

110TH CONGRESS  
1ST SESSION

# H. R. 3162

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## AN ACT

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

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

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

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

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

Sec. 1. Short title; table of contents.

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

Sec. 100. Purpose.

**Subtitle A—Funding**

Sec. 101. Establishment of new base CHIP allotments.

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

Sec. 103. Redistribution of unused allotments to address State funding short-falls.

Sec. 104. Extension of option for qualifying States.

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

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

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

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

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

Sec. 115. Continuous coverage under CHIP.

**Subtitle C—Coverage**

Sec. 121. Ensuring child-centered coverage.

Sec. 122. Improving benchmark coverage options.

Sec. 123. Premium grace period.

**Subtitle D—Populations**

Sec. 131. Optional coverage of children up to age 21 under CHIP.

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

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

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

Sec. 135. No Federal funding for illegal aliens.

Sec. 136. Auditing requirement to enforce citizenship restrictions on eligibility for Medicaid and CHIP benefits.

**Subtitle E—Access**

Sec. 141. Children’s Access, Payment, and Equality Commission.

- Sec. 142. Model of Interstate coordinated enrollment and coverage process.
- Sec. 143. Medicaid citizenship documentation requirements.
- Sec. 144. Access to dental care for children.
- Sec. 145. Prohibiting initiation of new health opportunity account demonstration programs.

#### Subtitle F—Quality and Program Integrity

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

### TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS

#### Subtitle A—Improvements in Benefits

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

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

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

#### Subtitle C—Part D Beneficiary Improvements

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

#### Subtitle D—Reducing Health Disparities

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

### TITLE III—PHYSICIANS’ SERVICE PAYMENT REFORM

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

### TITLE IV—MEDICARE ADVANTAGE REFORMS

#### Subtitle A—Payment Reform

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

#### Subtitle B—Beneficiary Protections

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

#### Subtitle C—Quality and Other Provisions

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

#### Subtitle D—Extension of Authorities

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

### TITLE V—PROVISIONS RELATING TO MEDICARE PART A

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

## TITLE VI—OTHER PROVISIONS RELATING TO MEDICARE PART B

### Subtitle A—Payment and Coverage Improvements

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

### Subtitle B—Extension of Medicare Rural Access Protections

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

### Subtitle C—End Stage Renal Disease Program

- Sec. 631. Chronic kidney disease demonstration projects.
- Sec. 632. Medicare coverage of kidney disease patient education services.
- Sec. 633. Required training for patient care dialysis technicians.
- Sec. 634. MedPAC report on treatment modalities for patients with kidney failure.
- Sec. 635. Adjustment for erythropoietin stimulating agents (ESAs).

- Sec. 636. Site neutral composite rate.
- Sec. 637. Development of ESRD bundling system and quality incentive payments.
- Sec. 638. MedPAC report on ESRD bundling system.
- Sec. 639. OIG study and report on erythropoietin.

#### Subtitle D—Miscellaneous

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

### TITLE VII—PROVISIONS RELATING TO MEDICARE PARTS A AND B

- Sec. 701. Home health payment update for 2008.
- Sec. 702. 2-year extension of temporary Medicare payment increase for home health services furnished in a rural area.
- Sec. 703. Extension of Medicare secondary payer for beneficiaries with end stage renal disease for large group plans.
- Sec. 704. Plan for Medicare payment adjustments for never events.
- Sec. 705. Reinstatement of residency slots.
- Sec. 706. Studies relating to home health.
- Sec. 707. Rural home health quality demonstration projects.

### TITLE VIII—MEDICAID

#### Subtitle A—Protecting Existing Coverage

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

#### Subtitle B—Payments

- Sec. 811. Payments for Puerto Rico and territories.
- Sec. 812. Medicaid drug rebate.
- Sec. 813. Adjustment in computation of Medicaid FMAP to disregard an extraordinary employer pension contribution.
- Sec. 814. Moratorium on certain payment restrictions.
- Sec. 815. Tennessee DSH.
- Sec. 816. Clarification treatment of regional medical center.
- Sec. 817. Extension of SSI web-based asset demonstration project to the Medicaid program.

#### Subtitle C—Miscellaneous

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

### TITLE IX—MISCELLANEOUS

- Sec. 901. Medicare Payment Advisory Commission status.
- Sec. 902. Repeal of trigger provision.

- Sec. 903. Repeal of comparative cost adjustment (CCA) program.  
 Sec. 904. Comparative effectiveness research.  
 Sec. 905. Implementation of Health information technology (IT) under Medicare.  
 Sec. 906. Development, reporting, and use of health care measures.  
 Sec. 907. Improvements to the Medigap program.  
 Sec. 908. Implementation funding.  
 Sec. 909. Access to data on prescription drug plans and medicare advantage plans.  
 Sec. 910. Abstinence education.

#### TITLE X—REVENUES

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

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

### 3     **SEC. 100. PURPOSE.**

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

### 9                   **Subtitle A—Funding**

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

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

14                   (1) in subsection (a)—

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

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

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

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

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

9 (3) by adding at the end the following new sub-  
10 section:

11 “(i) ALLOTMENTS FOR STATES AND TERRITORIES  
12 BEGINNING WITH FISCAL YEAR 2008.—

13 “(1) GENERAL ALLOTMENT COMPUTATION.—  
14 Subject to the succeeding provisions of this sub-  
15 section, the Secretary shall compute a State allot-  
16 ment for each State for each fiscal year as follows:

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

20 “(i) the State projection (in its sub-  
21 mission on forms CMS—21B and CMS—  
22 37 for May 2007) of Federal payments to  
23 the State under this title for such fiscal  
24 year, except that, in the case of a State  
25 that has enacted legislation to modify its



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

6 “(ii) the allotment of the State under  
7 this section for fiscal year 2007 multiplied  
8 by the allotment increase factor under  
9 paragraph (2) for fiscal year 2008.

10 “(B) INFLATION UPDATE FOR FISCAL  
11 YEAR 2009 AND EACH SECOND SUCCEEDING FIS-  
12 CAL YEAR.—For fiscal year 2009 and each sec-  
13 ond succeeding fiscal year, the allotment of a  
14 State is equal to the amount of the State allot-  
15 ment under this paragraph for the previous fis-  
16 cal year multiplied by the allotment increase  
17 factor under paragraph (2) for the fiscal year  
18 involved.

19 “(C) REBASING IN FISCAL YEAR 2010 AND  
20 EACH SECOND SUCCEEDING FISCAL YEAR.—For  
21 fiscal year 2010 and each second succeeding fis-  
22 cal year, the allotment of a State is equal to the  
23 Federal payments to the State that are attrib-  
24 utable to (and countable towards) the total  
25 amount of allotments available under this sec-

1           tion to the State (including allotments made  
2           available under paragraph (3) as well as  
3           amounts redistributed to the State) in the pre-  
4           vious fiscal year multiplied by the allotment in-  
5           crease factor under paragraph (2) for the fiscal  
6           year involved.

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

19          “(2) ALLOTMENT INCREASE FACTOR.—The al-  
20          lotment increase factor under this paragraph for a  
21          fiscal year is equal to the product of the following:

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

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

5 “(B) CHILD POPULATION GROWTH FAC-  
6 TOR.—1 plus the percentage increase (if any) in  
7 the population of children under 19 years of  
8 age in the State from July 1 in the previous fis-  
9 cal year to July 1 in the fiscal year involved, as  
10 determined by the Secretary based on the most  
11 recent published estimates of the Bureau of the  
12 Census before the beginning of the fiscal year  
13 involved, plus 1 percentage point.

14 “(3) PERFORMANCE-BASED SHORTFALL AD-  
15 JUSTMENT.—

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

1 rolled under the State plan under this title (in-  
2 cluding children receiving health care coverage  
3 through funds under this title pursuant to a  
4 waiver under section 1115) during such fiscal  
5 year exceeds its target average number of such  
6 enrollees (as determined under subparagraph  
7 (B)) for that fiscal year, the allotment under  
8 this section for the State for the subsequent fis-  
9 cal year (or, pursuant to subparagraph (F), for  
10 the fiscal year involved) shall be increased by  
11 the product of—

12 “(i) the amount by which such aver-  
13 age monthly caseload exceeds such target  
14 number of enrollees; and

15 “(ii) the projected per capita expendi-  
16 tures under the State child health plan (as  
17 determined under subparagraph (C) for  
18 the original fiscal year involved), multiplied  
19 by the enhanced FMAP (as defined in sec-  
20 tion 2105(b)) for the State and fiscal year  
21 involved.

22 “(B) TARGET AVERAGE NUMBER OF CHILD  
23 ENROLLEES.—In this subsection, the target av-  
24 erage number of child enrollees for a State—

1           “(i) for fiscal year 2008 is equal to  
2           the monthly average unduplicated number  
3           of children enrolled in the State child  
4           health plan under this title (including such  
5           children receiving health care coverage  
6           through funds under this title pursuant to  
7           a waiver under section 1115) during fiscal  
8           year 2007 increased by the population  
9           growth for children in that State for the  
10          year ending on June 30, 2006 (as esti-  
11          mated by the Bureau of the Census) plus  
12          1 percentage point; or

13           “(ii) for a subsequent fiscal year is  
14          equal to the target average number of child  
15          enrollees for the State for the previous fis-  
16          cal year increased by the population  
17          growth for children in that State for the  
18          year ending on June 30 before the begin-  
19          ning of the fiscal year (as estimated by the  
20          Bureau of the Census) plus 1 percentage  
21          point.

22           “(C) PROJECTED PER CAPITA EXPENDI-  
23          TURES.—For purposes of subparagraph (A)(ii),  
24          the projected per capita expenditures under a  
25          State child health plan—

1           “(i) for fiscal year 2008 is equal to  
2           the average per capita expenditures (in-  
3           cluding both State and Federal financial  
4           participation) under such plan for the tar-  
5           geted low-income children counted in the  
6           average monthly caseload for purposes of  
7           this paragraph during fiscal year 2007, in-  
8           creased by the annual percentage increase  
9           in the per capita amount of National  
10          Health Expenditures (as estimated by the  
11          Secretary) for 2008; or

12          “(ii) for a subsequent fiscal year is  
13          equal to the projected per capita expendi-  
14          tures under such plan for the previous fis-  
15          cal year (as determined under clause (i) or  
16          this clause) increased by the annual per-  
17          centage increase in the per capita amount  
18          of National Health Expenditures (as esti-  
19          mated by the Secretary) for the year in  
20          which such subsequent fiscal year ends.

21          “(D)        AVAILABILITY.—Notwithstanding  
22          subsection (e), an increase in allotment under  
23          this paragraph shall only be available for ex-  
24          penditure during the fiscal year in which it is  
25          provided.

1           “(E) NO REDISTRIBUTION OF PERFORM-  
2 ANCE-BASED SHORTFALL ADJUSTMENT.—In no  
3 case shall any increase in allotment under this  
4 paragraph for a State be subject to redistribu-  
5 tion to other States.

6           “(F) INTERIM ALLOTMENT ADJUST-  
7 MENT.—The Secretary shall develop a process  
8 to administer the performance-based shortfall  
9 adjustment in a manner so it is applied to (and  
10 before the end of) the fiscal year (rather than  
11 the subsequent fiscal year) involved for a State  
12 that the Secretary estimates will be in shortfall  
13 and will exceed its enrollment target for that  
14 fiscal year.

15           “(G) PERIODIC AUDITING.—The Comp-  
16 troller General of the United States shall peri-  
17 odically audit the accuracy of data used in the  
18 computation of allotment adjustments under  
19 this paragraph. Based on such audits, the  
20 Comptroller General shall make such rec-  
21 ommendations to the Congress and the Sec-  
22 retary as the Comptroller General deems appro-  
23 priate.

24           “(4) CONTINUED REPORTING.—For purposes of  
25 paragraph (3) and subsection (f), the State shall

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

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

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

9 “(e) AVAILABILITY OF AMOUNTS ALLOTTED.—

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

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

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

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



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

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

8 Section 2104(f) of the Social Security Act (42 U.S.C.  
9 1397dd(f)) is amended—

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

12 “(1) IN GENERAL.—The Secretary”;

13 (2) by striking “States that have fully expended  
14 the amount of their allotments under this section.”  
15 and inserting “States that the Secretary determines  
16 with respect to the fiscal year for which unused al-  
17 lotments are available for redistribution under this  
18 subsection, are shortfall States described in para-  
19 graph (2) for such fiscal year, but not to exceed the  
20 amount of the shortfall described in paragraph  
21 (2)(A) for each such State (as may be adjusted  
22 under paragraph (2)(C)). The amount of allotments  
23 not expended or redistributed under the previous  
24 sentence shall remain available for redistribution in  
25 the succeeding fiscal year.”; and

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

3           “(2) SHORTFALL STATES DESCRIBED.—

4                   “(A) IN GENERAL.—For purposes of para-  
5 graph (1), with respect to a fiscal year, a short-  
6 fall State described in this subparagraph is a  
7 State with a State child health plan approved  
8 under this title for which the Secretary esti-  
9 mates on the basis of the most recent data  
10 available to the Secretary, that the projected ex-  
11 penditures under such plan for the State for the  
12 fiscal year will exceed the sum of—

13                           “(i) the amount of the State’s allot-  
14 ments for any preceding fiscal years that  
15 remains available for expenditure and that  
16 will not be expended by the end of the im-  
17 mediately preceding fiscal year;

18                           “(ii) the amount (if any) of the per-  
19 formance based adjustment under sub-  
20 section (i)(3)(A); and

21                           “(iii) the amount of the State’s allot-  
22 ment for the fiscal year.

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

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

5 “(C) RETROSPECTIVE ADJUSTMENT.—The  
6 Secretary may adjust the estimates and deter-  
7 minations made under paragraph (1) and this  
8 paragraph with respect to a fiscal year as nec-  
9 essary on the basis of the amounts reported by  
10 States not later than November 30 of the suc-  
11 ceeding fiscal year, as approved by the Sec-  
12 retary.”.

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

14 Section 2105(g)(1)(A) of the Social Security Act (42  
15 U.S.C. 1397ee(g)(1)(A)) is amended by inserting after “or  
16 2007” the following: “or 100 percent of any allotment  
17 under section 2104 for any subsequent fiscal year”.

1 **Subtitle B—Improving Enrollment**  
2 **and Retention of Eligible Children**

3 **SEC. 111. CHIP PERFORMANCE BONUS PAYMENT TO OFF-**  
4 **SET ADDITIONAL ENROLLMENT COSTS RE-**  
5 **SULTING FROM ENROLLMENT AND RETEN-**  
6 **TION EFFORTS.**

7 (a) IN GENERAL.—Section 2105(a) of the Social Se-  
8 curity Act (42 U.S.C. 1397ee(a)) is amended by adding  
9 at the end the following new paragraphs:

10 “(3) PERFORMANCE BONUS PAYMENT TO OFF-  
11 SET ADDITIONAL MEDICAID AND CHIP CHILD EN-  
12 ROLLMENT COSTS RESULTING FROM ENROLLMENT  
13 AND RETENTION EFFORTS.—

14 “(A) IN GENERAL.—In addition to the  
15 payments made under paragraph (1), for each  
16 fiscal year (beginning with fiscal year 2008 and  
17 ending with fiscal year 2013) the Secretary  
18 shall pay to each State that meets the condition  
19 under paragraph (4) for the fiscal year, an  
20 amount equal to the amount described in sub-  
21 paragraph (B) for the State and fiscal year.  
22 The payment under this paragraph shall be  
23 made, to a State for a fiscal year, as a single  
24 payment not later than the last day of the first  
25 calendar quarter of the following fiscal year.

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

4           “(i) FOR ABOVE BASELINE MEDICAID  
5 CHILD ENROLLMENT COSTS.—

6           “(I) FIRST TIER ABOVE BASE-  
7 LINE MEDICAID ENROLLEES.—An  
8 amount equal to the number of first  
9 tier above baseline child enrollees (as  
10 determined under subparagraph  
11 (C)(i)) under title XIX for the State  
12 and fiscal year multiplied by 35 per-  
13 cent of the projected per capita State  
14 Medicaid expenditures (as determined  
15 under subparagraph (D)(i)) for the  
16 State and fiscal year under title XIX.

17           “(II) SECOND TIER ABOVE BASE-  
18 LINE MEDICAID ENROLLEES.—An  
19 amount equal to the number of second  
20 tier above baseline child enrollees (as  
21 determined under subparagraph  
22 (C)(ii)) under title XIX for the State  
23 and fiscal year multiplied by 90 per-  
24 cent of the projected per capita State  
25 Medicaid expenditures (as determined

1 under subparagraph (D)(i) for the  
2 State and fiscal year under title XIX.

3 “(ii) FOR ABOVE BASELINE CHIP EN-  
4 ROLLMENT COSTS.—

5 “(I) FIRST TIER ABOVE BASE-  
6 LINE CHIP ENROLLEES.—An amount  
7 equal to the number of first tier above  
8 baseline child enrollees under this title  
9 (as determined under subparagraph  
10 (C)(i)) for the State and fiscal year  
11 multiplied by 5 percent of the pro-  
12 jected per capita State CHIP expendi-  
13 tures (as determined under subpara-  
14 graph (D)(ii)) for the State and fiscal  
15 year under this title.

