph for fiscal year 2008 shall be 1 percent.*

* * * * * * *

(7) SPECIAL PAYMENT RULE FOR CERTAIN MEDICAL CONDITIONS.—

(A) IN GENERAL.—Subject to subparagraph (H), in the case of discharges occurring on or after October 1, 2008, in lieu of the standardized payment amount (as determined pursuant to the preceding provisions of this subsection) that would otherwise be applicable under this subsection, the Secretary shall substitute, for payment units with respect to

an applicable medical condition (as defined in subparagraph (G)(i)) that is treated in an inpatient rehabilitation facility, the modified standardized payment amount determined under subparagraph (B).

(B) MODIFIED STANDARDIZED PAYMENT AMOUNT.—The modified standardized payment amount for an applicable medical condition shall be based on the amount determined under subparagraph (C) for such condition, as adjusted under subparagraphs (D), (E), and (F).

(C) AMOUNT DETERMINED.—

(i) IN GENERAL.—The amount determined under this subparagraph for an applicable medical condition shall be based on the sum of the following:

(I) An amount equal to the average per stay skilled nursing facility payment rate for the applicable medical condition (as determined under clause (ii)).

(II) An amount equal to 25 percent of the difference between the overhead costs (as defined in subparagraph (G)(ii)) component of the average inpatient rehabilitation facility per stay payment amount for the applicable medical condition (as determined under the preceding paragraphs of this subsection) and the overhead costs component of the average per stay skilled nursing facility payment rate for such condition (as determined under clause (ii)).

(III) An amount equal to 33 percent of the difference between the patient care costs (as defined in subparagraph (G)(iii)) component of the average inpatient rehabilitation facility per stay payment amount for the applicable medical condition (as determined under the preceding paragraphs of this subsection) and the patient care costs component of the average per stay skilled nursing facility payment rate for such condition (as determined under clause (ii)).

(ii) DETERMINATION OF AVERAGE PER STAY SKILLED NURSING FACILITY PAYMENT RATE.—For purposes of clause (i), the Secretary shall convert skilled nursing facility payment rates for applicable medical conditions, as determined under section 1888(e), to average per stay skilled nursing facility payment rates for each such condition.

(D) ADJUSTMENTS.—The Secretary shall adjust the amount determined under subparagraph (C) for an applicable medical condition using the adjustments to the prospective payment rates for inpatient rehabilitation facilities described in paragraphs (2), (3), (4), and (6).

(E) UPDATE FOR INFLATION.—Except in the case of a fiscal year for which the Secretary rebases the amounts determined under subparagraph (C) for applicable medical conditions pursuant to subparagraph (F), the Secretary shall annually update the amounts determined under subpara-

graph (C) for each applicable medical condition by the increase factor for inpatient rehabilitation facilities (as described in paragraph (3)(C)).

(F) REBASING.—The Secretary shall periodically (but in no case less than once every 5 years) rebase the amounts determined under subparagraph (C) for applicable medical conditions using the methodology described in such subparagraph and the most recent and complete cost report and claims data available.

(G) DEFINITIONS.—In this paragraph:

(i) APPLICABLE MEDICAL CONDITION.—The term "applicable medical condition" means—

(I) unilateral knee replacement;

(II) unilateral hip replacement; and

(III) unilateral hip fracture.

(ii) OVERHEAD COSTS.—The term "overhead costs" means those Medicare-allowable costs that are contained in the General Service cost centers of the Medicare cost reports for inpatient rehabilitation facilities and for skilled nursing facilities, respectively, as determined by the Secretary.

(iii) PATIENT CARE COSTS.—The term "patient care costs" means total Medicare-allowable costs minus overhead costs.

(H) SUNSET.—The provisions of this paragraph shall cease to apply as of the date the Secretary implements an integrated, site-neutral payment methodology under this title for post-acute care.

[(7)**]** *(8)* LIMITATION ON REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the establishment of—

(A) * * *

* * * * * * *

(C) outlier and special payments under paragraph (4), **[**and**]**

(D) area wage adjustments under paragraph (6)**[**.**]***, and*

(E) modified standardized payment amounts under paragraph (7).

(k) PAYMENT TO NONHOSPITAL PROVIDERS.—

(1) * * *

(2) QUALIFIED NONHOSPITAL PROVIDERS.—For purposes of this subsection, the term "qualified nonhospital providers" means—

(A) * * *

* * * * * * *

(C) **[**Medicare+Choice**]** *Medicare Part C* organizations; and

* * * * * * *

(l) PAYMENT FOR NURSING AND ALLIED HEALTH EDUCATION FOR MANAGED CARE ENROLLEES.—

(1) * * *

(2) PAYMENT AMOUNT.—The additional payment amount under this subsection for each hospital for portions of cost reporting periods occurring in a year shall be an amount specified by the Secretary in a manner consistent with the following:

(A) * * *

* * * * * * *

(C) APPLICATION TO HOSPITAL.—The amount of payment under this subsection to a hospital for portions of cost reporting periods occurring in a year is equal to the total amount of payments determined under subparagraph (B) for the year multiplied by the ratio of—

(i) the product of (I) the Secretary's estimate of the ratio of the amount of payments made under section 1861(v) to the hospital for nursing and allied health education activities for the hospital's cost reporting period ending in the second preceding fiscal year, to the hospital's total inpatient days for such period, and (II) the total number of inpatient days (as established by the Secretary) for such period which are attributable to services furnished to individuals who are enrolled under a risk sharing contract with an eligible organization under section 1876 and who are entitled to benefits under part A or who are enrolled with a ⟦Medicare+Choice⟧ *Medicare Part C* organization under part C; to

* * * * * * *

(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 discharges for the hospital shall be the same as the base rate for discharges for the hospital occurring during the previous rate year.

(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 level of severity, as defined by the Secretary, and who are assigned to one or more of the following major diagnostic categories:

(A) Circulatory diagnoses.

(B) Digestive, endocrine, and metabolic diagnoses.

(C) Infection disease diagnoses.
(D) Neurological diagnoses.
(E) Renal diagnoses.
(F) Respiratory diagnoses.
(G) Skin diagnoses.
(H) Other major diagnostic categories as selected by the Secretary.

(2) MAJOR DIAGNOSTIC CATEGORY DEFINED.—In paragraph (1), the term "major diagnostic category" means the medical categories formed by dividing all possible principle diagnosis into mutually exclusive diagnosis areas which are referred to in 67 Federal Register 49985 (August 1, 2002).

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PAYMENT TO SKILLED NURSING FACILITIES FOR ROUTINE SERVICE COSTS

SEC. 1888. (a) * * *

* * * * * * *

(e) PROSPECTIVE PAYMENT.—

(1) * * *

(2) DEFINITIONS.—For purposes of this subsection:

(A) COVERED SKILLED NURSING FACILITY SERVICES.—

(i) * * *

(ii) SERVICES EXCLUDED.—Services described in this clause are physicians' services, services described by clauses (i) and (ii) of section 1861(s)(2)(K), certified nurse-midwife services, qualified psychologist services, *marriage and family therapist services (as defined in subsection (eee)(1)), mental health counselor services (as defined in section 1861(ddd)(2)), clinical social worker services,* services of a certified registered nurse anesthetist, items and services described in subparagraphs (F) and (O) of section 1861(s)(2), and, only with respect to services furnished during 1998, the transportation costs of electrocardiogram equipment for electrocardiogram test services (HCPCS Code R0076). Services described in this clause do not include any physical, occupational, or speech-language therapy services regardless of whether or not the services are furnished by, or under the supervision of, a physician or other health care professional.

* * * * * * *

(4) FEDERAL PER DIEM RATE.—

(A) * * *

* * * * * * *

(E) UPDATING.—

(i) * * *

(ii) SUBSEQUENT FISCAL YEARS.—The Secretary shall compute an unadjusted Federal per diem rate equal to the Federal per diem rate computed under this subparagraph—

(I) * * *

* * * * * * *

(III) for each of fiscal years 2002 and 2003, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved minus 0.5 percentage points; [and]

(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

[(IV)] *(VI)* for each subsequent fiscal year, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved.

* * * * * * *

DEVELOPMENT, REPORTING, AND USE OF HEALTH CARE MEASURES

SEC. 1890. (a) FOSTERING DEVELOPMENT OF HEALTH CARE MEASURES.—The Secretary shall designate, and have in effect an arrangement with, a single organization (such as the National Quality Forum) that meets the requirements described in subsection (c), under which such organization provides the Secretary with advice on, and recommendations with respect to, the key elements and priorities of a national system for establishing health care measures. The arrangement shall be effective beginning no sooner than January 1, 2008, and no later than September 30, 2008.

(b) DUTIES.—The duties of the organization designated under subsection (a) (in this title referred to as the "designated organization") shall, in accordance with subsection (d), include—

(1) establishing and managing an integrated national strategy and process for setting priorities and goals in establishing health care measures;

(2) coordinating the development and specifications of such measures;

(3) establishing standards for the development and testing of such measures;

(4) endorsing national consensus health care measures; and

(5) advancing the use of electronic health records for automating the collection, aggregation, and transmission of measurement information.

(c) REQUIREMENTS DESCRIBED.—For purposes of subsection (a), the requirements described in this subsection, with respect to an organization, are the following:

(1) PRIVATE NONPROFIT.—The organization is a private nonprofit entity governed by a board and an individual designated as president and chief executive officer.

(2) BOARD MEMBERSHIP.—The members of the board of the organization include representatives of—

(A) health care providers or groups representing such providers;

(B) health plans or groups representing health plans;

(C) groups representing health care consumers;

(D) health care purchasers and employers or groups representing such purchasers or employers; and

(E) health care practitioners or groups representing practitioners.

(3) OTHER MEMBERSHIP REQUIREMENTS.—The membership of the organization is representative of individuals with experience with—

(A) urban health care issues;

(B) safety net health care issues;

(C) rural and frontier health care issues; and

(D) health care quality and safety issues.

(4) OPEN AND TRANSPARENT.—With respect to matters related to the arrangement described in subsection (a), the organization conducts its business in an open and transparent manner and provides the opportunity for public comment.

(5) VOLUNTARY CONSENSUS STANDARDS SETTING ORGANIZATION.—The organization operates as a voluntary consensus standards setting organization as defined for purposes of section 12(d) of the National Technology Transfer and Advancement Act of 1995 (Public Law 104–113) and Office of Management and Budget Revised Circular A–119 (published in the Federal Register on February 10, 1998).

(6) EXPERIENCE.—The organization has at least 7 years experience in establishing national consensus standards.

(d) REQUIREMENTS FOR HEALTH CARE MEASURES.—In carrying out its duties under subsection (b), the designated organization shall ensure the following:

(1) MEASURES.—The designated organization shall ensure that the measures established or endorsed under subsection (b) are evidence-based, reliable, and valid; and include—

(A) measures of clinical processes and outcomes, patient experience, efficiency, and equity;

(B) measures to assess effectiveness, timeliness, patient self-management, patient centeredness, and safety; and

(C) measures of under use and over use.

(2) PRIORITIES.—

(A) IN GENERAL.—The designated organization shall ensure that priority is given to establishing and endorsing—

(i) measures with the greatest potential impact for improving the effectiveness and efficiency of health care;

(ii) measures that may be rapidly implemented by group health plans, health insurance issuers, physicians, hospitals, nursing homes, long-term care providers, and other providers;

(iii) measures which may inform health care decisions made by consumers and patients; and

(iv) measures that apply to multiple services furnished by different providers during an episode of care.

(B) ANNUAL REPORT ON PRIORITIES; SECRETARIAL PUBLICATION AND COMMENT.—

(i) ANNUAL REPORT.—The designated organization shall issue and submit to the Secretary a report by March 31 of each year (beginning with 2009) on the organization's recommendations for priorities and goals in establishing and endorsing health care measures under this section over the next five years.

(ii) SECRETARIAL REVIEW AND COMMENT.—After receipt of the report under clause (i) for a year, the Secretary shall publish the report in the Federal Register, including any comments of the Secretary on the priorities and goals set forth in the report.

(3) RISK ADJUSTMENT.—The designated organization, in consultation with health care measure developers and other stakeholders, shall establish procedures to assure that health care measures established and endorsed under this section account for differences in patient health status, patient characteristics, and geographic location, as appropriate.

(4) MAINTENANCE.—The designated organization, in consultation with owners and developers of health care measures, shall require the owners or developers of such measures to update and enhance such measures, including the development of more accurate and precise specifications, and retire existing outdated measures. Such updating shall occur not more often than once during each 12-month period, except in the case of emergent circumstances requiring a more immediate update to a measure.

(e) USE OF HEALTH CARE MEASURES; REPORTING.—

(1) USE OF MEASURES.—For purposes of activities authorized or required under this title, the Secretary shall select from health care measures—

(A) recommended by multi-stakeholder groups; and

(B) endorsed by the designated organization under subsection (b)(4).

(2) REPORTING.—The Secretary shall implement procedures, consistent with generally accepted standards, to enable the Department of Health and Human Services to accept the electronic submission of data for purposes of—

(A) effectiveness measurement using the health care measures developed pursuant to this section; and

(B) reporting to the Secretary measures used to make value-based payments under this title.

(f) CONTRACTS.—The Secretary, acting through the Agency for Healthcare Research and Quality, may contract with organizations to support the development and testing of health care measures meeting the standards established by the designated organization.

(g) DISSEMINATION OF INFORMATION.—In order to make information on health care measures available to health care consumers, health professionals, public health officials, oversight organizations, researchers, and other appropriate individuals and entities, the Secretary shall work with multi-stakeholder groups to provide for the dissemination of information developed pursuant to this title.

(h) FUNDING.—For purposes of carrying out subsections (a), (b), (c), and (d), including for expenses incurred for the arrangement

under subsection (a) with the designated organization, there is payable from the Federal Hospital Insurance Trust Fund (established under section 1817) and the Federal Supplementary Medical Insurance Trust Fund (established under section 1841)—

(1) for fiscal year 2008, $15,000,000, multiplied by the ratio of the total number of months in the year to the number of months (and portions of months) of such year during which the arrangement under subsection (a) is effective; and

(2) for each of the fiscal years, 2009 through 2012, $15,000,000.

* * * * * * *

PAYMENTS TO, AND COVERAGE OF BENEFITS UNDER, PROGRAMS OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

SEC. 1894. (a) * * *

(b) SCOPE OF BENEFITS; BENEFICIARY SAFEGUARDS.—

(1) * * *

* * * * * * *

(3) TREATMENT OF MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—

(A) APPLICATION OF [MEDICARE ADVANTAGE] *MEDICARE PART C* REQUIREMENT WITH RESPECT TO MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—Section 1852(k)(1) (relating to limitations on balance billing against [MA] *Medicare Part C* organizations for noncontract physicians and other entities with respect to services covered under this title) shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract or other agreement establishing payment amounts for services furnished to such an individual in the same manner as such section applies to [MA] *Medicare Part C* organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

* * * * * * *

(d) PAYMENTS TO PACE PROVIDERS ON A CAPITATED BASIS.—

(1) IN GENERAL.—In the case of a PACE provider with a PACE program agreement under this section, except as provided in this subsection or by regulations, the Secretary shall make prospective monthly payments of a capitation amount for each PACE program eligible individual enrolled under the agreement under this section in the same manner and from the same sources as payments are made to a [Medicare+Choice] *Medicare Part C* organization under section 1853 (or, for periods beginning before January 1, 1999, to an eligible organization under a risk-sharing contract under section 1876). Such payments shall be subject to adjustment in the manner described in section 1853(a)(2) or section 1876(a)(1)(E), as the case may be.

* * * * * * *

(e) PACE PROGRAM AGREEMENT.—

(1) * * *

* * * * * * *

(7) PROCEDURES FOR TERMINATION OR IMPOSITION OF SANCTIONS.—Under regulations, the provisions of section 1857(h) (or for periods before January 1, 1999, section 1876(i)(9)) shall apply to termination and sanctions respecting a PACE program agreement and PACE provider under this subsection in the same manner as they apply to a termination and sanctions with respect to a contract and a [Medicare+Choice] *Medicare Part C* organization under part C (or for such periods an eligible organization under section 1876).

* * * * * * *

(f) REGULATIONS.—

(1) * * *

* * * * * * *

(3) APPLICATION OF CERTAIN ADDITIONAL BENEFICIARY AND PROGRAM PROTECTIONS.—

(A) IN GENERAL.—In issuing such regulations and subject to subparagraph (B), the Secretary may apply with respect to PACE programs, providers, and agreements such requirements of part C (or, for periods before January 1, 1999, section 1876) and sections 1903(m) and 1932 relating to protection of beneficiaries and program integrity as would apply to [Medicare+Choice] *Medicare Part C* organizations under part C (or for such periods eligible organizations under risk-sharing contracts under section 1876) and to medicaid managed care organizations under prepaid capitation agreements under section 1903(m).

* * * * * * *

PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES

SEC. 1895. (a) * * *

(b) SYSTEM OF PROSPECTIVE PAYMENT FOR HOME HEALTH SERVICES.—

(1) * * *

* * * * * * *

(3) PAYMENT BASIS.—

(A) * * *

(B) ANNUAL UPDATE.—

(i) * * *

(ii) HOME HEALTH APPLICABLE INCREASE PERCENTAGE.—For purposes of this subparagraph, the term "home health applicable increase percentage" means, with respect to—

(I) * * *

* * * * * * *

(IV) 2006, 0 percent; [and]

(V) 2007, subject to clause (v), the home health market basket percentage increase;

(VI) 2008, subject to clause (v), 0 percent; and

[(V)] *(VII)* any subsequent year, subject to clause (v), the home health market basket percentage increase.

* * * * * * *

MEDICARE SUBVENTION DEMONSTRATION PROJECT FOR MILITARY RETIREES

SEC. 1896. (a) * * *

* * * * * * *

(d) WAIVER OF CERTAIN MEDICARE REQUIREMENTS.—

(1) AUTHORITY.—

(A) IN GENERAL.—Except as provided under subparagraph (B), the demonstration project shall meet all requirements of [Medicare+Choice] *Medicare Part C* plans under part C of this title and regulations pertaining thereto, and other requirements for receiving medicare payments, except that the prohibition of payments to Federal providers of services under sections 1814(c) and 1835(d), and paragraphs (2) and (3) of section 1862(a) shall not apply.

* * * * * * *

(h) ADDITIONAL PLANS.—Notwithstanding any provisions of title 10, United States Code, the administering Secretaries may agree to include in the demonstration project any of the [Medicare+Choice] *Medicare Part C* plans described in section 1851(a)(2)(A), and such agreement may include an agreement between the Secretary of Defense and the [Medicare+Choice] *Medicare Part C* organization offering such plan to provide medicare health care services to medicare-eligible military retirees or dependents and for such Secretary to receive payments from such organization for the provision of such services.

(i) PAYMENTS BASED ON REGULAR MEDICARE PAYMENT RATES.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, the Secretary shall reimburse the Secretary of Defense for services provided under the demonstration project at a rate equal to 95 percent of the amount paid to a [Medicare+Choice] *Medicare Part C* organization under part C of this title with respect to such an enrollee. In cases in which a payment amount may not otherwise be readily computed, the Secretary shall establish rules for computing equivalent or comparable payment amounts.

