

110TH CONGRESS
1ST SESSION

H. R. 2860

To amend title XVIII of the Social Security Act to protect and preserve access of Medicare beneficiaries in rural areas to health care providers under the Medicare Program, and for other purposes.

IN THE HOUSE OF REPRESENTATIVES

JUNE 26, 2007

Mr. POMEROY (for himself, Mr. WALDEN of Oregon, Mr. STUPAK, Mrs. EMERSON, Mr. THOMPSON of California, Mr. MORAN of Kansas, Mr. KIND, Mr. PETERSON of Pennsylvania, Mr. ALLEN, Mr. BERRY, Mr. CAMP of Michigan, Ms. HERSETH SANDLIN, Mr. MCINTYRE, Mr. TANNER, Mr. BISHOP of Georgia, Mr. BOSWELL, Mr. BOYD of Florida, Mr. BOUCHER, Mrs. BOYDA of Kansas, Mr. BRALEY of Iowa, Mr. CARNEY, Mr. DAVIS of Alabama, Mr. EDWARDS, Mr. ETHERIDGE, Mr. GILCHREST, Mr. GRAVES, Mr. HARE, Mr. HASTINGS of Washington, Mr. HINCHEY, Ms. JACKSON-LEE of Texas, Mr. JONES of North Carolina, Mr. KANJORSKI, Mr. LAHOOD, Mr. LUCAS, Mr. MATHESON, Mr. MCHUGH, Mrs. MCMORRIS RODGERS, Mr. MCNULTY, Mr. MELANCON, Mr. OBERSTAR, Mr. PAUL, Mr. PICKERING, Mr. RAHALL, Mr. REHBERG, Mr. RENZI, Mr. SALAZAR, Mr. SIMPSON, Mr. TIAHRT, Mr. WELCH of Vermont, Mr. WILSON of Ohio, Mr. YOUNG of Alaska, Mr. THORNBERRY, and Mr. ROSS) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

A BILL

To amend title XVIII of the Social Security Act to protect and preserve access of Medicare beneficiaries in rural areas to health care providers under the Medicare Program, and for other purposes.

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

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

4 (a) **SHORT TITLE.**—This Act may be cited as the
 5 “Health Care Access and Rural Equity (H–CARE) Act
 6 of 2007”.

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

Sec. 1. Short title; table of contents.

TITLE I—MEDICARE HOSPITAL SERVICES

Sec. 101. Fairness in the Medicare disproportionate share hospital (DSH) ad-
 justment for rural hospitals.

Sec. 102. Treatment of Medicare hospital reclassifications.

Sec. 103. Critical access hospital improvements.

Sec. 104. Rebasing for sole community hospitals.

Sec. 105. Establishment of rural community hospital (RCH) program.

Sec. 106. Hold harmless through 2012 for small rural hospitals and sole com-
 munity hospitals under the prospective payment system for
 hospital outpatient department services under the Medicare
 program.

TITLE II—MEDICARE PRACTITIONER SERVICES

Sec. 201. Coverage of marriage and family therapist services and mental health
 counselor services under part B of the Medicare program.

Sec. 202. Permanent treatment of certain physician pathology services under
 Medicare.

Sec. 203. Extension of Medicare incentive payment program for physician scar-
 city areas.

Sec. 204. Extension of Medicare increase payments for ground ambulance serv-
 ices in rural areas.

Sec. 205. Extension of floor on Medicare work geographic adjustment.

TITLE III—OTHER MEDICARE PROVISIONS

Sec. 301. Ensuring proportional representation of interests of rural areas on
 MedPAC.

Sec. 302. Rural health clinic improvements.

Sec. 303. Use of medical conditions for coding ambulance services.

Sec. 304. Improvement in payments to retain emergency and other capacity for
 ambulances in rural areas.

Sec. 305. Medicare remote monitoring pilot projects.

Sec. 306. Minimum payment rate by Medicare Advantage organizations for
 services furnished by a critical access hospital and a rural
 health clinic.

1 **SEC. 102. TREATMENT OF MEDICARE HOSPITAL RECLASSI-**
2 **FICATIONS.**

3 (a) EXTENDING CERTAIN MEDICARE HOSPITAL
4 WAGE INDEX RECLASSIFICATIONS THROUGH FISCAL
5 YEAR 2010.—

6 (1) IN GENERAL.—Section 106(a) of the Medi-
7 care Improvements and Extension Act of 2006 (divi-
8 sion B of public Law 109–432) is amended by strik-
9 ing “September 30, 2007” and inserting “September
10 30, 2010”.

11 (2) SPECIAL EXCEPTION RECLASSIFICATIONS.—
12 The Secretary of Health and Human Services shall
13 extend for discharges occurring through September
14 30, 2013, the special exception reclassification of a
15 sole community hospital located in a State with less
16 than 10 people per square mile, made under the au-
17 thority of section 1886(d)(5)(I)(i) of the Social Se-
18 curity Act (42 U.S.C. 1395ww(d)(5)(I)(i)) and con-
19 tained in the final rule promulgated by the Secretary
20 in the Federal Register on August 11, 2004 (69
21 Fed. Reg. 49107).

22 (b) DISREGARDING SECTION 508 HOSPITAL RECLAS-
23 SIFICATIONS FOR PURPOSES OF GROUP RECLASSIFICA-
24 TIONS.—Section 508 of the Medicare Prescription Drug,
25 Improvement, and Modernization Act of 2003 (Public Law

1 108–173, 42 U.S.C. 1395ww note) is amended by adding
2 at the end the following new subsection:

3 “(g) DISREGARDING HOSPITAL RECLASSIFICATIONS
4 FOR PURPOSES OF GROUP RECLASSIFICATIONS.—For
5 purposes of the reclassification of a group of hospitals in
6 a geographic area under section 1886(d), a hospital reclassi-
7 fied under this section (including any such reclassifica-
8 tion which is extended under section 106(a) of the Medi-
9 care Improvements and Extension Act of 2006) shall not
10 be taken into account and shall not prevent the other hos-
11 pitals in such area from establishing such a group for such
12 purpose.”.

13 **SEC. 103. CRITICAL ACCESS HOSPITAL IMPROVEMENTS.**

14 (a) CLARIFICATION OF PAYMENT FOR CLINICAL
15 LABORATORY TESTS FURNISHED BY CRITICAL ACCESS
16 HOSPITALS.—

17 (1) IN GENERAL.—Section 1834(g)(4) of the
18 Social Security Act (42 U.S.C. 1395m(g)(4)) is
19 amended—

20 (A) in the heading, by striking “NO BENE-
21 FICIARY COST-SHARING” and inserting “TREAT-
22 MENT OF”; and

23 (B) by adding at the end the following new
24 sentence: “For purposes of the preceding sen-
25 tence and section 1861(mm)(3), clinical diag-

1 nostic laboratory services furnished by a critical
2 access hospital shall be treated as being fur-
3 nished as part of outpatient critical access serv-
4 ices without regard to whether—

5 “(A) the individual with respect to whom
6 such services are furnished is physically present
7 in the critical access hospital at the time the
8 specimen is collected;

9 “(B) such individual is registered as an
10 outpatient on the records of, and receives such
11 services directly from, the critical access hos-
12 pital; or

13 “(C) payment is (or, but for this sub-
14 section, would be) available for such services
15 under the fee schedule established under section
16 1833(h).”.

17 (2) EFFECTIVE DATE.—The amendments made
18 by paragraph (1) shall apply to cost reporting peri-
19 ods beginning on or after October 1, 2003.

20 (b) ELIMINATION OF ISOLATION TEST FOR COST-
21 BASED AMBULANCE REIMBURSEMENT.—

22 (1) IN GENERAL.—Section 1834(l)(8) of the
23 Social Security Act (42 U.S.C. 1395m(l)(8)) is
24 amended—

25 (A) in subparagraph (B)—

1 (i) by striking “owned and”; and

2 (ii) by inserting “(including when
3 such services are provided by the entity
4 under an arrangement with the hospital)”
5 after “hospital”; and

6 (B) by striking the comma at the end of
7 subparagraph (B) and all that follows and in-
8 serting a period.

9 (2) EFFECTIVE DATE.—The amendments made
10 by this subsection shall apply to services furnished
11 on or after January 1, 2008.

12 (c) PROVISION OF A MORE FLEXIBLE ALTERNATIVE
13 TO THE CAH DESIGNATION 25 INPATIENT BED LIMIT
14 REQUIREMENT.—

15 (1) IN GENERAL.—Section 1820(c)(2) of the
16 Social Security Act (42 U.S.C. 1395i–4(c)(2)) is
17 amended—

18 (A) in subparagraph (B)(iii), by striking
19 “provides not more than” and inserting “sub-
20 ject to subparagraph (F), provides not more
21 than”; and

22 (B) by adding at the end the following new
23 subparagraph:

24 “(F) ALTERNATIVE TO 25 INPATIENT BED
25 LIMIT REQUIREMENT.—

1 “(i) IN GENERAL.—A State may elect
2 to treat a facility, with respect to the des-
3 ignation of the facility for a cost reporting
4 period, as satisfying the requirement of
5 subparagraph (B)(iii) relating to a max-
6 imum number of acute care inpatient beds
7 if the facility elects, in accordance with a
8 method specified by the Secretary and be-
9 fore the beginning of the cost reporting pe-
10 riod, to meet the requirement under clause
11 (ii).

12 “(ii) ALTERNATE REQUIREMENT.—
13 The requirement under this clause, with
14 respect to a facility and a cost reporting
15 period, is that the total number of inpa-
16 tient bed days described in subparagraph
17 (B)(iii) during such period will not exceed
18 7,300. For purposes of this subparagraph,
19 an individual who is an inpatient in a bed
20 in the facility for a single day shall be
21 counted as one inpatient bed day.

22 “(iii) WITHDRAWAL OF ELECTION.—
23 The option described in clause (i) shall not
24 apply to a facility for a cost reporting pe-
25 riod if the facility (for any two consecutive

1 cost reporting periods during the previous
2 5 cost reporting periods) was treated under
3 such option and had a total number of in-
4 patient bed days for each of such two cost
5 reporting periods that exceeded the num-
6 ber specified in such clause.”.

7 (2) EFFECTIVE DATE.—The amendments made
8 by paragraph (1) shall apply to cost reporting peri-
9 ods beginning on or after the date of the enactment
10 of this Act.

11 **SEC. 104. REBASING FOR SOLE COMMUNITY HOSPITALS.**

12 (a) REBASING PERMITTED.—Section 1886(b)(3) of
13 the Social Security Act (42 U.S.C. 1395ww(b)(3)) is
14 amended by adding at the end the following new subpara-
15 graph:

16 “(K)(i) For cost reporting periods beginning on or
17 after October 1, 2007, in the case of a sole community
18 hospital there shall be substituted for the amount other-
19 wise determined under subsection (d)(5)(D)(i) of this sec-
20 tion, if such substitution results in a greater amount of
21 payment under this section for the hospital—

22 “(I) with respect to discharges occurring in fis-
23 cal year 2008, 75 percent of the subsection
24 (d)(5)(D)(i) amount (as described in subparagraph

1 (I)(i)(I)) and 25 percent of the subparagraph (K)
2 rebased target amount (as defined in clause (ii));

3 “(II) with respect to discharges occurring in fis-
4 cal year 2009, 50 percent of the subsection
5 (d)(5)(D)(i) amount and 50 percent of the subpara-
6 graph (K) rebased target amount;

7 “(III) with respect to discharges occurring in
8 fiscal year 2010, 25 percent of the subsection
9 (d)(5)(D)(i) amount and 75 percent of the subpara-
10 graph (K) rebased target amount; and

11 “(IV) with respect to discharges occurring after
12 fiscal year 2010, 100 percent of the subparagraph
13 (K) rebased target amount.

14 “(ii) For purposes of this subparagraph, the ‘sub-
15 paragraph (K) rebased target amount’ has the meaning
16 given the term ‘target amount’ in subparagraph (C), ex-
17 cept that—

18 “(I) there shall be substituted for the base cost
19 reporting period the 12-month cost reporting period
20 beginning during fiscal year 2002;

21 “(II) any reference in subparagraph (C)(i) to
22 the ‘first cost reporting period’ described in such
23 subparagraph is deemed a reference to the first cost
24 reporting period beginning on or after October 1,
25 2007; and

1 “(III) the applicable percentage increase shall
2 only be applied under subparagraph (C)(iv) for dis-
3 charges occurring in fiscal years beginning with fis-
4 cal year 2009.”.