16 “(II) SECOND TIER ABOVE BASE-  
17 LINE CHIP ENROLLEES.—An amount  
18 equal to the number of second tier  
19 above baseline child enrollees under  
20 this title (as determined under sub-  
21 paragraph (C)(ii)) for the State and  
22 fiscal year multiplied by 75 percent of  
23 the projected per capita State CHIP  
24 expenditures (as determined under

1                   subparagraph (D)(ii)) for the State  
2                   and fiscal year under this title.

3                   “(C) NUMBER OF FIRST AND SECOND TIER  
4                   ABOVE BASELINE CHILD ENROLLEES; BASELINE  
5                   NUMBER OF CHILD ENROLLEES.—For purposes  
6                   of this paragraph:

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

14                  “(I) the monthly average  
15                  unduplicated number of qualifying  
16                  children (as defined in subparagraph  
17                  (E)) enrolled during the fiscal year  
18                  under the State child health plan  
19                  under this title or under the State  
20                  plan under title XIX, respectively; ex-  
21                  ceeds

22                  “(II) the baseline number of en-  
23                  rollees described in clause (iii) for the  
24                  State and fiscal year under this title  
25                  or title XIX, respectively;

1 but not to exceed 3 percent (in the case of  
2 title XIX) or 7.5 percent (in the case of  
3 this title) of the baseline number of enroll-  
4 ees described in subclause (II).

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

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

19 “(II) the sum of the baseline  
20 number of child enrollees described in  
21 clause (iii) for the State and fiscal  
22 year under this title or title XIX, re-  
23 spectively, as described in clause  
24 (i)(II), and the maximum number of  
25 first tier above baseline child enrollees



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

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

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

19 “(II) for a subsequent fiscal year  
20 is equal to the baseline number of  
21 child enrollees for the State for the  
22 previous fiscal year under this title or  
23 title XIX, respectively, increased by  
24 the population growth for children in  
25 that State for the year ending on

1                   June 30 before the beginning of the  
2                   fiscal year (as estimated by the Bu-  
3                   reau of the Census) plus 1 percentage  
4                   point.

5                   “(D) PROJECTED PER CAPITA STATE EX-  
6                   PENDITURES.—For purposes of subparagraph  
7                   (B)—

8                   “(i) PROJECTED PER CAPITA STATE  
9                   MEDICAID EXPENDITURES.—The projected  
10                  per capita State Medicaid expenditures for  
11                  a State and fiscal year under title XIX is  
12                  equal to the average per capita expendi-  
13                  tures (including both State and Federal fi-  
14                  nancial participation) for children under  
15                  the State plan under such title, including  
16                  under waivers but not including such chil-  
17                  dren eligible for assistance by virtue of the  
18                  receipt of benefits under title XVI, for the  
19                  most recent fiscal year for which actual  
20                  data are available (as determined by the  
21                  Secretary), increased (for each subsequent  
22                  fiscal year up to and including the fiscal  
23                  year involved) by the annual percentage in-  
24                  crease in per capita amount of National  
25                  Health Expenditures (as estimated by the

1 Secretary) for the calendar year in which  
2 the respective subsequent fiscal year ends  
3 and multiplied by a State matching per-  
4 centage equal to 100 percent minus the  
5 Federal medical assistance percentage (as  
6 defined in section 1905(b)) for the fiscal  
7 year involved.

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

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

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

16 “(4) ENROLLMENT AND RETENTION PROVI-  
17 SIONS FOR CHILDREN.— For purposes of paragraph  
18 (3)(A), a State meets the condition of this para-  
19 graph for a fiscal year if it is implementing at least  
20 4 of the following enrollment and retention provi-  
21 sions (treating each subparagraph as a separate en-  
22 rollment and retention provision) throughout the en-  
23 tire fiscal year:

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

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

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

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

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

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

1                   “(II) takes steps to verify assets  
2                   through means other than by requir-  
3                   ing documentation from parents and  
4                   applicants except in individual cases  
5                   of discrepancies or where otherwise  
6                   justified.

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

17                  “(D) USE OF JOINT APPLICATION FOR  
18                  MEDICAID AND CHIP.—The application form  
19                  and supplemental forms (if any) and informa-  
20                  tion verification process is the same for pur-  
21                  poses of establishing and renewing eligibility for  
22                  children for medical assistance under title XIX  
23                  and child health assistance under this title.

24                  “(E) AUTOMATIC RENEWAL (USE OF AD-  
25                  MINISTRATIVE RENEWAL).—

1           “(i) IN GENERAL.—The State pro-  
2           vides, in the case of renewal of a child’s  
3           eligibility for medical assistance under title  
4           XIX or child health assistance under this  
5           title, a pre-printed form completed by the  
6           State based on the information available to  
7           the State and notice to the parent or care-  
8           taker relative of the child that eligibility of  
9           the child will be renewed and continued  
10          based on such information unless the State  
11          is provided other information. Nothing in  
12          this clause shall be construed as preventing  
13          a State from verifying, through electronic  
14          and other means, the information so pro-  
15          vided.

16          “(ii) SATISFACTION THROUGH DEM-  
17          ONSTRATED USE OF EX PARTE PROCESS.—  
18          A State shall be treated as satisfying the  
19          requirement of clause (i) if renewal of eli-  
20          gibility of children under title XIX or this  
21          title is determined without any require-  
22          ment for an in-person interview, unless  
23          sufficient information is not in the State’s  
24          possession and cannot be acquired from  
25          other sources (including other State agen-

1           cies) without the participation of the appli-  
2           cant or the applicant’s parent or caretaker  
3           relative.

4           “(F) PRESUMPTIVE ELIGIBILITY FOR  
5 CHILDREN.—The State is implementing section  
6 1920A under title XIX as well as, pursuant to  
7 section 2107(e)(1), under this title.

8           “(G) EXPRESS LANE.—The State is imple-  
9           menting the option described in section  
10 1902(e)(13) under title XIX as well as, pursu-  
11 ant to section 2107(e)(1), under this title.”.

12 (b) GAO STUDY.—

13           (1) IN GENERAL.—The Comptroller General of  
14 the United States shall conduct a study on the effec-  
15 tiveness of the performance bonus payment program  
16 under the amendment made by subsection (a) on the  
17 enrollment and retention of eligible children under  
18 the Medicaid and CHIP programs and in reducing  
19 the rate of uninsurance among such children.

20           (2) REPORT.—Not later than January 1, 2013,  
21 the Comptroller General shall submit a report to  
22 Congress on such study and shall include in such re-  
23 port such recommendations for extending or modi-  
24 fying such program as the Comptroller General de-  
25 termines appropriate.



1 **SEC. 112. STATE OPTION TO RELY ON FINDINGS FROM AN**  
2 **EXPRESS LANE AGENCY TO CONDUCT SIM-**  
3 **PLIFIED ELIGIBILITY DETERMINATIONS.**

4 (a) **MEDICAID.**—Section 1902(e) of the Social Secu-  
5 rity Act (42 U.S.C. 1396a(e)) is amended by adding at  
6 the end the following:

7 “(13) **EXPRESS LANE OPTION.**—

8 “(A) **IN GENERAL.**—

9 “(i) **OPTION TO USE A FINDING FROM AN**  
10 **EXPRESS LANE AGENCY.**—At the option of the  
11 State, the State plan may provide that in deter-  
12 mining eligibility under this title for a child (as  
13 defined in subparagraph (F)), the State may  
14 rely on a finding made within a reasonable pe-  
15 riod (as determined by the State) from an Ex-  
16 press Lane agency (as defined in subparagraph  
17 (E)) when it determines whether a child satis-  
18 fies one or more components of eligibility for  
19 medical assistance under this title. The State  
20 may rely on a finding from an Express Lane  
21 agency notwithstanding sections  
22 1902(a)(46)(B), 1903(x), and 1137(d) and any  
23 differences in budget unit, disregard, deeming  
24 or other methodology, if the following require-  
25 ments are met:

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

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

22           “(III) COMPLIANCE WITH SCREEN  
23 AND ENROLL REQUIREMENT.—The State  
24 shall satisfy the requirements under (A)  
25 and (B) of section 2102(b)(3) (relating to

1 screen and enroll) before enrolling a child  
2 in child health assistance under title XXI.  
3 At its option, the State may fulfill such re-  
4 quirements in accordance with either op-  
5 tion provided under subparagraph (C) of  
6 this paragraph.

7 “(ii) OPTION TO APPLY TO RENEWALS AND  
8 REDETERMINATIONS.— The State may apply  
9 the provisions of this paragraph when con-  
10 ducting initial determinations of eligibility, re-  
11 determinations of eligibility, or both, as de-  
12 scribed in the State plan.

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

15 “(i) to limit or prohibit a State from tak-  
16 ing any actions otherwise permitted under this  
17 title or title XXI in determining eligibility for  
18 or enrolling children into medical assistance  
19 under this title or child health assistance under  
20 title XXI; or

21 “(ii) to modify the limitations in section  
22 1902(a)(5) concerning the agencies that may  
23 make a determination of eligibility for medical  
24 assistance under this title.

1           “(C) OPTIONS FOR SATISFYING THE SCREEN  
2           AND ENROLL REQUIREMENT.—

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

12          “(ii) ESTABLISHING A SCREENING  
13          THRESHOLD.—

14          “(I) IN GENERAL.—Under this clause,  
15          the State establishes a screening threshold  
16          set as a percentage of the Federal poverty  
17          level that exceeds the highest income  
18          threshold applicable under this title to the  
19          child by a minimum of 30 percentage  
20          points or, at State option, a higher number  
21          of percentage points that reflects the value  
22          (as determined by the State and described  
23          in the State plan) of any differences be-  
24          tween income methodologies used by the  
25          program administered by the Express Lane

1 agency and the methodologies used by the  
2 State in determining eligibility for medical  
3 assistance under this title.

4 “(II) CHILDREN WITH INCOME NOT  
5 ABOVE THRESHOLD.—If the income of a  
6 child does not exceed the screening thresh-  
7 old, the child is deemed to satisfy the in-  
8 come eligibility criteria for medical assist-  
9 ance under this title regardless of whether  
10 such child would otherwise satisfy such cri-  
11 teria.

12 “(III) CHILDREN WITH INCOME  
13 ABOVE THRESHOLD.—If the income of a  
14 child exceeds the screening threshold, the  
15 child shall be considered to have an income  
16 above the Medicaid applicable income level  
17 described in section 2110(b)(4) and to sat-  
18 isfy the requirement under section  
19 2110(b)(1)(C) (relating to the requirement  
20 that CHIP matching funds be used only  
21 for children not eligible for Medicaid). If  
22 such a child is enrolled in child health as-  
23 sistance under title XXI, the State shall  
24 provide the parent, guardian, or custodial  
25 relative with the following:

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

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

18           “(iii) TEMPORARY ENROLLMENT IN CHIP  
19          PENDING SCREEN AND ENROLL.—

20           “(I) IN GENERAL.—Under this clause,  
21          a State enrolls a child in child health as-  
22          sistance under title XXI for a temporary  
23          period if the child appears eligible for such  
24          assistance based on an income finding by  
25          an Express Lane agency.

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

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

16          “(IV) REQUIREMENT FOR SIMPLIFIED  
17          DETERMINATION.—In making such a de-  
18          termination, the State shall use procedures  
19          that, to the maximum feasible extent, re-  
20          duce the burden imposed on the individual  
21          of such determination. Such procedures  
22          may not require the child’s parent, guard-  
23          ian, or custodial relative to provide or  
24          verify information that already has been  
25          provided to the State agency by an Ex-

1 press Lane agency or another source of in-  
2 formation unless the State agency has rea-  
3 son to believe the information is erroneous.

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

12 “(D) OPTION FOR AUTOMATIC ENROLLMENT.—

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

22 “(ii) INDIVIDUAL CHOICE REQUIRE-  
23 MENT.—The requirement of this clause is that  
24 the child is enrolled in medical assistance under  
25 this title or child health assistance under title



1           XXI only if the child (or a parent, caretaker  
2           relative, or guardian on the behalf of the child)  
3           has affirmatively assented to such enrollment.

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

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

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

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

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

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

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

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

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

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

1 for medical assistance under this title or child health  
2 assistance under title XXI.

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

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

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

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

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

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

9 (d) AUTHORIZATION OF INFORMATION DISCLO-  
10 SURE.—

11 (1) IN GENERAL.—Title XIX of the Social Se-  
12 curity Act is amended—

13 (A) by redesignating section 1939 as sec-  
14 tion 1940; and

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

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

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

1 information about births in any State, and information de-  
2 scribed in sections 453(i) and 1902(a)(25)(I)) is author-  
3 ized to convey such data or information to the State agen-  
4 cy administering the State plan under this title, to the  
5 extent such conveyance meets the requirements of sub-  
6 section (b).

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

10 “(1) The individual whose circumstances are  
11 described in the data or information (or such indi-  
12 vidual’s parent, guardian, caretaker relative, or au-  
13 thorized representative) has either provided advance  
14 consent to disclosure or has not objected to disclo-  
15 sure after receiving advance notice of disclosure and  
16 a reasonable opportunity to object.

17 “(2) Such data or information are used solely  
18 for the purposes of—

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

23 “(B) verifying the eligibility of individuals  
24 for medical assistance under the State plan.

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

3                   “(A) prevents the unauthorized use, dislo-  
4                   sure, or modification of such data and other-  
5                   wise meets applicable Federal requirements  
6                   safeguarding privacy and data security; and

7                   “(B) requires the State agency admin-  
8                   istering the State plan to use the data and in-  
9                   formation obtained under this section to seek to  
10                  enroll individuals in the plan.

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

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

23           (2) CONFORMING AMENDMENT TO TITLE XXI.—  
24           Section 2107(e)(1) of such Act (42 U.S.C.  
25           1397gg(e)(1)), as amended by subsection (b), is

1 amended by adding at the end the following new  
2 subparagraph:

3 “(J) Section 1939 (relating to authoriza-  
4 tion to receive data potentially pertinent to eli-  
5 gibility determinations).”.

6 (3) CONFORMING AMENDMENT TO PROVIDE AC-  
7 CESS TO DATA ABOUT ENROLLMENT IN INSURANCE  
8 FOR PURPOSES OF EVALUATING APPLICATIONS AND  
9 FOR CHIP.—Section 1902(a)(25)(I)(i) of such Act  
10 (42 U.S.C. 1396a(a)(25)(I)(i)) is amended—

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

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

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

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

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

1           (1) in the matter before subparagraph (A), by  
2 striking “individuals for medical assistance under  
3 subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI),  
4 (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX)” and insert-  
5 ing “children and pregnant women for medical as-  
6 sistance under any provision of this title”; and

7           (2) in subparagraph (B), by inserting before  
8 the semicolon at the end the following: “, which need  
9 not be the same application form for all such indi-  
10 viduals”.

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

13 **SEC. 114. ENCOURAGING CULTURALLY APPROPRIATE EN-**  
14 **ROLLMENT AND RETENTION PRACTICES.**

15       (a) **USE OF MEDICAID FUNDS.**—Section 1903(a)(2)  
16 of the Social Security Act (42 U.S.C. 1396b(a)(2)) is  
17 amended by adding at the end the following new subpara-  
18 graph:

19           “(E) an amount equal to 75 percent of so much  
20 of the sums expended during such quarter (as found  
21 necessary by the Secretary for the proper and effi-  
22 cient administration of the State plan) as are attrib-  
23 utable to translation or interpretation services in  
24 connection with the enrollment and retention under



1 this title of children of families for whom English is  
2 not the primary language; plus”.

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

5 (1) IN GENERAL.—Section 2102(c)(1) of such  
6 Act (42 U.S.C. 1397bb(c)(1)) is amended by insert-  
7 ing “(through community health workers and oth-  
8 ers)” after “Outreach”.

9 (2) IN FEDERAL EVALUATION.—Section  
10 2108(e)(3)(B) of such Act (42 U.S.C.  
11 1397hh(c)(3)(B)) is amended by inserting “(such as  
12 through community health workers and others)”  
13 after “including practices”.

14 **SEC. 115. CONTINUOUS COVERAGE UNDER CHIP.**

15 (a) IN GENERAL.—Section 2102(b) of the Social Se-  
16 curity Act (42 U.S.C. 1397bb(b)) is amended by adding  
17 at the end the following new paragraph:

18 “(5) 12-MONTHS CONTINUOUS ELIGIBILITY.—  
19 In the case of a State child health plan that provides  
20 child health assistance under this title through a  
21 means other than described in section 2101(a)(2),  
22 the plan shall provide for implementation under this  
23 title of the 12-months continuous eligibility option  
24 described in section 1902(e)(12) for targeted low-in-

1 come children whose family income is below 200 per-  
2 cent of the poverty line.”.

3 (b) **EFFECTIVE DATE.**—The amendment made by  
4 subsection (a) shall apply to determinations (and redeter-  
5 minations) of eligibility made on or after January 1, 2008.