* * * * * * *

TITLE XIX—GRANTS TO STATES FOR MEDICAL ASSISTANCE PROGRAMS

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—

(A) review Federal and State payment policies of the Medicaid program established under this title (in this section referred to as "Medicaid") and the State Children's Health Insurance Program established under title XXI (in this section referred to as "CHIP"), including topics described in paragraph (2);

(B) review access to, and affordability of, coverage and services for enrollees under Medicaid and CHIP;

(C) make recommendations to Congress concerning such policies;

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

(E) by not later than June 1 of each year, submit to Congress a report containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

(2) SPECIFIC TOPICS TO BE REVIEWED.—Specifically, the Commission shall review the following:

(A) The factors affecting expenditures for services in different sectors (such as physician, hospital and other sectors), payment methodologies, and their relationship to access and quality of care for Medicaid and CHIP beneficiaries.

(B) The impact of Federal and State Medicaid and CHIP payment policies on access to services (including dental services) for children (including children with disabilities) and other Medicaid and CHIP populations.

(C) The impact of Federal and State Medicaid and CHIP policies on reducing health disparities, including geographic disparities and disparities among minority populations.

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

(E) The relation (if any) between payment rates for providers and improvement in care for children as measured under the children's health quality measurement program established under section 151 of the Children's Health and Medicare Protection Act of 2007.

(F) The affordability, cost effectiveness, and accessibility of services needed by special populations under Medicaid and CHIP as compared with private-sector coverage.

(G) The extent to which the operation of Medicaid and CHIP ensures access, comparable to access under employer-

sponsored or other private health insurance coverage (or in the case of federally-qualified health center services (as defined in section 1905(l)(2)) and rural health clinic services (as defined in section 1905(l)(1)), access comparable to the access to such services under title XIX), for targeted low-income children.

(H) The effect of demonstrations under section 1115, benchmark coverage under section 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.

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

* * * * * * *

STATE PLANS FOR MEDICAL ASSISTANCE

SEC. 1902. (a) A State plan for medical assistance must—

(1) * * *

* * * * * * *

(10) provide—

(A) for making medical assistance available, including at least the care and services listed in paragraphs (1) through (5), (17) and (21) of section 1905(a), to—

(i) * * *

(ii) at the option of the State, to any group or groups of individuals described in section 1905(a) (or, in the case of individuals described in section 1905(a)(i), to any reasonable categories of such individuals) who are not individuals described in clause (i) of this subparagraph but—

(I) * * *

* * * * * * *

(XVIII) who are described in subsection (aa) (relating to certain breast or cervical cancer patients); [or]

(XIX) who are disabled children described in subsection (cc)(1); *or*

(XX) who are described in subsection (ee) (relating to individuals who meet certain income standards);

* * * * * * *

(E)(i) * * *

* * * * * * *

(iv) subject to [sections 1933 and] *section* 1905(p)(4), for making medical assistance available [(but only for premiums payable with respect to months during the period beginning with January 1998, and ending with September 2007)] for medicare cost-sharing described in section 1905(p)(3)(A)(ii) for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) and is at least 120 percent, but less than 135 percent *(or, effective January 1, 2008, 150 percent)*, of the official poverty line (referred to in such section) for a family of the size

involved and who are not otherwise eligible for medical assistance under the State plan;

* * * * * * *

except that (I) the making available of the services described in paragraph (4), (14), or (16) of section 1905(a) to individuals meeting the age requirements prescribed therein shall not, by reason of this paragraph (10), require the making available of any such services, or the making available of such services of the same amount, duration, and scope, to individuals of any other ages, (II) the making available of supplementary medical insurance benefits under part B of title XVIII to individuals eligible therefor (either pursuant to an agreement entered into under section 1843 or by reason of the payment of premiums under such title by the State agency on behalf of such individuals), or provision for meeting part or all of the cost of deductibles, cost sharing, or similar charges under part B of title XVIII for individuals eligible for benefits under such part, shall not, by reason of this paragraph (10), require the making available of any such benefits, or the making available of services of the same amount, duration, and scope, to any other individuals, (III) the making available of medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in clause (A) to any classification of individuals approved by the Secretary with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them, a State supplementary payment shall not, by reason of this paragraph (10), require the making available of any such assistance, or the making available of such assistance of the same amount, duration, and scope, to any other individuals not described in clause (A), (IV) the imposition of a deductible, cost sharing, or similar charge for any item or service furnished to an individual not eligible for the exemption under section 1916(a)(2) or (b)(2) shall not require the imposition of a deductible, cost sharing, or similar charge for the same item or service furnished to an individual who is eligible for such exemption, (V) the making available to pregnant women covered under the plan of services relating to pregnancy (including prenatal, delivery, and postpartum services) or to any other condition which may complicate pregnancy shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any other individuals, provided such services are made available (in the same amount, duration, and scope) to all pregnant women covered under the State plan, (VI) with respect to the making available of medical assistance for hospice care to terminally ill individuals who have made a voluntary election described in section 1905(o) to receive hospice care instead of medical assistance for certain other services, such assistance may not be made available in an amount, duration, or scope less than that provided under title XVIII, and the making available of such assistance shall not, by reason of this paragraph (10), require the making available of medical assistance for hospice care to

other individuals or the making available of medical assistance for services waived by such terminally ill individuals, (VII) the medical assistance made available to an individual described in subsection (l)(1)(A) who is eligible for medical assistance only because of subparagraph (A)(i)(IV) or (A)(ii)(IX) shall be limited to medical assistance for services related to pregnancy (including prenatal, delivery, postpartum, and family planning services) and to other conditions which may complicate pregnancy, (VIII) the medical assistance made available to a qualified medicare beneficiary described in section 1905(p)(1) who is only entitled to medical assistance because the individual is such a beneficiary shall be limited to medical assistance for medicare cost-sharing (described in section 1905(p)(3)), subject to the provisions of subsection (n) and section 1916(b), (IX) the making available of respiratory care services in accordance with subsection (e)(9) shall not, by reason of this paragraph (10), require the making available of such services, or the making available of such services of the same amount, duration, and scope, to any individuals not included under subsection (e)(9)(A), provided such services are made available (in the same amount, duration, and scope) to all individuals described in such subsection, (X) if the plan provides for any fixed durational limit on medical assistance for inpatient hospital services (whether or not such a limit varies by medical condition or diagnosis), the plan must establish exceptions to such a limit for medically necessary inpatient hospital services furnished with respect to individuals under one year of age in a hospital defined under the State plan, pursuant to section 1923(a)(1)(A), as a disproportionate share hospital and subparagraph (B) (relating to comparability) shall not be construed as requiring such an exception for other individuals, services, or hospitals, (XI) the making available of medical assistance to cover the costs of premiums, deductibles, coinsurance, and other cost-sharing obligations for certain individuals for private health coverage as described in section 1906 shall not, by reason of paragraph (10), require the making available of any such benefits or the making available of services of the same amount, duration, and scope of such private coverage to any other individuals, (XII) the medical assistance made available to an individual described in subsection (u)(1) who is eligible for medical assistance only because of subparagraph (F) shall be limited to medical assistance for COBRA continuation premiums (as defined in subsection (u)(2)), (XIII) the medical assistance made available to an individual described in subsection (z)(1) who is eligible for medical assistance only because of subparagraph (A)(ii)(XII) shall be limited to medical assistance for TB-related services (described in subsection (z)(2)), **[**and (XIV)**]** *(XIV)* the medical assistance made available to an individual described in subsection (aa) who is eligible for medical assistance only because of subparagraph (A)(10)(ii)(XVIII) shall be limited to medical assistance provided during the period in which such an individual requires treatment for breast or cervical cancer*, and (XV) the medical assistance made available to an individual described in subsection (ee) shall be lim-*

ited to family planning services and supplies described in section 1905(a)(4)(C) including medical diagnosis or treatment services that are provided pursuant to a family planning service in a family planning setting provided during the period in which such an individual is eligible;

* * * * * * *

(25) provide—

(A) * * *

* * * * * * *

(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, managed care organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to—

(i) provide, with respect to individuals who are eligible *(and, at State option, individuals who are potentially eligible or who apply)* for, or are provided, medical assistance under the State plan *under this title (and, at State option, child health assistance under title XXI)*, upon the request of the State, information to determine during what period the individual or their spouses or their dependents may be (or may have been) covered by a health insurer and the nature of the coverage that is or was provided by the health insurer (including the name, address, and identifying number of the plan) in a manner prescribed by the Secretary;

* * * * * * *

(43) provide for—

(A) * * *

* * * * * * *

(D) reporting to the Secretary (in a uniform form and manner established by the Secretary, by age group and by basis of eligibility for medical assistance, and by not later than April 1 after the end of each fiscal year, beginning with fiscal year 1990) the following information relating to early and periodic screening, diagnostic, and treatment services provided under the plan during each fiscal year:

(i) * * *

* * * * * * *

(iii) the number of children receiving dental services, *and other information relating to the provision of dental services to such children described in section 2108(e)*, and

* * * * * * *

(46)*(A)* provide that information is requested and exchanged for purposes of income and eligibility verification in accordance with a State system which meets the requirements of section 1137 of this Act;

(B) at the option of the State, require that, with respect to a child under 21 years of age (other than an individual described in section 1903(x)(2)) who declares to be a citizen or national of the United States for purposes of establishing initial eligibility for medical assistance under this title (or, at State option, for purposes of renewing or redetermining such eligibility to the extent that such satisfactory documentary evidence of citizenship or nationality has not yet been presented), there is presented satisfactory documentary evidence of citizenship or nationality of the individual (using criteria determined by the State, which shall be no more restrictive than the documentation specified in section 1903(x)(3)); and

(C) comply with the auditing requirements of section 1903(x)(4);

(47) at the option of the State, provide for making ambulatory prenatal care available to pregnant women during a presumptive eligibility period in accordance with section 1920 and provide for making medical assistance for items and services described in subsection (a) of section 1920A available to children during a presumptive eligibility period in accordance with such section and provide for making medical assistance available to individuals described in subsection (a) of section 1920B during a presumptive eligibility period in accordance with such section *and provide for making medical assistance available to individuals described in subsection (a) of section 1920C during a presumptive eligibility period in accordance with such section*;

* * * * * * *

(55) provide for receipt and initial processing of applications of ⟦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)⟧ *children and pregnant women for medical assistance under any provision of this title—*

(A) * * *

(B) using applications which are other than those used for applications for aid under such part*, which need not be the same application form for all such individuals*;

* * * * * * *

(69) provide that the State must comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936; ⟦and⟧

(70) at the option of the State and notwithstanding paragraphs (1), (10)(B), and (23), provide for the establishment of a non-emergency medical transportation brokerage program in order to more cost-effectively provide transportation for individuals eligible for medical assistance under the State plan who need access to medical care or services and have no other means of transportation which—

(A)(i) * * *

* * * * * * *

(iv) complies with such requirements related to prohibitions on referrals and conflict of interest as the Secretary shall establish (based on the prohibitions on physician referrals under section 1877 and such other prohibitions and requirements as the Secretary determines to be appropriate)**[.]***; and*

(71) provide that the State will not prevent a Federally-qualified health center from entering into contractual relationships with private practice dental providers in the provision of Federally-qualified health center services.

* * * * * * *

(b) The Secretary shall approve any plan which fulfills the conditions specified in subsection (a) of this section, except that he shall not approve any plan which imposes, as a condition of eligibility for medical assistance under the plan—

(1) * * *

* * * * * * *

(3) any citizenship requirement which excludes any citizen of the United States *or any citizenship documentation requirement for a child under 21 years of age that is more restrictive than what a State may provide under section 1903(x).*

* * * * * * *

(e)(1)(A) * * *

(B) Subparagraph (A) shall not apply with respect to families that cease to be eligible for aid under part A of title IV during the period beginning on April 1, 1990, and ending on **[**September 30, 2003**]** *September 30, 2009*. During such period, for provisions relating to extension of eligibility for medical assistance for certain families who have received aid pursuant to a State plan approved under part A of title IV and have earned income, see section 1925.

* * * * * * *

(3) At the option of the State, any individual who—

(A) is **[**18 years of age or younger**]** *under 19 years of age (or under such higher age as the State has elected under subsection (l)(1)(D))* and qualifies as a disabled individual under section 1614(a);

* * * * * * *

(4) A child born to a woman eligible for and receiving medical assistance under a State plan on the date of the child's birth shall be deemed to have applied for medical assistance and to have been found eligible for such assistance under such plan on the date of such birth and to remain eligible for such assistance for a period of one year **[**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**]**. During the period in which a child is deemed under the preceding sentence to be eligible for medical assistance, the medical assistance eligibility identification number of the mother shall also serve as the identification number of the child, and all claims shall be submitted and paid under such num-

ber (unless the State issues a separate identification number for the child before such period expires).

* * * * * * *

(12) At the option of the State, the plan may provide that an individual who is under an age specified by the State (not to exceed 19 years of age *or such higher age as the State has elected under subsection (l)(1)(D)*) and who is determined to be eligible for benefits under a State plan approved under this title under subsection (a)(10)(A) shall remain eligible for those benefits until the earlier of—

(A) * * *

* * * * * * *

(13) EXPRESS LANE OPTION.—

(A) IN GENERAL.—

(i) OPTION TO USE A FINDING FROM AN EXPRESS LANE AGENCY.—At the option of the State, the State plan may provide that in determining eligibility under this title for a child (as defined in subparagraph (F)), the State may rely on a finding made within a reasonable period (as determined by the State) from an Express Lane agency (as defined in subparagraph (E)) when it determines whether a child satisfies one or more components of eligibility for medical assistance under this title. The State may rely on a finding from an Express Lane agency notwithstanding sections 1902(a)(46)(B), 1903(x), and 1137(d) and any differences in budget unit, disregard, deeming or other methodology, if the following requirements are met:

(I) PROHIBITION ON DETERMINING CHILDREN INELIGIBLE FOR COVERAGE.— If a finding from an Express Lane agency would result in a determination that a child does not satisfy an eligibility requirement for medical assistance under this title and for child health assistance under title XXI, the State shall determine eligibility for assistance using its regular procedures.

(II) NOTICE REQUIREMENT.—For any child who is found eligible for medical assistance under the State plan under this title or child health assistance under title 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 para-

graph 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—

(i) to limit or prohibit a State from taking any actions otherwise permitted under this title or title XXI in determining eligibility for or enrolling children into medical assistance under this title or child health assistance under title XXI; or

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

(C) OPTIONS FOR SATISFYING THE SCREEN AND ENROLL REQUIREMENT.—

(i) IN GENERAL.—With respect to a child whose eligibility for medical assistance under this title or for child health assistance under title XXI has been evaluated by a State agency using an income finding from an Express Lane agency, a State may carry out its duties under subparagraphs (A) and (B) of section 2102(b)(3) (relating to screen and enroll) in accordance with either clause (ii) or clause (iii).

(ii) ESTABLISHING A SCREENING THRESHOLD.—

(I) IN GENERAL.—Under this clause, the State establishes a screening threshold set as a percentage of the Federal poverty level that exceeds the highest income threshold applicable under this title to the child by a minimum of 30 percentage points or, at State option, a higher number of percentage points that reflects the value (as determined by the State and described in the State plan) of any differences between income methodologies used by the program administered by the Express Lane agency and the methodologies used by the State in determining eligibility for medical assistance under this title.

(II) CHILDREN WITH INCOME NOT ABOVE THRESHOLD.—If the income of a child does not exceed the screening threshold, the child is deemed to satisfy the income eligibility criteria for medical assistance under this title regardless of whether such child would otherwise satisfy such criteria.

(III) CHILDREN WITH INCOME ABOVE THRESHOLD.—If the income of a child exceeds the screening threshold, the 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 differences in cost-sharing requirements and covered benefits.

(iii) TEMPORARY ENROLLMENT IN CHIP PENDING SCREEN AND ENROLL.—

(I) IN GENERAL.—Under this clause, a State enrolls a child in child health assistance under title XXI for a temporary period if the child appears eligible for such assistance based on an income finding by an Express Lane agency.

(II) DETERMINATION OF ELIGIBILITY.—During such temporary enrollment period, the State shall determine the child's eligibility for child health assistance under title XXI or for medical assistance under this title in accordance with this clause.

(III) PROMPT FOLLOW UP.—In making such a determination, the State shall take prompt action to determine whether the child should be enrolled in medical assistance under this title or child health assistance under title XXI pursuant to subparagraphs (A) and (B) of section 2102(b)(3) (relating to screen and enroll).

(IV) REQUIREMENT FOR SIMPLIFIED DETERMINATION.—In making such a determination, the State shall use procedures that, to the maximum feasible extent, reduce the burden imposed on the individual of such determination. Such procedures may not require the child's parent, guardian, or custodial relative to provide or verify information that already has been provided to the State agency by an Express Lane agency or another source of information unless the State agency has reason to believe the information is erroneous.

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

(D) OPTION FOR AUTOMATIC ENROLLMENT.—

(i) IN GENERAL.— At its option, a State may initiate an evaluation of an individual's eligibility 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 informa-

tion 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.

(E) EXPRESS LANE AGENCY DEFINED.—In this paragraph, the term "express lane agency" means an agency that meets the following requirements:

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

(ii) The agency notifies the child (or a parent, caretaker relative, or guardian on the behalf of the child)—

(I) of the information which shall be disclosed;

(II) that the information will be used by the State solely for purposes of determining eligibility for and for providing medical assistance under this title or child health assistance under title XXI; and

(III) that the child, or parent, caretaker relative, or guardian, may elect to not have the information disclosed for such purposes.

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

(iv) The agency is determined by the State agency to be capable of making the determinations described in this paragraph and is identified in the State plan under this title or title XXI.

For purposes of this subparagraph, the term "State agency" refers to the agency determining eligibility for medical assistance under this title or child health assistance under title XXI.

(F) CHILD DEFINED.—For purposes of this paragraph, the term "child" means an individual under 19 years of age, or, at the option of a State, such higher age, not to exceed 21 years of age, as the State may elect.

* * * * * * *

(l)(1) Individuals described in this paragraph are—

(A) * * *

* * * * * * *

(D) children born after September 30, 1983 (or, at the option of a State, after any earlier date), who have attained 6 years of age [but have not attained 19 years of age] *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)*,

who are not described in any of subclauses (I) through (III) of subsection (a)(10)(A)(i) and whose family income does not exceed the income level established by the State under paragraph (2) for a family size equal to the size of the family, including the woman, infant, or child.

* * * * * * *

(dd) ELECTRONIC TRANSMISSION OF INFORMATION.—If the State agency determining eligibility for medical assistance under this title or child health assistance under title XXI verifies an element of eligibility based on information from an Express Lane Agency (as defined in subsection (e)(13)(F)), or from another public agency, then the applicant's signature under penalty of perjury shall not be required as to such element. Any signature requirement for an application for medical assistance may be satisfied through an electronic signature, as defined in section 1710(1) of the Government Paperwork Elimination Act (44 U.S.C. 3504 note). The requirements of subparagraphs (A) and (B) of section 1137(d)(2) may be met through evidence in digital or electronic form.