5 (b) CONFORMING AMENDMENTS.—Section
6 1886(b)(3) of such Act (42 U.S.C. 1395ww(b)(3)) is
7 amended—

8 (1) in subparagraph (C), by inserting “and sub-
9 paragraph (K)” after “subject to subparagraph (I)”
10 in the matter preceding clause (i); and

11 (2) in subparagraph (I)(i)—

12 (A) by striking “For” in the matter pre-
13 ceding subclause (I) and inserting “Subject to
14 subparagraph (K), for”; and

15 (B) in subclause (I), by inserting “and
16 subparagraph (K)” after “referred to in this
17 clause”.

18 **SEC. 105. ESTABLISHMENT OF RURAL COMMUNITY HOS-**
19 **PITAL (RCH) PROGRAM.**

20 (a) IN GENERAL.—Section 1861 of the Social Secu-
21 rity Act (42 U.S.C. 1395x), as amended by section 201,
22 is amended by adding at the end of the following new sub-
23 section:

1 “Rural Community Hospital; Rural Community Hospital
2 Services

3 “(ddd)(1) The term ‘rural community hospital’
4 means a hospital (as defined in subsection (e)) that—

5 “(A) is located in a rural area (as defined in
6 section 1886(d)(2)(D)) or treated as being so lo-
7 cated pursuant to section 1886(d)(8)(E);

8 “(B) subject to paragraph (2), has less than 51
9 acute care inpatient beds, as reported in its most re-
10 cent cost report;

11 “(C) makes available 24-hour emergency care
12 services;

13 “(D) subject to paragraph (3), has a provider
14 agreement in effect with the Secretary and is open
15 to the public as of January 1, 2008; and

16 “(E) applies to the Secretary for such designa-
17 tion.

18 “(2) For purposes of paragraph (1)(B), beds in a
19 psychiatric or rehabilitation unit of the hospital which is
20 a distinct part of the hospital shall not be counted.

21 “(3) Subparagraph (1)(D) shall not be construed to
22 prohibit any of the following from qualifying as a rural
23 community hospital:

24 “(A) A replacement facility (as defined by the
25 Secretary in regulations in effect on January 1,

1 2008) with the same service area (as defined by the
2 Secretary in regulations in effect on such date).

3 “(B) A facility obtaining a new provider num-
4 ber pursuant to a change of ownership.

5 “(C) A facility which has a binding written
6 agreement with an outside, unrelated party for the
7 construction, reconstruction, lease, rental, or financ-
8 ing of a building as of January 1, 2008.

9 “(4) Nothing in this subsection shall be construed as
10 prohibiting a critical access hospital from qualifying as a
11 rural community hospital if the critical access hospital
12 meets the conditions otherwise applicable to hospitals
13 under subsection (e) and section 1866.

14 “(5) Nothing in this subsection shall be construed as
15 prohibiting a rural community hospital participating in
16 the demonstration program under Section 410A of the
17 Medicare Prescription Drug, Improvement, and Mod-
18 ernization Act of 2003 (Public Law 108–173; 117 Stat.
19 2313) from qualifying as a rural community hospital if
20 the rural community hospital meets the conditions other-
21 wise applicable to hospitals under subsection (e) and sec-
22 tion 1866.”.

23 (b) PAYMENT.—

24 (1) INPATIENT HOSPITAL SERVICES.—Section
25 1814 of the Social Security Act (42 U.S.C. 1395f)

1 is amended by adding at the end the following new
2 subsection:

3 “Payment for Inpatient Services Furnished in Rural
4 Community Hospitals

5 “(m) The amount of payment under this part for in-
6 patient hospital services furnished in a rural community
7 hospital, other than such services furnished in a psy-
8 chiatric or rehabilitation unit of the hospital which is a
9 distinct part, is, at the election of the hospital in the appli-
10 cation referred to in section 1861(ddd)(1)(E)—

11 “(1) 101 percent of the reasonable costs of pro-
12 viding such services, without regard to the amount
13 of the customary or other charge, or

14 “(2) the amount of payment provided for under
15 the prospective payment system for inpatient hos-
16 pital services under section 1886(d).”.

17 (2) OUTPATIENT SERVICES.—Section 1834 of
18 such Act (42 U.S.C. 1395m) is amended by adding
19 at the end the following new subsection:

20 “(n) PAYMENT FOR OUTPATIENT SERVICES FUR-
21 NISHED IN RURAL COMMUNITY HOSPITALS.—The
22 amount of payment under this part for outpatient services
23 furnished in a rural community hospital is, at the election
24 of the hospital in the application referred to in section
25 1861(ddd)(1)(E)—

1 “(1) 101 percent of the reasonable costs of pro-
2 viding such services, without regard to the amount
3 of the customary or other charge and any limitation
4 under section 1861(v)(1)(U), or

5 “(2) the amount of payment provided for under
6 the prospective payment system for covered OPD
7 services under section 1833(t).”.

8 (3) EXEMPTION FROM 30-PERCENT REDUCTION
9 IN REIMBURSEMENT FOR BAD DEBT.—Section
10 1861(v)(1)(T) of such Act (42 U.S.C.
11 1395x(v)(1)(T)) is amended by inserting “(other
12 than for a rural community hospital)” after “In de-
13 termining such reasonable costs for hospitals”.

14 (c) BENEFICIARY COST-SHARING FOR OUTPATIENT
15 SERVICES.—Section 1834(n) of such Act (as added by
16 subsection (b)(2)) is amended—

17 (1) by redesignating paragraphs (1) and (2) as
18 subparagraphs (A) and (B), respectively;

19 (2) by inserting “(1)” after “(n)”; and

20 (3) by adding at the end the following:

21 “(2) The amounts of beneficiary cost-sharing for out-
22 patient services furnished in a rural community hospital
23 under this part shall be as follows:

24 “(A) For items and services that would have
25 been paid under section 1833(t) if provided by a

1 hospital, the amount of cost-sharing determined
2 under paragraph (8) of such section.

3 “(B) For items and services that would have
4 been paid under section 1833(h) if furnished by a
5 provider or supplier, no cost-sharing shall apply.

6 “(C) For all other items and services, the
7 amount of cost-sharing that would apply to the item
8 or service under the methodology that would be used
9 to determine payment for such item or service if pro-
10 vided by a physician, provider, or supplier, as the
11 case may be.”.

12 (d) CONFORMING AMENDMENTS.—

13 (1) PART A PAYMENT.—Section 1814(b) of
14 such Act (42 U.S.C. 1395f(b)) is amended in the
15 matter preceding paragraph (1) by inserting “other
16 than inpatient hospital services furnished by a rural
17 community hospital,” after “critical access hospital
18 services,”.

19 (2) PART B PAYMENT.—Section 1833(a) of
20 such Act (42 U.S.C. 1395l(a)) is amended—

21 (A) in paragraph (2), in the matter before
22 subparagraph (A), by striking “and (I)” and in-
23 serting “(I), and (K)”;

24 (B) by striking “and” at the end of para-
25 graph (8);

1 (C) by striking the period at the end of
2 paragraph (9) and inserting “; and”; and

3 (D) by adding at the end the following:

4 “(10) in the case of outpatient services fur-
5 nished by a rural community hospital, the amounts
6 described in section 1834(n).”.

7 (3) TECHNICAL AMENDMENTS.—

8 (A) CONSULTATION WITH STATE AGEN-
9 CIES.—Section 1863 of such Act (42 U.S.C.
10 1395z) is amended by striking “and (dd)(2)”
11 and inserting “(dd)(2), (mm)(1), and
12 (ddd)(1)”.

13 (B) PROVIDER AGREEMENTS.—Section
14 1866(a)(2)(A) of such Act (42 U.S.C.
15 1395cc(a)(2)(A)) is amended by inserting “sec-
16 tion 1834(n)(2),” after “section 1833(b),”.

17 (e) EFFECTIVE DATE.—The amendments made by
18 this section shall apply to items and services furnished on
19 or after October 1, 2007.

1 **SEC. 106. HOLD HARMLESS THROUGH 2012 FOR SMALL**
2 **RURAL HOSPITALS AND SOLE COMMUNITY**
3 **HOSPITALS UNDER THE PROSPECTIVE PAY-**
4 **MENT SYSTEM FOR HOSPITAL OUTPATIENT**
5 **DEPARTMENT SERVICES UNDER THE MEDI-**
6 **CARE PROGRAM.**

7 Section 1833(t)(7)(D)(i) of the Social Security Act
8 (42 U.S.C. 1395l(t)(7)(D)) is amended—

9 (1) in subclause (II)—

10 (A) by striking “January 1, 2009” and in-
11 serting “January 1, 2008”;

12 (B) by striking “2006, 2007, or 2008” and
13 inserting “2006 or 2007”; and

14 (C) by striking “95 percent, 90 percent,
15 and 85 percent” and inserting “95 percent and
16 90 percent”; and

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

19 “(III) In the case of a hospital located
20 in a rural area and that has not more than
21 100 beds or a sole community hospital (as
22 defined in section 1886(d)(5)(D)(iii)), for
23 covered OPD services furnished after De-
24 cember 31, 2007, and before January 1,
25 2013, for which the PPS amount is less
26 than the pre-BBA amount, the amount of

1 payment under this subsection shall be in-
2 creased by the amount of such dif-
3 ference.”.

4 **TITLE II—MEDICARE** 5 **PRACTITIONER SERVICES**

6 **SEC. 201. COVERAGE OF MARRIAGE AND FAMILY THERA-** 7 **PIST SERVICES AND MENTAL HEALTH COUN-** 8 **SELOR SERVICES UNDER PART B OF THE** 9 **MEDICARE PROGRAM.**

10 (a) COVERAGE OF SERVICES.—

11 (1) IN GENERAL.—Section 1861(s)(2) of the
12 Social Security Act (42 U.S.C. 1395x(s)(2)) is
13 amended—

14 (A) in subparagraph (Z), by striking
15 “and” at the end;

16 (B) in subparagraph (AA), by inserting
17 “and” at the end; and

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

20 “(BB) marriage and family therapist services
21 (as defined in subsection (ccc)(1)) and mental health
22 counselor services (as defined in subsection
23 (ccc)(3));”.

1 (2) DEFINITIONS.—Section 1861 of such Act
2 (42 U.S.C. 1395x) is amended by adding at the end
3 the following new subsection:

4 “Marriage and Family Therapist Services; Marriage and
5 Family Therapist; Mental Health Counselor Serv-
6 ices; Mental Health Counselor

7 “(ccc)(1) The term ‘marriage and family therapist
8 services’ means services performed by a marriage and
9 family therapist (as defined in paragraph (2)) for the diag-
10 nosis and treatment of mental illnesses, which the mar-
11 riage and family therapist is legally authorized to perform
12 under State law (or the State regulatory mechanism pro-
13 vided by State law) of the State in which such services
14 are performed, as would otherwise be covered if furnished
15 by a physician or as an incident to a physician’s profes-
16 sional service, but only if no facility or other provider
17 charges or is paid any amounts with respect to the fur-
18 nishing of such services.

19 “(2) The term ‘marriage and family therapist’ means
20 an individual who—

21 “(A) possesses a master’s or doctoral degree
22 which qualifies for licensure or certification as a
23 marriage and family therapist pursuant to State
24 law;

1 “(B) after obtaining such degree has performed
2 at least 2 years of clinical supervised experience in
3 marriage and family therapy; and

4 “(C) in the case of an individual performing
5 services in a State that provides for licensure or cer-
6 tification of marriage and family therapists, is li-
7 censed or certified as a marriage and family thera-
8 pist in such State.