## 6 **Subtitle C—Coverage**

### 7 **SEC. 121. ENSURING CHILD-CENTERED COVERAGE.**

8 (a) **ADDITIONAL REQUIRED SERVICES.**—

9 (1) **CHILD-CENTERED COVERAGE.**—Section  
10 2103 of the Social Security Act (42 U.S.C. 1397cc)  
11 is amended—

12 (A) in subsection (a)—

13 (i) in the matter before paragraph  
14 (1), by striking “subsection (c)(5)” and in-  
15 sserting “paragraphs (5) and (6) of sub-  
16 section (c)”; and

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

19 (B) in subsection (c)—

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

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

24 “(5) **DENTAL, FQHC, AND RHC SERVICES.**—The  
25 child health assistance provided to a targeted low-in-

1       come child (whether through benchmark coverage or  
2       benchmark-equivalent coverage or otherwise) shall  
3       include coverage of the following:

4               “(A) Dental services necessary to prevent  
5       disease and promote oral health, restore oral  
6       structures to health and function, and treat  
7       emergency conditions.

8               “(B) Federally-qualified health center serv-  
9       ices (as defined in section 1905(l)(2)) and rural  
10       health clinic services (as defined in section  
11       1905(l)(1)).

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

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

22               “(D) Section 1902(bb) (relating to pay-  
23       ment for services provided by Federally-quali-  
24       fied health centers and rural health clinics).”.

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

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

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

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

17                       (A) in subparagraph (A)—

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

22                               (ii) by striking “enrollment in cov-  
23                               erage that provides” and all that follows  
24                               and inserting “benchmark coverage de-  
25                               scribed in subsection (b)(1) or benchmark

1 equivalent coverage described in subsection  
2 (b)(2).”;

3 (B) by striking subparagraph (C) and in-  
4 serting the following new subparagraph:

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

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

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

22 (2) EFFECTIVE DATE.—The amendments made  
23 by paragraph (1) shall take effect as if included in  
24 the amendment made by section 6044(a) of the Def-  
25 icit Reduction Act of 2005.

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

4 (1) IN GENERAL.—Section 2110(a)(5) of such  
5 Act (42 U.S.C. 1397jj(a)(5)) is amended by insert-  
6 ing after “health center services” the following: “and  
7 school-based health center services for which cov-  
8 erage is otherwise provided under this title when fur-  
9 nished by a school-based health center that is au-  
10 thORIZED to furnish such services under State law”.

11 (2) EFFECTIVE DATE.—The amendment made  
12 by paragraph (1) shall apply to child health assist-  
13 ance furnished on or after the date of the enactment  
14 of this Act.

15 (d) ASSURING ACCESS TO CARE.—

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

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

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

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

4 (1) UNDER CHIP.—Section 2103(a)(4) of the  
5 Social Security Act (42 U.S.C. 1397cc(a)(4)) is  
6 amended by inserting before the period at the end  
7 the following: “if the health benefits coverage is at  
8 least equivalent to the benefits coverage in a bench-  
9 mark benefit package described in subsection (b)”.

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

17 (b) REQUIREMENT FOR MOST POPULAR FAMILY  
18 COVERAGE FOR STATE EMPLOYEE COVERAGE BENCH-  
19 MARK.—

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

1           (2) MEDICAID.—Section 1937(b)(1)(B) of such  
2 Act is amended by inserting “and that has been se-  
3 lected most frequently, by employees seeking depend-  
4 ent coverage, among such plans that provide such  
5 dependent coverage, in either of the previous 2 plan  
6 years” before the period at the end.

7           (c) EFFECTIVE DATE.—The amendments made by  
8 this section shall apply to health benefits coverage pro-  
9 vided on or after October 1, 2008.

10 **SEC. 123. PREMIUM GRACE PERIOD.**

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

14                   “(C) PREMIUM GRACE PERIOD.—The State  
15 child health plan—

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

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



1                   “(I) that failure to make a pre-  
 2                   mium payment within the grace pe-  
 3                   riod will result in termination of cov-  
 4                   erage under the State child health  
 5                   plan; and

6                   “(II) of the individual’s right to  
 7                   challenge the proposed termination  
 8                   pursuant to the applicable Federal  
 9                   regulations.

10                   For purposes of clause (i), the term ‘new cov-  
 11                   erage period’ means the month immediately fol-  
 12                   lowing the last month for which the premium  
 13                   has been paid.”.

14                   (b) EFFECTIVE DATE.—The amendment made by  
 15                   subsection (a) shall apply to new coverage periods begin-  
 16                   ning on or after January 1, 2009.

## 17                   **Subtitle D—Populations**

### 18                   **SEC. 131. OPTIONAL COVERAGE OF CHILDREN UP TO AGE**

#### 19                   **21 UNDER CHIP.**

20                   (a) IN GENERAL.—Section 2110(c)(1) of the Social  
 21                   Security Act (42 U.S.C. 1397jj(c)(1)) is amended by in-  
 22                   serting “(or, at the option of the State, under 20 or 21  
 23                   years of age)” after “19 years of age”.

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

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

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

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

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

9 “(4)(A) A State may elect (in a plan amendment  
10 under this title) to provide medical assistance under this  
11 title, notwithstanding sections 401(a), 402(b), 403, and  
12 421 of the Personal Responsibility and Work Opportunity  
13 Reconciliation Act of 1996, for aliens who are lawfully re-  
14 siding in the United States (including battered aliens de-  
15 scribed in section 431(c) of such Act) and who are other-  
16 wise eligible for such assistance, within either or both of  
17 the following eligibility categories:

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

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

25 “(B) In the case of a State that has elected to provide  
26 medical assistance to a category of aliens under subpara-

1 graph (A), no debt shall accrue under an affidavit of sup-  
2 port against any sponsor of such an alien on the basis  
3 of provision of medical assistance to such category and  
4 the cost of such assistance shall not be considered as an  
5 unreimbursed cost.”.

6 (b) CHIP.—Section 2107(e)(1) of such Act (42  
7 U.S.C. 1397gg(e)(1)), as amended by section 112(b),  
8 112(d)(2),and 121(a)(2), is amended by inserting after  
9 subparagraph (E) the following new subparagraphs:

10 “(F) Section 1903(v)(4)(A) (relating to op-  
11 tional coverage of certain categories of lawfully  
12 residing immigrants), insofar as it relates to the  
13 category of pregnant women described in clause  
14 (i) of such section, but only if the State has  
15 elected to apply such section with respect to  
16 such women under title XIX and the State has  
17 elected the option under section 2111 to provide  
18 assistance for pregnant women under this title.

19 “(G) Section 1903(v)(4)(A) (relating to  
20 optional coverage of categories of lawfully resid-  
21 ing immigrants), insofar as it relates to the cat-  
22 egory of children described in clause (ii) of such  
23 section, but only if the State has elected to  
24 apply such section with respect to such children  
25 under title XIX.”.

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

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

7 (a) CHIP.—

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

11 **“SEC. 2111. OPTIONAL COVERAGE OF TARGETED LOW-IN-**  
12 **COME PREGNANT WOMEN.**

13 “(a) OPTIONAL COVERAGE.—Notwithstanding any  
14 other provision of this title, a State may provide for cov-  
15 erage, through an amendment to its State child health  
16 plan under section 2102, of assistance for pregnant  
17 women for targeted low-income pregnant women in ac-  
18 cordance with this section, but only if—

19 “(1) the State has established an income eligi-  
20 bility level—

21 “(A) for pregnant women, under any of  
22 clauses (i)(III), (i)(IV), or (ii)(IX) of section  
23 1902(a)(10)(A), that is at least 185 percent (or  
24 such higher percent as the State has in effect  
25 for pregnant women under this title) of the pov-

1           erty line applicable to a family of the size in-  
2           volved, but in no case a percent lower than the  
3           percent in effect under any such clause as of  
4           July 1, 2007; and

5           “(B) for children under 19 years of age  
6           under this title (or title XIX) that is at least  
7           200 percent of the poverty line applicable to a  
8           family of the size involved; and

9           “(2) the State does not impose, with respect to  
10          the enrollment under the State child health plan of  
11          targeted low-income children during the quarter, any  
12          enrollment cap or other numerical limitation on en-  
13          rollment, any waiting list, any procedures designed  
14          to delay the consideration of applications for enroll-  
15          ment, or similar limitation with respect to enroll-  
16          ment.

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

18                 “(1) ASSISTANCE FOR PREGNANT WOMEN.—  
19                 The term ‘assistance for pregnant women’ has the  
20                 meaning given the term child health assistance in  
21                 section 2110(a) as if any reference to targeted low-  
22                 income children were a reference to targeted low-in-  
23                 come pregnant women.

1           “(2) TARGETED LOW-INCOME PREGNANT  
2 WOMAN.—The term ‘targeted low-income pregnant  
3 woman’ means a woman—

4           “(A) during pregnancy and through the  
5 end of the month in which the 60-day period  
6 (beginning on the last day of her pregnancy)  
7 ends;

8           “(B) whose family income exceeds 185 per-  
9 cent (or, if higher, the percent applied under  
10 subsection (a)(1)(A)) of the poverty level appli-  
11 cable to a family of the size involved, but does  
12 not exceed the income eligibility level estab-  
13 lished under the State child health plan under  
14 this title for a targeted low-income child; and

15           “(C) who satisfies the requirements of  
16 paragraphs (1)(A), (1)(C), (2), and (3) of sec-  
17 tion 2110(b), applied as if any reference to a  
18 child was a reference to a pregnant woman.

19           “(c) REFERENCES TO TERMS AND SPECIAL  
20 RULES.—In the case of, and with respect to, a State pro-  
21 viding for coverage of assistance for pregnant women to  
22 targeted low-income pregnant women under subsection  
23 (a), the following special rules apply:

24           “(1) Any reference in this title (other than in  
25 subsection (b)) to a targeted low-income child is

1 deemed to include a reference to a targeted low-in-  
2 come pregnant woman.

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

9 “(3) Any such reference (other than in section  
10 2105(d)) to a child is deemed a reference to a  
11 woman during pregnancy and the period described  
12 in subsection (b)(2)(A).

13 “(4) In applying section 2102(b)(3)(B), any  
14 reference to children found through screening to be  
15 eligible for medical assistance under the State med-  
16 icaid plan under title XIX is deemed a reference to  
17 pregnant women.

18 “(5) There shall be no exclusion of benefits for  
19 services described in subsection (b)(1) based on any  
20 preexisting condition and no waiting period (includ-  
21 ing any waiting period imposed to carry out section  
22 2102(b)(3)(C)) shall apply.

23 “(6) In applying section 2103(e)(3)(B) in the  
24 case of a pregnant woman provided coverage under  
25 this section, the limitation on total annual aggregate

1 cost-sharing shall be applied to such pregnant  
2 woman.

3 “(7) In applying section 2104(i)—

4 “(A) in the case of a State which did not  
5 provide for coverage for pregnant women under  
6 this title (under a waiver or otherwise) during  
7 fiscal year 2007, the allotment amount other-  
8 wise computed for the first fiscal year in which  
9 the State elects to provide coverage under this  
10 section shall be increased by an amount (deter-  
11 mined by the Secretary) equal to the enhanced  
12 FMAP of the expenditures under this title for  
13 such coverage, based upon projected enrollment  
14 and per capita costs of such enrollment; and

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

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

23 “(ii) in applying paragraph (3), preg-  
24 nant women (and per capita expenditures  
25 for such women) shall be accounted for



1                   separately from children, but shall be in-  
2                   cluded in the total amount of any allot-  
3                   ment adjustment under such paragraph.

4           “(d) AUTOMATIC ENROLLMENT FOR CHILDREN  
5 BORN TO WOMEN RECEIVING ASSISTANCE FOR PREG-  
6 NANT WOMEN.—If a child is born to a targeted low-in-  
7 come pregnant woman who was receiving assistance for  
8 pregnant women under this section on the date of the  
9 child’s birth, the child shall be deemed to have applied for  
10 child health assistance under the State child health plan  
11 and to have been found eligible for such assistance under  
12 such plan or to have applied for medical assistance under  
13 title XIX and to have been found eligible for such assist-  
14 ance under such title on the date of such birth, based on  
15 the mother’s reported income as of the time of her enroll-  
16 ment under this section and applicable income eligibility  
17 levels under this title and title XIX, and to remain eligible  
18 for such assistance until the child attains 1 year of age.  
19 During the period in which a child is deemed under the  
20 preceding sentence to be eligible for child health or med-  
21 ical assistance, the assistance for pregnant women or med-  
22 ical assistance eligibility identification number of the  
23 mother shall also serve as the identification number of the  
24 child, and all claims shall be submitted and paid under

1 such number (unless the State issues a separate identifica-  
2 tion number for the child before such period expires).”.

3 (2) ADDITIONAL AMENDMENT.—Section  
4 2107(e)(1)(I) of such Act (42 U.S.C.  
5 1397gg(e)(1)(H)), as redesignated by section  
6 112(b), is amended to read as follows:

7 “(I) Sections 1920 and 1920A (relating to  
8 presumptive eligibility for pregnant women and  
9 children).”.

10 (b) AMENDMENTS TO MEDICAID.—

11 (1) ELIGIBILITY OF A NEWBORN.—Section  
12 1902(e)(4) of the Social Security Act (42 U.S.C.  
13 1396a(e)(4)) is amended in the first sentence by  
14 striking “so long as the child is a member of the  
15 woman’s household and the woman remains (or  
16 would remain if pregnant) eligible for such assist-  
17 ance”.

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

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

1 **SEC. 134. LIMITATION ON WAIVER AUTHORITY TO COVER**  
2 **ADULTS.**

3 Section 2102 of the Social Security Act (42 U.S.C.  
4 1397bb) is amended by adding at the end the following  
5 new subsection:

6 “(d) **LIMITATION ON COVERAGE OF ADULTS.**—Not-  
7 withstanding any other provision of this title, the Sec-  
8 retary may not, through the exercise of any waiver author-  
9 ity on or after January 1, 2008, provide for Federal finan-  
10 cial participation to a State under this title for health care  
11 services for individuals who are not targeted low-income  
12 children or pregnant women unless the Secretary deter-  
13 mines that no eligible targeted low-income child in the  
14 State would be denied coverage under this title for health  
15 care services because of such eligibility. In making such  
16 determination, the Secretary must receive assurances  
17 that—

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

21 “(2) the State has in place an outreach pro-  
22 gram to reach all targeted low-income children in  
23 families with incomes less than 200 percent of the  
24 poverty line.”.

1 **SEC. 135. NO FEDERAL FUNDING FOR ILLEGAL ALIENS.**

2 Nothing in this Act allows Federal payment for indi-  
3 viduals who are not legal residents.

4 **SEC. 136. AUDITING REQUIREMENT TO ENFORCE CITIZEN-**  
5 **SHIP RESTRICTIONS ON ELIGIBILITY FOR**  
6 **MEDICAID AND CHIP BENEFITS.**

7 Section 1903(x) of the Social Security Act (as amend-  
8 ed by section 405(c)(1)(A) of division B of the Tax Relief  
9 and Health Care Act of 2006 (Public Law 109–432)) is  
10 amended by adding at the end the following new para-  
11 graph:

12 “(4)(A) Each State shall audit a statistically-based  
13 sample of cases of individuals whose eligibility for medical  
14 assistance (or child health assistance) is determined under  
15 section 1902(a)(46)(B) or under subsection (v)(4)(A) in  
16 order to demonstrate to the satisfaction of the Secretary  
17 that Federal funds under this title or title XXI are not  
18 unlawfully spent for benefits for individuals who are not  
19 legal residents. In conducting such audits, a State may  
20 rely on case reviews regularly conducted pursuant to its  
21 Medicaid Quality Control or Payment Error Rate Meas-  
22 urement (PERM) eligibility reviews under subsection (u)  
23 and the provisions of subsection (e) of section 1137 shall  
24 apply under this paragraph in the same manner as they  
25 apply under subsection (b) of such section.

1 “(B) The State shall remit to the Secretary the Fed-  
 2 eral share of any unlawful expenditures for benefits, for  
 3 aliens who are not legal residents, which are identified  
 4 under an audit conducted under subparagraph (A).”.

## 5 **Subtitle E—Access**

### 6 **SEC. 141. CHILDREN’S ACCESS, PAYMENT, AND EQUALITY** 7 **COMMISSION.**

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

10 “CHILDREN’S ACCESS, PAYMENT, AND EQUALITY  
 11 COMMISSION

12 “SEC. 1900. (a) ESTABLISHMENT.—There is hereby  
 13 established as an agency of Congress the Children’s Ac-  
 14 cess, Payment, and Equality Commission (in this section  
 15 referred to as the ‘Commission’).

16 “(b) DUTIES.—

17 “(1) REVIEW OF PAYMENT POLICIES AND AN-  
 18 NUAL REPORTS.—The Commission shall—

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

1           “(B) review access to, and affordability of,  
2 coverage and services for enrollees under Med-  
3 icaid and CHIP;

4           “(C) make recommendations to Congress  
5 concerning such policies;

6           “(D) by not later than March 1 of each  
7 year, submit to Congress a report containing  
8 the results of such reviews and its recommenda-  
9 tions concerning such policies; and

10          “(E) by not later than June 1 of each  
11 year, submit to Congress a report containing an  
12 examination of issues affecting Medicaid and  
13 CHIP, including the implications of changes in  
14 health care delivery in the United States and in  
15 the market for health care services on such pro-  
16 grams.