(ee)(1) Individuals described in this subsection are individuals—

(A) whose income does not exceed an income eligibility level established by the State that does not exceed the highest income eligibility level established under the State plan under this title (or under its State child health plan under title XXI) for pregnant women; and

(B) who are not pregnant.

(2) At the option of a State, individuals described in this subsection may include individuals who are determined to meet the eligibility requirements referred to in paragraph (1) under the terms, conditions, and procedures applicable to making eligibility determinations for medical assistance under this title under a waiver to provide the benefits described in clause (XV) of the matter following subparagraph (G) of section 1902(a)(10) granted to the State under section 1115 as of January 1, 2007.

PAYMENT TO STATES

SEC. 1903. (a) From the sums appropriated therefor, the Secretary (except as otherwise provided in this section) shall pay to each State which has a plan approved under this title, for each quarter, beginning with the quarter commencing January 1, 1966—

(1) * * *

(2)(A) * * *

* * * * * * *

(E) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to translation or interpretation services in connection

with the enrollment and retention under this title of children of families for whom English is not the primary language; plus

* * * * * * *

(i) Payment under the preceding provisions of this section shall not be made—

(1) * * *

* * * * * * *

(22) with respect to amounts expended for medical assistance for an individual *(other than a child under the age of 21)* who declares under section 1137(d)(1)(A) to be a citizen or national of the United States for purposes of establishing eligibility for benefits under this title, unless the requirement of subsection (x) is met.

* * * * * * *

(m)(1)(A) The term "medicaid managed care organization" means a health maintenance organization, an eligible organization with a contract under section 1876 or a [Medicare+Choice] *Medicare Part C* organization with a contract under part C of title XVIII, a provider sponsored organization, or any other public or private organization, which meets the requirement of section 1902(w) and—

(i) * * *

* * * * * * *

(u)(1)(A) * * *

* * * * * * *

(D)(i) * * *

* * * * * * *

(v) In determining the amount of erroneous excess payments, there shall not be included any erroneous payments made for ambulatory prenatal care provided during a presumptive eligibility period (as defined in section 1920(b)(1)), for items and services described in subsection (a) of section 1920A provided to a child during a presumptive eligibility period under such section, [or for] *for* medical assistance provided to an individual described in subsection (a) of section 1920B during a presumptive eligibility period under such section*, or for medical assistance provided to an individual described in subsection (a) of section 1920C during a presumptive eligibility period under such section*.

* * * * * * *

(v)(1) Notwithstanding the preceding provisions of this section, except as provided in [paragraph (2)] *paragraphs (2) and (4)*, no payment may be made to a State under this section for medical assistance furnished to an alien who is not lawfully admitted for permanent residence or otherwise permanently residing in the United States under color of law.

* * * * * * *

(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 otherwise eligible for such assistance, within either or both of the following eligibility categories:

(i) PREGNANT WOMEN.—Women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

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

(B) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of medical assistance to such category and the cost of such assistance shall not be considered as an unreimbursed cost.

* * * * * * *

(x)(1) * * *

(2) The requirement of paragraph (1) shall not apply to an individual declaring to be a citizen or national of the United States who is eligible for medical assistance under this title—

(A) * * *

* * * * * * *

(C) and with respect to whom—

(i) child welfare services are made available under part B of title IV on the basis of being a child in foster care; or

(ii) adoption or foster care assistance is made available under part E of title IV; **[**or**]**

(D) pursuant to the application of section 1902(e)(4) (and, in the case of an individual who is eligible for medical assistance on such basis, the individual shall be deemed to have provided satisfactory documentary evidence of citizenship or nationality and shall not be required to provide further documentary evidence on any date that occurs during or after the period in which the individual is eligible for medical assistance on such basis; or

[(D)**]** *(E)* on such basis as the Secretary may specify under which satisfactory documentary evidence of citizenship or nationality has been previously presented.

(3)(A) * * *

(B) The following are documents described in this subparagraph:

(i) * * *

* * * * * * *

(v) For an individual who is a member of, or enrolled in or affiliated with, a federally-recognized Indian tribe, a document issued by such tribe evidencing such membership, enrollment, or affiliation with the tribe (such as a tribal enrollment card or certificate of degree of Indian blood), and, only with respect to those federally-recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, such other

forms of documentation (including tribal documentation, if appropriate) as the Secretary, after consulting with such tribes, determines to be satisfactory documentary evidence of citizenship or nationality for purposes of satisfying the requirement of this subparagraph.

[(v)**]** *(vi)* Such other document as the Secretary may specify, by regulation, that provides proof of United States citizenship or nationality and that provides a reliable means of documentation of personal identity.

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

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

(C) If the erroneous error rate described in subparagraph (A)—

(i) exceeds 3 percent, the State shall—

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

(II) shall develop a corrective action plan; and

(III) shall conduct another audit the following fiscal year, after the corrective action plan is implemented; or

(ii) does not exceed 3 percent, the State is not required to conduct another audit under subparagraph (A) until the third fiscal year succeeding the fiscal year for which the audit was conducted.

(5) In the case of an individual declaring to be a citizen or national of the United States with respect to whom a State requires the presentation of satisfactory documentary evidence of citizenship or nationality under section 1902(a)(46)(B), the individual shall be provided at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality under this subsection as is provided under clauses (i) and (ii) of section 1137(d)(4)(A) to an individual for the submittal to the State of evidence indicating a satisfactory immigration status and shall not be denied medical assistance on the basis of failure to provide such documentation until the individual has had such an opportunity.

* * * * * * *

DEFINITIONS

SEC. 1905. For purposes of this title—

(a) The term "medical assistance" means payment of part or all of the cost of the following care and services (if provided in or after the third month before the month in which the recipient makes application for assistance or, in the case of medicare cost-sharing with respect to a qualified medicare beneficiary described in subsection (p)(1), if provided after the month in which the individual becomes such a beneficiary) for individuals, and, with respect to physicians' or dentists' services, at the option of the State, to individuals (other than individuals with respect to whom there is being paid, or who are eligible, or would be eligible if they were not in a medical institution, to have paid with respect to them a State supplementary payment and are eligible for medical assistance equal in amount, duration, and scope to the medical assistance made available to individuals described in section 1902(a)(10)(A)) not receiving aid or assistance under any plan of the State approved under title I, X, XIV, or XVI, or part A of title IV, and with respect to whom supplemental security income benefits are not being paid under title XVI, who are—

(i) under the age of 21, or, at the option of the State, under the age of 20, 19, or 18 as the State may choose *or under such higher age as the State has elected under subsection (l)(1)(D)*,

* * * * * * *

(xii) employed individuals with a medically improved disability (as defined in subsection (v)), **[**or**]**

(xiii) individuals described in section 1902(aa), *or*

(xiv) individuals described in section 1902(ee),

but whose income and resources are insufficient to meet all of such cost—

(1) * * *

* * * * * * *

(b) Subject to section **[**1933(d)**]** *1933(b)*, the term "Federal medical assistance percentage" for any State shall be 100 per centum less the State percentage; and the State percentage shall be that percentage which bears the same ratio to 45 per centum as the square of the per capita income of such State bears to the square of the per capita income of the continental United States (including Alaska) and Hawaii; except that (1) the Federal medical assistance percentage shall in no case be less than 50 per centum or more than 83 per centum, (2) the Federal medical assistance percentage for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa shall be 50 per centum, (3) for purposes of this title and title XXI, the Federal medical assistance percentage for the District of Columbia shall be 70 percent, and (4) the Federal medical assistance percentage shall be equal to the enhanced FMAP described in section 2105(b) with respect to medical assistance provided to individuals who are eligible for such assistance only on the basis of section 1902(a)(10)(A)(ii)(XVIII). The Fed-

eral medical assistance percentage for any State shall be determined and promulgated in accordance with the provisions of section 1101(a)(8)(B). Notwithstanding the first sentence of this section, the Federal medical assistance percentage shall be 100 per centum with respect to amounts expended as medical assistance for services which are received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization (as defined in section 4 of the Indian Health Care Improvement Act). Notwithstanding the first sentence of this subsection, in the case of a State plan that meets the condition described in subsection (u)(1), with respect to expenditures (other than expenditures under section 1923) described in subsection (u)(2)(A) or subsection (u)(3) for the State for a fiscal year, and that do not exceed the amount of the State's available allotment under section 2104, the Federal medical assistance percentage is equal to the enhanced FMAP described in section 2105(b).

* * * * * * *

(p)(1) The term "qualified medicare beneficiary" means an individual—

(A) * * *

* * * * * * *

(C) whose resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed twice the maximum amount of resources that an individual may have and obtain benefits under that program*, 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)*.

* * * * * * *

(5)(A) The Secretary shall develop and distribute to States a simplified application form for use by individuals (including both qualified medicare beneficiaries and specified low-income medicare beneficiaries) in applying for medical assistance for medicare cost-sharing under this title in the States which elect to use such form. Such form shall be easily readable by applicants and uniform nationally. *The Secretary shall provide for the translation of such application form into at least the 10 languages (other than English) that are most often used by individuals applying for hospital insurance benefits under section 226 or 226A and shall make the translated forms available to the States and to the Commissioner of Social Security.*

* * * * * * *

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

* * * * * * *

LIENS, ADJUSTMENTS AND RECOVERIES, AND TRANSFERS OF ASSETS

SEC. 1917. (a) * * *

(b)(1) No adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan may be made, except that the State shall seek adjustment or recovery of any medical assistance correctly paid on behalf of an individual under the State plan in the case of the following individuals:

(A) * * *

(B) In the case of an individual who was 55 years of age or older when the individual received such medical assistance, the State shall seek adjustment or recovery from the individual's estate, but only for medical assistance consisting of—

(i) * * *

(ii) at the option of the State, any items or services under the State plan *(but not including medical assistance for medicare cost-sharing or for benefits described in section 1902(a)(10)(E))*.

* * * * * * *

PRESUMPTIVE ELIGIBILITY FOR PREGNANT WOMEN

SEC. 1920. (a) * * *

(b) For purposes of this section—

(1) * * *

(2) the term "qualified provider" means any provider that—

(A) * * *

* * * * * * *

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

PRESUMPTIVE ELIGIBILITY FOR CHILDREN

SEC. 1920A. (a) * * *

(b) For purposes of this section:

(1) The term "child" means an individual under 19 years of age *or under such higher age as the State has elected under section 1902(l)(1)(D)*.

* * * * * * *

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 1902(ee), such medical assistance shall be limited to family planning services and supplies described in 1905(a)(4)(C) and, at the State's option, medical diagnosis or treatment services that are provided in conjunction with a family planning service in a family planning setting provided during the period in which such an individual is eligible.

(b) DEFINITIONS.—For purposes of this section:

(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The term "presumptive eligibility period" means, with respect to an individual described in subsection (a), the period that—

(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(ee); and

(B) ends with (and includes) the earlier of—

(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

(2) QUALIFIED ENTITY.—

(A) IN GENERAL.—Subject to subparagraph (B), the term "qualified entity" means any entity that—

(i) is eligible for payments under a State plan approved under this title; and

(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities in order to prevent fraud and abuse.

(c) ADMINISTRATION.—

(1) IN GENERAL.—The State agency shall provide qualified entities with—

(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

(B) information on how to assist such individuals in completing and filing such forms.

(2) NOTIFICATION REQUIREMENTS.—A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

(B) inform such individual at the time the determination is made that an application for medical assistance is required to be made by not later than the last day of the month following the month during which the determination is made.

(3) APPLICATION FOR MEDICAL ASSISTANCE.—In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance by not later than the last day of the month following the month during which the determination is made.

(d) PAYMENT.—Notwithstanding any other provision of this title, medical assistance that—

(1) is furnished to an individual described in subsection (a)—

(A) during a presumptive eligibility period;

(B) by a entity that is eligible for payments under the State plan; and

(2) is included in the care and services covered by the State plan, shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b).

* * * * * * *

TREATMENT OF INCOME AND RESOURCES FOR CERTAIN INSTITUTIONALIZED SPOUSES

SEC. 1924. (a) * * *

* * * * * * *

(h) DEFINITIONS.—In this section:

(1) The term "institutionalized spouse" means an individual who—

(A) is in a medical institution or nursing facility or who (at the option of the State) [is described in section 1902(a)(10)(A)(ii)(VI)] *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*, and

* * * * * * *

EXTENSION OF ELIGIBILITY FOR MEDICAL ASSISTANCE

SEC. 1925. (a) INITIAL 6-MONTH EXTENSION.—

(1) REQUIREMENT.—

(A) IN GENERAL.—Notwithstanding any other provision of this title *but subject to subparagraph (B) and paragraph (5)*, each State plan approved under this title must provide that each family which was receiving aid pursuant to a plan of the State approved under part A of title IV in at least 3 of the 6 months immediately preceding the month in which such family becomes ineligible for such aid, because of hours of, or income from, employment of the caretaker relative (as defined in subsection (e)) or because of section 402(a)(8)(B)(ii)(II) (providing for a time-limited earned income disregard), shall, subject to paragraph (3) and without any reapplication for benefits under the plan, remain eligible for assistance under the plan approved under this title during the immediately succeeding 6-month period in accordance with this subsection.

(B) STATE OPTION TO WAIVE REQUIREMENT FOR 3 MONTHS BEFORE RECEIPT OF MEDICAL ASSISTANCE.—A State may, at its option, elect also to apply subparagraph (A) in the case of a family that was receiving such aid for fewer than three months or that had applied for and was eligible for such

aid for fewer than 3 months during the 6 immediately preceding months described in such subparagraph.

* * * * * * *

(5) OPTION OF 12-MONTH INITIAL ELIGIBILITY PERIOD.—A State may elect to treat any reference in this subsection to a 6-month period (or 6 months) as a reference to a 12-month period (or 12 months). In the case of such an election, subsection (b) shall not apply.

(b) ADDITIONAL 6-MONTH EXTENSION.—

(1) REQUIREMENT.—Notwithstanding any other provision of this title *but subject to subsection (a)(5)*, each State plan approved under this title shall provide that the State shall offer to each family, which has received assistance during the entire 6-month period under subsection (a) and which meets the requirement of paragraph (2)(B)(i), in the last month of the period the option of extending coverage under this subsection for the succeeding 6-month period, subject to paragraph (3).

* * * * * * *

(f) SUNSET.—This section shall not apply with respect to families that cease to be eligible for aid under part A of title IV after [September 30, 2003] *September 30, 2009*.

(g) COLLECTION AND REPORTING OF PARTICIPATION INFORMATION.—

(1) COLLECTION OF INFORMATION FROM STATES.—Each State shall collect and submit to the Secretary (and make publicly available), in a format specified by the Secretary, information on average monthly enrollment and average monthly participation rates for adults and children under this section and of the number and percentage of children who become ineligible for medical assistance under this section whose medical assistance is continued under another eligibility category or who are enrolled under the State's child health plan under title XXI. Such information shall be submitted at the same time and frequency in which other enrollment information under this title is submitted to the Secretary.

(2) ANNUAL REPORTS TO CONGRESS.—Using the information submitted under paragraph (1), the Secretary shall submit to Congress annual reports concerning enrollment and participation rates described in such paragraph.

PAYMENT FOR COVERED OUTPATIENT DRUGS

SEC. 1927. (a) * * *

* * * * * * *

(c) DETERMINATION OF AMOUNT OF REBATE.—

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

(A) * * *

(B) RANGE OF REBATES REQUIRED.—

(i) MINIMUM REBATE PERCENTAGE.—For purposes of subparagraph (A)(ii)(II), the "minimum rebate percentage" for rebate periods beginning—

(I) * * *

* * * * * * *

(IV) after December 31, 1994, and before January 1, 1996, is 15.2 percent; [and]

(V) after December 31, 1995, *and before January 1, 2008,* is 15.1 percent[.]*; and*

(VI) after December 31, 2007, is 20.1 percent.

* * * * * * *

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

(i) * * *

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

(I) shall be inclusive of cash discounts, free goods that are contingent on any purchase requirement, volume discounts, [and] rebates (other than rebates under this section)*, and rebates, discounts, and other price concessions to pharmaceutical benefit managers (PBMs)*;

* * * * * * *

PROGRAM FOR DISTRIBUTION OF PEDIATRIC VACCINES

SEC. 1928. (a) * * *

* * * * * * *

(h) DEFINITIONS.—For purposes of this section:

(1) The term "child" means an individual [18 years of age or younger] *under 19 years of age or under such higher age as the State has elected under section 1902(l)(1)(D).*

* * * * * * *

PROVISIONS RELATING TO MANAGED CARE

SEC. 1932. (a) STATE OPTION TO USE MANAGED CARE.—

(1) * * *

(2) SPECIAL RULES.—

(A) EXEMPTION OF CERTAIN CHILDREN WITH SPECIAL NEEDS.—A State may not require under paragraph (1) the enrollment in a managed care entity of an individual under 19 years of age *(or under such higher age as the State has elected under section 1902(l)(1)(D))* who—

(i) * * *

* * * * * * *

(b) BENEFICIARY PROTECTIONS.—

(1) * * *

(2) ASSURING COVERAGE TO EMERGENCY SERVICES.—

(A) IN GENERAL.—Each contract with a medicaid managed care organization under section 1903(m) and each contract with a primary care case manager under section 1905(t)(3) shall require the organization or manager—

(i) * * *

(ii) to comply with guidelines established under section 1852(d)(2) (respecting coordination of post-stabilization care) in the same manner as such guidelines

apply to [Medicare+Choice] *Medicare Part C* plans offered under part C of title XVIII.

* * * * * * *

(c) QUALITY ASSURANCE STANDARDS.—

(1) * * *

(2) EXTERNAL INDEPENDENT REVIEW OF MANAGED CARE ACTIVITIES.—

(A) * * *

* * * * * * *

(C) DEEMED COMPLIANCE FOR MEDICARE MANAGED CARE ORGANIZATIONS.—At the option of a State, the requirements of subparagraph (A) shall not apply with respect to a medicaid managed care organization if the organization is an eligible organization with a contract in effect under section 1876 or a [Medicare+Choice] *Medicare Part C* organization with a contract in effect under part C of title XVIII and the organization has had a contract in effect under section 1903(m) at least during the previous 2-year period.

* * * * * * *

STATE COVERAGE OF MEDICARE COST-SHARING FOR ADDITIONAL LOW-INCOME MEDICARE BENEFICIARIES

SEC. 1933. (a) IN GENERAL.—A State plan under this title shall provide, under section 1902(a)(10)(E)(iv) and subject to the succeeding provisions of this section and through a plan amendment, for medical assistance for payment of the cost of medicare cost-sharing described in such section on behalf of all individuals described in such section (in this section referred to as "qualifying individuals") [who are selected to receive such assistance under subsection (b)].

[(b) SELECTION OF QUALIFYING INDIVIDUALS.—A State shall select qualifying individuals, and provide such individuals with assistance, under this section consistent with the following:

[(1) ALL QUALIFYING INDIVIDUALS MAY APPLY.—The State shall permit all qualifying individuals to apply for assistance during a calendar year.