9 “(3) The term ‘mental health counselor services’
10 means services performed by a mental health counselor (as
11 defined in paragraph (4)) for the diagnosis and treatment
12 of mental illnesses which the mental health counselor is
13 legally authorized to perform under State law (or the
14 State regulatory mechanism provided by the State law) of
15 the State in which such services are performed, as would
16 otherwise be covered if furnished by a physician or as inci-
17 dent to a physician’s professional service, but only if no
18 facility or other provider charges or is paid any amounts
19 with respect to the furnishing of such services.

20 “(4) The term ‘mental health counselor’ means an
21 individual who—

22 “(A) possesses a master’s or doctor’s degree in
23 mental health counseling or a related field;

1 “(B) after obtaining such a degree has per-
2 formed at least 2 years of supervised mental health
3 counselor practice; and

4 “(C) in the case of an individual performing
5 services in a State that provides for licensure or cer-
6 tification of mental health counselors or professional
7 counselors, is licensed or certified as a mental health
8 counselor or professional counselor in such State.”.

9 (3) PROVISION FOR PAYMENT UNDER PART
10 B.—Section 1832(a)(2)(B) of such Act (42 U.S.C.
11 1395k(a)(2)(B)) is amended by adding at the end
12 the following new clause:

13 “(v) marriage and family therapist
14 services and mental health counselor serv-
15 ices;”.

16 (4) AMOUNT OF PAYMENT.—Section 1833(a)(1)
17 of such Act (42 U.S.C. 1395l(a)(1)) is amended—

18 (A) by striking “and (V)” and inserting
19 “(V)”; and

20 (B) by inserting before the semicolon at
21 the end the following: “, and (W) with respect
22 to marriage and family therapist services and
23 mental health counselor services under section
24 1861(s)(2)(BB), the amounts paid shall be 80
25 percent of the lesser of the actual charge for

1 the services or 75 percent of the amount deter-
 2 mined for payment of a psychologist under sub-
 3 paragraph (L)”.

4 (5) EXCLUSION OF MARRIAGE AND FAMILY
 5 THERAPIST SERVICES AND MENTAL HEALTH COUN-
 6 SELOR SERVICES FROM SKILLED NURSING FACILITY
 7 PROSPECTIVE PAYMENT SYSTEM.—Section
 8 1888(e)(2)(A)(ii) of such Act (42 U.S.C.
 9 1395yy(e)(2)(A)(ii)) is amended by inserting “mar-
 10 riage and family therapist services (as defined in
 11 section 1861(ccc)(1)), mental health counselor serv-
 12 ices (as defined in section 1861(ccc)(3)),” after
 13 “qualified psychologist services,”.

14 (6) INCLUSION OF MARRIAGE AND FAMILY
 15 THERAPISTS AND MENTAL HEALTH COUNSELORS AS
 16 PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Sec-
 17 tion 1842(b)(18)(C) of such Act (42 U.S.C.
 18 1395u(b)(18)(C)) is amended by adding at the end
 19 the following new clauses:

20 “(vii) A marriage and family therapist (as de-
 21 fined in section 1861(ccc)(2)).

22 “(viii) A mental health counselor (as defined in
 23 section 1861(ccc)(4)).”.

24 (b) COVERAGE OF CERTAIN MENTAL HEALTH SERV-
 25 ICES PROVIDED IN CERTAIN SETTINGS.—

1 (1) RURAL HEALTH CLINICS AND FEDERALLY
2 QUALIFIED HEALTH CENTERS.—Section
3 1861(aa)(1)(B) of the Social Security Act (42
4 U.S.C. 1395x(aa)(1)(B)) is amended by striking “or
5 by a clinical social worker (as defined in subsection
6 (hh)(1)),” and inserting “, by a clinical social worker
7 (as defined in subsection (hh)(1)), by a marriage
8 and family therapist (as defined in subsection
9 (ccc)(2)), or by a mental health counselor (as de-
10 fined in subsection (ccc)(4)),”.

11 (2) HOSPICE PROGRAMS.—Section
12 1861(dd)(2)(B)(i)(III) of such Act (42 U.S.C.
13 1395x(dd)(2)(B)(i)(III)) is amended by inserting “or
14 one marriage and family therapist (as defined in
15 subsection (ccc)(2))” after “social worker”.

16 (c) AUTHORIZATION OF MARRIAGE AND FAMILY
17 THERAPISTS TO DEVELOP DISCHARGE PLANS FOR POST-
18 HOSPITAL SERVICES.—Section 1861(ee)(2)(G) of the So-
19 cial Security Act (42 U.S.C. 1395x(ee)(2)(G)) is amended
20 by inserting “marriage and family therapist (as defined
21 in subsection (ccc)(2)),” after “social worker,”.

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

1 **SEC. 202. PERMANENT TREATMENT OF CERTAIN PHYSI-**
2 **CIAN PATHOLOGY SERVICES UNDER MEDI-**
3 **CARE.**

4 Section 1848(i) of the Social Security Act (42 U.S.C.
5 1395w-4(i)) is amended by adding at the end the fol-
6 lowing new paragraph:

7 “(4) TREATMENT OF CERTAIN PHYSICIAN PA-
8 THOLOGY SERVICES.—

9 “(A) IN GENERAL.—With respect to serv-
10 ices furnished on or after January 1, 2008, if
11 an independent laboratory furnishes the tech-
12 nical component of a physician pathology serv-
13 ice to a fee-for-service Medicare beneficiary who
14 is an inpatient or outpatient of a covered hos-
15 pital, the Secretary shall treat such component
16 as a service for which payment shall be made
17 to the laboratory under this section and not as
18 an inpatient hospital service for which payment
19 is made to the hospital under section 1886(d)
20 or as a hospital outpatient service for which
21 payment is made to the hospital under section
22 1833(t).

23 “(B) DEFINITIONS.—In this paragraph:

24 “(i) COVERED HOSPITAL.—

25 “(I) IN GENERAL.—The term
26 ‘covered hospital’ means, with respect

1 to an inpatient or outpatient, a hos-
2 pital that had an arrangement with
3 an independent laboratory that was in
4 effect as of July 22, 1999, under
5 which a laboratory furnished the tech-
6 nical component of physician pathol-
7 ogy services to fee-for-service Medi-
8 care beneficiaries who were hospital
9 inpatients or outpatients, respectively,
10 and submitted claims for payment for
11 such component to a carrier with a
12 contract under section 1842 and not
13 to the hospital.

14 “(II) CHANGE IN OWNERSHIP
15 DOES NOT AFFECT DETERMINA-
16 TION.—A change in ownership with
17 respect to a hospital on or after the
18 date referred to in subclause (I) shall
19 not affect the determination of wheth-
20 er such hospital is a covered hospital
21 for purposes of such subclause.

22 “(ii) FEE-FOR-SERVICE MEDICARE
23 BENEFICIARY.—The term ‘fee-for-service
24 Medicare beneficiary’ means an individual
25 who is entitled to (or enrolled for) benefits

1 under part A, or enrolled under this part,
2 or both, but who is not enrolled in any of
3 the following:

4 “(I) A Medicare Advantage plan
5 under part C.

6 “(II) A plan offered by an eligi-
7 ble organization under section 1876.

8 “(III) A program of all-inclusive
9 care for the elderly (PACE) under
10 section 1894.

11 “(IV) A social health mainte-
12 nance organization (SHMO) dem-
13 onstration project established under
14 section 4018(b) of the Omnibus
15 Budget Reconciliation Act of 1987
16 (Public Law 100–203).

17 “(C) REFERENCE.—For the provision re-
18 lated to the treatment of certain services fur-
19 nished prior to January 1, 2008, see section
20 542 of the Medicare, Medicaid, and SCHIP
21 Benefits Improvement and Protection Act of
22 2000, as amended by section 732 of the Medi-
23 care Prescription Drug, Improvement, and
24 Modernization Act of 2003 and section 104 of

1 the Medicare Improvements and Extension Act
2 of 2006 (division B of Public Law 109–432).”.

3 **SEC. 203. EXTENSION OF MEDICARE INCENTIVE PAYMENT**
4 **PROGRAM FOR PHYSICIAN SCARCITY AREAS.**

5 Section 1833(u)(1) of the Social Security Act (42
6 U.S.C. 1395l(u)(1)) is amended by striking “2008” and
7 inserting “2013”.

8 **SEC. 204. EXTENSION OF MEDICARE INCREASE PAYMENTS**
9 **FOR GROUND AMBULANCE SERVICES IN**
10 **RURAL AREAS.**

11 Section 1834(l)(13) of the Social Security Act (42
12 U.S.C. 1395m(l)(13)) is amended—

13 (1) in subparagraph (A)—

14 (A) in the matter before clause (i), by
15 striking “furnished on or after July 1, 2004,
16 and before January 1, 2007,”;

17 (B) in clause (i), by inserting “for services
18 furnished on or after July 1, 2004, and before
19 January 1, 2012,” after “in such paragraph,”;
20 and

21 (C) in clause (ii), by inserting “for services
22 furnished on or after July 1, 2004, and before
23 January 1, 2007,” after “in clause (i),”; and

24 (2) in subparagraph (B)—

1 (A) in the heading, by striking “AFTER
2 2006” and inserting “FOR SUBSEQUENT PERI-
3 ODS”;

4 (B) by inserting “clauses (i) and (ii) of”
5 before “subparagraph (A)”; and

6 (C) by striking “in such subparagraph”
7 and inserting “in the respective clause”.

8 **SEC. 205. EXTENSION OF FLOOR ON MEDICARE WORK GEO-**
9 **GRAPHIC ADJUSTMENT.**

10 Section 1848(e)(1)(E) of the Social Security Act (42
11 U.S.C. 1395w-4(e)(1)(E)) is amended by striking “2008”
12 and inserting “2012”.

13 **TITLE III—OTHER MEDICARE**
14 **PROVISIONS**

15 **SEC. 301. ENSURING PROPORTIONAL REPRESENTATION OF**
16 **INTERESTS OF RURAL AREAS ON MEDPAC.**

17 (a) IN GENERAL.—Section 1805(c)(2) of the Social
18 Security Act (42 U.S.C. 1395b-6(c)(2)) is amended—

19 (1) in subparagraph (A), by inserting “con-
20 sistent with subparagraph (E)” after “rural rep-
21 resentatives”; and

22 (2) by adding at the end the following new sub-
23 paragraph:

24 “(E) PROPORTIONAL REPRESENTATION OF
25 INTERESTS OF RURAL AREAS.—In order to pro-

1 vide a balance between urban and rural rep-
2 representatives under subparagraph (A), the pro-
3 portion of members who represent the interests
4 of health care providers and Medicare bene-
5 ficiaries located in rural areas shall be no less
6 than the proportion, of the total number of
7 Medicare beneficiaries, who reside in rural
8 areas.”.

9 (b) **EFFECTIVE DATE.**—The amendments made by
10 subsection (a) shall apply with respect to appointments
11 made to the Medicare Payment Advisory Commission after
12 the date of the enactment of this Act.

13 **SEC. 302. RURAL HEALTH CLINIC IMPROVEMENTS.**

14 Section 1833(f) of the Social Security Act (42 U.S.C.
15 1395l(f)) is amended—

16 (1) in paragraph (1), by striking “, and” at the
17 end and inserting a semicolon;

18 (2) in paragraph (2)—

19 (A) by inserting “(before 2008)” after “in
20 a subsequent year”; and

21 (B) by striking the period at the end and
22 inserting a semicolon; and

23 (3) by adding at the end the following new
24 paragraphs:

25 “(3) in 2008, at \$92 per visit; and

1 “(4) in a subsequent year, at the limit estab-
2 lished under this subsection for the previous year in-
3 creased by the percentage increase in the MEI (as
4 so defined) applicable to primary care services (as so
5 defined) furnished as of the first day of that year.”.

6 **SEC. 303. USE OF MEDICAL CONDITIONS FOR CODING AM-**
7 **BULANCE SERVICES.**

8 Section 1834(l)(7) of the Social Security Act (42
9 U.S.C. 1395m(l)(7)) is amended to read as follows:

10 “(7) CODING SYSTEM.—

11 “(A) IN GENERAL.—The Secretary shall,
12 in accordance with section 1173(c)(1)(B) and
13 not later than January 1, 2008, establish a
14 mandatory system or systems for the coding of
15 claims for ambulance services for which pay-
16 ment is made under this subsection, including a
17 code set specifying the medical condition of the
18 individual who is transported and the level of
19 service that is appropriate for the transpor-
20 tation of an individual with that medical condi-
21 tion.