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

19           “(A) The factors affecting expenditures for  
20 services in different sectors (such as physician,  
21 hospital and other sectors), payment methodolo-  
22 gies, and their relationship to access and qual-  
23 ity of care for Medicaid and CHIP beneficiaries.

24           “(B) The impact of Federal and State  
25 Medicaid and CHIP payment policies on access

1 to services (including dental services) for chil-  
2 dren (including children with disabilities) and  
3 other Medicaid and CHIP populations.

4 “(C) The impact of Federal and State  
5 Medicaid and CHIP policies on reducing health  
6 disparities, including geographic disparities and  
7 disparities among minority populations.

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

20 “(E) The relation (if any) between pay-  
21 ment rates for providers and improvement in  
22 care for children as measured under the chil-  
23 dren’s health quality measurement program es-  
24 tablished under section 151 of the Children’s  
25 Health and Medicare Protection Act of 2007.

1           “(F) The affordability, cost effectiveness,  
2           and accessibility of services needed by special  
3           populations under Medicaid and CHIP as com-  
4           pared with private-sector coverage.

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

15          “(H) The effect of demonstrations under  
16          section 1115, benchmark coverage under section  
17          1937, and other coverage under section 1938,  
18          on access to care, affordability of coverage, pro-  
19          vider ability to achieve children’s health quality  
20          performance measures, and access to safety net  
21          services.

22          “(3) COMMENTS ON CERTAIN SECRETARIAL RE-  
23          PORTS.—If the Secretary submits to Congress (or a  
24          committee of Congress) a report that is required by  
25          law and that relates to payment policies under Med-



1       icaid or CHIP, the Secretary shall transmit a copy  
2       of the report to the Commission. The Commission  
3       shall review the report and, not later than 6 months  
4       after the date of submittal of the Secretary's report  
5       to Congress, shall submit to the appropriate commit-  
6       tees of Congress written comments on such report.  
7       Such comments may include such recommendations  
8       as the Commission deems appropriate.

9               “(4) AGENDA AND ADDITIONAL REVIEWS.—The  
10       Commission shall consult periodically with the  
11       Chairmen and Ranking Minority Members of the ap-  
12       propriate committees of Congress regarding the  
13       Commission's agenda and progress towards achiev-  
14       ing the agenda. The Commission may conduct addi-  
15       tional reviews, and submit additional reports to the  
16       appropriate committees of Congress, from time to  
17       time on such topics relating to the program under  
18       this title or title XXI as may be requested by such  
19       Chairmen and Members and as the Commission  
20       deems appropriate.

21               “(5) AVAILABILITY OF REPORTS.—The Com-  
22       mission shall transmit to the Secretary a copy of  
23       each report submitted under this subsection and  
24       shall make such reports available to the public.

1           “(6) APPROPRIATE COMMITTEE OF CON-  
2           GRESS.—For purposes of this section, the term ‘ap-  
3           propriate committees of Congress’ means the Com-  
4           mittees on Energy and Commerce of the House of  
5           Representatives and the Committee on Finance of  
6           the Senate.

7           “(7) VOTING AND REPORTING REQUIRE-  
8           MENTS.—With respect to each recommendation con-  
9           tained in a report submitted under paragraph (1),  
10          each member of the Commission shall vote on the  
11          recommendation, and the Commission shall include,  
12          by member, the results of that vote in the report  
13          containing the recommendation.

14          “(8) EXAMINATION OF BUDGET CON-  
15          SEQUENCES.—Before making any recommendations,  
16          the Commission shall examine the budget con-  
17          sequences of such recommendations, directly or  
18          through consultation with appropriate expert enti-  
19          ties.

20          “(c) APPLICATION OF PROVISIONS.—The following  
21          provisions of section 1805 shall apply to the Commission  
22          in the same manner as they apply to the Medicare Pay-  
23          ment Advisory Commission:

24                  “(1) Subsection (c) (relating to membership),  
25                  except that the membership of the Commission shall

1 also include representatives of children, pregnant  
2 women, individuals with disabilities, seniors, low-in-  
3 come families, and other groups of CHIP and Med-  
4 icaid beneficiaries.

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

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

8 “(d) AUTHORIZATION OF APPROPRIATIONS.—

9 “(1) REQUEST FOR APPROPRIATIONS.—The  
10 Commission shall submit requests for appropriations  
11 in the same manner as the Comptroller General sub-  
12 mits requests for appropriations, but amounts ap-  
13 propriated for the Commission shall be separate  
14 from amounts appropriated for the Comptroller Gen-  
15 eral.

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

19 **SEC. 142. MODEL OF INTERSTATE COORDINATED ENROLL-**  
20 **MENT AND COVERAGE PROCESS.**

21 (a) IN GENERAL.—In order to assure continuity of  
22 coverage of low-income children under the Medicaid pro-  
23 gram and the State Children’s Health Insurance Program  
24 (CHIP), not later than 18 months after the date of the  
25 enactment of this Act, the Comptroller General of the

1 United States, in consultation with State Medicaid and  
2 CHIP directors and organizations representing program  
3 beneficiaries, shall develop a model process for the coordi-  
4 nation of the enrollment, retention, and coverage under  
5 such programs of children who, because of migration of  
6 families, emergency evacuations, educational needs, or  
7 otherwise, frequently change their State of residency or  
8 otherwise are temporarily located outside of the State of  
9 their residency.

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

16 **SEC. 143. MEDICAID CITIZENSHIP DOCUMENTATION RE-**  
17 **QUIREMENTS.**

18 (a) STATE OPTION TO REQUIRE CHILDREN TO  
19 PRESENT SATISFACTORY DOCUMENTARY EVIDENCE OF  
20 PROOF OF CITIZENSHIP OR NATIONALITY FOR PURPOSES  
21 OF ELIGIBILITY FOR MEDICAID; REQUIREMENT FOR AU-  
22 DITING.—

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

25 (A) in subsection (a)(46)—

1 (i) by inserting “(A)” after “(46)”;

2 and

3 (ii) by adding at the end the following

4 new subparagraphs:

5 “(B) at the option of the State, require that,  
6 with respect to a child under 21 years of age (other  
7 than an individual described in section 1903(x)(2))  
8 who declares to be a citizen or national of the  
9 United States for purposes of establishing initial eli-  
10 gibility for medical assistance under this title (or, at  
11 State option, for purposes of renewing or redeter-  
12 mining such eligibility to the extent that such satis-  
13 factory documentary evidence of citizenship or na-  
14 tionality has not yet been presented), there is pre-  
15 sented satisfactory documentary evidence of citizen-  
16 ship or nationality of the individual (using criteria  
17 determined by the State, which shall be no more re-  
18 strictive than the documentation specified in section  
19 1903(x)(3)); and

20 “(C) comply with the auditing requirements of  
21 section 1903(x)(4);” and

22 (B) in subsection (b)(3), by inserting “or  
23 any citizenship documentation requirement for  
24 a child under 21 years of age that is more re-

1           strictive than what a State may provide under  
2           section 1903(x)” before the period at the end.

3           (2) ELIMINATION OF DENIAL OF PAYMENTS  
4           FOR CHILDREN.—Section 1903(i)(22) of such Act  
5           (42 U.S.C. 1396b(i)(22)) is amended by inserting  
6           “(other than a child under the age of 21)” after “for  
7           an individual”.

8           (b) CLARIFICATION OF RULES FOR CHILDREN BORN  
9           IN THE UNITED STATES TO MOTHERS ELIGIBLE FOR  
10          MEDICAID.—Section 1903(x)(2) of such Act (42 U.S.C.  
11          1396b(x)(2)) is amended—

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

14           (2) by redesignating subparagraph (D) as sub-  
15          paragraph (E); and

16           (3) by inserting after subparagraph (C) the fol-  
17          lowing new subparagraph:

18           “(D) pursuant to the application of section  
19          1902(e)(4) (and, in the case of an individual who is  
20          eligible for medical assistance on such basis, the in-  
21          dividual shall be deemed to have provided satisfac-  
22          tory documentary evidence of citizenship or nation-  
23          ality and shall not be required to provide further  
24          documentary evidence on any date that occurs dur-

1       ing or after the period in which the individual is eli-  
2       gible for medical assistance on such basis; or”.

3       (c) DOCUMENTATION FOR NATIVE AMERICANS .—

4 Section 1903(x)(3)(B) of such Act is amended—

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

6       and

7           (2) by inserting after clause (iv) the following

8       new clause:

9           “(v) For an individual who is a member of, or  
10       enrolled in or affiliated with, a federally-recognized  
11       Indian tribe, a document issued by such tribe evi-  
12       dencing such membership, enrollment, or affiliation  
13       with the tribe (such as a tribal enrollment card or  
14       certificate of degree of Indian blood), and, only with  
15       respect to those federally-recognized Indian tribes lo-  
16       cated within States having an international border  
17       whose membership includes individuals who are not  
18       citizens of the United States, such other forms of  
19       documentation (including tribal documentation, if  
20       appropriate) as the Secretary, after consulting with  
21       such tribes, determines to be satisfactory documen-  
22       tary evidence of citizenship or nationality for pur-  
23       poses of satisfying the requirement of this subpara-  
24       graph.”.

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

5 “(5) In the case of an individual declaring to be a  
6 citizen or national of the United States with respect to  
7 whom a State requires the presentation of satisfactory  
8 documentary evidence of citizenship or nationality under  
9 section 1902(a)(46)(B), the individual shall be provided  
10 at least the reasonable opportunity to present satisfactory  
11 documentary evidence of citizenship or nationality under  
12 this subsection as is provided under clauses (i) and (ii)  
13 of section 1137(d)(4)(A) to an individual for the submittal  
14 to the State of evidence indicating a satisfactory immigra-  
15 tion status and shall not be denied medical assistance on  
16 the basis of failure to provide such documentation until  
17 the individual has had such an opportunity.”

18 (e) EFFECTIVE DATE.—

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

23 (2) RESTORATION OF ELIGIBILITY.—In the  
24 case of an individual who, during the period that  
25 began on July 1, 2006, and ends on the date of the



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

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

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

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

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

3           (A) by striking “and” at the end of para-  
4 graph (69);

5           (B) by striking the period at the end of  
6 paragraph (70) and inserting “; and”; and

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

9           “(71) provide that the State will not prevent a  
10 Federally-qualified health center from entering into  
11 contractual relationships with private practice dental  
12 providers in the provision of Federally-qualified  
13 health center services.”.

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

18           “(B) Section 1902(a)(71) (relating to lim-  
19 iting FQHC contracting for provision of dental  
20 services).”.

21           (3) EFFECTIVE DATE.—The amendments made  
22 by this subsection shall take effect on January 1,  
23 2008.

24           (c) REPORTING INFORMATION ON DENTAL  
25 HEALTH.—

1           (1) MEDICAID.—Section 1902(a)(43)(D)(iii) of  
2 such Act (42 U.S.C. 1396a(a)(43)(D)(iii)) is amend-  
3 ed by inserting “and other information relating to  
4 the provision of dental services to such children de-  
5 scribed in section 2108(e)” after “receiving dental  
6 services,”.

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

10       “(e) INFORMATION ON DENTAL CARE FOR CHIL-  
11 DREN.—

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

18           “(A) The number of enrolled children by  
19 age grouping used for reporting purposes under  
20 section 1902(a)(43).

21           “(B) For children within each such age  
22 grouping, information of the type contained in  
23 questions 12(a)–(c) of CMS Form 416 (that  
24 consists of the number of enrolled targeted low

1 income children who receive any, preventive, or  
2 restorative dental care under the State plan).

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

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

14 (3) EFFECTIVE DATE.—The amendments made  
15 by this subsection shall be effective for annual re-  
16 ports submitted for years beginning after date of en-  
17 actment.

18 (d) GAO STUDY AND REPORT.—

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

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

24 (B) the feasibility and appropriateness of  
25 using qualified mid-level dental health pro-

1           viders, in coordination with dentists, to improve  
2           access for children to oral health services and  
3           public health overall.

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

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

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

15   **Subtitle F—Quality and Program**  
16                           **Integrity**

17   **SEC. 151. PEDIATRIC HEALTH QUALITY MEASUREMENT**  
18                           **PROGRAM.**

19           (a) QUALITY MEASUREMENT OF CHILDREN’S  
20           HEALTH.—

21           (1) ESTABLISHMENT OF PROGRAM TO DEVELOP  
22           QUALITY MEASURES FOR CHILDREN’S HEALTH.—  
23           The Secretary of Health and Human Services (in  
24           this section referred to as the “Secretary”) shall es-  
25           tablish a child health care quality measurement pro-

1       gram (in this subsection referred to as the “chil-  
2       dren’s health quality measurement program”) to de-  
3       velop and implement—

4               (A) pediatric quality measures on chil-  
5       dren’s health care that may be used by public  
6       and private health care purchasers (and a sys-  
7       tem for reporting such measures); and

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

11      The Secretary shall publish, not later than Sep-  
12      tember 30, 2009, the recommended measures under  
13      the program for application under the amendments  
14      made by subsection (b) for years beginning with  
15      2010.

16              (2) MEASURES.—

17               (A) SCOPE.—The measures developed  
18      under the children’s health quality measure-  
19      ment program shall—

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

24                      (ii) be designed to identify disparities  
25                      by pediatric characteristics (including, at a

1 minimum, those specified in subparagraph  
2 (C)) in child health and the provision of  
3 health care;

4 (iii) be designed to ensure that the  
5 data required for such measures is col-  
6 lected and reported in a standard format  
7 that permits comparison at a State, plan,  
8 and provider level, and between insured  
9 and uninsured children;

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

13 (v) include measures of clinical health  
14 care quality which meet the requirements  
15 for pediatric quality measures in para-  
16 graph (1);

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

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

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

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

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

14 (iii) The effectiveness of early health  
15 care interventions for children whose as-  
16 sessments indicate the presence or risk of  
17 physical or mental conditions that could  
18 adversely affect growth and development.

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

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



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

3 (vii) Data on State efforts to reduce  
4 hospitalization rate of premature infants  
5 under the age of 12 months who were born  
6 prior to 35 weeks.

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

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

18 (i) Age.

19 (ii) Gender.

20 (iii) Race.

21 (iv) Ethnicity.

22 (v) Primary language of the child’s  
23 parents (or caretaker relative).

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

1 (vii) Geographic location.

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

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

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

17 (A) States;

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

25 (C) dental professionals;

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

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

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

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

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

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

1 cordance with the children’s health quality measure-  
2 ment program.

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

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

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

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

24 (1) the quality of health care for children en-  
25 rolled under titles XIX and XXI of the Social Secu-

1 rity Act under the children’s health quality measure-  
2 ment program; and

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

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

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

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

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

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

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

5 “(5) SUBSEQUENT EVALUATION USING UP-  
6 DATED INFORMATION.—

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

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

17 “(C) SUBMISSION TO CONGRESS.—Not  
18 later than December 31, 2010, the Secretary  
19 shall submit to Congress the results of the eval-  
20 uation conducted under this paragraph.

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

1           subparagraph shall remain available for expend-  
2           iture through fiscal year 2011.”.

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

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

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

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

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

1 **SEC. 156. RELIANCE ON LAW; EXCEPTION FOR STATE LEG-**  
2 **ISLATION.**

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

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

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

20 (b) **EXCEPTION FOR STATE LEGISLATION.**—In the  
21 case of a State plan under title XIX or State child health  
22 plan under XXI of the Social Security Act, which the Sec-  
23 retary of Health and Human Services determines requires  
24 State legislation in order for respective plan to meet one  
25 or more additional requirements imposed by amendments  
26 made by this title or title VIII, the respective State plan



1 shall not be regarded as failing to comply with the require-  
2 ments of such title solely on the basis of its failure to meet  
3 such an additional requirement before the first day of the  
4 first calendar quarter beginning after the close of the first  
5 regular session of the State legislature that begins after  
6 the date of enactment of this Act. For purposes of the  
7 previous sentence, in the case of a State that has a 2-  
8 year legislative session, each year of the session shall be  
9 considered to be a separate regular session of the State  
10 legislature.

11 **TITLE II—MEDICARE**  
12 **BENEFICIARY IMPROVEMENTS**  
13 **Subtitle A—Improvements in**  
14 **Benefits**

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

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

20 (1) in subsection (s)(2)—

21 (A) in subparagraph (Z), by striking  
22 “and” after the semicolon at the end;

23 (B) in subparagraph (AA), by adding  
24 “and” after the semicolon at the end; and

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

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

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

9 “Preventive Services

10 “(ccc)(1) The term ‘preventive services’ means the  
11 following:

12 “(A) Prostate cancer screening tests (as  
13 defined in subsection (oo)).

14 “(B) Colorectal cancer screening tests (as  
15 defined in subsection (pp)).

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

18 “(D) Screening for glaucoma for certain  
19 individuals (as described in subsection  
20 (s)(2)(U)).

21 “(E) Medical nutrition therapy services for  
22 certain individuals (as described in subsection  
23 (s)(2)(V)).

24 “(F) An initial preventive physical exam-  
25 ination (as defined in subsection (ww)).