[(2) SELECTION ON FIRST-COME, FIRST-SERVED BASIS.—

[(A) IN GENERAL.—For each calendar year (beginning with 1998), from (and to the extent of) the amount of the allocation under subsection (c) for the State for the fiscal year ending in such calendar year, the State shall select qualifying individuals who apply for the assistance in the order in which they apply.

[(B) CARRYOVER.—For calendar years after 1998, the State shall give preference to individuals who were provided such assistance (or other assistance described in section 1902(a)(10)(E)) in the last month of the previous year and who continue to be (or become) qualifying individuals.

[(3) LIMIT ON NUMBER OF INDIVIDUALS BASED ON ALLOCATION.—The State shall limit the number of qualifying individuals selected with respect to assistance in a calendar year so

that the aggregate amount of such assistance provided to such individuals in such year is estimated to be equal to (but not exceed) the State's allocation under subsection (c) for the fiscal year ending in such calendar year.

[(4) RECEIPT OF ASSISTANCE DURING DURATION OF YEAR.—If a qualifying individual is selected to receive assistance under this section for a month in a year, the individual is entitled to receive such assistance for the remainder of the year if the individual continues to be a qualifying individual. The fact that an individual is selected to receive assistance under this section at any time during a year does not entitle the individual to continued assistance for any succeeding year.

[(c) ALLOCATION.—

[(1) TOTAL ALLOCATION.—The total amount available for allocation under this section for—

[(A) fiscal year 1998 is $200,000,000;

[(B) fiscal year 1999 is $250,000,000;

[(C) fiscal year 2000 is $300,000,000;

[(D) fiscal year 2001 is $350,000,000; and

[(E) each of fiscal years 2002 and 2003 is $400,000,000.

[(2) ALLOCATION TO STATES.—The Secretary shall provide for the allocation of the total amount described in paragraph (1) for a fiscal year, among the States that executed a plan amendment in accordance with subsection (a), based upon the Secretary's estimate of the ratio of—

[(A) an amount equal to the the total number of individuals described in section 1902(a)(10)(E)(iv) in the State; to

[(B) the sum of the amounts computed under subparagraph (A) for all eligible States.]

[(d)] *(b)* APPLICABLE FMAP.—With respect to assistance described in section 1902(a)(10)(E)(iv) [furnished in a State for calendar quarters in a calendar year—

[(1) to the extent that such assistance does not exceed the State's allocation under subsection (c) for the fiscal year ending in the calendar year, the Federal medical assistance percentage shall be equal to 100 percent; and

[(2) to the extent that such assistance exceeds such allocation, the Federal medical assistance percentage is 0 percent.] *the Federal medical assistance percentage shall be equal to 100 percent.*

[(e) LIMITATION ON ENTITLEMENT.—Except as specifically provided under this section, nothing in this title shall be construed as establishing any entitlement of individuals described in section 1902(a)(10)(E)(iv) to assistance described in such section.]

[(f)] *(c)* COVERAGE OF COSTS THROUGH PART B OF THE MEDICARE PROGRAM.—For each fiscal year, the Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund under section 1841 to the appropriate account in the Treasury that provides for payments under section 1903(a) with respect to medical assistance provided under this section, of an amount equivalent to the total of the amount of payments made under such section that is attributable to this section and such transfer shall be treated as an expenditure from such Trust Fund for purposes of section 1839.

[(g) SPECIAL RULES.—

[(1) IN GENERAL.—With respect to each period described in paragraph (2), a State shall select qualifying individuals, subject to paragraph (3), and provide such individuals with assistance, in accordance with the provisions of this section as in effect with respect to calendar year 2003, except that for such purpose—

[(A) references in the preceding subsections of this section to a year, whether fiscal or calendar, shall be deemed to be references to such period; and

[(B) the total allocation amount under subsection (c) for such period shall be the amount described in paragraph (2) for that period.

[(2) PERIODS AND TOTAL ALLOCATION AMOUNTS DESCRIBED.—For purposes of this subsection—

[(A) for the period that begins on January 1, 2004, and ends on September 30, 2004, the total allocation amount is $300,000,000;

[(B) for the period that begins on October 1, 2004, and ends on December 31, 2004, the total allocation amount is $100,000,000;

[(C) for the period that begins on January 1, 2005, and ends on September 30, 2005, the total allocation amount is $300,000,000;

[(D) for the period that begins on October 1, 2005, and ends on December 31, 2005, the total allocation amount is $100,000,000;

[(E) for the period that begins on January 1, 2006, and ends on September 30, 2006, the total allocation amount is $300,000,000;

[(F) for the period that begins on October 1, 2006, and ends on December 31, 2006, the total allocation amount is $100,000,000; and

[(G) for the period that begins on January 1, 2007, and ends on September 30, 2007, the total allocation amount is $300,000,000.

[(3) RULES FOR PERIODS THAT BEGIN AFTER JANUARY 1.—For any specific period described in subparagraph (B), (D), or (F) of paragraph (2), the following applies:

[(A) The specific period shall be treated as a continuation of the immediately preceding period in that calendar year for purposes of applying subsection (b)(2) and qualifying individuals who received assistance in the last month of such immediately preceding period shall be deemed to be selected for the specific period (without the need to complete an application for assistance for such period).

[(B) The limit to be applied under subsection (b)(3) for the specific period shall be the same as the limit applied under such subsection for the immediately preceding period.

[(C) The ratio to be applied under subsection (c)(2) for the specific period shall be the same as the ratio applied under such subsection for the immediately preceding period.]

PROGRAM OF ALL-INCLUSIVE CARE FOR THE ELDERLY (PACE)

SEC. 1934. (a) * * *

(b) SCOPE OF BENEFITS; BENEFICIARY SAFEGUARDS.—

(1) * * *

* * * * * * *

(3) TREATMENT OF MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—

(A) APPLICATION OF MEDICARE ADVANTAGE REQUIREMENT WITH RESPECT TO MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—Section 1852(k)(1) (relating to limitations on balance billing against [MA] *Medicare Part C* organizations for noncontract physicians and other entities with respect to services covered under title XVIII) shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract or other agreement establishing payment amounts for services furnished to such an individual in the same manner as such section applies to [MA] *Medicare Part C* organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

* * * * * * *

(e) PACE PROGRAM AGREEMENT.—

(1) * * *

* * * * * * *

(7) PROCEDURES FOR TERMINATION OR IMPOSITION OF SANCTIONS.—Under regulations, the provisions of section 1857(h) (or for periods before January 1, 1999, section 1876(i)(9)) shall apply to termination and sanctions respecting a PACE program agreement and PACE provider under this subsection in the same manner as they apply to a termination and sanctions with respect to a contract and a [Medicare+Choice] *Medicare Part C* organization under part C of title XVIII (or for such periods an eligible organization under section 1876).

* * * * * * *

(f) REGULATIONS.—

(1) * * *

* * * * * * *

(3) APPLICATION OF CERTAIN ADDITIONAL BENEFICIARY AND PROGRAM PROTECTIONS.—

(A) IN GENERAL.—In issuing such regulations and subject to subparagraph (B), the Secretary may apply with respect to PACE programs, providers, and agreements such requirements of part C of title XVIII (or, for periods before January 1, 1999, section 1876) and sections 1903(m) and 1932 relating to protection of beneficiaries and program integrity as would apply to [Medicare+Choice] *Medicare Part C* organizations under such part C (or for such periods eligible organizations under risk-sharing contracts under section 1876) and to medicaid managed care organi-

zations under prepaid capitation agreements under section 1903(m).

* * * * * * *

SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

SEC. 1935. (a) REQUIREMENTS RELATING TO MEDICARE PRESCRIPTION DRUG LOW-INCOME SUBSIDIES AND MEDICARE TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE.—As a condition of its State plan under this title under section 1902(a)(66) and receipt of any Federal financial assistance under section 1903(a) subject to subsection (e), a State shall do the following:

(1) * * *

* * * * * * *

(4) CONSIDERATION OF MSP APPLICATIONS.—The State shall accept medicare savings program applications transmitted under section 1144(c)(3) and act on such applications in the same manner and deadlines as if they had been submitted directly by the applicant.

* * * * * * *

STATE FLEXIBILITY IN BENEFIT PACKAGES

SEC. 1937. (a) STATE OPTION OF PROVIDING BENCHMARK BENEFITS.—

(1) AUTHORITY.—

(A) IN GENERAL.—[Notwithstanding any other provision of this title] *Subject to subparagraph (E)*, a State, at its option as a State plan amendment, may provide for medical assistance under this title to individuals within one or more groups of individuals specified by the State through [enrollment in coverage that provides—

[(i) benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2); and

[(ii) for any child under 19 years of age who is covered under the State plan under section 1902(a)(10)(A), wrap-around benefits to the benchmark coverage or benchmark equivalent coverage consisting of early and periodic screening, diagnostic, and treatment services defined in section 1905(r).] *benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2).*

* * * * * * *

[(C) OPTION OF WRAP-AROUND BENEFITS.—In the case of coverage described in subparagraph (A), a State, at its option, may provide such wrap-around or additional benefits as the State may specify.]

(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 bench-

mark equivalent coverage described in subsection (b)(2) as the State may specify.

* * * * * * *

(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) APPLICATION.—

(A) * * *

* * * * * * *

(B) LIMITATION ON APPLICATION.—A State may not require under subparagraph (A) an individual to obtain benefits through enrollment described in paragraph (1)(A) if the individual is within one of the following categories of individuals:

(i) * * *

* * * * * * *

(viii) CHILDREN IN FOSTER CARE RECEIVING CHILD WELFARE SERVICES AND CHILDREN RECEIVING FOSTER CARE OR ADOPTION ASSISTANCE.—The individual is an individual with respect to whom [aid or assistance is made available under part B of title IV to children in foster care] *child welfare services are made available under part B of title IV on the basis of being a child in foster care* and individuals with respect to whom adoption or foster care assistance is made available under part E of such title, without regard to age.

* * * * * * *

(b) BENCHMARK BENEFIT PACKAGES.—

(1) IN GENERAL.—For purposes of subsection (a)(1), each of the following coverages shall be considered to be benchmark coverage:

(A) * * *

(B) STATE EMPLOYEE COVERAGE.—A health benefits coverage plan that is offered and generally available to State employees in the State involved *and that has been selected most frequently, by employees seeking dependent coverage, among such plans that provide such dependent coverage, in either of the previous 2 plan years.*

* * * * * * *

(D) SECRETARY-APPROVED COVERAGE.—Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population proposed to be provided such coverage *if the health benefits coverage is at least equivalent to the benefits coverage in benchmark coverage described in subparagraph (A), (B), or (C).*

* * * * * * *

(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.

* * * * * * *

SEC. 1939. AUTHORIZATION TO RECEIVE PERTINENT INFORMATION.

(a) IN GENERAL.—Notwithstanding any other provision of law, a Federal or State agency or private entity in possession of the sources of data potentially pertinent to eligibility determinations under this title (including eligibility files maintained by Express Lane agencies described in section 1902(e)(13)(F), information described in paragraph (2) or (3) of section 1137(a), vital records information about births in any State, and information described in sections 453(i) and 1902(a)(25)(I)) is authorized to convey such data or information to the State agency administering the State plan under this title, to the extent such conveyance meets the requirements of subsection (b).

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

(1) The individual whose circumstances are described in the data or information (or such individual's parent, guardian, caretaker relative, or authorized representative) has either provided advance consent to disclosure or has not objected to disclosure after receiving advance notice of disclosure and a reasonable opportunity to object.

(2) Such data or information are used solely for the purposes of—

(A) identifying individuals who are eligible or potentially eligible for medical assistance under this title and enrolling or attempting to enroll such individuals in the State plan; and

(B) verifying the eligibility of individuals for medical assistance under the State plan.

(3) An interagency or other agreement, consistent with standards developed by the Secretary—

(A) prevents the unauthorized use, disclosure, or modification of such data and otherwise meets applicable Federal requirements safeguarding privacy and data security; and

(B) requires the State agency administering the State plan to use the data and information obtained under this section to seek to enroll individuals in the plan.

(c) CRIMINAL PENALTY.—A private entity described in the subsection (a) that publishes, discloses, or makes known in any manner, or to any extent not authorized by Federal law, any information obtained under this section 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).

REFERENCES TO LAWS DIRECTLY AFFECTING MEDICAID PROGRAM

SEC. [1939.] *1940.* (a) * * *

* * * * * * *

TITLE XXI—STATE CHILDREN'S HEALTH INSURANCE PROGRAM

* * * * * * *

SEC. 2102. GENERAL CONTENTS OF STATE CHILD HEALTH PLAN; ELIGIBILITY; OUTREACH.

(a) GENERAL BACKGROUND AND DESCRIPTION.—A State child health plan shall include a description, consistent with the requirements of this title, of—

(1) * * *

* * * * * * *

(7) methods (including monitoring) used—

(A) * * *

(B) to assure access to covered services, including emergency services *and services described in section 2103(c)(5)*.

* * * * * * *

(c) OUTREACH AND COORDINATION.—A State child health plan shall include a description of the procedures to be used by the State to accomplish the following:

(1) OUTREACH.—Outreach *(through community health workers and others)* to families of children likely to be eligible for child health assistance under the plan or under other public or private health coverage programs to inform these families of the availability of, and to assist them in enrolling their children in, such a program.

* * * * * * *

(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.

SEC. 2103. COVERAGE REQUIREMENTS FOR CHILDREN'S HEALTH INSURANCE.

(a) REQUIRED SCOPE OF HEALTH INSURANCE COVERAGE.—The child health assistance provided to a targeted low-income child under the plan in the form described in paragraph (1) of section 2101(a) shall consist, consistent with ⟦subsection (c)(5)⟧ *paragraphs (5) and (6) of subsection (c)*, of any of the following:

(1) BENCHMARK COVERAGE.—Health benefits coverage that is *at least* equivalent to the benefits coverage in a benchmark benefit package described in subsection (b).

(2) BENCHMARK-EQUIVALENT COVERAGE.—Health benefits coverage that meets the following requirements:

(A) * * *

* * * * * * *

(C) SUBSTANTIAL ACTUARIAL VALUE FOR ADDITIONAL SERVICES INCLUDED IN BENCHMARK PACKAGE.—With respect to each of the categories of additional services described in subsection (c)(2) for which coverage is provided under the benchmark benefit package used under subparagraph (B), the coverage has an actuarial value that is equal to at least 75 percent *(or 100 percent in the case of the category of services described in subparagraph (B) of such subsection)* of the actuarial value of the coverage of that category of services in such package.

* * * * * * *

(4) SECRETARY-APPROVED COVERAGE.—Any other health benefits coverage that the Secretary determines, upon application by a State, provides appropriate coverage for the population of targeted low-income children proposed to be provided such coverage *if the health benefits coverage is at least equivalent to the benefits coverage in a benchmark benefit package described in subsection (b)*.

(b) BENCHMARK BENEFIT PACKAGES.—The benchmark benefit packages are as follows:

(1) * * *

(2) STATE EMPLOYEE COVERAGE.—A health benefits coverage plan that is offered and generally available to State employees in the State involved *and that has been selected most frequently by employees seeking dependent coverage, among such plans that provide such dependent coverage, in either of the previous 2 plan years*.

* * * * * * *

(c) CATEGORIES OF SERVICES; DETERMINATION OF ACTUARIAL VALUE OF COVERAGE.—

(1) * * *

* * * * * * *

(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.

[(5)**]** *(6)* CONSTRUCTION ON PROHIBITED COVERAGE.—Nothing in this section shall be construed as requiring any health benefits coverage offered under the plan to provide coverage for items or services for which payment is prohibited under this title, notwithstanding that any benchmark benefit package includes coverage for such an item or service.

* * * * * * *

(e) COST-SHARING.—

(1) * * *

* * * * * * *

(3) LIMITATIONS ON PREMIUMS AND COST-SHARING.—

(A) * * *

* * * * * * *

(C) PREMIUM GRACE PERIOD.—The State child health plan—

(i) shall afford individuals enrolled under the plan a grace period of at least 30 days from the beginning of a new coverage period to make premium payments before the individual's coverage under the plan may be terminated; and

(ii) shall provide to such an individual, not later than 7 days after the first day of such grace period, notice—

(I) that failure to make a premium payment within the grace period will result in termination of coverage under the State child health 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.

* * * * * * *

(f) APPLICATION OF CERTAIN REQUIREMENTS.—

(1) * * *

* * * * * * *

(3) COMPLIANCE WITH MANAGED CARE REQUIREMENTS.—The State child health plan shall provide for the application of subsections (a)(4), (a)(5), (b), (c), (d), and (e) of section 1932 (relat-

ing to requirements for managed care) to coverage, State agencies, enrollment brokers, managed care entities, and managed care organizations under this title in the same manner as such subsections apply to coverage and such entities and organizations under title XIX.

SEC. 2104. ALLOTMENTS.

(a) APPROPRIATION; TOTAL ALLOTMENT.—For the purpose of providing allotments to States under this section, subject to subsection (d), there is appropriated, out of any money in the Treasury not otherwise appropriated—

(1) * * *

* * * * * * *

(9) for fiscal year 2006, $4,050,000,000; **[**and**]**

(10) for fiscal year 2007, $5,000,000,000**[**.**]***; and*

(11) for fiscal year 2008 and each succeeding fiscal year, the sum of the State allotments provided under subsection (i) for such fiscal year plus for fiscal year 2009 the total of the amount specified in subsection (j).

(b) ALLOTMENTS TO 50 STATES AND DISTRICT OF COLUMBIA.—

(1) IN GENERAL.—Subject to paragraph (4) and **[**subsection (d)**]** *subsections (d) and (i)*, of the amount available for allotment under subsection (a) for a fiscal year, reduced by the amount of allotments made under subsection (c) (determined without regard to paragraph (4) thereof) for the fiscal year, the Secretary shall allot to each State (other than a State described in such subsection) with a State child health plan approved under this title the same proportion as the ratio of—

(A) * * *

* * * * * * *

(c) ALLOTMENTS TO TERRITORIES.—

(1) IN GENERAL.—Of the amount available for allotment under subsection (a) for a fiscal year, subject to **[**subsection (d)**]** *subsections (d) and (i)*, the Secretary shall allot 0.25 percent among each of the commonwealths and territories described in paragraph (3) in the same proportion as the percentage specified in paragraph (2) for such commonwealth or territory bears to the sum of such percentages for all such commonwealths or territories so described.

* * * * * * *

[(e) 3-YEAR AVAILABILITY OF AMOUNTS ALLOTTED.—Amounts allotted to a State pursuant to this section for a fiscal year shall remain available for expenditure by the State through the end of the second succeeding fiscal year; except that amounts reallotted to a State under subsection (f) shall be available for expenditure by the State through the end of the fiscal year in which they are reallotted.**]**

(e) AVAILABILITY OF AMOUNTS ALLOTTED.—

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

(A) for each of fiscal years 1998 through 2007, shall remain available for expenditure by the State through the end of the second succeeding fiscal year; and

(B) for fiscal year 2008 and each fiscal year thereafter, shall remain available for expenditure by the State through the end of the succeeding fiscal year.