22 “(B) MEDICAL CONDITIONS.—The code set
23 established under subparagraph (A) shall take
24 into account the list of medical conditions devel-

1 oped in the course of the negotiated rulemaking
2 process conducted under paragraph (1).”.

3 **SEC. 304. IMPROVEMENT IN PAYMENTS TO RETAIN EMER-**
4 **GENCY AND OTHER CAPACITY FOR AMBU-**
5 **LANCES IN RURAL AREAS.**

6 (a) IN GENERAL.—Section 1834(l) of the Social Se-
7 curity Act (42 U.S.C. 1395m(l)) is amended by adding
8 at the end the following new paragraph:

9 “(15) ADDITIONAL PAYMENTS FOR PROVIDERS
10 FURNISHING AMBULANCE SERVICES IN RURAL
11 AREAS.—

12 “(A) IN GENERAL.—In the case of ground
13 ambulance services furnished on or after Janu-
14 ary 1, 2008, for which the transportation origi-
15 nates in a rural area (as determined under sub-
16 paragraph (B)), the Secretary shall provide for
17 a percent increase in the base rate of the fee
18 schedule for a trip identified under this sub-
19 section.

20 “(B) IDENTIFICATION OF RURAL AREAS.—
21 The Secretary, in consultation with the Office
22 of Rural Health Policy, shall use the Rural-
23 Urban Commuting Areas (RUCA) coding sys-
24 tem, adopted by that Office, to designate rural
25 areas for the purposes of this paragraph. A

1 rural area is any area in RUCA levels 2
2 through 10 and any unclassified area.

3 “(C) TIERING OF RURAL AREAS.—The
4 Secretary shall designate 4 tiers of rural areas,
5 using a ZIP Code population-based method-
6 ology generated by the RUCA coding system, as
7 follows:

8 “(i) TIER 1.—A rural area that is a
9 high metropolitan commuting area, in
10 which 30 percent or more of the com-
11 muting flow is to an urban area, as des-
12 ignated by the Bureau of the Census
13 (RUCA level 2).

14 “(ii) TIER 2.—A rural area that is a
15 low metropolitan commuting area, in which
16 less than 30 percent of the commuting flow
17 is to an urban area or to a large town, as
18 designated by the Bureau of the Census
19 (RUCA levels 3–6).

20 “(iii) TIER 3.—A rural area that is a
21 small town core, as designated by the Bu-
22 reau of the Census, in which no significant
23 portion of the commuting flow is to an
24 area of population greater than 10,000
25 people (RUCA levels 7–9).

1 “(iv) TIER 4.—A rural area in which
2 there is no dominant commuting flow
3 (RUCA level 10) and any unclassified area.

4 The Secretary shall consult with the Office of
5 Rural Health Policy not less often than every 2
6 years to update the designation of rural areas
7 in accordance with any changes that are made
8 to the RUCA system.

9 “(D) PAYMENT ADJUSTMENTS FOR TRIPS
10 IN RURAL AREAS.—The Secretary shall adjust
11 the payment rate under this section for ambu-
12 lance trips that originate in each of the tiers es-
13 tablished in subparagraph (C) according to the
14 national average cost of full-cost providers for
15 providing ambulance services in each such
16 tier.”.

17 (b) REVIEW OF PAYMENTS FOR RURAL AMBULANCE
18 SERVICES AND REPORT TO CONGRESS.—

19 (1) REVIEW.—Not later than July 1, 2009, the
20 Secretary of Health and Human Services shall re-
21 view the system for adjusting payments for rural
22 ambulance services under section 1834(l)(15) of the
23 Social Security Act, as added by subsection (a), to
24 determine the adequacy and appropriateness of such
25 adjustments. In conducting such review, the Sec-

1 retary shall consult with providers and suppliers af-
2 fected by such adjustments and with representatives
3 of the ambulance industry generally to determine—

4 (A) whether such adjustments adequately
5 cover the additional costs incurred in serving
6 areas of low population density; and

7 (B) whether the tiered structure for mak-
8 ing such adjustments appropriately reflects the
9 difference in costs of providing services in dif-
10 ferent types of rural areas.

11 (2) REPORT.—Not later than January 1, 2011,
12 the Secretary shall submit to Congress a report on
13 the review conducted under paragraph (1) together
14 with any recommendations for revision to the sys-
15 tems for adjusting payments for ambulance services
16 in rural areas that the Secretary of Health and
17 Human Services determines appropriate.

18 (c) CONFORMING AMENDMENTS.—(1) Section
19 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)),
20 as amended by subsection (a), is amended by adding at
21 the end the following new paragraph:

22 “(16) DESIGNATION OF RURAL AREAS FOR
23 MILEAGE PAYMENT PURPOSES.—In establishing any
24 differential in the amount of payment for mileage
25 between rural and urban areas in the fee schedule

1 established under paragraph (1), the Secretary shall,
2 in the case of ambulance services furnished on or
3 after January 1, 2008, identify rural areas in the
4 same manner as provided in paragraph (15)(B).”.

5 (2) Section 1834(l)(12)(A) of such Act (42 U.S.C.
6 1395m(l)(12)(A)) is amended by striking “January 1,
7 2010” and inserting “January 1, 2008”.

8 (3) Section 1834(l)(13)(A)(i) of such Act (42 U.S.C.
9 1395m(l)(13)(A)(i)) is amended—

10 (A) by inserting “(or in the case of such serv-
11 ices furnished in 2008, in a rural area identified by
12 the Secretary under paragraph (15)(B))” after
13 “such paragraph”; and

14 (B) by striking “paragraphs (11) and (12)”
15 and inserting “paragraphs (11), (12), and (15)”.

16 **SEC. 305. MEDICARE REMOTE MONITORING PILOT**
17 **PROJECTS.**

18 (a) **PILOT PROJECTS.**—

19 (1) **IN GENERAL.**—Not later than 9 months
20 after the date of enactment of this Act, the Sec-
21 retary of Health and Human Services (in this sec-
22 tion referred to as the “Secretary”) shall conduct
23 pilot projects under title XVIII of the Social Secu-
24 rity Act for the purpose of providing incentives to

1 home health agencies to utilize home monitoring and
2 communications technologies that—

3 (A) enhance health outcomes for Medicare
4 beneficiaries; and

5 (B) reduce expenditures under such title.

6 (2) SITE REQUIREMENTS.—

7 (A) URBAN AND RURAL.—The Secretary
8 shall conduct the pilot projects under this sec-
9 tion in both urban and rural areas.

10 (B) SITE IN A SMALL STATE.—The Sec-
11 retary shall conduct at least 3 of the pilot
12 projects in a State with a population of less
13 than 1,000,000.

14 (3) DEFINITION OF HOME HEALTH AGENCY.—

15 In this section, the term “home health agency” has
16 the meaning given that term in section 1861(o) of
17 the Social Security Act (42 U.S.C. 1395x(o)).

18 (b) MEDICARE BENEFICIARIES WITHIN THE SCOPE
19 OF PROJECTS.—The Secretary shall specify the criteria
20 for identifying those Medicare beneficiaries who shall be
21 considered within the scope of the pilot projects under this
22 section for purposes of the application of subsection (c)
23 and for the assessment of the effectiveness of the home
24 health agency in achieving the objectives of this section.
25 Such criteria may provide for the inclusion in the projects

1 of Medicare beneficiaries who begin receiving home health
2 services under title XVIII of the Social Security Act after
3 the date of the implementation of the projects.

4 (c) INCENTIVES.—

5 (1) PERFORMANCE TARGETS.—The Secretary
6 shall establish for each home health agency partici-
7 pating in a pilot project under this section a per-
8 formance target using one of the following meth-
9 odologies, as determined appropriate by the Sec-
10 retary:

11 (A) ADJUSTED HISTORICAL PERFORMANCE
12 TARGET.—The Secretary shall establish for the
13 agency—

14 (i) a base expenditure amount equal
15 to the average total payments made to the
16 agency under parts A and B of title XVIII
17 of the Social Security Act for Medicare
18 beneficiaries determined to be within the
19 scope of the pilot project in a base period
20 determined by the Secretary; and

21 (ii) an annual per capita expenditure
22 target for such beneficiaries, reflecting the
23 base expenditure amount adjusted for risk
24 and adjusted growth rates.

1 (B) COMPARATIVE PERFORMANCE TAR-
2 GET.—The Secretary shall establish for the
3 agency a comparative performance target equal
4 to the average total payments under such parts
5 A and B during the pilot project for comparable
6 individuals in the same geographic area that
7 are not determined to be within the scope of the
8 pilot project.

9 (2) INCENTIVE.—Subject to paragraph (3), the
10 Secretary shall pay to each participating home care
11 agency an incentive payment for each year under the
12 pilot project equal to a portion of the Medicare sav-
13 ings realized for such year relative to the perform-
14 ance target under paragraph (1).

15 (3) LIMITATION ON EXPENDITURES.—The Sec-
16 retary shall limit incentive payments under this sec-
17 tion in order to ensure that the aggregate expendi-
18 tures under title XVIII of the Social Security Act
19 (including incentive payments under this subsection)
20 do not exceed the amount that the Secretary esti-
21 mates would have been expended if the pilot projects
22 under this section had not been implemented.

23 (d) WAIVER AUTHORITY.—The Secretary may waive
24 such provisions of titles XI and XVIII of the Social Secu-

1 rity Act as the Secretary determines to be appropriate for
2 the conduct of the pilot projects under this section.

3 (e) REPORT TO CONGRESS.—Not later than 5 years
4 after the date that the first pilot project under this section
5 is implemented, the Secretary shall submit to Congress a
6 report on the pilot projects. Such report shall contain a
7 detailed description of issues related to the expansion of
8 the projects under subsection (f) and recommendations for
9 such legislation and administrative actions as the Sec-
10 retary considers appropriate.

11 (f) EXPANSION.—If the Secretary determines that
12 any of the pilot projects under this section enhance health
13 outcomes for Medicare beneficiaries and reduce expendi-
14 tures under title XVIII of the Social Security Act, the Sec-
15 retary may initiate comparable projects in additional
16 areas.

17 (g) INCENTIVE PAYMENTS HAVE NO EFFECT ON
18 OTHER MEDICARE PAYMENTS TO AGENCIES.—An incen-
19 tive payment under this section—

20 (1) shall be in addition to the payments that a
21 home health agency would otherwise receive under
22 title XVIII of the Social Security Act for the provi-
23 sion of home health services; and

24 (2) shall have no effect on the amount of such
25 payments.

1 **SEC. 306. MINIMUM PAYMENT RATE BY MEDICARE ADVAN-**
2 **TAGE ORGANIZATIONS FOR SERVICES FUR-**
3 **NISHED BY A CRITICAL ACCESS HOSPITAL**
4 **AND A RURAL HEALTH CLINIC.**

5 (a) IN GENERAL.—Section 1857(e) of the Social Se-
6 curity Act (42 U.S.C. 1395w–27(e)) is amended by adding
7 at the end the following:

8 “(4) MINIMUM PAYMENT RATE FOR SERVICES
9 FURNISHED BY A CRITICAL ACCESS HOSPITAL AND
10 A RURAL HEALTH CLINIC.—A contract under this
11 section between an MA organization and the Sec-
12 retary for the offering of an MA plan shall require
13 the organization to provide for a payment rate under
14 the plan for inpatient and outpatient critical access
15 hospital services and rural health clinic services fur-
16 nished to enrollees of the plan and for extended care
17 services furnished by a critical access hospital under
18 an agreement entered into under section 1883 to
19 such enrollees (whether or not the services are fur-
20 nished pursuant to an agreement between such orga-
21 nization and a critical access hospital or a rural
22 health clinic) that is not less than—

23 “(A) the applicable payment rate estab-
24 lished under part A or part B (which includes
25 the payment of an interim rate and a subse-
26 quent cost reconciliation) with respect to the

1 critical access hospital for such inpatient, out-
2 patient, and extended care services or the rural
3 health clinic for such rural health clinic serv-
4 ices; or

5 “(B) if the critical access hospital or the
6 rural health clinic determines appropriate, 103
7 percent of the applicable interim payment rate
8 established under part A or part B with respect
9 to the critical access hospital for such inpatient,
10 outpatient, and extended care services or the
11 rural health clinic for such rural health clinic
12 services.”.