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

3           “(H) Diabetes screening tests (as defined  
4           in subsection described in subsection (s)(2)(Y)).

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

8           “(J) Pneumococcal and influenza vaccine  
9           and their administration (as described in sub-  
10          section (s)(10)(A)).

11          “(K) Hepatitis B vaccine and its adminis-  
12          tration for certain individuals (as described in  
13          subsection (s)(10)(B)).

14          “(L) Screening mammography (as defined  
15          in subsection (jj)).

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

18          “(N) Bone mass measurement (as defined  
19          in subsection (rr)).

20          “(O) Additional preventive services (as de-  
21          termined under paragraph (2)).

22          “(2)(A) The term ‘additional preventive serv-  
23          ices’ means items and services, including mental  
24          health services, not described in subparagraphs (A)  
25          through (N) of paragraph (1) that the Secretary de-

1 termines to be reasonable and necessary for the pre-  
2 vention or early detection of an illness or disability.

3 “(B) In making determinations under subpara-  
4 graph (1), the Secretary shall—

5 “(i) take into account evidence-based rec-  
6 ommendations by the United States Preventive  
7 Services Task Force and other appropriate or-  
8 ganizations; and

9 “(ii) use the process for making national  
10 coverage determinations (as defined in section  
11 1869(f)(1)(B)) under this title.”.

12 (b) PAYMENT AND ELIMINATION OF COST-SHAR-  
13 ING.—

14 (1) IN GENERAL.—

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

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

20 (ii) by striking “and” before “(V)”;  
21 and

22 (iii) by inserting before the semicolon  
23 at the end the following: “, and (W) with  
24 respect to additional preventive services (as  
25 defined in section 1861(ccc)(2)) and other

1 preventive services for which a payment  
2 rate is not otherwise established under this  
3 section, the amount paid shall be 100 per-  
4 cent of the lesser of the actual charge for  
5 the services or the amount determined  
6 under a fee schedule established by the  
7 Secretary for purposes of this clause”.

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

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

13 “(ii) NO COINSURANCE.—In the case  
14 of a beneficiary who receives services de-  
15 scribed in clause (i), there shall be no coin-  
16 surance applied.”; and

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

19 “(ii) NO COINSURANCE.—In the case  
20 of a beneficiary who receives services de-  
21 scribed in clause (i), there shall be no coin-  
22 surance applied.”.

23 (2) ELIMINATION OF COINSURANCE IN OUT-  
24 PATIENT HOSPITAL SETTINGS.—

1 (A) EXCLUSION FROM OPD FEE SCHED-  
2 ULE.—Section 1833(t)(1)(B)(iv) of the Social  
3 Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is  
4 amended by striking “screening mammography  
5 (as defined in section 1861(jj)) and diagnostic  
6 mammography” and inserting “diagnostic  
7 mammography and preventive services (as de-  
8 fined in section 1861(ccc)(1))”.

9 (B) CONFORMING AMENDMENTS.—Section  
10 1833(a)(2) of the Social Security Act (42  
11 U.S.C. 1395l(a)(2)) is amended—

12 (i) in subparagraph (F), by striking  
13 “and” after the semicolon at the end;

14 (ii) in subparagraph (G)(ii), by adding  
15 “and” at the end; and

16 (iii) by adding at the end the fol-  
17 lowing new subparagraph:

18 “(H) with respect to additional preventive  
19 services (as defined in section 1861(ccc)(2))  
20 furnished by an outpatient department of a hos-  
21 pital, the amount determined under paragraph  
22 (1)(W);”.

23 (3) WAIVER OF APPLICATION OF DEDUCTIBLE  
24 FOR ALL PREVENTIVE SERVICES.—The first sen-

1 tence of section 1833(b) of the Social Security Act  
2 (42 U.S.C. 1395l(b)) is amended—

3 (A) in clause (1), by striking “items and  
4 services described in section 1861(s)(10)(A)”  
5 and inserting “preventive services (as defined in  
6 section 1861(ccc)(1))”;

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

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

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

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

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

18 **SEC. 202. WAIVER OF DEDUCTIBLE FOR COLORECTAL CAN-**  
19 **CER SCREENING TESTS REGARDLESS OF**  
20 **CODING, SUBSEQUENT DIAGNOSIS, OR ANCIL-**  
21 **LARY TISSUE REMOVAL.**

22 (a) IN GENERAL.—Section 1833(b) of the Social Se-  
23 curity Act (42 U.S.C. 1395l(b)), as amended by section  
24 201(b), is amended by adding at the end the following new  
25 sentence: “Clause (1) of the first sentence of this sub-

1 section shall apply with respect to a colorectal cancer  
2 screening test regardless of the code applied, of the estab-  
3 lishment of a diagnosis as a result of the test, or of the  
4 removal of tissue or other matter or other procedure that  
5 is performed in connection with and as a result of the  
6 screening test.”.

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

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

11 Section 1833(c) of the Social Security Act (42 U.S.C.  
12 1395l(c)) is amended by inserting “before 2008” after “in  
13 any calendar year”.

14 **Subtitle B—Improving, Clarifying,**  
15 **and Simplifying Financial As-**  
16 **sistance for Low Income Medi-**  
17 **care Beneficiaries**

18 **SEC. 211. IMPROVING ASSETS TESTS FOR MEDICARE SAV-**  
19 **INGS PROGRAM AND LOW-INCOME SUBSIDY**  
20 **PROGRAM.**

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

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



1 (A) in paragraph (1), in the matter before  
2 subparagraph (A), by inserting “(or, beginning  
3 with 2009, paragraph (3)(E))” after “para-  
4 graph (3)(D)”; and

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

7 (2) ANNUAL INCREASE IN LIS RESOURCE  
8 TEST.—Section 1860D–14(a)(3)(E)(i) of such Act  
9 (42 U.S.C. 1395w–114(a)(3)(E)(i)) is amended—

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

12 (B) in subclause (II), by inserting “(before  
13 2009)” after “subsequent year”;

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

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

18 “(III) for 2009, \$17,000 (or  
19 \$34,000 in the case of the combined  
20 value of the individual’s assets or re-  
21 sources and the assets or resources of  
22 the individual’s spouse); and

23 “(IV) for a subsequent year, the  
24 dollar amounts specified in this sub-  
25 clause (or subclause (III)) for the pre-

1           vious year increased by the annual  
2           percentage increase in the consumer  
3           price index (all items; U.S. city aver-  
4           age) as of September of such previous  
5           year.”; and

6           (E) in the last sentence, by inserting “or  
7           (IV)” after “subclause (II)”.

8           (3) APPLICATION OF LIS TEST UNDER MEDI-  
9           CARE SAVINGS PROGRAM.—Section 1905(p)(1)(C) of  
10          such Act (42 U.S.C. 1396d(p)(1)(C)) is amended by  
11          inserting before the period at the end the following:  
12          “or, effective beginning with January 1, 2009, whose  
13          resources (as so determined) do not exceed the max-  
14          imum resource level applied for the year under sec-  
15          tion 1860D–14(a)(3)(E) applicable to an individual  
16          or to the individual and the individual’s spouse (as  
17          the case may be)”.

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

22          **SEC. 212. MAKING QI PROGRAM PERMANENT AND EXPAND-**  
23          **ING ELIGIBILITY.**

24          (a) MAKING PROGRAM PERMANENT.—

1           (1) IN GENERAL.—Section 1902(a)(10)(E)(iv)  
2 of the Social Security Act (42 U.S.C.  
3 1396b(a)(10)(E)(iv)) is amended—

4           (A) by striking “sections 1933 and” and  
5 by inserting “section”; and

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

8           (2) ELIMINATION OF FUNDING LIMITATION.—

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

11           (i) in subsection (a), by striking “who  
12 are selected to receive such assistance  
13 under subsection (b)”;

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

16           (iii) in subsection (d), by striking  
17 “furnished in a State” and all that follows  
18 and inserting “the Federal medical assist-  
19 ance percentage shall be equal to 100 per-  
20 cent.”; and

21           (iv) by redesignating subsections (d)  
22 and (f) as subsections (b) and (c), respec-  
23 tively.

24           (B) CONFORMING AMENDMENT.—Section  
25 1905(b) of such Act (42 U.S.C. 1396d(b)) is

1           amended by striking “1933(d)” and inserting  
2           “1933(b)”.

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

6           (b) INCREASE IN ELIGIBILITY TO 150 PERCENT OF  
7 THE FEDERAL POVERTY LEVEL.—Section  
8 1902(a)(10)(E)(iv) of such Act is further amended by in-  
9 serting “(or, effective January 1, 2008, 150 percent)”  
10 after “135 percent”.

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

12           (a) ADMINISTRATIVE VERIFICATION OF INCOME AND  
13 RESOURCES UNDER THE LOW-INCOME SUBSIDY PRO-  
14 GRAM.—Clause (iii) of section 1860D–14(a)(3)(E) of the  
15 Social Security Act (42 U.S.C. 1395w–114(a)(3)(E)) is  
16 amended to read as follows:

17                           “(iii) CERTIFICATION OF INCOME AND  
18                           RESOURCES.—For purposes of applying  
19                           this section—

20   “(I) an individual shall be per-  
21   mitted to apply on the basis of self-  
22   certification of income and resources;  
23   and

24   “(II) matters attested to in the  
25   application shall be subject to appro-

1                   priate methods of verification without  
2                   the need of the individual to provide  
3                   additional documentation, except in  
4                   extraordinary situations as determined  
5                   by the Commissioner.”.

6           (b) AUTOMATIC REENROLLMENT WITHOUT NEED TO  
7 REAPPLY UNDER LOW-INCOME SUBSIDY PROGRAM.—  
8 Section 1860D–14(a)(3) of such Act (42 U.S.C. 1395w–  
9 114(a)(3)) is amended by adding at the end the following  
10 new subparagraph:

11                   “(G) AUTOMATIC REENROLLMENT.—For  
12                   purposes of applying this section, in the case of  
13                   an individual who has been determined to be a  
14                   subsidy eligible individual (and within a par-  
15                   ticular class of such individuals, such as a full-  
16                   subsidy eligible individual or a partial subsidy  
17                   eligible individual), the individual shall be  
18                   deemed to continue to be so determined without  
19                   the need for any annual or periodic application  
20                   unless and until the individual notifies a Fed-  
21                   eral or State official responsible for such deter-  
22                   minations that the individual’s eligibility condi-  
23                   tions have changed so that the individual is no  
24                   longer a subsidy eligible individual (or is no  
25                   longer within such class of such individuals).”.

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

5           “(7) The Secretary shall take all reasonable steps to  
6 encourage States to provide for administrative verification  
7 of income and automatic reenrollment (as provided under  
8 subparagraphs (C)(iii) and (G) of section 1860D–14(a)(3)  
9 in the case of the low-income subsidy program).”.

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

15          “(c) ASSISTANCE WITH MEDICARE SAVINGS PRO-  
16 GRAM AND LOW-INCOME SUBSIDY PROGRAM APPLICA-  
17 TIONS.—

18                 “(1) DISTRIBUTION OF APPLICATIONS TO AP-  
19 PPLICANTS FOR MEDICARE.—In the case of each indi-  
20 vidual applying for hospital insurance benefits under  
21 section 226 or 226A, the Commissioner shall provide  
22 the following:

23                         “(A) Information describing the low-in-  
24 come subsidy program under section 1860D–14

1 and the medicare savings program under title  
2 XIX.

3 “(B) An application for enrollment under  
4 such low-income subsidy program as well as a  
5 simplified application form (developed under  
6 section 1905(p)(5)) for medical assistance for  
7 medicare cost-sharing under title XIX.

8 “(C) Information on how the individual  
9 may obtain assistance in completing such appli-  
10 cations, including information on how the indi-  
11 vidual may contact the State health insurance  
12 assistance program (SHIP) for the State in  
13 which the individual is located.

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

17 “(2) TRAINING PERSONNEL IN ASSISTING IN  
18 COMPLETING APPLICATIONS.—The Commissioner  
19 shall provide training to those employees of the So-  
20 cial Security Administration who are involved in re-  
21 ceiving applications for benefits described in para-  
22 graph (1) in assisting applicants in completing a  
23 medicare savings program application described in  
24 paragraph (1). Such employees who are so trained  
25 shall provide such assistance upon request.

1           “(3) TRANSMITTAL OF APPLICATION.—If such  
2           an employee assists in completing such an applica-  
3           tion, the employee, with the consent of the applicant,  
4           shall transmit the application to the appropriate  
5           State medicaid agency for processing.

6           “(4) COORDINATION WITH OUTREACH.—The  
7           Commissioner shall coordinate outreach activities  
8           under this subsection with outreach activities con-  
9           ducted by States in connection with the low-income  
10          subsidy program and the medicare savings pro-  
11          gram.”.

12          (e) MEDICAID AGENCY CONSIDERATION OF APPLICA-  
13          TIONS.—Section 1935(a) of such Act (42 U.S.C. 1396u-  
14          5(a)) is amended by adding at the end the following new  
15          paragraph:

16                 “(4) CONSIDERATION OF MSP APPLICATIONS.—  
17                 The State shall accept medicare savings program ap-  
18                 plications transmitted under section 1144(c)(3) and  
19                 act on such applications in the same manner and  
20                 deadlines as if they had been submitted directly by  
21                 the applicant.”.

22          (f) TRANSLATION OF MODEL FORM.—Section  
23          1905(p)(5)(A) of the Social Security Act (42 U.S.C.  
24          1396d(p)(5)(A)) is amended by adding at the end the fol-  
25          lowing: “The Secretary shall provide for the translation



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

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

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

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

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

1 low-income subsidies under section 1860D–14  
2 of the Social Security Act—

3 “(i) whether the adjusted gross in-  
4 come for the applicable year is less than  
5 135 percent of the poverty line (as speci-  
6 fied by the Commissioner in such request),

7 “(ii) whether such adjusted gross in-  
8 come is between 135 percent and 150 per-  
9 cent of the poverty line (as so specified),

10 “(iii) whether any designated distribu-  
11 tions (as defined in section 3405(e)(1))  
12 were reported with respect to such indi-  
13 vidual under section 6047(d) for the appli-  
14 cable year, and the amount (if any) of the  
15 distributions so reported,

16 “(iv) whether the return was a joint  
17 return for the applicable year, and

18 “(v) the applicable year.

19 “(B) APPLICABLE YEAR.—

20 “(i) IN GENERAL.—For the purposes  
21 of this paragraph, the term ‘applicable  
22 year’ means the most recent taxable year  
23 for which information is available in the  
24 Internal Revenue Service’s taxpayer data  
25 information systems, or, if there is no re-

1           turn filed for the individual for such year,  
2           the prior taxable year.

3           “(ii) NO RETURN.—If no return is  
4           filed for such individual for both taxable  
5           years referred to in clause (i), the Sec-  
6           retary shall disclose the fact that there is  
7           no return filed for such individual for the  
8           applicable year in lieu of the information  
9           described in subparagraph (A).

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

18          “(D) TERMINATION.—No disclosure shall  
19          be made under this paragraph after the 2-year  
20          period beginning on the date of the enactment  
21          of this paragraph.”.

22          (2) PROCEDURES AND RECORDKEEPING RE-  
23          LATED TO DISCLOSURES.—Paragraph (4) of section  
24          6103(p) of such Code is amended by striking “or

1 (17)” each place it appears and inserting “(17), or  
2 (21)”.

3 (3) REPORT.—Not later than 18 months after  
4 the date of the enactment of this Act, the Secretary  
5 of the Treasury, after consultation with the Commis-  
6 sioner of Social Security, shall submit a written re-  
7 port to Congress regarding the use of disclosures  
8 made under section 6103(l)(21) of the Internal Rev-  
9 enue Code of 1986, as added by this subsection, in  
10 identifying individuals eligible for the low-income  
11 subsidies under section 1860D–14 of the Social Se-  
12 curity Act.

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

16 (h) EFFECTIVE DATE.—Except as otherwise pro-  
17 vided, the amendments made by this section shall take ef-  
18 fect on January 1, 2009.

19 **SEC. 214. ELIMINATING APPLICATION OF ESTATE RECOV-**  
20 **ERY.**

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

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

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

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

9 (1) by striking “INSTITUTIONALIZED INDIVID-  
10 UALS.—In” and inserting “ELIMINATION OF COST-  
11 SHARING FOR CERTAIN FULL-BENEFIT DUAL ELIGI-  
12 BLE INDIVIDUALS.—

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

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

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

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

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

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

18 (a) IN GENERAL.—Section 1860D-14(a)(3) of the  
19 Social Security Act (42 U.S.C. 1395w-114(a)(3)), as  
20 amended by subsections (a) and (b) of section 213, is fur-  
21 ther amended—

22 (1) in subparagraph (C)(i), by inserting “and  
23 except that support and maintenance furnished in  
24 kind shall not be counted as income” after “section  
25 1902(r)(2)”;

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

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

9 (4) by adding at the end the following new sub-  
10 paragraph:

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

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

20 “(ii) PENSION OR RETIREMENT  
21 PLAN.—No balance in any pension or re-  
22 tirement plan shall be taken into ac-  
23 count.”.