(2) AVAILABILITY OF AMOUNTS REDISTRIBUTED.—Amounts redistributed to a State under subsection (f) shall be available for expenditure by the State through the end of the fiscal year in which they are redistributed, except that funds so redistributed 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.

(f) PROCEDURE FOR REDISTRIBUTION OF UNUSED ALLOTMENTS.—[The Secretary]

(1) IN GENERAL.—The Secretary shall determine an appropriate procedure for redistribution of allotments from States that were provided allotments under this section for a fiscal year but that do not expend all of the amount of such allotments during the period in which such allotments are available for expenditure under subsection (e), to [States that have fully expended the amount of their allotments under this section.] *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.*

(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.

* * * * * * *

(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 section 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 enrolled under the State plan under this title (including children receiving health care coverage through funds under this title pursuant to a waiver under section 1115) during such fiscal year exceeds its target average number of such enrollees (as determined under subparagraph (B)) for that fiscal year, the allotment under this section for the State for the subsequent fiscal year (or, pursuant to subparagraph (F), for the fiscal year involved) shall be increased by the product of—

(i) the amount by which such average monthly caseload exceeds such target number of enrollees; and

(ii) the projected per capita expenditures under the State child health plan (as determined under subparagraph (C) for the original fiscal year involved), multiplied by the enhanced FMAP (as defined in section 2105(b)) for the State and fiscal year involved

(B) TARGET AVERAGE NUMBER OF CHILD ENROLLEES.—In this subsection, the target average number of child enrollees for a State—

(i) for fiscal year 2008 is equal to the monthly average unduplicated number of children enrolled in the State child health plan under this title (including such children receiving health care coverage through funds under this title pursuant to a waiver under section 1115) 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 target average number of child enrollees for the State for the previous fiscal year increased by the population growth for children in that State for the year ending on June 30 before the beginning of the fiscal year (as estimated by the Bureau of the Census) plus 1 percentage point.

(C) PROJECTED PER CAPITA EXPENDITURES.—For purposes of subparagraph (A)(ii), the projected per capita expenditures under a State child health plan—

(i) for fiscal year 2008 is equal to the average per capita expenditures (including both State and Federal financial participation) under such plan for the targeted low-income children counted in the average monthly caseload for purposes of this paragraph during fiscal year 2007, increased by the annual percentage increase in the per capita amount of National Health Expenditures (as estimated by the Secretary) for 2008; or

(ii) for a subsequent fiscal year is equal to the projected per capita expenditures under such plan for the previous fiscal year (as determined under clause (i) or this clause) increased by the annual percentage increase in the per capita amount of National Health Expenditures (as estimated by the Secretary) for the year in which such subsequent fiscal year ends.

(D) AVAILABILITY.—Notwithstanding subsection (e), an increase in allotment under this paragraph shall only be available for expenditure during the fiscal year in which it is provided.

(E) NO REDISTRIBUTION OF PERFORMANCE-BASED SHORTFALL ADJUSTMENT.—In no case shall any increase in allotment under this paragraph for a State be subject to redistribution to other States.

(F) INTERIM ALLOTMENT ADJUSTMENT.—The Secretary shall develop a process to administer the performance-based shortfall adjustment in a manner so it is applied to (and before the end of) the fiscal year (rather than the subsequent fiscal year) involved for a State that the Secretary estimates will be in shortfall and will exceed its enrollment target for that fiscal year.

(G) PERIODIC AUDITING.—The Comptroller General of the United States shall periodically audit the accuracy of data used in the computation of allotment adjustments under this paragraph. Based on such audits, the Comptroller General shall make such recommendations to the Congress and the Secretary as the Comptroller General deems appropriate.

(4) CONTINUED REPORTING.—For purposes of paragraph (3) and subsection (f), the State shall submit to the Secretary the State's projected Federal expenditures, even if the amount of such expenditures exceeds the total amount of allotments available to the State in such fiscal year.

(j) FUNDING FOR DIABETES GRANTS.—From the amounts appropriated under subsection (a)(11), for fiscal year 2009 from the amounts—

(1) $150,000,000 is hereby transferred and made available in such fiscal year for grants under section 330B of the Public Health Service Act; and

(2) $150,000,000 is hereby transferred and made available in such fiscal year for grants under section 330C of such Act.

SEC. 2105. PAYMENTS TO STATES.

(a) PAYMENTS.—

(1) * * *

* * * * * * *

(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.

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

(i) FOR ABOVE BASELINE MEDICAID CHILD ENROLLMENT COSTS.—

(I) FIRST TIER ABOVE BASELINE MEDICAID ENROLLEES.—An amount equal to the number of first tier above baseline child enrollees (as determined under subparagraph (C)(i)) under title XIX for the State and fiscal year multiplied by 35 percent of the projected per capita State Medicaid expenditures (as determined under subparagraph (D)(i)) for the State and fiscal year under title XIX.

(II) SECOND TIER ABOVE BASELINE MEDICAID ENROLLEES.—An amount equal to the number of second tier above baseline child enrollees (as determined under subparagraph (C)(ii)) under title XIX for the State and fiscal year multiplied by 90 percent of the projected per capita State Medicaid expenditures (as determined under subparagraph (D)(i)) for the State and fiscal year under title XIX.

(ii) FOR ABOVE BASELINE CHIP ENROLLMENT COSTS.—

(I) FIRST TIER ABOVE BASELINE CHIP ENROLLEES.—An amount equal to the number of first tier above baseline child enrollees under this title (as determined under subparagraph (C)(i)) for the State and fiscal year multiplied by 5 percent of the projected per capita State CHIP expenditures (as

determined under subparagraph (D)(ii)) for the State and fiscal year under this title.

(II) SECOND TIER ABOVE BASELINE CHIP ENROLLEES.—An amount equal to the number of second tier above baseline child enrollees under this title (as determined under subparagraph (C)(ii)) for the State and fiscal year multiplied by 75 percent of the projected per capita State CHIP expenditures (as determined under subparagraph (D)(ii)) for the State and fiscal year under this title.

(C) NUMBER OF FIRST AND SECOND TIER ABOVE BASELINE CHILD ENROLLEES; BASELINE NUMBER OF CHILD ENROLLEES.—For purposes of this paragraph:

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

(I) the monthly average unduplicated number of qualifying children (as defined in subparagraph (E)) enrolled during the fiscal year under the State child health plan under this title or under the State plan under title XIX, respectively; exceeds

(II) the baseline number of enrollees described in clause (iii) for the State and fiscal year under this title or title XIX, respectively;

but not to exceed 3 percent (in the case of title XIX) or 7.5 percent (in the case of this title) of the baseline number of enrollees described in subclause (II).

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

(I) the monthly average unduplicated number of qualifying children (as defined in subparagraph (E)) enrolled during the fiscal year under this title or under title XIX, respectively, as described in clause (i)(I); exceeds

(II) the sum of the baseline number of child enrollees described in clause (iii) for the State and fiscal year under this title or title XIX, respectively, as described in clause (i)(II), and the maximum number of 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 June 30 before the beginning of the fiscal year (as estimated by the Bureau of the Census) plus 1 percentage point.

(D) PROJECTED PER CAPITA STATE EXPENDITURES.—For purposes of subparagraph (B)—

(i) PROJECTED PER CAPITA STATE MEDICAID EXPENDITURES.—The projected per capita State Medicaid expenditures for a State and fiscal year under title XIX is equal to the average per capita expenditures (including both State and Federal financial participation) for children under the State plan under such title, including under waivers but not including such children eligible for assistance by virtue of the receipt of benefits under title XVI, for the most recent fiscal year for which actual data are available (as determined by the Secretary), increased (for each subsequent fiscal year up to and including the fiscal year involved) by the annual percentage increase in per capita amount of National Health Expenditures (as estimated by the Secretary) for the calendar year in which the respective subsequent fiscal year ends and multiplied by a State matching percentage equal to 100 percent minus the Federal medical assistance percentage (as defined in section 1905(b)) for the fiscal year involved.

(ii) PROJECTED PER CAPITA STATE CHIP EXPENDITURES.—The projected per capita State CHIP expenditures for a State and fiscal year under this title is equal to the average per capita expenditures (including both State and Federal financial participation) for children under the State child health plan under this title, including under waivers, for the most recent fiscal year for which actual data are available (as determined by the Secretary), increased (for each subsequent fiscal year up to and including the fiscal year involved) by the annual percentage increase in per capita amount of National Health Expenditures (as estimated by the Secretary) for the calendar year in which the 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 eligibility for a full 12 months for all children described in section 1902(e)(12) under title XIX under 19 years of age, as well as applying such policy under its State child health plan under this title.

(B) LIBERALIZATION OF ASSET REQUIREMENTS.—The State meets the requirement specified in either of the following clauses:

(i) ELIMINATION OF ASSET TEST.—The State does not apply any asset or resource test for eligibility for children under title XIX or this title.

(ii) ADMINISTRATIVE VERIFICATION OF ASSETS.—The State—

(I) permits a parent or caretaker relative who is applying on behalf of a child for medical assistance under title XIX or child health assistance under this title to declare and certify by signature under penalty of perjury information relating to family assets for purposes of determining and redetermining financial eligibility; and

(II) takes steps to verify assets through means other than by requiring documentation from parents and applicants except in individual cases of discrepancies or where otherwise justified.

(C) ELIMINATION OF IN-PERSON INTERVIEW REQUIREMENT.—The State does not require an application of a child for medical assistance under title XIX (or for child health assistance under this title), including an application for renewal of such assistance, to be made in person nor does the State require a face-to-face interview, unless there are discrepancies or individual circumstances justifying an in-person application or face-to-face interview.

(D) USE OF JOINT APPLICATION FOR MEDICAID AND CHIP.—The application form and supplemental forms (if any) and information verification process is the same for purposes of establishing and renewing eligibility for children for medical assistance under title XIX and child health assistance under this title.

(E) AUTOMATIC RENEWAL (USE OF ADMINISTRATIVE RENEWAL).—

(i) IN GENERAL.—The State provides, in the case of renewal of a child's eligibility for medical assistance under title XIX or child health assistance under this

title, a pre-printed form completed by the State based on the information available to the State and notice to the parent or caretaker relative of the child that eligibility of the child will be renewed and continued based on such information unless the State is provided other information. Nothing in this clause shall be construed as preventing a State from verifying, through electronic and other means, the information so provided.

(ii) SATISFACTION THROUGH DEMONSTRATED USE OF EX PARTE PROCESS.—A State shall be treated as satisfying the requirement of clause (i) if renewal of eligibility of children under title XIX or this title is determined without any requirement for an in-person interview, unless sufficient information is not in the State's possession and cannot be acquired from other sources (including other State agencies) without the participation of the applicant or the applicant's parent or caretaker relative.

(F) PRESUMPTIVE ELIGIBILITY FOR CHILDREN.—The State is implementing section 1920A under title XIX as well as, pursuant to section 2107(e)(1), under this title .

(G) EXPRESS LANE.—The State is implementing the option described in section 1902(e)(13) under title XIX as well as, pursuant to section 2107(e)(1), under this title.

* * * * * * *

(g) AUTHORITY FOR QUALIFYING STATES TO USE CERTAIN FUNDS FOR MEDICAID EXPENDITURES.—

(1) STATE OPTION.—

(A) IN GENERAL.—Notwithstanding any other provision of law, a qualifying State (as defined in paragraph (2)) may elect to use not more than 20 percent of any allotment under section 2104 for fiscal year 1998, 1999, 2000, 2001, 2004, 2005, 2006, or 2007 *or 30 percent of any allotment under section 2104 for any subsequent fiscal year* (insofar as it is available under subsections (e) and (g) of such section) for payments under title XIX in accordance with subparagraph (B), instead of for expenditures under this title.

* * * * * * *

SEC. 2107. STRATEGIC OBJECTIVES AND PERFORMANCE GOALS; PLAN ADMINISTRATION.

(a) * * *

* * * * * * *

(e) APPLICATION OF CERTAIN GENERAL PROVISIONS.—The following sections of this Act shall apply to States under this title in the same manner as they apply to a State under title XIX:

(1) TITLE XIX PROVISIONS.—

(A) Section 1902(a)(4)(C) (relating to conflict of interest standards).

(B) Section 1902(a)(71) (relating to limiting FQHC contracting for provision of dental services).

(C) Section 1902(e)(13) (relating to the State option to rely on findings from an Express Lane agency to help evaluate a child's eligibility for medical assistance).

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

[(B)**]** *(E)* Paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment).

(F) Section 1903(v)(4)(A) (relating to optional coverage of certain categories of lawfully 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.

(G) 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)**]** *(H)* Section 1903(w) (relating to limitations on provider taxes and donations).

[(D) Section 1920A (relating to presumptive eligibility for children).**]**

(I) Sections 1920 and 1920A (relating to presumptive eligibility for pregnant women and children).

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

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SEC. 2108. ANNUAL REPORTS; EVALUATIONS.

(a) * * *

* * * * * * *

(c) FEDERAL EVALUATION.—

(1) * * *

* * * * * * *

(3) MATTERS INCLUDED.—In addition to the elements described in subsection (b)(1), the evaluation conducted under this subsection shall include each of the following:

(A) * * *

(B) Evaluation of effective and ineffective outreach and enrollment practices with respect to children (for both the program under this title and the medicaid program under title XIX), and identification of enrollment barriers and key elements of effective outreach and enrollment practices, including practices *(such as through community health workers and others)* that have successfully enrolled hard-to-reach populations such as children who are eligible for medical assistance under title XIX but have not been

enrolled previously in the medicaid program under that title.

* * * * * * *

[(5) FUNDING.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $10,000,000 for fiscal year 2000 for the purpose of conducting the evaluation authorized under this subsection. Amounts appropriated under this paragraph shall remain available for expenditure through fiscal year 2002.]

(5) SUBSEQUENT EVALUATION USING UPDATED INFORMATION.—

(A) IN GENERAL.—The Secretary, directly or through contracts or interagency agreements, shall conduct an independent subsequent evaluation of 10 States with approved child health plans.

(B) SELECTION OF STATES AND MATTERS INCLUDED.—Paragraphs (2) and (3) shall apply to such subsequent evaluation in the same manner as such provisions apply to the evaluation conducted under paragraph (1).

(C) SUBMISSION TO CONGRESS.—Not later than December 31, 2010, the Secretary shall submit to Congress the results of the evaluation conducted under this paragraph.

(D) FUNDING.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $10,000,000 for fiscal year 2009 for the purpose of conducting the evaluation authorized under this paragraph. Amounts appropriated under this subparagraph shall remain available for expenditure through fiscal year 2011.

[(d) INSPECTOR GENERAL AUDIT AND GAO REPORT.—

[(1) AUDIT.—Beginning with fiscal year 2000, and every third fiscal year thereafter, the Secretary, through the Inspector General of the Department of Health and Human Services, shall audit a sample from among the States described in paragraph (2) in order to—

[(A) determine the number, if any, of enrollees under the plan under this title who are eligible for medical assistance under title XIX (other than as optional targeted low-income children under section 1902(a)(10)(A)(ii)(XIV)); and

[(B) assess the progress made in reducing the number of uncovered low-income children, including the progress made to achieve the strategic objectives and performance goals included in the State child health plan under section 2107(a).

[(2) STATE DESCRIBED.—A State described in this paragraph is a State with an approved State child health plan under this title that does not, as part of such plan, provide health benefits coverage under the State's medicaid program under title XIX.

[(3) MONITORING AND REPORT FROM GAO.—The Comptroller General of the United States shall monitor the audits conducted under this subsection and, not later than March 1 of each fiscal year after a fiscal year in which an audit is conducted under this subsection, shall submit a report to Congress

on the results of the audit conducted during the prior fiscal year.]

(d) ACCESS TO RECORDS FOR IG AND GAO AUDITS AND EVALUATIONS.—For the purpose of evaluating and auditing the program established under this title, the Secretary, the Office of Inspector General, and the Comptroller General shall have access to any books, accounts, records, correspondence, and other documents that are related to the expenditure of Federal funds under this title and that are in the possession, custody, or control of States receiving Federal funds under this title or political subdivisions thereof, or any grantee or contractor of such States or political subdivisions.

(e) INFORMATION ON DENTAL CARE FOR CHILDREN.—

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

(A) The number of enrolled children by age grouping used for reporting purposes under 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.

* * * * * * *

SEC. 2110. DEFINITIONS.

(a) CHILD HEALTH ASSISTANCE.—For purposes of this title, the term "child health assistance" means payment for part or all of the cost of health benefits coverage for targeted low-income children that includes any of the following (and includes, in the case described in section 2105(a)(1)(D)(i), payment for part or all of the cost of providing any of the following), as specified under the State plan:

(1) * * *

* * * * * * *

(5) Clinic services (including health center services *and school-based health center services 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*) and other ambulatory health care services.

* * * * * * *

(c) ADDITIONAL DEFINITIONS.—For purposes of this title:

(1) CHILD.—The term "child" means an individual under 19 years of age *(or, at the option of the State and subject to section 131(d) of the Children's Health and Medicare Protection Act of 2007, under such higher age as the State has elected under section 1902(l)(1)(D))*.

* * * * * * *

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 enrollment cap or other numerical limitation on enrollment, any waiting list, any procedures designed to delay the consideration of applications for enrollment, or similar limitation with respect to enrollment.

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

(1) ASSISTANCE FOR PREGNANT WOMEN.—The term "assistance for pregnant women" has the meaning given the term child health assistance in section 2110(a) as if any reference to targeted low-income children were a reference to targeted low-income pregnant women.

(2) TARGETED LOW-INCOME PREGNANT WOMAN.—The term "targeted low-income pregnant woman" means a woman—

(A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends;

(B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (a)(1)(A)) of the poverty level applicable to a family of the size involved, but does not exceed the income eligibility level established 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).

(4) In applying section 2102(b)(3)(B), any reference to children found through screening to be eligible for medical assistance under the State medicaid plan under title XIX is deemed a reference to pregnant women.

(5) There shall be no exclusion of benefits for services described in subsection (b)(1) based on any preexisting condition and no waiting period (including any waiting period imposed to carry out section 2102(b)(3)(C)) shall apply.

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

(7) In applying section 2104(i)—

(A) in the case of a State which did not provide for coverage for pregnant women under this title (under a waiver or otherwise) during fiscal year 2007, the allotment amount otherwise computed for the first fiscal year in which the State elects to provide coverage under this section shall be increased by an amount (determined by the Secretary) equal to the enhanced FMAP of the expenditures under this title for such coverage, based upon projected enrollment and per capita costs of such enrollment; and

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

(i) in applying paragraph (2)(B) of such section, there shall also be taken into account (in an appropriate proportion) the percentage increase in births in the State for the relevant period; and

(ii) in applying paragraph (3), pregnant women (and per capita expenditures for such women) shall be accounted for separately from children, but shall be included in the total amount of any allotment adjustment under such paragraph.