13 (b) EFFECTIVE DATE.—The amendments made by
14 this section shall apply to Medicare Advantage contract
15 years beginning on or after January 1, 2008.

16 **SEC. 307. PROMPT PAYMENT BY MEDICARE PRESCRIPTION**
17 **DRUG PLANS AND MA-PD PLANS UNDER**
18 **PART D.**

19 (a) APPLICATION TO PRESCRIPTION DRUG PLANS.—
20 Section 1860D–12(b) of the Social Security Act (42
21 U.S.C. 1395w–112(b)) is amended by adding at the end
22 the following new paragraph:

23 “(4) PROMPT PAYMENT OF CLEAN CLAIMS.—

24 “(A) PROMPT PAYMENT.—Each contract
25 entered into with a PDP sponsor under this

1 subsection with respect to a prescription drug
2 plan offered by such sponsor shall provide that
3 payment shall be issued, mailed, or otherwise
4 transmitted with respect to all clean claims sub-
5 mitted under this part within the applicable
6 number of calendar days after the date on
7 which the claim is received.

8 “(B) DEFINITIONS.—In this paragraph:

9 “(i) CLEAN CLAIM.—The term ‘clean
10 claim’ means a claim, with respect to a
11 covered part D drug, that has no apparent
12 defect or impropriety (including any lack
13 of any required substantiating documenta-
14 tion) or particular circumstance requiring
15 special treatment that prevents timely pay-
16 ment from being made on the claim under
17 this part.

18 “(ii) APPLICABLE NUMBER OF CAL-
19 ENDAR DAYS.—The term ‘applicable num-
20 ber of calendar days’ means—

21 “(I) with respect to claims sub-
22 mitted electronically, 14 calendar
23 days; and

24 “(II) with respect to claims sub-
25 mitted otherwise, 30 calendar days.

1 “(C) INTEREST PAYMENT.—If payment is
2 not issued, mailed, or otherwise transmitted
3 within the applicable number of calendar days
4 (as defined in subparagraph (B)) after a clean
5 claim is received, interest shall be paid at a rate
6 used for purposes of section 3902(a) of title 31,
7 United States Code (relating to interest pen-
8 alties for failure to make prompt payments), for
9 the period beginning on the day after the re-
10 quired payment date and ending on the date on
11 which payment is made.

12 “(D) PROCEDURES INVOLVING CLAIMS.—

13 “(i) CLAIMS DEEMED TO BE CLEAN
14 CLAIMS.—

15 “(I) IN GENERAL.—A claim for a
16 covered part D drug shall be deemed
17 to be a clean claim for purposes of
18 this paragraph if the PDP sponsor in-
19 volved does not provide a notification
20 of deficiency to the claimant by the
21 10th day that begins after the date on
22 which the claim is submitted.

23 “(II) NOTIFICATION OF DEFICI-
24 CIENCY.—For purposes of subclause
25 (II), the term ‘notification of defi-

1 ciency’ means a notification that
2 specifies all defects or improprieties in
3 the claim involved and that lists all
4 additional information or documents
5 necessary for the proper processing
6 and payment of the claim.

7 “(ii) PAYMENT OF CLEAN PORTIONS
8 OF CLAIMS.—A PDP sponsor shall, as ap-
9 propriate, pay any portion of a claim for a
10 covered part D drug that would be a clean
11 claim but for a defect or impropriety in a
12 separate portion of the claim in accordance
13 with subparagraph (A).

14 “(iii) OBLIGATION TO PAY.—A claim
15 for a covered part D drug submitted to a
16 PDP sponsor that is not paid or contested
17 by the provider within the applicable num-
18 ber of calendar days (as defined in sub-
19 paragraph (B)) shall be deemed to be a
20 clean claim and shall be paid by the PDP
21 sponsor in accordance with subparagraph
22 (A).

23 “(iv) DATE OF PAYMENT OF CLAIM.—
24 Payment of a clean claim under subpara-
25 graph (A) is considered to have been made

1 on the date on which full payment is re-
2 ceived by the provider.

3 “(E) ELECTRONIC TRANSFER OF
4 FUNDS.—A PDP sponsor shall pay all clean
5 claims submitted electronically by an electronic
6 funds transfer mechanism.”.

7 (b) APPLICATION TO MA–PD PLANS.—Section
8 1857(f) of such Act (42 U.S.C. 1395w–27) is amended
9 by adding at the end the following new paragraph:

10 “(3) INCORPORATION OF CERTAIN PRESCRIP-
11 TION DRUG PLAN CONTRACT REQUIREMENTS.—The
12 provisions of section 1860D–12(b)(4) shall apply to
13 contracts with a Medicare Advantage organization in
14 the same manner as they apply to contracts with a
15 PDP sponsor offering a prescription drug plan
16 under part D.”.

17 (c) EFFECTIVE DATE.—The amendments made by
18 this section shall apply to contracts entered into or re-
19 newed on or after the date of the enactment of this Act.

1 **SEC. 308. EXTENSION OF MEDICARE REASONABLE COSTS**
 2 **PAYMENTS FOR CERTAIN CLINICAL DIAG-**
 3 **NOSTIC LABORATORY TESTS FURNISHED TO**
 4 **HOSPITAL PATIENTS IN CERTAIN RURAL**
 5 **AREAS.**

6 Section 416(b) of the Medicare Prescription Drug,
 7 Improvement, and Modernization Act of 2003 (Public Law
 8 108–173; 117 Stat. 2282; 42 U.S.C. 1395l–4(b)) is
 9 amended by striking “2-year” and inserting “8-year”.

10 **SEC. 309. EXTENSION OF TEMPORARY MEDICARE PAYMENT**
 11 **INCREASE FOR HOME HEALTH SERVICES**
 12 **FURNISHED IN A RURAL AREA.**

13 (a) **IN GENERAL.**—Section 421 of the Medicare Pre-
 14 scription Drug, Improvement, and Modernization Act of
 15 2003 (Public Law 108–173; 117 Stat. 2283; 42 U.S.C.
 16 1395fff note), as amended by section 5201(b) of the Def-
 17 icit Reduction Act of 2005, is amended—

18 (1) in the heading, by striking “**ONE-YEAR**”
 19 and inserting “**TEMPORARY**”; and

20 (2) in subsection (a) by striking “before April
 21 1, 2005, and episodes and visits beginning on or
 22 after January 1, 2006, and before January 1, 2007”
 23 and inserting “before December 31, 2012”.

24 (b) **APPLICATION TO CERTAIN HOME HEALTH SERV-**
 25 **ICES FURNISHED PRIOR TO DATE OF ENACTMENT.**—For
 26 episodes and visits for home health services furnished on

1 or after January 1, 2007, and before the date of the enact-
 2 ment of this Act, the Secretary of Health and Human
 3 Services shall provide for a lump sum payment, not later
 4 than 60 days after such enactment, of amounts due under
 5 the amendment made by subsection (a)(2).

6 (c) EFFECTIVE DATE.—The amendments made by
 7 subsection (a) shall apply to episodes and visits on or after
 8 April 1, 2005.

9 **TITLE IV—OTHER PROVISIONS**

10 **SEC. 401. HEALTH INFORMATION TECHNOLOGY GRANTS** 11 **FOR RURAL HEALTH CARE PROVIDERS.**

12 Title II of the Public Health Service Act is amended
 13 by adding at the end the following new part:

14 **“PART D—HEALTH INFORMATION TECHNOLOGY** 15 **GRANTS**

16 **“SEC. 271. GRANTS TO FACILITATE THE WIDESPREAD** 17 **ADOPTION OF INTEROPERABLE HEALTH IN-** 18 **FORMATION TECHNOLOGY IN RURAL AREAS.**

19 “(a) COMPETITIVE GRANTS TO ELIGIBLE ENTITIES
 20 IN RURAL AREAS.—

21 “(1) IN GENERAL.—The Secretary may award
 22 competitive grants to eligible entities in rural areas
 23 to facilitate the purchase and enhance the utilization
 24 of qualified health information technology systems to
 25 improve the quality and efficiency of health care.

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

3 “(A) submit to the Secretary an applica-
4 tion at such time, in such manner, and con-
5 taining such information as the Secretary may
6 require;

7 “(B) submit to the Secretary a strategic
8 plan for the implementation of data sharing
9 and interoperability measures;

10 “(C) be a rural health care provider;

11 “(D) adopt any applicable core interoper-
12 ability guidelines (endorsed under other provi-
13 sions of law);

14 “(E) agree to notify patients if their indi-
15 vidually identifiable health information is
16 wrongfully disclosed;

17 “(F) demonstrate significant financial
18 need; and

19 “(G) provide matching funds in accordance
20 with paragraph (4).

21 “(3) USE OF FUNDS.—Amounts received under
22 a grant under this subsection shall be used to facili-
23 tate the purchase and enhance the utilization of
24 qualified health information technology systems and
25 training personnel in the use of such technology.

1 “(4) MATCHING REQUIREMENT.—To be eligible
2 for a grant under this subsection an entity shall con-
3 tribute non-Federal contributions to the costs of car-
4 rying out the activities for which the grant is award-
5 ed in an amount equal to \$1 for each \$3 of Federal
6 funds provided under the grant.

7 “(5) LIMIT ON GRANT AMOUNT.—In no case
8 shall the payment amount under this subsection with
9 respect to the purchase or enhanced utilization of
10 qualified health information technology for a rural
11 health care provider, in addition to the amount of
12 any loan made to the provider from a grant to a
13 State under subsection (b) for such purpose, exceed
14 100 percent of the provider’s costs for such purchase
15 or enhanced utilization (taking into account costs for
16 training, implementation, and maintenance).

17 “(6) PREFERENCE IN AWARDING GRANTS.—In
18 awarding grants to eligible entities under this sub-
19 section, the Secretary shall give preference to each
20 of the following types of applicants:

21 “(A) An entity that is located in a frontier
22 or other rural underserved area as determined
23 by the Secretary.

24 “(B) An entity that will link, to the extent
25 practicable, the qualified health information

1 system to a local or regional health information
2 plan or plans.

3 “(C) A rural health care provider that is a
4 nonprofit hospital or a Federally qualified
5 health center.

6 “(D) A rural health care provider that is
7 an individual practice or group practice.

8 “(b) AUTHORIZATION OF APPROPRIATIONS.—

9 “(1) IN GENERAL.—For the purpose of car-
10 rying out this section, there is authorized to be ap-
11 propriated \$20,000,000 for fiscal year 2008,
12 \$30,000,000 for fiscal year 2009, and such sums as
13 may be necessary, but not to exceed \$30,000,000 for
14 each of fiscal years 2010 through 2012.

15 “(2) AVAILABILITY.—Amounts appropriated
16 under paragraph (1) shall remain available through
17 fiscal year 2011.

18 “(c) DEFINITIONS.—In this section:

19 “(1) FEDERALLY QUALIFIED HEALTH CEN-
20 TER.—The term ‘Federally qualified health center’
21 has the meaning given that term in section
22 1861(aa)(4) of the Social Security Act (42 U.S.C.
23 1395x(aa)(4)).

24 “(2) GROUP PRACTICE.—The term ‘group prac-
25 tice’ has the meaning given that term in section

1 1877(h)(4) of the Social Security Act (42 U.S.C.
2 1395nn(h)(4)).

3 “(3) HEALTH CARE PROVIDER.—The term
4 ‘health care provider’ means a hospital, skilled nurs-
5 ing facility, home health agency (as defined in sub-
6 section (o) of section 1861 of the Social Security
7 Act, 42 U.S.C. 1395x), health care clinic, rural
8 health clinic, Federally qualified health center, group
9 practice, a pharmacist, a pharmacy, a laboratory, a
10 physician (as defined in subsection (r) of such sec-
11 tion), a practitioner (as defined in section
12 1842(b)(18)(CC) of such Act, 42 U.S.C.
13 1395u(b)(18)(CC)), a health facility operated by or
14 pursuant to a contract with the Indian Health Serv-
15 ice, and any other category of facility or clinician de-
16 termined appropriate by the Secretary.