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

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

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

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

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

9 “(iv) OVERALL LIMITATION ON COST-  
10 SHARING.—In the case of all such individ-  
11 uals, a limitation on aggregate cost-sharing  
12 under this part for a year not to exceed 5  
13 percent of income.”; and

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

16 “(F) OVERALL LIMITATION ON COST-SHAR-  
17 ING.—A limitation on aggregate cost-sharing  
18 under this part for a year not to exceed 5 per-  
19 cent of income.”.

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

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

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



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

4           (2) by adding at the end the following new sub-  
5           paragraph:

6                   “(D) INTELLIGENT ASSIGNMENT.—In the  
7                   case of any auto-enrollment under subpara-  
8                   graph (C), no part D eligible individual de-  
9                   scribed in such subparagraph shall be enrolled  
10                   in a prescription drug plan which does not meet  
11                   the following requirements:

12                           “(i) FORMULARY.—The plan has a  
13                           formulary that covers at least—

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

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

24                           “(ii) PHARMACY NETWORK.—The  
25                           plan has a network of pharmacies that

1 substantially exceeds the minimum require-  
2 ments for prescription drug plans in the  
3 State and that provides access in areas  
4 where lower income individuals reside.

5 “(iii) QUALITY.—

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

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

15 “(iv) LOW COST.—The total cost  
16 under this title of providing prescription  
17 drug coverage under the plan consistent  
18 with the previous clauses of this subpara-  
19 graph is among the lowest 25th percentile  
20 of prescription drug plans under this part  
21 in the State.

22 In the case that no plan meets the requirements  
23 under clauses (i) through (iv), the Secretary  
24 shall implement this subparagraph to the great-  
25 est extent possible with the goal of protecting

1 beneficiary access to drugs without increasing  
2 the cost relative to the enrollment process under  
3 subparagraph (C) as in existence before the  
4 date of the enactment of this subparagraph.”.

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

8 **Subtitle C—Part D Beneficiary**  
9 **Improvements**

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

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

18 (1) in clause (i), by striking “and” at the end;

19 (2) in clause (ii)—

20 (A) by striking “such costs shall be treated  
21 as incurred only if” and inserting “subject to  
22 clause (iii), such costs shall be treated as in-  
23 curred only if”;

1 (B) by striking “, under section 1860D–  
2 14, or under a State Pharmaceutical Assistance  
3 Program”; and

4 (C) by striking the period at the end and  
5 inserting “; and”; and

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

8 “(iii) such costs shall be treated as in-  
9 curred and shall not be considered to be  
10 reimbursed under clause (ii) if such costs  
11 are borne or paid—

12 “(I) under section 1860D–14;

13 “(II) under a State Pharma-  
14 ceutical Assistance Program;

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

20 “(IV) under an AIDS Drug As-  
21 sistance Program under part B of  
22 title XXVI of the Public Health Serv-  
23 ice Act.”.

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

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

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

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

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

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

1                   issued by the Food and Drug Administra-  
2                   tion.”.

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

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

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

12                   (1) by striking “subparagraph (E)” and insert-  
13                   ing “subparagraphs (E) and (J)”; and

14                   (2) by inserting “and benzodiazepines, respec-  
15                   tively” after “smoking cessation agents”.

16           (b) **EFFECTIVE DATE.**—The amendments made by  
17 subsection (a) shall apply to prescriptions dispensed on or  
18 after January 1, 2013.

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

22           Section 1860D–4(b)(3)(C) of the Social Security Act  
23 (42 U.S.C. 1395w–104(b)(3)(C)) is amended by adding  
24 at the end the following new clause:

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

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

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

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

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

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

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

24   “(I) Anticonvulsants.

25   “(II) Antineoplastics.

1 “(III) Antiretrovirals.

2 “(IV) Antidepressants.

3 “(V) Antipsychotics.

4 “(VI) Immunosuppressants.

5 “(ii) USE OF UTILIZATION MANAGE-  
6 MENT TOOLS.—A PDP sponsor of a pre-  
7 scription drug plan may use prior author-  
8 ization or step therapy for the initiation of  
9 medications within one of the classifica-  
10 tions specified in clause (i) but only when  
11 approved by the Secretary, except that  
12 such prior authorization or step therapy  
13 may not be used in the case of  
14 antiretrovirals and in the case of individ-  
15 uals who already are stabilized on a drug  
16 treatment regimen.”.

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

20 **SEC. 226. ELIMINATION OF MEDICARE PART D LATE EN-**  
21 **ROLLMENT PENALTIES PAID BY LOW-INCOME**  
22 **SUBSIDY-ELIGIBLE INDIVIDUALS.**

23 (a) INDIVIDUALS WITH INCOME BELOW 135 PER-  
24 CENT OF POVERTY LINE.—Paragraph (1)(A)(ii) of sec-



1 tion 1860D–14(a) of the Social Security Act (42 U.S.C.  
2 1395w–114(a)) is amended to read as follows:

3                   “(ii) 100 percent of any late enroll-  
4                   ment penalties imposed under section  
5                   1860D–13(b) for such individual.”.

6           (b) INDIVIDUALS WITH INCOME BETWEEN 135 AND  
7 150 PERCENT OF POVERTY LINE.—Paragraph (2)(A) of  
8 such section is amended—

9                   (1) by inserting “equal to (i) an amount” after  
10                  “premium subsidy”;

11                  (2) by striking “paragraph (1)(A)” and insert-  
12                  ing “clause (i) of paragraph (1)(A)”; and

13                  (3) by adding at the end before the period the  
14                  following: “, plus (ii) 100 percent of the amount de-  
15                  scribed in clause (ii) of such paragraph for such in-  
16                  dividual”.

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

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

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

1           “(G) ELIGIBILITY FOR LOW-INCOME SUB-  
2           SIDY.—

3           “(i) IN GENERAL.—In the case of an  
4           applicable subsidy eligible individual (as  
5           defined in clause (ii)), the special enroll-  
6           ment period described in clause (iii).

7           “(ii) APPLICABLE SUBSIDY ELIGIBLE  
8           INDIVIDUAL DEFINED.—For purposes of  
9           this subparagraph, the term ‘applicable  
10          subsidy eligible individual’ means a part D  
11          eligible individual who is determined under  
12          subparagraph (B) of section 1860D–  
13          14(a)(3) to be a subsidy eligible individual  
14          (as defined in subparagraph (A) of such  
15          section), and includes such an individual  
16          who was enrolled in a prescription drug  
17          plan or an MA–PD plan on the date of  
18          such determination.

19          “(iii) SPECIAL ENROLLMENT PERIOD  
20          DESCRIBED.—The special enrollment pe-  
21          riod described in this clause, with respect  
22          to an applicable subsidy eligible individual,  
23          is the 90-day period beginning on the date  
24          the individual receives notification that  
25          such individual has been determined under

1 section 1860D–14(a)(3)(B) to be a subsidy  
2 eligible individual (as so defined).”.

3 (b) AUTOMATIC ENROLLMENT PROCESS FOR CER-  
4 TAIN SUBSIDY ELIGIBLE INDIVIDUALS.—Section 1860D–  
5 1(b)(1) of the Social Security Act (42 U.S.C. 1395w–  
6 101(b)(1)), as amended by section 218(a)(2), is further  
7 amended by adding at the end the following new subpara-  
8 graph:

9 “(E) SPECIAL RULE FOR SUBSIDY ELIGI-  
10 BLE INDIVIDUALS.—The process established  
11 under subparagraph (A) shall include, in the  
12 case of an applicable subsidy eligible individual  
13 (as defined in clause (ii) of paragraph (3)(F))  
14 who fails to enroll in a prescription drug plan  
15 or an MA–PD plan during the special enroll-  
16 ment period described in clause (iii) of such  
17 paragraph applicable to such individual, a proc-  
18 ess for the facilitated enrollment of the indi-  
19 vidual in the prescription drug plan or MA–PD  
20 plan that is most appropriate for such indi-  
21 vidual (as determined by the Secretary). Noth-  
22 ing in the previous sentence shall prevent an in-  
23 dividual described in such sentence from declin-  
24 ing enrollment in a plan determined appropriate

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

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

6 **Subtitle D—Reducing Health**  
7 **Disparities**

8 **SEC. 231. MEDICARE DATA ON RACE, ETHNICITY, AND PRI-**  
9 **MARY LANGUAGE.**

10 (a) REQUIREMENTS.—

11 (1) IN GENERAL.—The Secretary of Health and  
12 Human Services (in this subtitle referred to as the  
13 “Secretary”) shall—

14 (A) collect data on the race, ethnicity, and  
15 primary language of each applicant for and re-  
16 cipient of benefits under title XVIII of the So-  
17 cial Security Act—

18 (i) using, at a minimum, the cat-  
19 egories for race and ethnicity described in  
20 the 1997 Office of Management and Budg-  
21 et Standards for Maintaining, Collecting,  
22 and Presenting Federal Data on Race and  
23 Ethnicity;

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

4           (iii) where practicable, collecting data  
5           for additional population groups if such  
6           groups can be aggregated into the min-  
7           imum race and ethnicity categories; and

8           (iv) where practicable, through self-re-  
9           porting;

10          (B) with respect to the collection of the  
11          data described in subparagraph (A) for appli-  
12          cants and recipients who are minors or other-  
13          wise legally incapacitated, require that—

14               (i) such data be collected from the  
15               parent or legal guardian of such an appli-  
16               cant or recipient; and

17               (ii) the preferred language of the par-  
18               ent or legal guardian of such an applicant  
19               or recipient be collected;

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

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

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

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

16 (A) to permit the use of information col-  
17 lected under this subsection in a manner that  
18 would adversely affect any individual providing  
19 any such information; and

20 (B) to require health care providers to col-  
21 lect data.

22 (b) PROTECTION OF DATA.—The Secretary shall en-  
23 sure (through the promulgation of regulations or other-  
24 wise) that all data collected pursuant to subsection (a) is  
25 protected—

1           (1) under the same privacy protections as the  
2       Secretary applies to other health data under the reg-  
3       ulations promulgated under section 264(c) of the  
4       Health Insurance Portability and Accountability Act  
5       of 1996 (Public Law 104–191; 110 Stat. 2033) re-  
6       lating to the privacy of individually identifiable  
7       health information and other protections; and

8           (2) from all inappropriate internal use by any  
9       entity that collects, stores, or receives the data, in-  
10      cluding use of such data in determinations of eligi-  
11      bility (or continued eligibility) in health plans, and  
12      from other inappropriate uses, as defined by the  
13      Secretary.

14      (c) COLLECTION PLAN.—In carrying out the duties  
15      specified in subsection (a), the Secretary shall develop and  
16      implement a plan to improve the collection, analysis, and  
17      reporting of racial, ethnic, and primary language data  
18      within the programs administered under title XVIII of the  
19      Social Security Act, and, in consultation with the National  
20      Committee on Vital Health Statistics, the Office of Minor-  
21      ity Health, and other appropriate public and private enti-  
22      ties, shall make recommendations on how to—

23           (1) implement subsection (a) while minimizing  
24      the cost and administrative burdens of data collec-  
25      tion and reporting;

1           (2) expand awareness that data collection, anal-  
2           ysis, and reporting by race, ethnicity, and primary  
3           language is legal and necessary to assure equity and  
4           non-discrimination in the quality of health care serv-  
5           ices;

6           (3) ensure that future patient record systems,  
7           including electronic health records, electronic med-  
8           ical records and patient health records, have data  
9           code sets for racial, ethnic, and primary language  
10          identifiers and that such identifiers can be retrieved  
11          from clinical records, including records transmitted  
12          electronically;

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

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

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

22          (d) COMPLIANCE WITH STANDARDS.—Data collected  
23          under subsection (a) shall be obtained, maintained, and  
24          presented (including for reporting purposes and at a min-  
25          imum) in accordance with the 1997 Office of Management



1 and Budget Standards for Maintaining, Collecting, and  
2 Presenting Federal Data on Race and Ethnicity.

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

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

12 (1) IN GENERAL.—The Secretary may, either  
13 directly or through grant or contract, provide tech-  
14 nical assistance to enable a health care provider or  
15 plan operating under the Medicare program to com-  
16 ply with the requirements of this section.

17 (2) TYPES OF ASSISTANCE.—Assistance pro-  
18 vided under this subsection may include assistance  
19 to—

20 (A) enhance or upgrade computer tech-  
21 nology that will facilitate racial, ethnic, and pri-  
22 mary language data collection and analysis;

23 (B) improve methods for health data col-  
24 lection and analysis including additional popu-  
25 lation groups beyond the Office of Management

1 and Budget categories if such groups can be  
2 aggregated into the minimum race and ethnicity  
3 categories;

4 (C) develop mechanisms for submitting col-  
5 lected data subject to existing privacy and con-  
6 fidentiality regulations;

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

12 (E) provide for the revision of existing  
13 HIPAA claims-related code sets to mandate the  
14 collection of racial and ethnicity data, and to  
15 provide a code set for primary language.

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

21 (1) identify appropriate quality assurance mech-  
22 anisms to monitor for health disparities under the  
23 Medicare program;

24 (2) specify the clinical, diagnostic, or thera-  
25 peutic measures which should be monitored;

1 (3) develop new quality measures relating to ra-  
2 cial and ethnic disparities in health and health care;

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

5 (5) share data with external organizations for  
6 research and quality improvement purposes, in com-  
7 pliance with applicable Federal privacy laws.

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

17 (i) AUTHORIZATION OF APPROPRIATIONS.—There is  
18 authorized to be appropriated to carry out this section,  
19 such sums as may be necessary for each of fiscal years  
20 2008 through 2012.

21 **SEC. 232. ENSURING EFFECTIVE COMMUNICATION IN MEDI-**  
22 **CARE.**

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

1           (1) STUDY ON MEDICARE PAYMENTS FOR LAN-  
2           GUAGE SERVICES.—The Secretary of Health and  
3           Human Services shall conduct a study that examines  
4           ways that Medicare should develop payment systems  
5           for language services using the results of the dem-  
6           onstration program conducted under section 233.

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

9                   (A) How to develop and structure appro-  
10                  priate payment systems for language services  
11                  for all Medicare service providers.

12                   (B) The feasibility of adopting a payment  
13                  methodology for on-site interpreters, including  
14                  interpreters who work as independent contrac-  
15                  tors and interpreters who work for agencies  
16                  that provide on-site interpretation, pursuant to  
17                  which such interpreters could directly bill Medi-  
18                  care for services provided in support of physi-  
19                  cian office services for an LEP Medicare pa-  
20                  tient.

21                   (C) The feasibility of Medicare contracting  
22                  directly with agencies that provide off-site inter-  
23                  pretation including telephonic and video inter-  
24                  pretation pursuant to which such contractors  
25                  could directly bill Medicare for the services pro-

1           vided in support of physician office services for  
2           an LEP Medicare patient.

3           (D) The feasibility of modifying the exist-  
4           ing Medicare resource-based relative value scale  
5           (RBRVS) by using adjustments (such as multi-  
6           pliers or add-ons) when a patient is LEP.

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

12          (3) VARIATION IN PAYMENT SYSTEM DE-  
13          SCRIBED.—The payment systems described in sub-  
14          section (b) may allow variations based upon types of  
15          service providers, available delivery methods, and  
16          costs for providing language services including such  
17          factors as—

18                 (A) the type of language services provided  
19                 (such as provision of health care or health care  
20                 related services directly in a non-English lan-  
21                 guage by a bilingual provider or use of an inter-  
22                 preter);

23                 (B) type of interpretation services provided  
24                 (such as in-person, telephonic, video interpreta-  
25                 tion);

1 (C) the methods and costs of providing  
2 language services (including the costs of pro-  
3 viding language services with internal staff or  
4 through contract with external independent con-  
5 tractors and/or agencies);

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

9 (E) providing services in rural areas.

10 (4) REPORT.—The Secretary shall submit a re-  
11 port on the study conducted under subsection (a) to  
12 appropriate committees of Congress not later than 1  
13 year after the expiration of the demonstration pro-  
14 gram conducted under section 3.

15 (b) HEALTH PLANS.—Section 1857(g)(1) of the So-  
16 cial Security Act (42 U.S.C. 1395w–27(g)(1)) is amend-  
17 ed—

18 (1) by striking “or” at the end of subparagraph  
19 (F);

20 (2) by adding “or” at the end of subparagraph  
21 (G); and

22 (3) by inserting after subparagraph (G) the fol-  
23 lowing new subparagraph:

24 “(H) fails substantially to provide lan-  
25 guage services to limited English proficient

1 beneficiaries enrolled in the plan that are re-  
2 quired under law;”.

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

8 (a) IN GENERAL.—Within one year after the date of  
9 the enactment of this Act the Secretary, acting through  
10 the Centers for Medicare & Medicaid Services, shall award  
11 24 3-year demonstration grants to eligible Medicare serv-  
12 ice providers to improve effective communication between  
13 such providers and Medicare beneficiaries who are living  
14 in communities where racial and ethnic minorities, includ-  
15 ing populations that face language barriers, are under-  
16 served with respect to such services. The Secretary shall  
17 not authorize a grant larger than \$500,000 over three  
18 years for any grantee.