(d) AUTOMATIC ENROLLMENT FOR CHILDREN BORN TO WOMEN RECEIVING ASSISTANCE FOR PREGNANT WOMEN.—If a child is born to a targeted low-income pregnant woman who was receiving assistance for pregnant women under this section on the date of the child's birth, the child shall be deemed to have applied for child health assistance under the State child health plan and to have been found eligible for such assistance under such plan or to have applied for medical assistance under title XIX and to have been

found eligible for such assistance under such title on the date of such birth, based on the mother's reported income as of the time of her enrollment under this section and applicable income eligibility levels under this title and title XIX, and to remain eligible for such assistance until the child attains 1 year of age. During the period in which a child is deemed under the preceding sentence to be eligible for child health or medical assistance, the assistance for pregnant women or medical assistance eligibility identification number of the mother shall also serve as the identification number of the child, and all claims shall be submitted and paid under such number (unless the State issues a separate identification number for the child before such period expires).

SEC. 2112. DEMONSTRATION PROJECT FOR EMPLOYER BUY-IN.

(a) AUTHORITY.—

(1) IN GENERAL.—The Secretary shall establish a demonstration project under which up to 10 States (each referred to in this section as a "participating State") that meets the conditions of paragraph (2) may provide, under its State child health plan (notwithstanding section 2102(b)(3)(C)) for a period of 5 years, for child health assistance in relation to family coverage described in subsection (d) for children who would be targeted low-income children but for coverage as beneficiaries under a group health plan as the children of participants by virtue of a qualifying employer's contribution under subsection (b)(2). :

(2) CONDITIONS.—The conditions described in this paragraph for a State are as follows:

(A) NO WAITING LISTS.—The State does not impose any waiting list, enrollment cap, or similar limitation on enrollment of targeted low-income children under the State child health plan.

(B) ELIGIBILITY OF ALL CHILDREN UNDER 200 PERCENT OF POVERTY LINE.—The State is applying an income eligibility level under section 2110(b)(1)(B)(ii)(I) that is at least 200 percent of the poverty line.

(3) QUALIFYING EMPLOYER DEFINED.—In this section, the term "qualifying employer" means an employer that has a majority of its workforce composed of full-time workers with family incomes reasonably estimated by the employer (based on wage information available to the employer) at or below 200 percent of the poverty line. In applying the previous sentence, two part-time workers shall be treated as a single full-time worker.

(b) FUNDING.—A demonstration project under this section in a participating State shall be funded, with respect to assistance provided to children described in subsection (a)(1), consistent with the following:

(1) LIMITED FAMILY CONTRIBUTION.—The family involved shall be responsible for providing payment towards the premium for such assistance of such amount as the State may specify, except that the limitations on cost-sharing (including premiums) under paragraphs (2) and (3) of section 2103(e) shall apply to all cost-sharing of such family under this section.

(2) MINIMUM EMPLOYER CONTRIBUTION.—The qualifying employer involved shall be responsible for providing payment to the State child health plan in the State of at least 50 percent

of the portion of the cost (as determined by the State) of the family coverage in which the employer is enrolling the family that exceeds the amount of the family contribution under paragraph (1) applied towards such coverage.

(3) LIMITATION ON FEDERAL FINANCIAL PARTICIPATION.—In no case shall the Federal financial participation under section 2105 with respect to a demonstration project under this section be made for any portion of the costs of family coverage described in subsection (d) (including the costs of administration of such coverage) that are not attributable to children described in subsection (a)(1).

(c) UNIFORM ELIGIBILITY RULES.—In providing assistance under a demonstration project under this section—

(1) a State shall establish uniform rules of eligibility for families to participate; and

(2) a State shall not permit a qualifying employer to select, within those families that meet such eligibility rules, which families may participate.

(d) TERMS AND CONDITIONS.—The family coverage offered to families of qualifying employers under a demonstration project under this section in a State shall be the same as the coverage and benefits provided under the State child health plan in the State for targeted low-income children with the highest family income level permitted.

MEDICARE, MEDICAID, AND SCHIP BALANCED BUDGET REFINEMENT ACT OF 1999

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO BBA; TABLE OF CONTENTS.

(a) * * *

* * * * * * *

(d) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; references to BBA; table of contents.

* * * * * * *

TITLE VII—STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

* * * * * * *

[Sec. 704. References to SCHIP and State children's health insurance program.]

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TITLE VII—STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)

* * * * * * *

[SEC. 704. REFERENCES TO SCHIP AND STATE CHILDREN'S HEALTH INSURANCE PROGRAM.

[The Secretary of Health and Human Services or any other Federal officer or employee, with respect to any reference to the program under title XXI of the Social Security Act (42 U.S.C. 1397aa

et seq.) in any publication or other official communication, shall use—

[(1) the term "SCHIP" instead of the term "CHIP"; and

[(2) the term "State children's health insurance program" instead of the term "children's health insurance program".]

SECTION 542 OF THE MEDICARE, MEDICAID, AND SCHIP BENEFITS IMPROVEMENT AND PROTECTION ACT OF 2000

SEC. 542. TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE.

(a) * * *

* * * * * * *

(c) EFFECTIVE DATE.—This section shall apply to services furnished during the 2-year period beginning on January 1, 2001, and for services furnished during 2005, 2006, [and 2007] *2007, 2008, and 2009*.

* * * * * * *

SECTION 9517 OF THE CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT OF 1985

SEC. 9517. MODIFYING APPLICATION OF MEDICAID HMO PROVISIONS FOR CERTAIN HEALTH CENTERS.

(a) * * *

* * * * * * *

(c) HEALTH INSURING ORGANIZATIONS.—(1) * * *

* * * * * * *

(3)(A) Subject to subparagraph (C), in the case of up to 3 health insuring organizations which are described in subparagraph (B)*, 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*, which first become operational on or after January 1, 1986, and which are designated by the Governor, and approved by the Legislature, of California, the amendments made by paragraph (1) shall not apply.

* * * * * * *

(C) Subparagraph (A) shall not apply with respect to any period for which the Secretary of Health and Human Services determines that the number of medicaid beneficiaries enrolled with health insuring organizations described in subparagraph (B) exceeds [14] *16* percent of the number of such beneficiaries in the State of California.

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INTERNAL REVENUE CODE OF 1986

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Subtitle D—Miscellaneous Excise Taxes

* * * * * * *

[CHAPTER 34—POLICIES ISSUED BY FOREIGN INSURERS]

CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

* * * * * * *

CHAPTER 31—RETAIL EXCISE TAXES

* * * * * * *

Subchapter B—Special Fuels

* * * * * * *

SEC. 4041. IMPOSITION OF TAX.

(a) * * *

* * * * * * *

[(l) EXEMPTION FOR CERTAIN USES.—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.]

(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.

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[CHAPTER 34—POLICIES ISSUED BY FOREIGN INSURERS]

CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

Subchapter A—Policies Issued By Foreign Insurers

SEC. 4371. IMPOSITION OF TAX.

There is hereby imposed, on each policy of insurance, indemnity bond, annuity contract, or policy of reinsurance issued by any foreign insurer or reinsurer, a tax at the following rates:

(1) * * *

* * * * * * *

Subchapter B—Insured and Self-Insured Health Plans

Sec. 4375. Health insurance
Sec. 4376. Self-insured health plans
Sec. 4377. Definitions and special rules

SEC. 4375. HEALTH INSURANCE.

(a) IMPOSITION OF FEE.—There is hereby imposed on each specified health insurance policy for each policy year a fee equal to the fair share per capita amount determined under section 9511(c)(1) multiplied by the average number of lives covered under the policy.

(b) LIABILITY FOR FEE.—The fee imposed by subsection (a) shall be paid by the issuer of the policy.

(c) SPECIFIED HEALTH INSURANCE POLICY.—For purposes of this section—

(1) IN GENERAL.—Except as otherwise provided in this section, the term "specified health insurance policy" means any accident or health insurance policy issued with respect to individuals residing in the United States.

(2) EXEMPTION OF CERTAIN POLICIES.—The term "specified health insurance policy" does not include any insurance policy if substantially all of the coverage provided under such policy relates to—

(A) liabilities incurred under workers' compensation laws,

(B) tort liabilities,

(C) liabilities relating to ownership or use of property,

(D) credit insurance,

(E) medicare supplemental coverage, or

(F) such other similar liabilities as the Secretary may specify by regulations.

(3) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS.—

(A) IN GENERAL.—In the case of any arrangement described in subparagraph (B)—

(i) such arrangement shall be treated as a specified health insurance policy, and

(ii) the person referred to in such subparagraph shall be treated as the issuer.

(B) DESCRIPTION OF ARRANGEMENTS.—An arrangement is described in this subparagraph if under such arrangement fixed payments or premiums are received as consideration for any person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided.

SEC. 4376. SELF-INSURED HEALTH PLANS.

(a) IMPOSITION OF FEE.—In the case of any applicable self-insured health plan for each plan year, there is hereby imposed a fee equal to the fair share per capita amount determined under section 9511(c)(1) multiplied by the average number of lives covered under the plan.

(b) LIABILITY FOR FEE.—

(1) IN GENERAL.—The fee imposed by subsection (a) shall be paid by the plan sponsor.

(2) PLAN SPONSOR.—For purposes of paragraph (1) the term "plan sponsor" means—

(A) the employer in the case of a plan established or maintained by a single employer,

(B) the employee organization in the case of a plan established or maintained by an employee organization,

(C) in the case of—

(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

(ii) a multiple employer welfare arrangement, or

(iii) a voluntary employees' beneficiary association described in section 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),

(E) by any organization described in section 501(c)(6), or

(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40) of Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

SEC. 4377. DEFINITIONS AND SPECIAL RULES.

(a) DEFINITIONS.—For purposes of this subchapter—

(1) ACCIDENT AND HEALTH COVERAGE.—The term "accident and health coverage" means any coverage which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4375(c)).

(2) INSURANCE POLICY.—The term "insurance policy" means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended.

(3) UNITED STATES.—The term "United States" includes any possession of the United States.

(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

(1) IN GENERAL.—For purposes of this subchapter—

(A) the term "person" includes any governmental entity, and

(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the fees imposed by this subchapter except as provided in paragraph (2).

(2) TREATMENT OF EXEMPT GOVERNMENTAL PROGRAMS.—In the case of an exempt governmental program, no fee shall be imposed under section 4375 or section 4376 on any covered life under such program.

(3) EXEMPT GOVERNMENTAL PROGRAM DEFINED.—For purposes of this subchapter, the term "exempt governmental program" means—

(A) any insurance program established under title XVIII of the Social Security Act,

(B) the medical assistance program established by title XIX or XXI of the Social Security Act,

(C) any program established by Federal law for providing medical care (other than through insurance policies) to individuals (or the spouses and dependents thereof) by reason of such individuals being—

(i) members of the Armed Forces of the United States, or

(ii) veterans, and

(D) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

(c) TREATMENT AS TAX.—For purposes of subtitle F, the fees imposed by this subchapter shall be treated as if they were taxes.

(d) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States.

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Subtitle E—Alcohol, Tobacco, and Certain Other Excise Taxes

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CHAPTER 52—TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES

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Subchapter A—Definitions; Rate and Payment of Tax; Exemption From Tax; and Refund and Drawback of Tax

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SEC. 5701. RATE OF TAX.

(a) CIGARS.—On cigars, manufactured in or imported into the United States, there shall be imposed the following taxes:

(1) SMALL CIGARS.—On cigars, weighing not more than 3 pounds per thousand, **[**$1.828 cents per thousand ($1.594 cents per thousand on cigars removed during 2000 or 2001)**]** *$42 per thousand*;

(2) LARGE CIGARS.—On cigars weighing more than 3 pounds per thousand, a tax equal to **[**20.719 percent (18.063 percent on cigars removed during 2000 or 2001)**]** *44.63 percent* of the price for which sold but not more than **[**$48.75 per thousand ($42.50 per thousand on cigars removed during 2000 or 2001**]** *$1 per cigar*).

Cigars not exempt from tax under this chapter which are removed but not intended for sale shall be taxed at the same rate as similar cigars removed for sale.

(b) CIGARETTES.—On cigarettes, manufactured in or imported into the United States, there shall be imposed the following taxes:

(1) SMALL CIGARETTES.—On cigarettes, weighing not more than 3 pounds per thousand, **[**$19.50 per thousand ($17 per thousand on cigarettes removed during 2000 or 2001)**]** *$42 per thousand*;

(2) LARGE CIGARETTES.—On cigarettes, weighing more than 3 pounds per thousand, **[**$40.95 per thousand ($35.70 per thousand on cigarettes removed during 2000 or 2001)**]** *$88.20 per thousand*; except that, if more than 6½ inches in length, they shall be taxable at the rate prescribed for cigarettes weighing not more than 3 pounds per thousand, counting each 2¾ inches, or fraction thereof, of the length of each as one cigarette.

(c) CIGARETTE PAPERS.—On cigarette papers, manufactured in or imported into the United States, there shall be imposed a tax of **[**1.22 cents (1.06 cents on cigarette papers removed during 2000 or 2001**]** *2.63 cents*) for each 50 papers or fractional part thereof; except that, if cigarette papers measure more than 6½ inches in length, they shall be taxable at the rate prescribed, counting each

2¾ inches, or fraction thereof, of the length of each as one cigarette paper.

(d) CIGARETTE TUBES.—On cigarette tubes, manufactured in or imported into the United States, there shall be imposed a tax of [2.44 cents (2.13 cents on cigarette tubes removed during 2000 or 2001)] *5.26 cents* for each 50 tubes or fractional part thereof, except that if cigarette tubes measure more than 6½ inches in length, they shall be taxable at the rate prescribed, counting each 2¾ inches, or fraction thereof, of the length of each as one cigarette tube.

(e) SMOKELESS TOBACCO.—On smokeless tobacco, manufacturered in or imported into the United States, there shall be imposed the following taxes:

(1) SNUFF.—On snuff, [58.5 cents (51 cents on snuff removed during 2000 or 2001)] *$1.26* per pound and a proportionate tax at the like rate on all fractional parts of a pound.

(2) CHEWING TOBACCO.—On chewing tobacco, [19.5 cents (17 cents on chewing tobacco removed during 2000 or 2001)] *42 cents* per pound and a proportionate tax at the like rate on all fractional parts of a pound.

(f) PIPE TOBACCO.—On pipe tobacco, manufactured in or imported into the United States, there shall be imposed a tax of [$1.0969 cents (95.67 cents on pipe tobacco removed during 2000 or 2001)] *$2.36* per pound (and a proportionate tax at the like rate on all fractional parts of a pound).

(g) ROLL-YOUR-OWN TOBACCO.—On roll-your-own tobacco, manufactured in or imported into the United States, there shall be imposed a tax of [$1.0969 cents (95.67 cents on roll-your-own tobacco removed during 2000 or 2001)] *$7.4667* per pound (and a proportionate tax at the like rate on all fractional parts of a pound).

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SEC. 5702. DEFINITIONS.

When used in this chapter—

(a) * * *

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(o) ROLL-YOUR-OWN TOBACCO.—The term "roll-your-own tobacco" means any tobacco which, because of its appearance, type, packaging, or labeling, is suitable for use and likely to be offered to, or purchased by, consumers as tobacco for making cigarettes *or cigars, or for use as wrappers for making cigars*.

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Subtitle F—Procedure and Administration

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CHAPTER 61—INFORMATION AND RETURNS

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Subchapter B—Miscellaneous Provisions

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SEC. 6103. CONFIDENTIALITY AND DISCLOSURE OF RETURNS AND RETURN INFORMATION.

(a) * * *

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(l) DISCLOSURE OF RETURNS AND RETURN INFORMATION FOR PURPOSES OTHER THAN TAX ADMINISTRATION * * *

(1) * * *

* * * * * * *

(21) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF PROVIDING LOW-INCOME SUBSIDIES UNDER MEDICARE.—

(A) RETURN INFORMATION FROM INTERNAL REVENUE SERVICE TO SOCIAL SECURITY ADMINISTRATION.—The Secretary, upon written request from the Commissioner of Social Security, shall disclose to the officers and employees of the Social Security Administration with respect to any individual identified by the 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.

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(p) PROCEDURE AND RECORDKEEPING.—

(1) * * *

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(4) SAFEGUARDS.—Any Federal agency described in subsection (h)(2), (h)(5), (i)(1), (2), (3), (5), or (7), (j)(1), (2), or (5), (k)(8), (l)(1), (2), (3), (5), (10), (11), (13), (14), [or (17)] *(17), or (21)* or (o)(1), the Government Accountability Office, the Congressional Budget Office, or any agency, body, or commission described in subsection (d), (i)(3)(B)(i) or 7(A)(ii), or (l)(6), (7), (8), (9), (12), (15), or (16), any appropriate State officer (as defined in section 6104(c)), or any other person described in subsection (l)(16), (18), (19), or (20) shall, as a condition for receiving returns or return information—

(A) * * *

* * * * * * *

(F) upon completion of use of such returns or return information—

(i) * * *

(ii) in the case of an agency described in subsections 2 (h)(2), (h)(5), (i)(1), (2), (3), (5) or (7), (j)(1), (2), or (5), (k)(8), (l)(1), (2), (3), (5), (10), (11), (12), (13), (14), (15), [or (17)] *(17), or (21)*, or (o)(1), the Government Accountability Office, or the Congressional Budget Office, either—

(I) * * *

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CHAPTER 65—ABATEMENTS, CREDITS, AND REFUNDS

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Subchapter B—Rules of Special Application

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SEC. 6427. FUELS NOT USED FOR TAXABLE PURPOSES.

(a) * * *

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(d) USE BY CERTAIN AIRCRAFT MUSEUMS OR IN CERTAIN OTHER AIRCRAFT USES.—Except as provided in subsection (k), if—

(1) * * *

* * * * * * *

is used by an aircraft museum (as defined in section 4041(h)(2)) in an aircraft or vehicle owned by such museum and used exclusively

for purposes set forth in section 4041(h)(2)(C), or is used in a helicopter or a fixed-wing aircraft for a purpose described in section [4041(l)] *4041(l)(1)*, the Secretary shall pay (without interest) to the ultimate purchaser of such gasoline or fuel an amount equal to the aggregate amount of the tax imposed on such gasoline or fuel.

* * * * * * *

(f) USE TO PROVIDE EMERGENCY MEDICAL SERVICES.—Except as provided in subsection (k), if any fuel on which tax was imposed by section 4081 or 4041 is used in an ambulance for a purpose described in section 4041(l)(2), the Secretary shall pay (without interest) to the ultimate purchaser of such fuel an amount equal to the aggregate amount of the tax imposed on such fuel. The preceding sentence shall not apply to any liquid used after December 31, 2012.

* * * * * * *

(i) TIME FOR FILING CLAIMS; PERIOD COVERED.—

(1) GENERAL RULE.—Except as otherwise provided in this subsection, not more than one claim may be filed under subsection (a), (b), (c), (d), *(f),* (h), (l), (m), or (o) by any person with respect to fuel used during his taxable year; and no claim shall be allowed under this paragraph with respect to fuel used during any taxable year unless filed by the purchaser not later than the time prescribed by law for filing a claim for credit or refund of overpayment of income tax for such taxable year. For purposes of this paragraph, a person's taxable year shall be his taxable year for purposes of subtitle A.