17 “(4) HEALTH INFORMATION; INDIVIDUALLY
18 IDENTIFIABLE HEALTH INFORMATION.—The terms
19 ‘health information’ and ‘individually identifiable
20 health information’ have the meanings given those
21 terms in paragraphs (4) and (6), respectively, of sec-
22 tion 1171 of the Social Security Act (42 U.S.C.
23 1320d).

24 “(5) LABORATORY.—The term ‘laboratory’ has
25 the meaning given that term in section 353.

1 “(6) PHARMACIST.—The term ‘pharmacist’ has
2 the meaning given that term in section 804(a)(2) of
3 the Federal Food, Drug, and Cosmetic Act (21
4 U.S.C. 384(a)(2)).

5 “(7) QUALIFIED HEALTH INFORMATION TECH-
6 NOLOGY.—The term ‘qualified health information
7 technology’ means a system or components of health
8 information technology that meet any applicable core
9 interoperability guidelines (endorsed under applica-
10 ble provisions of law) when in use or that use inter-
11 face software that allows for interoperability in ac-
12 cordance with such guidelines.

13 “(8) RURAL AREA.—The term ‘rural area’ has
14 the meaning given such term for purposes of section
15 1886(d)(2)(D) of the Social Security Act (42 U.S.C.
16 1395ww(d)(2)(D)).

17 “(9) RURAL HEALTH CARE PROVIDER.—The
18 term ‘rural health care provider’ means a health
19 care provider that is located in a rural area.

20 “(10) STATE.—The term ‘State’ means each of
21 the several States, the District of Columbia, Puerto
22 Rico, the Virgin Islands, Guam, American Samoa,
23 and the Northern Mariana Islands.”.

1 **SEC. 402. RURAL HEALTH QUALITY ADVISORY COMMISSION**
2 **AND DEMONSTRATION PROJECTS.**

3 (a) RURAL HEALTH QUALITY ADVISORY COMMISS-
4 SION.—

5 (1) ESTABLISHMENT.—Not later than 6
6 months after the date of the enactment of this sec-
7 tion, the Secretary of Health and Human Services
8 (in this section referred to as the “Secretary”) shall
9 establish a commission to be known as the Rural
10 Health Quality Advisory Commission (in this section
11 referred to as the “Commission”).

12 (2) DUTIES OF COMMISSION.—

13 (A) NATIONAL PLAN.—The Commission
14 shall develop, coordinate, and facilitate imple-
15 mentation of a national plan for rural health
16 quality improvement. The national plan shall—

17 (i) identify objectives for rural health
18 quality improvement;

19 (ii) identify strategies to eliminate
20 known gaps in rural health system capacity
21 and improve rural health quality; and

22 (iii) provide for Federal programs to
23 identify opportunities for strengthening
24 and aligning policies and programs to im-
25 prove rural health quality.

1 (B) DEMONSTRATION PROJECTS.—The
2 Commission shall design demonstration projects
3 to test alternative models for rural health qual-
4 ity improvement, including with respect to both
5 personal and population health.

6 (C) MONITORING.—The Commission shall
7 monitor progress toward the objectives identi-
8 fied pursuant to paragraph (1)(A).

9 (3) MEMBERSHIP.—

10 (A) NUMBER.—The Commission shall be
11 composed of 11 members appointed by the Sec-
12 retary.

13 (B) SELECTION.—The Secretary shall se-
14 lect the members of the Commission from
15 among individuals with significant rural health
16 care and health care quality expertise, including
17 expertise in clinical health care, health care
18 quality research, population or public health, or
19 purchaser organizations.

20 (4) CONTRACTING AUTHORITY.—Subject to the
21 availability of funds, the Commission may enter into
22 contracts and make other arrangements, as may be
23 necessary to carry out the duties described in para-
24 graph (2).

1 (5) STAFF.—Upon the request of the Commis-
2 sion, the Secretary may detail, on a reimbursable
3 basis, any of the personnel of the Office of Rural
4 Health Policy of the Health Resources and Services
5 Administration, the Agency for Health Care Quality
6 and Research, or the Centers for Medicare & Med-
7 icaid Services to the Commission to assist in car-
8 rying out this subsection.

9 (6) REPORTS TO CONGRESS.—Not later than 1
10 year after the establishment of the Commission, and
11 annually thereafter, the Commission shall submit a
12 report to the Congress on rural health quality. Each
13 such report shall include the following:

14 (A) An inventory of relevant programs and
15 recommendations for improved coordination and
16 integration of policy and programs.

17 (B) An assessment of achievement of the
18 objectives identified in the national plan devel-
19 oped under paragraph (2) and recommenda-
20 tions for realizing such objectives.

21 (C) Recommendations on Federal legisla-
22 tion, regulations, or administrative policies to
23 enhance rural health quality and outcomes.

24 (b) RURAL HEALTH QUALITY DEMONSTRATION
25 PROJECTS.—

1 (1) IN GENERAL.—Not later than 270 days
2 after the date of the enactment of this section, the
3 Secretary, in consultation with the Rural Health
4 Quality Advisory Commission, the Office of Rural
5 Health Policy of the Health Resources and Services
6 Administration, the Agency for Healthcare Research
7 and Quality, and the Centers for Medicare & Med-
8 icaid Services, shall make grants to eligible entities
9 for 5 demonstration projects to implement and
10 evaluate methods for improving the quality of health
11 care in rural communities. Each such demonstration
12 project shall include—

13 (A) alternative community models that—

14 (i) will achieve greater integration of
15 personal and population health services;
16 and

17 (ii) address safety, effectiveness,
18 patient- or community-centeredness, timeli-
19 ness, efficiency, and equity (the six aims
20 identified by the Institute of Medicine of
21 the National Academies in its report enti-
22 tled “Crossing the Quality Chasm: A New
23 Health System for the 21st Century” re-
24 leased on March 1, 2001);

1 (B) innovative approaches to the financing
2 and delivery of health services to achieve rural
3 health quality goals; and

4 (C) development of quality improvement
5 support structures to assist rural health sys-
6 tems and professionals (such as workforce sup-
7 port structures, quality monitoring and report-
8 ing, clinical care protocols, and information
9 technology applications).

10 (2) ELIGIBLE ENTITIES.—In this subsection,
11 the term “eligible entity” means a consortium
12 that—

13 (A) shall include—

14 (i) at least one health care provider or
15 health care delivery system located in a
16 rural area; and

17 (ii) at least one organization rep-
18 resenting multiple community stakeholders;
19 and

20 (B) may include other partners such as
21 rural research centers.

22 (3) CONSULTATION.—In developing the pro-
23 gram for awarding grants under this subsection, the
24 Secretary shall consult with the Administrator of the
25 Agency for Healthcare Research and Quality, rural

1 health care providers, rural health care researchers,
2 and private and non-profit groups (including na-
3 tional associations) which are undertaking similar
4 efforts.

5 (4) EXPEDITED WAIVERS.—The Secretary shall
6 expedite the processing of any waiver that—

7 (A) is authorized under title XVIII or XIX
8 of the Social Security Act (42 U.S.C. 1395 et
9 seq.); and

10 (B) is necessary to carry out a demonstra-
11 tion project under this subsection.

12 (5) DEMONSTRATION PROJECT SITES.—The
13 Secretary shall ensure that the 5 demonstration
14 projects funded under this subsection are conducted
15 at a variety of sites representing the diversity of
16 rural communities in the Nation.

17 (6) DURATION.—Each demonstration project
18 under this subsection shall be for a period of 4
19 years.

20 (7) INDEPENDENT EVALUATION.—The Sec-
21 retary shall enter into an arrangement with an enti-
22 ty that has experience working directly with rural
23 health systems for the conduct of an independent
24 evaluation of the program carried out under this
25 subsection.

1 (8) REPORT.—Not later than one year after the
2 conclusion of all of the demonstration projects fund-
3 ed under this subsection, the Secretary shall submit
4 a report to the Congress on the results of such
5 projects. The report shall include—

6 (A) an evaluation of patient access to care,
7 patient outcomes, and an analysis of the cost
8 effectiveness of each such project; and

9 (B) recommendations on Federal legisla-
10 tion, regulations, or administrative policies to
11 enhance rural health quality and outcomes.

12 (c) APPROPRIATION.—

13 (1) IN GENERAL.—Out of funds in the Treas-
14 ury not otherwise appropriated, there are appro-
15 priated to the Secretary to carry out this section
16 \$30,000,000 for the period of fiscal years 2008
17 through 2012.

18 (2) AVAILABILITY.—

19 (A) IN GENERAL.—Funds appropriated
20 under paragraph (1) shall remain available for
21 expenditure through fiscal year 2012.

22 (B) REPORT.—For purposes of carrying
23 out subsection (b)(8), funds appropriated under
24 paragraph (1) shall remain available for ex-
25 penditure through fiscal year 2013.

1 (3) RESERVATION.—Of the amount appro-
2 priated under paragraph (1), the Secretary shall re-
3 serve—

4 (A) \$5,000,000 to carry out subsection (a);

5 and

6 (B) \$25,000,000 to carry out subsection

7 (b), of which—

8 (i) 2 percent shall be for the provision
9 of technical assistance to grant recipients;

10 and

11 (ii) 5 percent shall be for independent
12 evaluation under subsection (b)(7).

13 **SEC. 403. RURAL HEALTH CARE SERVICES.**

14 Section 330A of the Public Health Service Act (42
15 U.S.C. 254e) is amended to read as follows:

16 **“SEC. 330A. RURAL HEALTH CARE SERVICES OUTREACH,**
17 **RURAL HEALTH NETWORK DEVELOPMENT,**
18 **DELTA RURAL DISPARITIES AND HEALTH**
19 **SYSTEMS DEVELOPMENT, AND SMALL RURAL**
20 **HEALTH CARE PROVIDER QUALITY IMPROVE-**
21 **MENT GRANT PROGRAMS.**

22 “(a) PURPOSE.—The purpose of this section is to
23 provide for grants—

24 “(1) under subsection (b), to promote rural
25 health care services outreach;

1 “(2) under subsection (c), to provide for the
2 planning and implementation of integrated health
3 care networks in rural areas;

4 “(3) under subsection (d), to assist rural com-
5 munities in the Delta Region to reduce health dis-
6 parities and to promote and enhance health system
7 development; and

8 “(4) under subsection (e), to provide for the
9 planning and implementation of small rural health
10 care provider quality improvement activities.

11 “(b) RURAL HEALTH CARE SERVICES OUTREACH
12 GRANTS.—

13 “(1) GRANTS.—The Director of the Office of
14 Rural Health Policy of the Health Resources and
15 Services Administration may award grants to eligible
16 entities to promote rural health care services out-
17 reach by expanding the delivery of health care serv-
18 ices to include new and enhanced services in rural
19 areas. The Director may award the grants for peri-
20 ods of not more than 3 years.

21 “(2) ELIGIBILITY.—To be eligible to receive a
22 grant under this subsection for a project, an enti-
23 ty—

24 “(A) shall be a rural public or rural non-
25 profit private entity, a facility that qualifies as

1 a rural health clinic under title XVIII of the
2 Social Security Act, a public or nonprofit entity
3 existing exclusively to provide services to mi-
4 grant and seasonal farm workers in rural areas,
5 or a tribal government whose grant-funded ac-
6 tivities will be conducted within federally recog-
7 nized tribal areas;

8 “(B) shall represent a consortium com-
9 posed of members—

10 “(i) that include 3 or more independ-
11 ently-owned health care entities; and

12 “(ii) that may be nonprofit or for-
13 profit entities; and

14 “(C) shall not previously have received a
15 grant under this subsection for the same or a
16 similar project, unless the entity is proposing to
17 expand the scope of the project or the area that
18 will be served through the project.