19 (b) ELIGIBILITY; PRIORITY.—

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

22 (A) be—

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

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

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

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

8 (B) prepare and submit to the Secretary  
9 an application, at such time, in such manner,  
10 and accompanied by such additional informa-  
11 tion as the Secretary may require.

12 (2) PRIORITY.—

13 (A) DISTRIBUTION.—To the extent fea-  
14 sible, in awarding grants under this section, the  
15 Secretary shall award—

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

18 (ii) 6 grants to service providers de-  
19 scribed in paragraph (1)(A)(ii);

20 (iii) 6 grants to organizations de-  
21 scribed in paragraph (1)(A)(iii); and

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

24 (B) FOR COMMUNITY ORGANIZATIONS.—

25 The Secretary shall give priority to applicants



1 that have developed partnerships with commu-  
2 nity organizations or with agencies with experi-  
3 ence in language access.

4 (C) VARIATION IN GRANTEES.—The Sec-  
5 retary shall also ensure that the grantees under  
6 this section represent, among other factors,  
7 variations in—

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

11 (ii) languages needed and their fre-  
12 quency of use;

13 (iii) urban and rural settings;

14 (iv) at least two geographic regions;

15 and

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

18 (c) USE OF FUNDS.—

19 (1) IN GENERAL.—A grantee shall use grant  
20 funds received under this section to pay for the pro-  
21 vision of competent language services to Medicare  
22 beneficiaries who are limited English proficient.  
23 Competent interpreter services may be provided  
24 through on-site interpretation, telephonic interpreta-  
25 tion, or video interpretation or direct provision of

1 health care or health care related services by a bilin-  
2 gual health care provider. A grantee may use bilin-  
3 gual providers, staff, or contract interpreters. A  
4 grantee may use grant funds to pay for competent  
5 translation services. A grantee may use up to 10  
6 percent of the grant funds to pay for administrative  
7 costs associated with the provision of competent lan-  
8 guage services and for reporting required under sub-  
9 section (E).

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

17 (3) DETERMINATION OF PAYMENTS FOR LAN-  
18 GUAGE SERVICES.—Payments to grantees shall be  
19 calculated based on the estimated numbers of LEP  
20 Medicare beneficiaries in a grantee’s service area  
21 utilizing—

22 (A) data on the numbers of limited  
23 English proficient individuals who speak  
24 English less than “very well” from the most re-  
25 cently available data from the Bureau of the

1           Census or other State-based study the Sec-  
2           retary determines likely to yield accurate data  
3           regarding the number of LEP individuals  
4           served by the grantee; or

5           (B) the grantee's own data if the grantee  
6           routinely collects data on Medicare bene-  
7           ficiaries' primary language in a manner deter-  
8           mined by the Secretary to yield accurate data  
9           and such data shows greater numbers of LEP  
10          individuals than the data listed in subparagraph  
11          (A).

12          (4) LIMITATIONS.—

13           (A) REPORTING.—Payments shall only be  
14           provided under this section to grantees that re-  
15           port their costs of providing language services  
16           as required under subsection (e). If a grantee  
17           fails to provide the reports under such section  
18           for the first year of a grant, the Secretary may  
19           terminate the grant and solicit applications  
20           from new grantees to participate in the subse-  
21           quent two years of the demonstration program.

22           (B) TYPE OF SERVICES.—

23           (i) IN GENERAL.—Subject to clause  
24           (ii), payments shall be provided under this  
25           section only to grantees that utilize com-

1           petent bilingual staff or competent inter-  
2           preter or translation services which—

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

7                   (II) if the grantee operates in a  
8                   State that does not have statewide  
9                   health care interpreter standards, uti-  
10                  lizes competent interpreters who fol-  
11                  low the National Council on Inter-  
12                  preting in Health Care’s Code of Eth-  
13                  ics and Standards of Practice.

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

16                   (I) in the case of a Medicare ben-  
17                   eficiary who is limited English pro-  
18                   ficient (who has been informed in the  
19                   beneficiary’s primary language of the  
20                   availability of free interpreter and  
21                   translation services) and who requests  
22                   the use of family, friends, or other  
23                   persons untrained in interpretation or  
24                   translation and the grantee documents

1 the request in the beneficiary's record;  
2 and

3 (II) in the case of a medical  
4 emergency where the delay directly as-  
5 sociated with obtaining a competent  
6 interpreter or translation services  
7 would jeopardize the health of the pa-  
8 tient.

9 Nothing in clause (ii)(II) shall be con-  
10 strued to exempt an emergency rooms or  
11 similar entities that regularly provide  
12 health care services in medical emergencies  
13 from having in place systems to provide  
14 competent interpreter and translation serv-  
15 ices without undue delay.

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

18 (1) ensure that appropriate clinical and support  
19 staff receive ongoing education and training in lin-  
20 guistically appropriate service delivery; ensure the  
21 linguistic competence of bilingual providers;

22 (2) offer and provide appropriate language serv-  
23 ices at no additional charge to each patient with lim-  
24 ited English proficiency at all points of contact, in  
25 a timely manner during all hours of operation;

1           (3) notify Medicare beneficiaries of their right  
2           to receive language services in their primary lan-  
3           guage;

4           (4) post signage in the languages of the com-  
5           monly encountered group or groups present in the  
6           service area of the organization; and

7           (5) ensure that—

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

10                   (B) consistent with the privacy protections  
11                   provided under the regulations promulgated  
12                   pursuant to section 264(e) of the Health Insur-  
13                   ance Portability and Accountability Act of 1996  
14                   (42 U.S.C. 1320d–2 note), if the recipient of  
15                   language services is a minor or is incapacitated,  
16                   the primary language of the parent or legal  
17                   guardian is collected and utilized.

18           (e) REPORTING REQUIREMENTS.—Grantees under  
19           this section shall provide the Secretary with reports at the  
20           conclusion of the each year of a grant under this section.  
21           each report shall include at least the following informa-  
22           tion:

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

1           (2) The languages of those Medicare bene-  
2           ficiaries.

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

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

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

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

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

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

20          (g) EVALUATION AND REPORT.—The Secretary shall  
21          conduct an evaluation of the demonstration program  
22          under this section and shall submit to the appropriate  
23          committees of Congress a report not later than 1 year  
24          after the completion of the program. The report shall in-  
25          clude the following:

1           (1) An analysis of the patient outcomes and  
2 costs of furnishing care to the LEP Medicare bene-  
3 ficiaries participating in the project as compared to  
4 such outcomes and costs for limited English pro-  
5 ficient Medicare beneficiaries not participating.

6           (2) The effect of delivering culturally and lin-  
7 guistically appropriate services on beneficiary access  
8 to care, utilization of services, efficiency and cost-ef-  
9 fectiveness of health care delivery, patient satisfac-  
10 tion, and select health outcomes.

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

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

18           (i) AUTHORIZATION OF APPROPRIATIONS.—There  
19 are authorized to be appropriated to carry out this section  
20 \$10,000,000 for each fiscal year of the demonstration.

21 **SEC. 234. DEMONSTRATION TO IMPROVE CARE TO PRE-**  
22 **VIOUSLY UNINSURED.**

23           (a) ESTABLISHMENT.—Within one year after the  
24 date of enactment of this Act, the Secretary shall establish  
25 a demonstration project to determine the greatest needs



1 and most effective methods of outreach to medicare bene-  
2 ficiaries who were previously uninsured.

3 (b) SCOPE.—The demonstration shall be in no fewer  
4 than 10 sites, and shall include state health insurance as-  
5 sistance programs, community health centers, community-  
6 based organizations, community health workers, and other  
7 service providers under parts A, B, and C of title XVIII  
8 of the Social Security Act. Grantees that are plans oper-  
9 ating under part C shall document that enrollees who were  
10 previously uninsured receive the “Welcome to Medicare”  
11 physical exam.

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

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

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

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

5 **SEC. 235. OFFICE OF THE INSPECTOR GENERAL REPORT**  
6                   **ON COMPLIANCE WITH AND ENFORCEMENT**  
7                   **OF NATIONAL STANDARDS ON CULTURALLY**  
8                   **AND LINGUISTICALLY APPROPRIATE SERV-**  
9                   **ICES (CLAS) IN MEDICARE.**

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

14           (1) the extent to which Medicare providers and  
15           plans are complying with the Office for Civil Rights’  
16           Guidance to Federal Financial Assistance Recipients  
17           Regarding Title VI Prohibition Against National Or-  
18           igin Discrimination Affecting Limited English Pro-  
19           ficient Persons and the Office of Minority Health’s  
20           Culturally and Linguistically Appropriate Services  
21           Standards in health care; and

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

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

4 (b) IMPLEMENTATION.—Not later than one year  
5 after the date of publication of the report under subsection  
6 (a), the Department of Health and Human Services shall  
7 implement changes responsive to any deficiencies identi-  
8 fied in the report.

9 **SEC. 236. IOM REPORT ON IMPACT OF LANGUAGE ACCESS**  
10 **SERVICES.**

11 (a) IN GENERAL.—The Secretary of Health and  
12 Human Services shall seek to enter into an arrangement  
13 with the Institute of Medicine under which the Institute  
14 will prepare and publish, not later than 3 years after the  
15 date of the enactment of this Act, a report on the impact  
16 of language access services on the health and health care  
17 of limited English proficient populations.

18 (b) CONTENTS.—Such report shall include—

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

23 (2) a description of the effect of providing lan-  
24 guage access services on quality of health care and  
25 access to care and reduced medical error; and

1           (3) a description of the costs associated with or  
2           savings related to provision of language access serv-  
3           ices.

4 **SEC. 237. DEFINITIONS.**

5           In this subtitle:

6           (1) **BILINGUAL.**—The term “bilingual” with re-  
7           spect to an individual means a person who has suffi-  
8           cient degree of proficiency in two languages and can  
9           ensure effective communication can occur in both  
10          languages.

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

23          (3) **COMPETENT TRANSLATION SERVICES.**—The  
24          term “competent translation services” means a  
25          trans-language rendition of a written document in

1 which the translator comprehends the source lan-  
2 guage and can write comprehensively in the target  
3 language to convey the meaning intended in the  
4 source language. The translator knows health and  
5 health-related terminology and provides accurate  
6 translations by choosing equivalent expressions that  
7 convey the best matching and meaning to the source  
8 language and captures, to the greatest possible ex-  
9 tent, all nuances intended in the source document.

10 (4) EFFECTIVE COMMUNICATION.—The term  
11 “effective communication” means an exchange of in-  
12 formation between the provider of health care or  
13 health care-related services and the limited English  
14 proficient recipient of such services that enables lim-  
15 ited English proficient individuals to access, under-  
16 stand, and benefit from health care or health care-  
17 related services.

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

22 (6) HEALTH CARE SERVICES.—The term  
23 “health care services” means services that address  
24 physical as well as mental health conditions in all  
25 care settings.

1           (7) HEALTH CARE-RELATED SERVICES.—The  
2 term “health care-related services” means human or  
3 social services programs or activities that provide ac-  
4 cess, referrals or links to health care.

5           (8) LANGUAGE ACCESS.—The term “language  
6 access” means the provision of language services to  
7 an LEP individual designed to enhance that individ-  
8 ual’s access to, understanding of or benefit from  
9 health care or health care-related services.

10          (9) LANGUAGE SERVICES.—The term “lan-  
11 guage services” means provision of health care serv-  
12 ices directly in a non-English language, interpreta-  
13 tion, translation, and non-English signage.

14          (10) LIMITED ENGLISH PROFICIENT.—The  
15 term “limited English proficient” or “LEP” with re-  
16 spect to an individual means an individual who  
17 speaks a primary language other than English and  
18 who cannot speak, read, write or understand the  
19 English language at a level that permits the indi-  
20 vidual to effectively communicate with clinical or  
21 nonclinical staff at an entity providing health care or  
22 health care related services.

23          (11) MEDICARE PROGRAM.—The term “Medi-  
24 care program” means the programs under parts A  
25 through D of title XVIII of the Social Security Act.

1           (12) SERVICE PROVIDER.—The term “service  
2           provider” includes all suppliers, providers of services,  
3           or entities under contract to provide coverage, items  
4           or services under any part of title XVIII of the So-  
5           cial Security Act.

6           **TITLE III—PHYSICIANS’ SERVICE**  
7           **PAYMENT REFORM**

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

10          (a) ESTABLISHMENT OF SERVICE CATEGORIES.—  
11          Subsection (j) of section 1848 of the Social Security Act  
12          (42 U.S.C. 1395w-4) is amended by adding at the end  
13          the following new paragraph:

14                 “(5) SERVICE CATEGORIES.—For services fur-  
15                 nished on or after January 1, 2008, each of the fol-  
16                 lowing categories of physicians’ services shall be  
17                 treated as a separate ‘service category’:

18                         “(A) Evaluation and management services  
19                         for primary care (including new and established  
20                         patient office visits delivered by physicians who  
21                         the Secretary determines provide accessible,  
22                         continuous, coordinated, and comprehensive  
23                         care for Medicare beneficiaries, emergency de-  
24                         partment visits, and home visits), and for pre-  
25                         ventive services (including screening mammog-

1 raphy, colorectal cancer screening, and other  
2 services as defined by the Secretary, limited to  
3 the recommendations of the United States Pre-  
4 ventive Services Task Force).

5 “(B) Evaluation and management services  
6 not described in subparagraph (A).

7 “(C) Imaging services (as defined in sub-  
8 section (b)(4)(B)) and diagnostic tests (other  
9 than clinical diagnostic laboratory tests) not de-  
10 scribed in subparagraph (A).

11 “(D) Procedures that are subject (under  
12 regulations promulgated to carry out this sec-  
13 tion) to a 10-day or 90-day global period (in  
14 this paragraph referred to as ‘major proce-  
15 dures’), except that the Secretary may reclas-  
16 sify as minor procedures under subparagraph  
17 (F) any procedures that would otherwise be in-  
18 cluded in this category if the Secretary deter-  
19 mines that such procedures are not major pro-  
20 cedures.

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



1           “(F) Minor procedures and any other phy-  
2           sicians’ services that are not described in a pre-  
3           ceding subparagraph.”.

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

8           (1) in subparagraph (A)—

9           (A) by designating the sentence beginning  
10           “The conversion factor” as clause (i) with the  
11           heading “APPLICATION OF SINGLE CONVERSION  
12           FACTOR.—” and with appropriate indentation;

13           (B) by striking “The conversion factor”  
14           and inserting “Subject to clause (ii), the con-  
15           version factor”; and

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

18           “(ii) APPLICATION OF MULTIPLE CON-  
19           VERSION FACTORS BEGINNING WITH  
20           2008.—

21           “(I) IN GENERAL.—In applying  
22           clause (i) for years beginning with  
23           2008, separate conversion factors  
24           shall be established for each service  
25           category of physicians’ services (as de-

1            fined in subsection (j)(5)) and any  
2            reference in this section to a conver-  
3            sion factor for such years shall be  
4            deemed to be a reference to the con-  
5            version factor for each of such cat-  
6            egories.

7            “(II) INITIAL CONVERSION FAC-  
8            TORS; SPECIAL RULE FOR ANES-  
9            THESIA SERVICES.— Such factors for  
10           2008 shall be based upon the single  
11           conversion factor for 2007 multiplied  
12           by the update established under para-  
13           graph (8) for such category for 2008.  
14           In the case of the service category de-  
15           scribed in subsection (j)(5)(F) (relat-  
16           ing to anesthesia services), the conver-  
17           sion factor for 2008 shall be based on  
18           the separate conversion factor speci-  
19           fied in subparagraph (D) for 2007  
20           multiplied by the update established  
21           under paragraph (8) for such category  
22           for 2008.

23           “(III) UPDATING OF CONVER-  
24           SION FACTORS.— Such factor for a  
25           service category for a subsequent year

1 shall be based upon the conversion  
2 factor for such category for the pre-  
3 vious year and adjusted by the update  
4 established for such category under  
5 paragraph (8) for the year involved.”;  
6 and

7 (2) in subparagraph (D), by inserting “(before  
8 2008)” after “for a year”.

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

12 (1) in paragraph (4)(B), by striking “and (6)”  
13 and inserting “, (6), (8), and (9)”;

14 (2) in paragraph (4)(C)(iii), by striking “The  
15 allowed” and inserting “Subject to paragraph  
16 (8)(B), the allowed”;

17 (3) in paragraph (4)(D), by striking “The up-  
18 date” and inserting “Subject to paragraph (8)(E),  
19 the update”; and

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

22 “(8) UPDATES FOR SERVICE CATEGORIES BE-  
23 GINNING WITH 2008 AND ENDING WITH 2012.—

1           “(A) IN GENERAL.—In applying paragraph  
2 (4) for a year beginning with 2008 and ending  
3 with 2012, the following rules apply:

4           “(i) APPLICATION OF SEPARATE UP-  
5 DATE ADJUSTMENTS FOR EACH SERVICE  
6 CATEGORY.—Pursuant to paragraph  
7 (1)(A)(ii)(I), the update shall be made to  
8 the conversion factor for each service cat-  
9 egory (as defined in subsection (j)(5))  
10 based upon an update adjustment factor  
11 for the respective category and year and  
12 the update adjustment factor shall be com-  
13 puted, for a year, separately for each serv-  
14 ice category.