(2) EXCEPTIONS.—

(A) IN GENERAL.—If, at the close of any quarter of the taxable year of any person, at least $750 is payable in the aggregate under subsections (a), (b), (d), *(f),* (h), (l), (m), and (o) of this section and section 6421 to such person with respect to fuel used during—

(i) * * *

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Subtitle I—Trust Fund Code

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CHAPTER 98—TRUST FUND CODE

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Subchapter A—Establishment of Trust Funds

Sec. 9501. Black Lung Disability Trust Fund.

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Sec. 9511. Health Care Comparative Effectiveness Research Trust Fund.

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SEC. 9511. HEALTH CARE COMPARATIVE EFFECTIVENESS RESEARCH TRUST FUND.

(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the "Health Care Comparative Effectiveness Research Trust Fund" (hereinafter in this section referred to as the "CERTF"), consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section and section 9602(b).

(b) TRANSFERS TO FUND.—There are hereby appropriated to the Trust Fund the following:

(1) For fiscal year 2008, $90,000,000.

(2) For fiscal year 2009, $100,000,000.

(3) For fiscal year 2010, $110,000,000.

(4) For each fiscal year beginning with fiscal year 2011—

(A) an amount equivalent to the net revenues received in the Treasury from the fees imposed under subchapter B of chapter 34 (relating to fees on health insurance and self-insured plans) for such fiscal year; and

(B) subject to subsection (c)(2), amounts determined by the Secretary of Health and Human Services to be equivalent to the fair share per capita amount computed under subsection (c)(1) for the fiscal year multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of title XVIII of the Social Security Act during such fiscal year.

The amounts appropriated under paragraphs (1), (2), (3), and (4)(B) shall be transferred from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (established under section 1841 of such Act), and from the Medicare Prescription Drug Account within such Trust Fund, in proportion (as estimated by the Secretary) to the total expenditures during such fiscal year that are made under title XVIII of such Act from the respective trust fund or account.

(c) FAIR SHARE PER CAPITA AMOUNT.—

(1) COMPUTATION.—

(A) IN GENERAL.—Subject to subparagraph (B), the fair share per capita amount under this paragraph for a fiscal year (beginning with fiscal year 2011) is an amount computed by the Secretary of Health and Human Services for such fiscal year that, when applied under this section and subchapter B of chapter 34 of the Internal Revenue Code of 1986, will result in revenues to the CERTF of $375,000,000 for the fiscal year.

(B) ALTERNATIVE COMPUTATION.—

(i) IN GENERAL.—If the Secretary is unable to compute the fair share per capita amount under subparagraph (A) for a fiscal year, the fair share per capita amount under this paragraph for the fiscal year shall be the default amount determined under clause (ii) for the fiscal year.

(ii) DEFAULT AMOUNT.—The default amount under this clause for—

(I) fiscal year 2011 is equal to $2; or

(II) a subsequent year is equal to the default amount under this clause for the preceeding fiscal year increased by the annual percentage increase in the medical care component of the consumer price index (United States city average) for the 12-month period ending with April of the preceding fiscal year.

Any amount determined under subclause (II) shall be rounded to the nearest penny.

(2) LIMITATION ON MEDICARE FUNDING.—In no case shall the amount transferred under subsection (b)(4)(B) for any fiscal year exceed $90,000,000.

(d) EXPENDITURES FROM FUND.—

(1) IN GENERAL.—Subject to paragraph (2), amounts in the CERTF are available to the Secretary of Health and Human Services for carrying out section 1822 of the Social Security Act.

(2) ALLOCATION FOR COMMISSION.—Not less than the following amounts in the CERTF for a fiscal year shall be available to carry out the activities of the Comparative Effectiveness Research Commission established under section 1822(b) of the Social Security Act for such fiscal year:

(A) For fiscal year 2008, $7,000,000.

(B) For fiscal year 2009, $9,000,000.

(C) For each fiscal year beginning with 2010, $10,000,000.

Nothing in this paragraph shall be construed as preventing additional amounts in the CERTF from being made available to the Comparative Effectiveness Research Commission for such activities.

(e) NET REVENUES.—For purposes of this section, the term "net revenues" means the amount estimated by the Secretary based on the excess of—

(1) the fees received in the Treasury under subchapter B of chapter 34, over

(2) the decrease in the tax imposed by chapter 1 resulting from the fees imposed by such subchapter.

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SECTION 5005 OF THE DEFICIT REDUCTION ACT OF 2005

SEC. 5005. EXTENDED PHASE-IN OF THE INPATIENT REHABILITATION FACILITY CLASSIFICATION CRITERIA.

(a) IN GENERAL.—Notwithstanding section 412.23(b)(2) of title 42, Code of Federal Regulations, the Secretary of Health and Human Services shall ❚apply the applicable percent specified in subsection (b)❚ *require a compliance rate that is no greater than the 60 percent compliance rate that became effective for cost reporting periods beginning on or after July 1, 2006,* in the classification criterion used under the IRF regulation (as defined in subsection (c)) to determine whether a hospital or unit of a hospital is an inpatient rehabilitation facility under the Medicare program under title XVIII of the Social Security Act.

[(b) APPLICABLE PERCENT.—For purposes of subsection (a), the applicable percent specified in this subsection for cost reporting periods—

[(1) beginning during the 12-month period beginning on July 1, 2006, is 60 percent;

[(2) beginning during the 12-month period beginning on July 1, 2007, is 65 percent; and

[(3) beginning on or after July 1, 2008, is 75 percent.]

(b) CONTINUED USE OF COMORBIDITIES.—For portions of cost reporting periods occurring on or after the date of the enactment of the Children's Health and Medicare Protection Act of 2007, the Secretary shall include patients with comorbidities as described in section 412.23(b)(2)(i) of title 42, Code of Federal Regulations (as in effect as of January 1, 2007), in the inpatient population that counts towards the percent specified in subsection (a).

* * * * * * *

SECTION 106 OF THE MEDICARE IMPROVEMENTS AND EXTENSION ACT OF 2006

SEC. 106. HOSPITAL MEDICARE REPORTS AND CLARIFICATIONS.

(a) CORRECTION OF MID-YEAR RECLASSIFICATION EXPIRATION.—Notwithstanding any other provision of law, in the case of a subsection (d) hospital (as defined for purposes of section 1886 of the Social Security Act (42 U.S.C. 1395ww)) with respect to which a reclassification of its wage index for purposes of such section would (but for this subsection) expire on March 31, 2007, such reclassification of such hospital shall be extended through [September 30, 2007] *September 30, 2009*. The previous sentence shall not be effected in a budget-neutral manner.

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MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003

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TITLE IV—RURAL PROVISIONS

Subtitle A—Provisions Relating to Part A Only

* * * * * * *

SEC. 405. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL PROGRAM.

(a) * * *

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(h) WAIVER AUTHORITY.—

(1) * * *

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(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 care services to residents in the area of the hospital.

(B) CRITERIA DESCRIBED.—A hospital meets the criteria described in this subparagraph if the hospital

(i) has been granted an exception by the State to an otherwise applicable statutory restriction on hospital construction or licensing prior to the date of enactment of this subparagraph; and

(ii) is located on property which the State has approved for conveyance to a county within the State prior to such date of enactment.

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Subtitle B—Provisions Relating to Part B Only

* * * * * * *

SEC. 416. TREATMENT OF CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITAL OUTPATIENTS IN CERTAIN RURAL AREAS.

(a) * * *

(b) APPLICATION.—A cost reporting period described in this subsection is a cost reporting period beginning during the [3-year] *5-year* period period beginning on July 1, 2004.

* * * * * * *

Subtitle C—Provisions Relating to Parts A and B

SEC. 421. [ONE-YEAR] *TEMPORARY* INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

(a) IN GENERAL.—With respect to episodes and visits ending on or after April 1, 2004, and before April 1, 2005, [and episodes and visits beginning on or after January 1, 2006, and before January 1, 2007] *episodes and visits beginning on or after January 1, 2006, and before January 1, 2007, and episodes and visits beginning on or after January 1, 2008, and before January 1, 2010*, in the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))), the Secretary shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 5 percent.

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TITLE V—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

* * * * * * *

SEC. 508. ONE-TIME APPEALS PROCESS FOR HOSPITAL WAGE INDEX CLASSIFICATION.

(a) * * *

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(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.

* * * * * * *

TITLE VIII—COST CONTAINMENT

[Subtitle A—Cost Containment

[SEC. 801. INCLUSION IN ANNUAL REPORT OF MEDICARE TRUSTEES OF INFORMATION ON STATUS OF MEDICARE TRUST FUNDS.

[(a) DETERMINATIONS OF EXCESS GENERAL REVENUE MEDICARE FUNDING.—

[(1) IN GENERAL.—The Board of Trustees of each medicare trust fund shall include in the annual reports submitted under subsection (b)(2) of sections 1817 and 1841 of the Social Security Act (42 U.S.C. 1395i and 1395t)—

[(A) the information described in subsection (b); and

[(B) a determination as to whether there is projected to be excess general revenue medicare funding (as defined in subsection (c)) for the fiscal year in which the report is submitted or for any of the succeeding 6 fiscal years.

[(2) MEDICARE FUNDING WARNING.—For purposes of section 1105(h) of title 31, United States Code, and this subtitle, an affirmative determination under paragraph (1)(B) in 2 consecutive annual reports shall be treated as a medicare funding warning in the year in which the second such report is made.

[(3) 7-FISCAL-YEAR REPORTING PERIOD.—For purposes of this subtitle, the term "7-fiscal-year reporting period" means, with respect to a year in which an annual report described in paragraph (1) is made, the period of 7 consecutive fiscal years beginning with the fiscal year in which the report is submitted.

[(b) INFORMATION.—The information described in this subsection for an annual report in a year is as follows:

[(1) PROJECTIONS OF GROWTH OF GENERAL REVENUE SPENDING.—A statement of the general revenue medicare funding as a percentage of the total medicare outlays for each of the following:

[(A) Each fiscal year within the 7-fiscal-year reporting period.

[(B) Previous fiscal years and as of 10, 50, and 75 years after such year.

[(2) COMPARISON WITH OTHER GROWTH TRENDS.—A comparison of the trend of such percentages with the annual growth rate in the following:

[(A) The gross domestic product.

[(B) Private health costs.

[(C) National health expenditures.

[(D) Other appropriate measures.

[(3) PART D SPENDING.—Expenditures, including trends in expenditures, under part D of title XVIII of the Social Security Act, as added by section 101.

[(4) COMBINED MEDICARE TRUST FUND ANALYSIS.—A financial analysis of the combined medicare trust funds if general revenue medicare funding were limited to the percentage specified in subsection (c)(1)(B) of total medicare outlays.

[(c) DEFINITIONS.—For purposes of this section:

[(1) EXCESS GENERAL REVENUE MEDICARE FUNDING.—The term "excess general revenue medicare funding" means, with respect to a fiscal year, that—

[(A) general revenue medicare funding (as defined in paragraph (2)), expressed as a percentage of total medicare outlays (as defined in paragraph (4)) for the fiscal year; exceeds

[(B) 45 percent.

[(2) GENERAL REVENUE MEDICARE FUNDING.—The term "general revenue medicare funding" means for a year—

[(A) the total medicare outlays (as defined in paragraph (4)) for the year; minus

[(B) the dedicated medicare financing sources (as defined in paragraph (3)) for the year.

[(3) DEDICATED MEDICARE FINANCING SOURCES.—The term "dedicated medicare financing sources" means the following:

[(A) HOSPITAL INSURANCE TAX.—Amounts appropriated to the Hospital Insurance Trust Fund under the third sentence of section 1817(a) of the Social Security Act (42 U.S.C. 1395i(a)) and amounts transferred to such Trust Fund under section 7(c)(2) of the Railroad Retirement Act of 1974 (45 U.S.C. 231f(c)(2)).

[(B) TAXATION OF CERTAIN OASDI BENEFITS.—Amounts appropriated to the Hospital Insurance Trust Fund under section 121(e)(1)(B) of the Social Security Amendments of 1983 (Public Law 98–21), as inserted by section 13215(c) of the Omnibus Budget Reconciliation Act of 1993 (Public Law 103–66).

[(C) STATE TRANSFERS.—The State share of amounts paid to the Federal Government by a State under section

1843 of the Social Security Act (42 U.S.C. 1395v) or pursuant to section 1935(c) of such Act.

[(D) PREMIUMS.—The following premiums:

[(i) PART A.—Premiums paid by non-Federal sources under sections 1818 and section 1818A (42 U.S.C. 1395i–2 and 1395i–2a) of such Act.

[(ii) PART B.—Premiums paid by non-Federal sources under section 1839 of such Act (42 U.S.C. 1395r), including any adjustments in premiums under such section.

[(iii) PART D.—Monthly beneficiary premiums paid under part D of title XVIII of such Act, as added by section 101, and MA monthly prescription drug beneficiary premiums paid under part C of such title insofar as they are attributable to basic prescription drug coverage.

Premiums under clauses (ii) and (iii) shall be determined without regard to any reduction in such premiums attributable to a beneficiary rebate under section 1854(b)(1)(C) of such title, as amended by section 222(b)(1), and premiums under clause (iii) are deemed to include any amounts paid under section 1860D–13(b) of such title, as added by section 101.

[(E) GIFTS.—Amounts received by the medicare trust funds under section 201(i) of the Social Security Act (42 U.S.C. 401(i)).

[(4) TOTAL MEDICARE OUTLAYS.—The term "total medicare outlays" means total outlays from the medicare trust funds and shall—

[(A) include payments made to plans under part C of title XVIII of the Social Security Act that are attributable to any rebates under section 1854(b)(1)(C) of such Act (42 U.S.C. 1395w–24(b)(1)(C)), as amended by section 222(b)(1);

[(B) include administrative expenditures made in carrying out title XVIII of such Act and Federal outlays under section 1935(b) of such Act, as added by section 103(a)(2); and

[(C) offset outlays by the amount of fraud and abuse collections insofar as they are applied or deposited into a medicare trust fund.

[(5) MEDICARE TRUST FUND.—The term "medicare trust fund" means—

[(A) the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i); and

[(B) the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), including the Medicare Prescription Drug Account under such Trust Fund.

[(d) CONFORMING AMENDMENTS.—

[(1) FEDERAL HOSPITAL INSURANCE TRUST FUND.—Section 1817(b)(2) (42 U.S.C. 1395i(b)(2)) is amended by adding at the end the following: "Each report provided under paragraph (2) beginning with the report in 2005 shall include the information

specified in section 801(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.".

[(2) FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—Section 1841(b)(2) (42 U.S.C. 1395t(b)(2)) is amended by adding at the end the following: "Each report provided under paragraph (2) beginning with the report in 2005 shall include the information specified in section 801(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003.".

[(e) NOTICE OF MEDICARE FUNDING WARNING.—Whenever any report described in subsection (a) contains a determination that for any fiscal year within the 7-fiscal-year reporting period there will be excess general revenue medicare funding, Congress and the President should address the matter under existing rules and procedures.

[SEC. 802. PRESIDENTIAL SUBMISSION OF LEGISLATION.

[(a) IN GENERAL.—Section 1105 of title 31, United States Code, is amended by adding at the end the following new subsection:

["(h)(1) If there is a medicare funding warning under section 801(a)(2) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 made in a year, the President shall submit to Congress, within the 15-day period beginning on the date of the budget submission to Congress under subsection (a) for the succeeding year, proposed legislation to respond to such warning.

["(2) Paragraph (1) does not apply if, during the year in which the warning is made, legislation is enacted which eliminates excess general revenue medicare funding (as defined in section 801(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) for the 7-fiscal-year reporting period, as certified by the Board of Trustees of each medicare trust fund (as defined in section 801(c)(5) of such Act) not later than 30 days after the date of the enactment of such legislation.".

[(b) SENSE OF CONGRESS.—It is the sense of Congress that legislation submitted pursuant to section 1105(h) of title 31, United States Code, in a year should be designed to eliminate excess general revenue medicare funding (as defined in section 801(c)) for the 7-fiscal-year period that begins in such year.

[SEC. 803. PROCEDURES IN THE HOUSE OF REPRESENTATIVES.

[(a) INTRODUCTION AND REFERRAL OF PRESIDENT'S LEGISLATIVE PROPOSAL.—

[(1) INTRODUCTION.—In the case of a legislative proposal submitted by the President pursuant to section 1105(h) of title 31, United States Code, within the 15-day period specified in paragraph (1) of such section, the Majority Leader of the House of Representatives (or his designee) and the Minority Leader of the House of Representatives (or his designee) shall introduce such proposal (by request), the title of which is as follows: "A bill to respond to a medicare funding warning." Such bill shall be introduced within 3 legislative days after Congress receives such proposal.

[(2) REFERRAL.—Any legislation introduced pursuant to paragraph (1) shall be referred to the appropriate committees of the House of Representatives.

[(b) DIRECTION TO THE APPROPRIATE HOUSE COMMITTEES.—

[(1) IN GENERAL.—In the House, in any year during which the President is required to submit proposed legislation to Congress under section 1105(h) of title 31, United States Code, the appropriate committees shall report medicare funding legislation by not later than June 30 of such year.

[(2) MEDICARE FUNDING LEGISLATION.—For purposes of this section, the term "medicare funding legislation" means—

[(A) legislation introduced pursuant to subsection (a)(1), but only if the legislative proposal upon which the legislation is based was submitted within the 15-day period referred to in such subsection; or

[(B) any bill the title of which is as follows: "A bill to respond to a medicare funding warning.".

[(3) CERTIFICATION.—With respect to any medicare funding legislation or any amendment to such legislation to respond to a medicare funding warning, the chairman of the Committee on the Budget of the House shall certify—

[(A) whether or not such legislation eliminates excess general revenue medicare funding (as defined in section 801(c)) for each fiscal year in the 7-fiscal-year reporting period; and

[(B) with respect to such an amendment, whether the legislation, as amended, would eliminate excess general revenue medicare funding (as defined in section 801(c)) for each fiscal year in such 7-fiscal-year reporting period.

[(c) FALLBACK PROCEDURE FOR FLOOR CONSIDERATION IF THE HOUSE FAILS TO VOTE ON FINAL PASSAGE BY JULY 30.—

[(1) After July 30 of any year during which the President is required to submit proposed legislation to Congress under section 1105(h) of title 31, United States Code, unless the House of Representatives has voted on final passage of any medicare funding legislation for which there is an affirmative certification under subsection (b)(3)(A), then, after the expiration of not less than 30 calendar days (and concurrently 5 legislative days), it is in order to move to discharge any committee to which medicare funding legislation which has such a certification and which has been referred to such committee for 30 calendar days from further consideration of the legislation.

[(2) A motion to discharge may be made only by an individual favoring the legislation, may be made only if supported by one-fifth of the total membership of the House (a quorum being present), and is highly privileged in the House. Debate thereon shall be limited to not more than one hour, the time to be divided in the House equally between those favoring and those opposing the motion. An amendment to the motion is not in order, and it is not in order to move to reconsider the vote by which the motion is agreed to or disagreed to.