19 “(3) APPLICATIONS.—To be eligible to receive a
20 grant under this subsection, an eligible entity shall
21 prepare and submit to the Director an application at
22 such time, in such manner, and containing such in-
23 formation as the Director may require, including—

1 “(A) a description of the project that the
2 eligible entity will carry out using the funds
3 provided under the grant;

4 “(B) a description of the manner in which
5 the project funded under the grant will meet
6 the health care needs of rural populations in
7 the local community or region to be served;

8 “(C) a plan for quantifying how health
9 care needs will be met through identification of
10 the target population and benchmarks of service
11 delivery or health status, such as—

12 “(i) quantifiable measurements of
13 health status improvement for projects fo-
14 cusing on health promotion; or

15 “(ii) benchmarks of increased access
16 to primary care, including tracking factors
17 such as the number and type of primary
18 care visits, identification of a medical
19 home, or other general measures of such
20 access;

21 “(D) a description of how the local com-
22 munity or region to be served will be involved
23 in the development and ongoing operations of
24 the project;

1 “(E) a plan for sustaining the project after
2 Federal support for the project has ended;

3 “(F) a description of how the project will
4 be evaluated;

5 “(G) the administrative capacity to submit
6 annual performance data electronically as speci-
7 fied by the Director; and

8 “(H) other such information as the Direc-
9 tor determines to be appropriate.

10 “(c) RURAL HEALTH NETWORK DEVELOPMENT
11 GRANTS.—

12 “(1) GRANTS.—

13 “(A) IN GENERAL.—The Director may
14 award rural health network development grants
15 to eligible entities to promote, through planning
16 and implementation, the development of inte-
17 grated health care networks that have combined
18 the functions of the entities participating in the
19 networks in order to—

20 “(i) achieve efficiencies and economies
21 of scale;

22 “(ii) expand access to, coordinate, and
23 improve the quality of the health care de-
24 livery system through development of orga-
25 nizational efficiencies;

1 “(iii) implement health information
2 technology to achieve efficiencies, reduce
3 medical errors, and improve quality;

4 “(iv) coordinate care and manage
5 chronic illness; and

6 “(v) strengthen the rural health care
7 system as a whole in such a manner as to
8 show a quantifiable return on investment
9 to the participants in the network.

10 “(B) GRANT PERIODS.—The Director may
11 award such a rural health network development
12 grant—

13 “(i) for a period of 3 years for imple-
14 mentation activities; or

15 “(ii) for a period of 1 year for plan-
16 ning activities to assist in the initial devel-
17 opment of an integrated health care net-
18 work, if the proposed participants in the
19 network do not have a history of collabo-
20 rative efforts and a 3-year grant would be
21 inappropriate.

22 “(2) ELIGIBILITY.—To be eligible to receive a
23 grant under this subsection, an entity—

24 “(A) shall be a rural public or rural non-
25 profit private entity, a facility that qualifies as

1 a rural health clinic under title XVIII of the
2 Social Security Act, a public or nonprofit entity
3 existing exclusively to provide services to mi-
4 grant and seasonal farm workers in rural areas,
5 or a tribal government whose grant-funded ac-
6 tivities will be conducted within federally recog-
7 nized tribal areas;

8 “(B) shall represent a network composed
9 of participants—

10 “(i) that include 3 or more independ-
11 ently-owned health care entities; and

12 “(ii) that may be nonprofit or for-
13 profit entities; and

14 “(C) shall not previously have received a
15 grant under this subsection (other than a 1-
16 year grant for planning activities) for the same
17 or a similar project.

18 “(3) APPLICATIONS.—To be eligible to receive a
19 grant under this subsection, an eligible entity, in
20 consultation with the appropriate State office of
21 rural health or another appropriate State entity,
22 shall prepare and submit to the Director an applica-
23 tion at such time, in such manner, and containing
24 such information as the Director may require, in-
25 cluding—

1 “(A) a description of the project that the
2 eligible entity will carry out using the funds
3 provided under the grant;

4 “(B) an explanation of the reasons why
5 Federal assistance is required to carry out the
6 project;

7 “(C) a description of—

8 “(i) the history of collaborative activi-
9 ties carried out by the participants in the
10 network;

11 “(ii) the degree to which the partici-
12 pants are ready to integrate their func-
13 tions; and

14 “(iii) how the local community or re-
15 gion to be served will benefit from and be
16 involved in the activities carried out by the
17 network;

18 “(D) a description of how the local com-
19 munity or region to be served will experience in-
20 creased access to quality health care services
21 across the continuum of care as a result of the
22 integration activities carried out by the net-
23 work, including a description of—

24 “(i) return on investment for the com-
25 munity and the network members; and

1 “(ii) other quantifiable performance
2 measures that show the benefit of the net-
3 work activities;

4 “(E) a plan for sustaining the project after
5 Federal support for the project has ended;

6 “(F) a description of how the project will
7 be evaluated;

8 “(G) the administrative capacity to submit
9 annual performance data electronically as speci-
10 fied by the Director; and

11 “(H) other such information as the Direc-
12 tor determines to be appropriate.

13 “(d) DELTA RURAL DISPARITIES AND HEALTH SYS-
14 TEMS DEVELOPMENT GRANTS.—

15 “(1) GRANTS.—The Director may award grants
16 to eligible entities to support reduction of health dis-
17 parities, improve access to health care, and enhance
18 rural health system development in the Delta Re-
19 gion.

20 “(2) ELIGIBILITY.—To be eligible to receive a
21 grant under this subsection, an entity shall be a
22 rural public or rural nonprofit private entity, a facil-
23 ity that qualifies as a rural health clinic under title
24 XVIII of the Social Security Act, a public or non-
25 profit entity existing exclusively to provide services

1 to migrant and seasonal farm workers in rural
2 areas, or a tribal government whose grant-funded
3 activities will be conducted within federally recog-
4 nized tribal areas.

5 “(3) APPLICATIONS.—To be eligible to receive a
6 grant under this subsection, an eligible entity shall
7 prepare and submit to the Director an application at
8 such time, in such manner, and containing such in-
9 formation as the Director may require, including—

10 “(A) a description of the project that the
11 eligible entity will carry out using the funds
12 provided under the grant;

13 “(B) an explanation of the reasons why
14 Federal assistance is required to carry out the
15 project;

16 “(C) a description of the manner in which
17 the project funded under the grant will meet
18 the health care needs of the Delta Region;

19 “(D) a description of how the local com-
20 munity or region to be served will experience in-
21 creased access to quality health care services as
22 a result of the activities carried out by the enti-
23 ty;

1 “(E) a description of how health dispari-
2 ties will be reduced or the health system will be
3 improved;

4 “(F) a plan for sustaining the project after
5 Federal support for the project has ended;

6 “(G) a description of how the project will
7 be evaluated including process and outcome
8 measures related to the quality of care provided
9 or how the health care system improves its per-
10 formance;

11 “(H) a description of how the grantee will
12 develop an advisory group made up of rep-
13 resentatives of the communities to be served to
14 provide guidance to the grantee to best meet
15 community need; and

16 “(I) other such information as the Director
17 determines to be appropriate.

18 “(e) SMALL RURAL HEALTH CARE PROVIDER QUAL-
19 ITY IMPROVEMENT GRANTS.—

20 “(1) GRANTS.—The Director may award grants
21 to provide for the planning and implementation of
22 small rural health care provider quality improvement
23 activities. The Director may award the grants for
24 periods of 1 to 3 years.

1 “(2) ELIGIBILITY.—To be eligible for a grant
2 under this subsection, an entity—

3 “(A) shall be—

4 “(i) a rural public or rural nonprofit
5 private health care provider or provider of
6 health care services, such as a rural health
7 clinic; or

8 “(ii) another rural provider or net-
9 work of small rural providers identified by
10 the Director as a key source of local care;
11 and

12 “(B) shall not previously have received a
13 grant under this subsection for the same or a
14 similar project.

15 “(3) PREFERENCE.—In awarding grants under
16 this subsection, the Director shall give preference to
17 facilities that qualify as rural health clinics under
18 title XVIII of the Social Security Act.

19 “(4) APPLICATIONS.—To be eligible to receive a
20 grant under this subsection, an eligible entity shall
21 prepare and submit to the Director an application at
22 such time, in such manner, and containing such in-
23 formation as the Director may require, including—

1 “(A) a description of the project that the
2 eligible entity will carry out using the funds
3 provided under the grant;

4 “(B) an explanation of the reasons why
5 Federal assistance is required to carry out the
6 project;

7 “(C) a description of the manner in which
8 the project funded under the grant will assure
9 continuous quality improvement in the provision
10 of services by the entity;

11 “(D) a description of how the local com-
12 munity or region to be served will experience in-
13 creased access to quality health care services as
14 a result of the activities carried out by the enti-
15 ty;

16 “(E) a plan for sustaining the project after
17 Federal support for the project has ended;

18 “(F) a description of how the project will
19 be evaluated including process and outcome
20 measures related to the quality of care pro-
21 vided; and

22 “(G) other such information as the Direc-
23 tor determines to be appropriate.

24 “(f) GENERAL REQUIREMENTS.—

1 “(1) PROHIBITED USES OF FUNDS.—An entity
2 that receives a grant under this section may not use
3 funds provided through the grant—

4 “(A) to build or acquire real property; or
5 “(B) for construction.

6 “(2) COORDINATION WITH OTHER AGENCIES.—
7 The Director shall coordinate activities carried out
8 under grant programs described in this section, to
9 the extent practicable, with Federal and State agen-
10 cies and nonprofit organizations that are operating
11 similar grant programs, to maximize the effect of
12 public dollars in funding meritorious proposals.

13 “(g) REPORT.—Not later than September 30, 2010,
14 the Secretary shall prepare and submit to the appropriate
15 committees of Congress a report on the progress and ac-
16 complishments of the grant programs described in sub-
17 sections (b), (c), (d), and (e).

18 “(h) DEFINITIONS.—In this section:

19 “(1) The term ‘Delta Region’ has the meaning
20 given to the term ‘region’ in section 382A of the
21 Consolidated Farm and Rural Development Act (7
22 U.S.C. 2009aa).

23 “(2) The term ‘Director’ means the Director of
24 the Office of Rural Health Policy of the Health Re-
25 sources and Services Administration.

1 “(i) AUTHORIZATION OF APPROPRIATIONS.—There
2 are authorized to be appropriated to carry out this section
3 \$40,000,000 for fiscal year 2008, and such sums as may
4 be necessary for each of fiscal years 2009 through 2012.”.

5 **SEC. 404. COMMUNITY HEALTH CENTER COLLABORATIVE**
6 **ACCESS EXPANSION.**

7 Section 330 of the Public Health Service Act (42
8 U.S.C. 254b) is amended by adding at the end the fol-
9 lowing:

10 “(s) MISCELLANEOUS PROVISIONS.—

11 “(1) RULE OF CONSTRUCTION WITH RESPECT
12 TO RURAL HEALTH CLINICS.—

13 “(A) IN GENERAL.—Nothing in this sec-
14 tion shall be construed to prevent a community
15 health center from contracting with a federally
16 certified rural health clinic (as defined by sec-
17 tion 1861(aa)(2) of the Social Security Act) for
18 the delivery of primary health care services that
19 are available at the rural health clinic to indi-
20 viduals who would otherwise be eligible for free
21 or reduced cost care if that individual were able
22 to obtain that care at the community health
23 center. Such services may be limited in scope to
24 those primary health care services available in
25 that rural health clinic.

1 “(B) ASSURANCES.—In order for a rural
2 health clinic to receive funds under this section
3 through a contract with a community health
4 center under paragraph (1), such rural health
5 clinic shall establish policies to ensure—

6 “(i) nondiscrimination based upon the
7 ability of a patient to pay; and

8 “(ii) the establishment of a sliding fee
9 scale for low-income patients.”.

10 **SEC. 405. FACILITATING THE PROVISION OF TELEHEALTH**
11 **SERVICES ACROSS STATE LINES.**

12 (a) IN GENERAL.—For purposes of expediting the
13 provision of telehealth services, for which payment is made
14 under the Medicare program, across State lines, the Sec-
15 retary of Health and Human Services shall, in consulta-
16 tion with representatives of States, physicians, health care
17 practitioners, and patient advocates, encourage and facili-
18 tate the adoption of provisions allowing for multistate
19 practitioner practice across State lines.