[(3) Only one motion to discharge a particular committee may be adopted under this subsection in any session of a Congress.

[(4) Notwithstanding paragraph (1), it shall not be in order to move to discharge a committee from further consideration of medicare funding legislation pursuant to this subsection dur-

ing a session of a Congress if, during the previous session of the Congress, the House passed medicare funding legislation for which there is an affirmative certification under subsection (b)(3)(A).

[(d) FLOOR CONSIDERATION IN THE HOUSE OF DISCHARGED LEGISLATION.—

[(1) In the House, not later than 3 legislative days after any committee has been discharged from further consideration of legislation under subsection (c), the Speaker shall resolve the House into the Committee of the Whole for consideration of the legislation.

[(2) The first reading of the legislation shall be dispensed with. All points of order against consideration of the legislation are waived. General debate shall be confined to the legislation and shall not exceed five hours, which shall be divided equally between those favoring and those opposing the legislation. After general debate the legislation shall be considered for amendment under the five-minute rule. During consideration of the legislation, no amendments shall be in order in the House or in the Committee of the Whole except those for which there has been an affirmative certification under subsection (b)(3)(B). All points of order against consideration of any such amendment in the Committee of the Whole are waived. The legislation, together with any amendments which shall be in order, shall be considered as read. During the consideration of the bill for amendment, the Chairman of the Committee of the Whole may accord priority in recognition on the basis of whether the Member offering an amendment has caused it to be printed in the portion of the Congressional Record designated for that purpose in clause 8 of Rule XVIII of the Rules of the House of Representatives. Debate on any amendment shall not exceed one hour, which shall be divided equally between those favoring and those opposing the amendment, and no pro forma amendments shall be offered during the debate. The total time for debate on all amendments shall not exceed 10 hours. At the conclusion of consideration of the legislation for amendment, the Committee shall rise and report the legislation to the House with such amendments as may have been adopted. The previous question shall be considered as ordered on the legislation and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions. If the Committee of the Whole rises and reports that it has come to no resolution on the bill, then on the next legislative day the House shall, immediately after the third daily order of business under clause 1 of Rule XIV of the Rules of the House of Representatives, resolve into the Committee of the Whole for further consideration of the bill.

[(3) All appeals from the decisions of the Chair relating to the application of the Rules of the House of Representatives to the procedure relating to any such legislation shall be decided without debate.

[(4) Except to the extent specifically provided in the preceding provisions of this subsection, consideration of any such legislation and amendments thereto (or any conference report

thereon) shall be governed by the Rules of the House of Representatives applicable to other bills and resolutions, amendments, and conference reports in similar circumstances.

[(e) LEGISLATIVE DAY DEFINED.—As used in this section, the term "legislative day" means a day on which the House of Representatives is in session.

[(f) RESTRICTION ON WAIVER.—In the House, the provisions of this section may be waived only by a rule or order proposing only to waive such provisions.

[(g) RULEMAKING POWER.—The provisions of this section are enacted by the Congress—

[(1) as an exercise of the rulemaking power of the House of Representatives and, as such, shall be considered as part of the rules of that House and shall supersede other rules only to the extent that they are inconsistent therewith; and

[(2) with full recognition of the constitutional right of that House to change the rules (so far as they relate to the procedures of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

[SEC. 804. PROCEDURES IN THE SENATE.

[(a) INTRODUCTION AND REFERRAL OF PRESIDENT'S LEGISLATIVE PROPOSAL.—

[(1) INTRODUCTION.—In the case of a legislative proposal submitted by the President pursuant to section 1105(h) of title 31, United States Code, within the 15-day period specified in paragraph (1) of such section, the Majority Leader and Minority Leader of the Senate (or their designees) shall introduce such proposal (by request), the title of which is as follows: "A bill to respond to a medicare funding warning." Such bill shall be introduced within 3 days of session after Congress receives such proposal.

[(2) REFERRAL.—Any legislation introduced pursuant to paragraph (1) shall be referred to the Committee on Finance.

[(b) MEDICARE FUNDING LEGISLATION.—For purposes of this section, the term "medicare funding legislation" means—

[(1) legislation introduced pursuant to subsection (a)(1), but only if the legislative proposal upon which the legislation is based was submitted within the 15-day period referred to in such subsection; or

[(2) any bill the title of which is as follows: "A bill to respond to a medicare funding warning.".

[(c) QUALIFICATION FOR SPECIAL PROCEDURES.—

[(1) IN GENERAL.—The special procedures set forth in subsections (d) and (e) shall apply to medicare funding legislation, as described in subsection (b), only if the legislation—

[(A) is medicare funding legislation that is passed by the House of Representatives; or

[(B) contains matter within the jurisdiction of the Committee on Finance in the Senate.

[(2) FAILURE TO QUALIFY FOR SPECIAL PROCEDURES.—If the medicare funding legislation does not satisfy paragraph (1), then the legislation shall be considered under the ordinary procedures of the Standing Rules of the Senate.

[(d) DISCHARGE.—

[(1) IN GENERAL.—If the Committee on Finance has not reported medicare funding legislation described in subsection (c)(1) by June 30 of a year in which the President is required to submit medicare funding legislation to Congress under section 1105(h) of title 31, United States Code, then any Senator may move to discharge the Committee of any single medicare funding legislation measure. Only one such motion shall be in order in any session of Congress.

[(2) DEBATE LIMITS.—Debate in the Senate on any such motion to discharge, and all appeals in connection therewith, shall be limited to not more than 2 hours. The time shall be equally divided between, and controlled by, the maker of the motion and the Majority Leader, or their designees, except that in the event the Majority Leader is in favor of such motion, the time in opposition thereto shall be controlled by the Minority Leader or the Minority Leader's designee. A point of order under this subsection may be made at any time. It is not in order to move to proceed to another measure or matter while such motion (or the motion to reconsider such motion) is pending.

[(3) AMENDMENTS.—No amendment to the motion to discharge shall be in order.

[(4) EXCEPTION IF CERTIFIED LEGISLATION ENACTED.—Notwithstanding paragraph (1), it shall not be in order to discharge the Committee from further consideration of medicare funding legislation pursuant to this subsection during a session of a Congress if the chairman of the Committee on the Budget of the Senate certifies that medicare funding legislation has been enacted that eliminates excess general revenue medicare funding (as defined in section 801(c)) for each fiscal year in the 7-fiscal-year reporting period.

[(e) CONSIDERATION.—After the date on which the Committee on Finance has reported medicare funding legislation described in subsection (c)(1), or has been discharged (under subsection (d)) from further consideration of, such legislation, it is in order (even though a previous motion to the same effect has been disagreed to) for any Member of the Senate to move to proceed to the consideration of such legislation.

[(f) RULES OF THE SENATE.—This section is enacted by the Senate—

[(1) as an exercise of the rulemaking power of the Senate and as such it is deemed a part of the rules of the Senate, but applicable only with respect to the procedure to be followed in the Senate in the case of a bill described in this paragraph, and it supersedes other rules only to the extent that it is inconsistent with such rules; and

[(2) with full recognition of the constitutional right of the Senate to change the rules (so far as relating to the procedure of the Senate) at any time, in the same manner, and to the same extent as in the case of any other rule of the Senate.]

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SECTION 4410 OF THE BALANCED BUDGET ACT OF 1997

SEC. 4410. FLOOR ON AREA WAGE INDEX.

(a) * * *

* * * * * * *

(d) APPLICATION TO RECLASSIFIED HOSPITALS.—In the case of a hospital that is reclassified based on wages under paragraph (8) or (10) of section 1886(d) of the Social Security Act into an area the area wage index for which is increased under subsection (a), such increased area wage index shall also apply to such hospital.

VII. DISSENTING VIEWS

H.R. 3162 is fundamentally flawed legislation that threatens to do irreparable harm to the Medicare program and its beneficiaries. The provisions in the bill will drastically cut payments to Medicare providers and deny millions of beneficiaries the opportunity to choose Medicare plans that provide additional benefits and improve the quality of care they receive. The bill uses these devastating Medicare cuts to fund a sweeping expansion of an existing government run healthcare program, intended for low income children, but now broadened to include many middle and upper income families.

UNFAIRLY TARGETS SENIORS ENROLLED IN MEDICARE ADVANTAGE

Today, more than 8 million Medicare beneficiaries are enrolled in the Medicare Advantage ("MA") program. Seniors are attracted to MA because plans provide benefits that traditional Medicare does not offer, including vision and dental coverage. Furthermore, MA plans provide protection against catastrophic health expenses, with many plans offering caps on annual out-of-pocket costs. Traditional Medicare does not offer this protection. According to the Centers for Medicare and Medicaid Services ("CMS"), MA plans also offer additional assistance with co-payments and deductibles, which saves beneficiaries nearly $90 per month over what they would have spent in traditional Medicare.

History shows that when MA payments are cut, seniors lose access to the benefits on which they depend. As a result of payment changes made in the Balanced Budget Act of 1997, MA enrollment dropped from a high of 6.6 million down to 5.1 million in 2003. CBO projects that if the MA payment cuts contained in H.R. 3162 are enacted, 7 million fewer beneficiaries will be enrolled in MA plans in 2012. CBO also predicts that 3 million beneficiaries who are currently enrolled will be forced back into the fee-for-service Medicare program. This payment change will deny seniors their ability to choose how they wish to receive their Medicare benefits and prevent them from electing the Medicare benefits that best meet their health needs.

Extensive research has been conducted to determine that the types of beneficiaries that are most likely to be hurt by these unprecedented cuts will be minority, low-income, rural, and union retiree beneficiaries. According to a report from Dr. Kenneth Thorpe, a researcher at Emory University and former Clinton Administration official, 1.7 million low-income beneficiaries and 800,000 minority beneficiaries will be forced out of their MA plans by these payment changes.

These cuts will be especially harmful to minorities, given that 40 percent of African-Americans and 53 percent of Hispanics who depend on Medicare are enrolled in MA. It is not surprising therefore

that both the NAACP and the League of United Latin American Citizens have expressed their concerns about these drastic cuts. These payment cuts will also have severe impacts on rural beneficiaries. As a result of the changes included in the Medicare Modernization Act of 2003, MA enrollment in rural areas has actually increased by 300% since 2004, and every Medicare beneficiary living in a rural area now has the opportunity to enroll in a MA plan.

Several amendments were offered during the mark-up of H.R. 3162 to protect Medicare beneficiaries from losing the enhanced Medicare benefits offered by MA plans, but all were rejected by the majority. Rep. English offered an amendment that would have allowed the Secretary of HHS to adjust the MA payment benchmarks on a county by county basis to ensure that at least one plan continued to be available to serve seniors in every county in the nation. Rep. Tiberi offered an amendment that would prohibit the cutting of Medicare payments to MA plans whose membership disproportionately consisted of minority and low-income beneficiaries. These amendments would have protected beneficiaries and we believe their rejection will negatively impact beneficiaries' ability to select the Medicare benefits that best meet their health needs.

Mr. Camp offered an amendment that would have repealed a provision in H.R. 3162 that would limit employer MA plans ability to enroll retirees who have moved out-of-state. MA currently provides employers and unions with an important means of providing health care coverage to their retirees. Today, 1.2 million retirees and former union members are enrolled in MA employer plans. Since some MA plans do not have to build provider networks, these plans are able to partner with unions and employers to ensure that all retirees can receive the same health care coverage, irrespective of where they choose to spend their retirement. H.R. 3162 curtails the flexibility that unions and employers currently enjoy with MA plans, by requiring plans to draw 90% of their enrollment from a single county. By defeating the Camp amendment, the Majority will make it very difficult, if not impossible, for many retirees to gain access to the additional benefits and protections offered by employer MA plans, if they have chosen to retire to an area distant from the primary location of their former employer's MA plan.

LIMITS ACCESS TO PROVIDERS

As part of its efforts to expand a single-payor, government run health system, H.R. 3162 also exposes a principle weakness of such systems. The bill utilizes Medicare's government mandated pricing systems to arbitrarily reduce payments to a broad range of providers, with little thought to the disruption and potential shortages that these cuts may trigger in the healthcare marketplace. In order to fund priorities having nothing to do with Medicare, the majority has chosen to reduce Medicare payments that will cause significant disruptions for many types of providers and may reduce beneficiaries access to important healthcare services.

Medicare accounts for nearly 41 percent of the care hospitals provide, yet it often fails to cover the actual costs of providing care to Medicare beneficiaries. In fact, the level of under-funding has grown markedly in recent years—to more than $15 billion in 2004. This under-funding jeopardizes the financial status of hospitals and

shifts costs to the private sector. Hospitals' total Medicare margin will reach a ten-year low in 2007 at negative 5.4 percent. As a result, 68 percent of hospitals lose money serving Medicare patients today. The Medicare Payment Advisory Commission (MedPAC) recommended a full market basket update for hospitals for FY 2008. Despite this recommendation, H.R. 3162 requires hospital market basket reductions that will further reduce Medicare payments to hospitals. Mr. Brady offered an amendment to protect America's hospitals by eliminating the 0.25 percent reduction to the hospital market basket, but this amendment was rejected by the majority.

Other providers whose payments were cut by H.R. 3162 include End Stage Renal Disease (ESRD) and power wheelchair providers. Mr. Camp introduced an amendment to provide a two-year update to ESRD providers and address current inequities that exist in Medicare payments for ESRD. An amendment, offered by Mr. Nunes, would have preserved Medicare beneficiaries' ability to purchase power wheelchairs in the first month. Currently, more than 95 percent of Medicare beneficiaries utilize the purchase option. The financial outlay for the supplier to produce a customized wheelchair occurs principally in the first month, and modifying Medicare's payment rules may mean that suppliers will no longer be able to provide customized wheelchairs to these beneficiaries. By rejecting these amendments, the majority allowed payment cuts to these providers which may diminish vulnerable beneficiaries' access to these items and services.

H.R. 3162 also imposed a moratorium on Medicare's approval of new physician owned hospitals, while imposing significant new regulatory burdens upon existing physician owned hospitals. The provision prevents any new development of physician-owned hospitals, as well as halting existing projects. The additional regulatory burdens the bill imposes may also make it more difficult for smaller physician owned hospitals to continue to operate, which could put as many as 29,000 full time employees out of work. This provision goes far beyond prior proposals to regulate these types of hospitals and has not been the subject of a single hearing. Mr. Johnson offered an amendment to strike this provision. By failing to adopt this amendment, the majority will reduce patients' ability to choose a hospital in many communities, and further limit competition in the hospital marketplace.

H.R. 3162 also substantially cut Medicare payments for Skilled Nursing Facilities (SNFs), home health providers, inpatient rehabilitation facilities (IRFs) and long-term care hospitals. Financial stability is critical to ensuring sustainable, high-quality long term care for the more than 1.5 million frail, elderly, and disabled Americans who rely on these services. H.R. 3162 cuts $7.7 billion from these providers over 5 years, and as a result, has raised significant concerns about whether these providers will continue to be able to provide the same level of high quality care for Medicare beneficiaries. Amendments offered by Reps. English and Weller sought to eliminate these cuts, but they were both defeated by the majority.

INSOLVENCY OF MEDICARE PROGRAM

The Medicare Modernization Act (MMA) of 2003 requires that Trustees issue a "Medicare funding warning" when general revenue funding is projected to account for 45 percent or more of total Medicare expenditures for any one year. This year, the Trustee's report issued a second 45 percent funding warning, which triggered a requirement that Congress consider legislation under expedited procedures to address these funding issues. Medicare currently faces $32 trillion dollars of unfunded liability, which will increase to $54 trillion by 2012. H.R. 3162 strikes the MMA provision, which would have forced Congress to confront this issue and take steps to ensure the continued viability of the Medicare program. Mr. Ryan introduced an amendment to ensure the continuing funding of the Medicare program and protect Medicare beneficiaries by retaining the 45 percent trigger. By rejecting this amendment, the Majority has undermined the long term prospects of the Medicare program and thereby endangered the beneficiaries who depend on this vital program to provide their healthcare.

EARMARKS

The manager's amendment to H.R. 3162 included several earmarks that increase the Medicare payment amounts for specifically targeted hospitals. Congressman Stark also introduced an amendment, which was subsequently adopted, to benefit specific additional hospitals through targeted increased spending. We are concerned about the magnitude of these earmarks and how this language fails to provide any policy rationale for their last minute addition to this bill. The Committee has held no hearings on these proposed changes and the majority has failed to explain why these hospitals are any more qualified to receive these increased payments than any other similarly situated hospital. This lack of transparency undermines Medicare's ability to pay hospitals in a fair and equitable way, and also spends valuable taxpayer dollars without any oversight and accountability. This provision would also seem to clearly violate the intent and spirit of recent efforts to stop the abuse of legislative earmarks.

TAX IMPLICATIONS

We were disappointed that two amendments related to the tax portion of the bill were rejected by the Committee. The first, by Mr. Lewis, would have struck the ill-advised increase in federal excise taxes on tobacco products. As was pointed out, this tax is a regressive one, hitting hardest those with lower incomes. And, as a policy matter, we have grave reservations about using a declining revenue source as a means to fund a quickly expanding program. The dangers this presents are obvious when considering how out-of-balance the bill is over the ten-year budget window.

Mr. McCrery offered to strike a second tax increase in the bill, which is to be used to fund research on the comparative effects of various treatments. While a laudable goal, the funding mechanism, a tax on health insurance policies along with transfers from the Medicare Trust Funds, seems to be at cross-purposes with the Majority's stated goal of getting more people health insurance cov-

erage. We believe it was unwise for the Committee to reject this amendment.

DISRUPTING CURRENT IMPLEMENTATION OF HEALTH INFORMATION TECHNOLOGY

Implementing a widely adopted and interoperable health information network is crucial to reforming the current state of the U.S. healthcare system. Section 905 causes concern because it usurps the progress currently being made in doctors' offices across the country and replaces it with a one size, fits all mandate for Medicare providers. Every physician is entitled to selecting a system that will best suit their practice and their patients' needs; this is the only way to ensure successful nationwide implementation. Having the federal government and the large bureaucracy select one system for every type of provider is a recipe for disaster and the minority believes Section 905 is just that.

CONCLUSION

We support the goals of reauthorizing the SCHIP program and providing health insurance coverage for low income children. We believe that it was unfortunate that the majority chose to attempt to impose arbitrary Medicare payment cuts and significantly expand government run health care programs to middle and upper income children in the name of reauthorizing SCHIP. Secretary Leavitt has already made clear that this bill, along with its Senate companion, will likely be vetoed by the President if it should ever be sent to him. We hope that after such a veto, the majority will afford us the opportunity to work with them to craft a truly bi-partisan bill that will provide for the healthcare needs of America's uninsured children.

JIM MCCRERY.
JERRY WELLER.
WALLY HEGER.
RON LEWIS.
TOM REYNOLDS.
ERIC CANTOR.
JON PORTER.
DAVE CAMP.
PHIL ENGLISH.
KENNY HULSHOF.
KEVIN BRADY.
PAUL RYAN.
PAT TIBERI.

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