20 (b) DEFINITIONS.—In subsection (a):

21 (1) TELEHEALTH SERVICE.—The term “tele-
22 health service” has the meaning given that term in
23 subparagraph (F) of section 1834(m)(4) of the So-
24 cial Security Act (42 U.S.C. 1395m(m)(4)).

1 (2) PHYSICIAN, PRACTITIONER.—The terms
2 “physician” and “practitioner” have the meaning
3 given those terms in subparagraphs (D) and (E), re-
4 spectively, of such section.

5 (3) MEDICARE PROGRAM.—The term “Medicare
6 program” means the program of health insurance
7 administered by the Secretary of Health and Human
8 Services under title XVIII of the Social Security Act
9 (42 U.S.C. 1395 et seq.).

10 **SEC. 406. EXPANDED APPLICATION OF THE 340B PROGRAM**
11 **TO DRUGS PROVIDED IN RURAL HOSPITALS.**

12 (a) EXPANDED PARTICIPATION IN 340B PROGRAM
13 TO CERTAIN RURAL HOSPITALS.—Section 340B(a)(4) of
14 the Public Health Service Act (42 U.S.C. 256b(a)(4)) is
15 amended by adding at the end the following new subpara-
16 graphs:

17 “(M) An entity that is a critical access
18 hospital (as determined under section
19 1820(c)(2) of the Social Security Act (42
20 U.S.C. 1395i-4(c)(2)).

21 “(N) An entity that is a Medicare-depend-
22 ent, small rural hospital (as defined in section
23 1886(d)(5)(G)(iv) of the Social Security Act).

1 “(O) An entity that is a sole community
2 hospital (as defined in section
3 1886(d)(5)(D)(iii) of the Social Security Act).

4 “(P) An entity that is classified as a rural
5 referral center under section 1886(d)(5)(C) of
6 the Social Security Act.”.

7 (b) EXTENSION OF DISCOUNTS TO INPATIENT
8 DRUGS.—

9 (1) IN GENERAL.—Section 340B of the Public
10 Health Service Act (42 U.S.C. 256b) is amended—

11 (A) in subsection (b)—

12 (i) by designating the matter begin-
13 ning “In this section” as a paragraph (1)
14 with the heading “IN GENERAL” ; and

15 (ii) by adding at the end the following
16 new paragraph:

17 “(2) COVERED DRUG.—In this section, the term
18 ‘covered drug’—

19 “(A) means a covered outpatient drug (as
20 defined in section 1927(k)(2) of the Social Se-
21 curity Act); and

22 “(B) includes, notwithstanding the section
23 1927(k)(3)(A) of such Act, a drug used in con-
24 nection with an inpatient or outpatient service
25 provided by a hospital described in subpara-

1 graph (M), (N), (O), or (P) of subsection (a)(4)
2 that is enrolled to participate in the drug dis-
3 count program under this section.”; and

4 (B) in paragraphs (5), (7), and (9), by
5 striking “outpatient” each place it appears.

6 (2) MEDICAID CREDITS ON INPATIENT
7 DRUGS.—Subsection (c) of section 340B of the Pub-
8 lic Health Service Act (42 U.S.C. 256b(c)) is
9 amended to read as follows:

10 “(c) MEDICAID CREDITS ON INPATIENT DRUGS.—

11 “(1) IN GENERAL.—For the cost reporting pe-
12 riod covered by the most recently filed Medicare cost
13 report under title XVIII of the Social Security Act,
14 a hospital described in subparagraph (M), (N), (O),
15 or (P) of subsection (a)(4) and enrolled to partici-
16 pate in the drug discount program under this section
17 shall provide to each State under its plan under title
18 XIX of such Act —

19 “(A) a credit on the estimated annual
20 costs to such hospital of single source and inno-
21 vator multiple source drugs provided to Med-
22 icaid recipients for inpatient use; and

23 “(B) a credit on the estimated annual
24 costs to such hospital of noninnovator multiple

1 source drugs provided to Medicaid recipients for
2 inpatient use.

3 “(2) CALCULATION OF CREDITS.—

4 “(A) SINGLE SOURCE AND INNOVATOR
5 MULTIPLE SOURCE DRUGS.—For purposes of
6 paragraph (1)(A)—

7 “(i) the credit under such paragraph
8 shall be equal to the product of—

9 “(I) the estimated annual costs
10 of single source and innovator mul-
11 tiple source drugs provided by the
12 hospital to Medicaid recipients for in-
13 patient use;

14 “(II) the average manufacturer
15 price adjustment; and

16 “(III) the minimum rebate per-
17 centage described in section
18 1927(c)(1)(B) of the Social Security
19 Act;

20 “(ii) the estimated annual costs of
21 single source drugs and innovator multiple
22 source drugs provided by the hospital to
23 Medicaid recipients for inpatient use under
24 clause (i)(I) shall be equal to the product
25 of—

1 “(I) the hospital’s actual acquisi-
2 tion costs of all drugs purchased dur-
3 ing the cost reporting period for inpa-
4 tient use;

5 “(II) the Medicaid inpatient drug
6 charges as reported on the hospital’s
7 most recently filed Medicare cost re-
8 port divided by total inpatient drug
9 charges reported on the cost report;
10 and

11 “(III) the percent of the hos-
12 pital’s annual inpatient drug costs de-
13 scribed in subclause (I) arising out of
14 the purchase of single source and in-
15 novator multiple source drugs;

16 “(iii) the average manufacturer price
17 adjustment referenced in clause (i)(II)
18 shall be determined annually by the Sec-
19 retary for single source and innovator mul-
20 tiple source drugs by dividing on an aggre-
21 gate basis the average manufacturer price
22 as defined in section 1927(k)(1)(D) of the
23 Social Security Act, averaged across all
24 covered drugs reported to the Secretary
25 pursuant to section 1927(b)(3) of such Act

1 by the average 340B ceiling price for cov-
2 ered drugs calculated pursuant to sub-
3 section (a)(1); and

4 “(iv) the terms ‘single source drug’
5 and ‘innovator multiple source drug’ have
6 the meanings given such terms in section
7 1927(k)(7) of the Social Security Act.

8 “(B) NONINNOVATOR MULTIPLE SOURCE
9 DRUGS.—For purposes of subparagraph
10 (1)(B)—

11 “(i) the credit under such paragraph
12 shall be calculated by multiplying—

13 “(I) the estimated annual costs
14 to the hospital of noninnovator mul-
15 tiple source drugs provided to Med-
16 icaid recipients for inpatient use,

17 “(II) the average manufacturer
18 price adjustment, and

19 “(III) the applicable percentage
20 as defined in section 1927(e)(3)(B) of
21 the Social Security Act;

22 “(ii) the estimated annual costs to a
23 hospital of noninnovator multiple source
24 drugs provided to Medicaid recipients for

1 inpatient use under clause (i)(I) shall be
2 equal to the product of—

3 “(I) the hospital’s actual acquisi-
4 tion cost of all drugs purchased dur-
5 ing the cost reporting period for inpa-
6 tient use;

7 “(II) the Medicaid inpatient drug
8 charges as reported on the hospital’s
9 most recently filed Medicare cost re-
10 port divided by total inpatient drug
11 charges reported on the cost report;

12 “(III) the percent of the hos-
13 pital’s annual inpatient drug costs de-
14 scribed in subclause (I) arising out of
15 the purchase of noninnovator multiple
16 source drugs;

17 “(iii) the average manufacturer price
18 adjustment referenced in clause (i)(II)
19 shall be determined annually by the Sec-
20 retary for noninnovator multiple source
21 drugs by dividing on an aggregate basis
22 the average manufacturer price as defined
23 in Section 1927(k)(1)(D) of the Social Se-
24 curity Act, averaged across all covered
25 drugs reported to the Secretary pursuant

1 to Section 1927(b)(3) of such Act by the
2 average 340B ceiling price for covered
3 drugs calculated pursuant to section
4 340B(a)(1) of the Public Health Service
5 Act; and

6 “(iv) the term ‘noninnovator multiple
7 source drug’ has the meaning given such
8 term in section 1927(k)(7) of the Social
9 Security Act.

10 “(3) PAYMENT DEADLINE.—The credits pro-
11 vided by a hospital under paragraph (1) shall be
12 paid within 90 days of the filing of the hospital’s
13 most recently filed Medicare cost report.

14 “(4) OPT OUT.—A hospital shall not be re-
15 quired to provide the Medicaid credit required under
16 paragraph (1) if—

17 “(A) it can demonstrate to the State that
18 the amount of the credit would not exceed the
19 loss of reimbursement under the State plan re-
20 sulting from the extension of discounts to inpa-
21 tient drugs under subsection (b)(2); or

22 “(B) the hospital and State agree to an al-
23 ternative arrangement.

24 Any dispute between the hospital and the State
25 under this paragraph shall be adjudicated through

1 the administrative dispute resolution process under
2 this section.

3 “(5) OFFSET AGAINST MEDICAL ASSISTANCE.—
4 Amounts received by a State under this subsection
5 in any quarter shall be considered to be a reduction
6 in the amount expended under the State plan in the
7 quarter for medical assistance for purposes of sec-
8 tion 1903(a)(1) of the Social Security Act.

9 “(6) REFERENCES TO SOCIAL SECURITY ACT
10 PROVISIONS.—Notwithstanding any other provision
11 of law, all references to provisions of the Social Se-
12 curity Act in this section shall be deemed to be ref-
13 erences to the Social Security Act as in effect on the
14 effective date specified in section 406(c)(1) of the
15 Health Care Access and Rural Equity (H-CARE)
16 Act of 2007.”.

17 (3) CONFORMING AMENDMENTS.—Section 1927
18 of the Social Security Act (42 U.S.C. 1396r-8), is
19 amended—

20 (A) in subsection (a)(5)(A), by striking
21 “covered outpatient drugs” and inserting “cov-
22 ered drugs (as defined in section 340B(b)(2) of
23 the Public Health Service Act)”;

24 (B) in subsection (a)(5)(D), by striking
25 “title VI of the Veterans Health Care Act of

1 1992” and inserting the “Health Care Access
2 and Rural Equity (H-CARE) Act of 2007”;

3 (C) in subsection (c)(1)(C)(i), by redesignig-
4 nating subclauses (II) through (IV) as sub-
5 clauses (III) through (V), respectively and by
6 inserting after subclause (I) the following new
7 subclause:

8 “(II) any prices charged for a
9 covered drug as defined in section
10 340B(b)(2) of the Public Health Serv-
11 ice Act;”; and

12 (D) in subsection (k)(1)—

13 (i) in subparagraph (A), by striking
14 “subparagraph (B)” and inserting “sub-
15 paragraph (B) and (D)”; and

16 (ii) by adding at the end the following
17 new subparagraph:

18 “(D) CALCULATION FOR COVERED
19 DRUGS.—With respect to a covered drug (as de-
20 fined in section 340B(b)(2) of the Public
21 Health Service Act), the average manufacturer
22 price is the average price paid to the manufac-
23 turer for the drug in the United States by
24 wholesalers for drugs distributed to both the re-
25 tail pharmacy and acute care classes of trade,

1 after deducting customary prompt pay dis-
2 counts.”.

3 (c) EFFECTIVE DATES.—

4 (1) IN GENERAL.—The amendments made by
5 this section shall take effect on January 1, 2008,
6 and shall apply to drugs purchased on or after Jan-
7 uary 1, 2008.

8 (2) GENERAL CONFORMING REFERENCE.—Sec-
9 tion 340B(d) of the Public Health Service Act (42
10 U.S.C. 256b(d)) is amended by striking “Veterans
11 Health Care Act of 1992” and inserting “the effec-
12 tive date specified in section 406(c)(1) of the Health
13 Care Access and Rural Equity (H-CARE) Act of
14 2007”.

15 (3) EFFECTIVENESS.—The amendments made
16 by this section shall be effective, and shall be taken
17 into account in determining whether a manufacturer
18 is deemed to meet the requirements of section
19 340B(a) of the Public Health Service Act (42
20 U.S.C. 256b(a)) and of section 1927(a)(5) of the
21 Social Security Act (42 U.S.C. 1396r-8(a)(5)), not-
22 withstanding any other provision of law.

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