15           “(ii) COMPUTATION OF ALLOWED AND  
16 ACTUAL EXPENDITURES BASED ON SERV-  
17 ICE CATEGORIES.—In computing the prior  
18 year adjustment component and the cumu-  
19 lative adjustment component under clauses  
20 (i) and (ii) of paragraph (4)(B), the fol-  
21 lowing rules apply:

22           “(I) APPLICATION BASED ON  
23 SERVICE CATEGORIES.—The allowed  
24 expenditures and actual expenditures  
25 shall be the allowed and actual ex-

1           penditures for the service category, as  
2           determined under subparagraph (B).

3           “(II) LIMITATION TO PHYSICIAN  
4           FEE-SCHEDULE SERVICES.—Actual  
5           expenditures shall only take into ac-  
6           count expenditures for services fur-  
7           nished under the physician fee sched-  
8           ule.

9           “(III) APPLICATION OF CAT-  
10          EGORY SPECIFIC TARGET GROWTH  
11          RATE.—The growth rate applied  
12          under clause (ii)(II) of such para-  
13          graph shall be the target growth rate  
14          for the service category involved under  
15          subsection (f)(5).

16          “(IV) ALLOCATION OF CUMU-  
17          LATIVE OVERHANG.—There shall be  
18          substituted for the difference de-  
19          scribed in subparagraph (B)(ii)(I) of  
20          such paragraph the amount described  
21          in subparagraph (C)(i) for the service  
22          category involved.

23          “(B) DETERMINATION OF ALLOWED EX-  
24          PENDITURES.—In applying paragraph (4) for a  
25          year beginning with 2008, notwithstanding sub-

1 paragraph (C)(iii) of such paragraph, the al-  
2 lowed expenditures for a service category for a  
3 year is an amount computed by the Secretary  
4 as follows:

5 “(i) FOR 2008.—For 2008:

6 “(I) TOTAL 2007 ALLOWED EX-  
7 PENDITURES FOR ALL SERVICES IN-  
8 CLUDED IN SGR COMPUTATION.—  
9 Compute total allowed expenditures  
10 for physicians’ services (as defined in  
11 subsection (f)(4)(A)) for 2007 that  
12 would otherwise be calculated under  
13 subsection (d) but for this paragraph.

14 “(II) TOTAL 2007 ALLOWED EX-  
15 PENDITURES FOR PHYSICIAN FEE  
16 SCHEDULE SERVICES.—Compute total  
17 allowed expenditures for services fur-  
18 nished under the physician fee sched-  
19 ule for 2007 by subtracting, from the  
20 total allowed expenditures computed  
21 under subclause (I), the Secretary’s  
22 estimate of the amount of the actual  
23 expenditures for 2007 for services in-  
24 cluded in such subclause for which  
25 payment is not made under the fee

1 schedule established pursuant to this  
2 section.

3 “(III) ALLOCATION OF 2007 AL-  
4 LOWED EXPENDITURES TO SERVICE  
5 CATEGORY.—Compute allowed ex-  
6 penditures for the service category in-  
7 volved for 2007 by multiplying the  
8 total allowed expenditures computed  
9 under subclause (II) by the overhang  
10 allocation factor for the service cat-  
11 egory (as defined in subparagraph  
12 (C)(iii)).

13 “(IV) INCREASE BY GROWTH  
14 RATE TO OBTAIN 2008 ALLOWED EX-  
15 PENDITURES FOR SERVICE CAT-  
16 EGORY.—Compute allowed expendi-  
17 tures for the service category for 2008  
18 by increasing the allowed expenditures  
19 for the service category for 2007 com-  
20 puted under subclause (III) by the  
21 target growth rate for such service  
22 category under subsection (f) for  
23 2008.

24 “(ii) FOR SUBSEQUENT YEARS.—For  
25 a subsequent year, take the amount of al-

1           lowed expenditures for such category for  
2           the preceding year (under clause (i) or this  
3           clause) and increase it by the target  
4           growth rate determined under subsection  
5           (f) for such category and year.

6           “(C) COMPUTATION AND APPLICATION OF  
7           CUMULATIVE OVERHANG AMONG CAT-  
8           EGORIES.—

9           “(i) IN GENERAL.—For purposes of  
10          applying paragraph (4)(B)(ii)(II) under  
11          clause (ii)(IV), the amount described in  
12          this clause for a year (beginning with  
13          2008) is the sum of the following:

14          “(I) PRE-2008 CUMULATIVE  
15          OVERHANG.—The amount of the pre-  
16          2008 cumulative excess spending (as  
17          defined in clause (ii)) multiplied by  
18          the overhang allocation factor for the  
19          service category (under clause (iii)).

20          “(II) POST-2007 CUMULATIVE  
21          AMOUNTS.—For a year beginning  
22          with 2009, the difference (which may  
23          be positive or negative) between the  
24          amount of the allowed expenditures  
25          for physicians’ services (as determined



1 under paragraph (4)(C)) in the serv-  
2 ice category from January 1, 2008,  
3 through the end of the prior year and  
4 the amount of the actual expenditures  
5 for such services in such category dur-  
6 ing that period.

7 “(ii) PRE-2008 CUMULATIVE EXCESS  
8 SPENDING DEFINED.—For purposes of  
9 clause (i)(I), the term ‘pre-2008 cumu-  
10 lative excess spending’ means the dif-  
11 ference described in paragraph  
12 (4)(B)(ii)(I) as determined for the year  
13 2008, taking into account expenditures  
14 through December 31, 2007. Such dif-  
15 ference takes into account expenditures in-  
16 cluded in subsection (f)(4)(A).

17 “(iii) OVERHANG ALLOCATION FAC-  
18 TOR.—For purposes of this paragraph, the  
19 term ‘overhang allocation factor’ means,  
20 for a service category, the proportion, as  
21 determined by the Secretary of total actual  
22 expenditures under this part for items and  
23 services in such category during 2007 to  
24 the total of such actual expenditures for all  
25 the service categories. In calculating such

1           proportion, the Secretary shall only take  
2           into account services furnished under the  
3           physician fee schedule.

4           “(D) UPDATES FOR 2008 AND 2009.—The  
5           update to the conversion factors for each service  
6           category for each of 2008 and 2009 shall be  
7           equal to 0.5 percent.

8           “(E) CHANGE IN RESTRICTION ON UPDATE  
9           ADJUSTMENT FACTOR FOR 2010 AND 2011.—The  
10          update adjustment factor determined under  
11          subparagraph (4)(B), as modified by this para-  
12          graph, for a service category for a year (begin-  
13          ning with 2010 and ending with 2011) may be  
14          less than  $-0.07$ , but may not be less than  
15           $-0.14$ .

16          “(9) NO UPDATE FOR SERVICE CATEGORIES  
17          BEGINNING WITH 2013.—The update to the conver-  
18          sion factor for each of the service categories estab-  
19          lished under paragraph (8) for 2013 and each suc-  
20          ceeding year shall be 0 percent.”.

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

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

1           “(5) APPLICATION OF SEPARATE TARGET  
2 GROWTH RATES FOR EACH SERVICE CATEGORY BE-  
3 GINNING WITH 2008.—The target growth rate for a  
4 year beginning with 2008 shall be computed and ap-  
5 plied separately under this subsection for each serv-  
6 ice category (as defined in subsection (j)(5)) and  
7 shall be computed using the same method for com-  
8 puting the sustainable growth rate except for the fol-  
9 lowing:

10           “(A) The reference in paragraphs (2)(A)  
11 and (2)(D) to ‘all physicians’ services’ is  
12 deemed a reference to the physicians’ services  
13 included in such category but shall not take  
14 into account items and services included in phy-  
15 sicians’ services through the operation of para-  
16 graph (4)(A).

17           “(B) The factor described in paragraph  
18 (2)(C) for the service category described in sub-  
19 section (j)(5)(A) shall be increased by 0.025.

20           “(C) A national coverage determination (as  
21 defined in section 1869(f)(1)(B)) shall be treat-  
22 ed as a change in regulation described in para-  
23 graph (2)(D).”.

24           (2) USE OF TARGET GROWTH RATES.—Section  
25 1848 of such Act is further amended—

1 (A) in subsection (d)—

2 (i) in paragraph (1)(E)(ii), by insert-  
3 ing “or target” after “sustainable”; and

4 (ii) in paragraph (4)(B)(ii)(II), by in-  
5 serting “or target” after “sustainable”;  
6 and

7 (B) in subsection (f)—

8 (i) in the heading by inserting “; TAR-  
9 GET GROWTH RATE” after “SUSTAINABLE  
10 GROWTH RATE”;

11 (ii) in paragraph (1)—

12 (I) by striking “and” at the end  
13 of subparagraph (A);

14 (II) in subparagraph (B), by in-  
15 serting “before 2008” after “each  
16 succeeding year” and by striking the  
17 period at the end and inserting “;  
18 and”; and

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

21 “(C) November 1 of each succeeding year  
22 the target growth rate for such succeeding year  
23 and each of the 2 preceding years.”; and

24 (iii) in paragraph (2), in the matter  
25 before subparagraph (A), by inserting after

1                   “beginning with 2000” the following: “and  
2                   ending with 2007”.

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

6           (1) REPORTING REQUIREMENT.—The Secretary  
7           of Health and Human Services shall include infor-  
8           mation in the annual physician fee schedule pro-  
9           posed rule on the change in the annual rate of  
10          growth of actual expenditures for clinical diagnostic  
11          laboratory tests or drugs, biologicals, and radio-  
12          pharmaceuticals for which payment is made under  
13          part B of title XVIII of the Social Security Act.

14          (2) RECOMMENDATIONS.—The report sub-  
15          mitted under paragraph (1) shall include an analysis  
16          of the reasons for such excess expenditures and rec-  
17          ommendations for addressing them in the future.

18 **SEC. 302. IMPROVING ACCURACY OF RELATIVE VALUES**  
19                   **UNDER THE MEDICARE PHYSICIAN FEE**  
20                   **SCHEDULE.**

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

1           “(7) USE OF EXPERT PANEL TO IDENTIFY  
2 MISVALUED PHYSICIANS’ SERVICES.—

3           “(A) IN GENERAL.—The Secretary shall  
4 establish an expert panel (in this paragraph re-  
5 ferred to as the ‘expert panel’)—

6           “(i) to identify, through data analysis,  
7 physicians’ services for which the relative  
8 value under this subsection is potentially  
9 misvalued, particularly those services for  
10 which such relative value may be over-  
11 valued;

12           “(ii) to assess whether those  
13 misvalued services warrant review using  
14 existing processes (referred to in para-  
15 graph (2)(J)(ii)) for the consideration of  
16 coding changes; and

17           “(iii) to advise the Secretary con-  
18 cerning the exercise of authority under  
19 clauses (ii)(III) and (vi) of paragraph  
20 (2)(B).

21           “(B) COMPOSITION OF PANEL.—The ex-  
22 pert panel shall be appointed by the Secretary  
23 and composed of—

24           “(i) members with expertise in med-  
25 ical economics and technology diffusion;

- 1 “(ii) members with clinical expertise;
- 2 “(iii) physicians, particularly physi-
- 3 cians (such as a physician employed by the
- 4 Veterans Administration or a physician
- 5 who has a full time faculty appointment at
- 6 a medical school) who are not directly af-
- 7 fected by changes in the physician fee
- 8 schedule under this section;
- 9 “(iv) carrier medical directors; and
- 10 “(v) representatives of private payor
- 11 health plans.

12 “(C) APPOINTMENT CONSIDERATIONS.—In

13 appointing members to the expert panel, the

14 Secretary shall assure racial and ethnic diver-

15 sity on the panel and may consider appointing

16 a liaison from organizations with experience in

17 the consideration of coding changes to the

18 panel.”.

19 (b) EXAMINATION OF SERVICES WITH SUBSTANTIAL

20 CHANGES.—Such section is further amended by adding at

21 the end the following new paragraph:

22 “(8) EXAMINATION OF SERVICES WITH SUB-

23 STANTIAL CHANGES.—The Secretary, in consultation

24 with the expert panel under paragraph (7), shall—

1           “(A) conduct a five-year review of physi-  
2           cians’ services in conjunction with the RUC 5-  
3           year review, particularly for services that have  
4           experienced substantial changes in length of  
5           stay, site of service, volume, practice expense,  
6           or other factors that may indicate changes in  
7           physician work;

8           “(B) identify new services to determine if  
9           they are likely to experience a reduction in rel-  
10          ative value over time and forward a list of the  
11          services so identified for such five-year review;  
12          and

13          “(C) for physicians’ services that are oth-  
14          erwise unreviewed under the process the Sec-  
15          retary has established, periodically review a  
16          sample of relative value units within different  
17          types of services to assess the accuracy of the  
18          relative values contained in the Medicare physi-  
19          cian fee schedule.”.

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

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

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



1                   “(III) REDUCTIONS IN WORK  
2                   VALUE UNITS FOR SERVICES WITH AC-  
3                   CELERATED VOLUME GROWTH.—Ef-  
4                   fective January 1, 2009, reduced ex-  
5                   penditures attributable to clause  
6                   (vi).”; and

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

9                   “(vi) AUTHORIZING REDUCTION IN  
10                  WORK VALUE UNITS FOR SERVICES WITH  
11                  ACCELERATED VOLUME GROWTH.—The  
12                  Secretary may provide (without using ex-  
13                  isting processes the Secretary has estab-  
14                  lished for review of relative value) for a re-  
15                  duction in the work value units for a par-  
16                  ticular physician’s service if the annual  
17                  rate of growth in the expenditures for such  
18                  service for which payment is made under  
19                  this part for individuals for 2006 or a sub-  
20                  sequent year exceeds the average annual  
21                  rate of growth in expenditures of all physi-  
22                  cians’ services for which payment is made  
23                  under this part by more than 10 percent-  
24                  age points for such year.

1                   “(vii) CONSULTATION WITH EXPERT  
2                   PANEL AND BASED ON CLINICAL EVI-  
3                   DENCE.—The Secretary shall exercise au-  
4                   thority under clauses (ii)(III) and (vi) in  
5                   consultation with the expert panel estab-  
6                   lished under paragraph (7) and shall take  
7                   into account clinical evidence supporting or  
8                   refuting the merits of such accelerated  
9                   growth.”.

10                   (2) EFFECTIVE DATE.—The amendments made  
11                   by paragraph (1) shall apply with respect to pay-  
12                   ment for services furnished on or after January 1,  
13                   2009.

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

18   “(III) ADJUSTMENT AUTHORITY  
19   FOR EFFICIENCY GAINS FOR NEW  
20   PROCEDURES.—In carrying out sub-  
21   clauses (I) and (II), the Secretary  
22   may apply a methodology, based on  
23   supporting evidence, under which  
24   there is imposed a reduction over a  
25   period of years in specified relative

1 value units in the case of a new (or  
2 newer) procedure to take into account  
3 inherent efficiencies that are typically  
4 or likely to be gained during the pe-  
5 riod of initial increased application of  
6 the procedure.”.

7 **SEC. 303. FEEDBACK MECHANISM ON PRACTICE PATTERNS.**

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

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

19 Section 1833 of the Social Security Act (42 U.S.C.  
20 1395l) is amended by adding at the end the following new  
21 subsection:

22 “(v) INCENTIVE PAYMENTS FOR EFFICIENT  
23 AREAS.—

24 “(1) IN GENERAL.—In the case of services fur-  
25 nished under the physician fee schedule under sec-

1 tion 1848 on or after January 1, 2009, and before  
2 January 1, 2011, by a supplier that is paid under  
3 such fee schedule in an efficient area (as identified  
4 under paragraph (2)), in addition to the amount of  
5 payment that would otherwise be made for such  
6 services under this part, there also shall be paid an  
7 amount equal to 5 percent of the payment amount  
8 for the services under this part.

9 “(2) IDENTIFICATION OF EFFICIENT AREAS.—

10 “(A) IN GENERAL.—Based upon available  
11 data, the Secretary shall identify those counties  
12 or equivalent areas in the United States in the  
13 lowest fifth percentile of utilization based on  
14 per capita spending for services provided in  
15 2007 under this part and part A as standard-  
16 ized to eliminate the effect of geographic ad-  
17 justments in payment rates.

18 “(B) IDENTIFICATION OF COUNTIES  
19 WHERE SERVICE IS FURNISHED.—For pur-  
20 poses of paying the additional amount specified  
21 in paragraph (1), if the Secretary uses the 5-  
22 digit postal ZIP Code where the service is fur-  
23 nished, the dominant county of the postal ZIP  
24 Code (as determined by the United States Post-  
25 al Service, or otherwise) shall be used to deter-

1 mine whether the postal ZIP Code is in a coun-  
2 try described in subparagraph (A).

3 “(C) JUDICIAL REVIEW.— There shall be  
4 no administrative or judicial review under sec-  
5 tion 1869, 1878, or otherwise, respecting—

6 “(i) the identification of a county or  
7 other area under subparagraph (A); or

8 “(ii) the assignment of a postal ZIP  
9 Code to a county or other area under sub-  
10 paragraph (B).

11 “(D) PUBLICATION OF LIST OF COUNTIES;  
12 POSTING ON WEBSITE.—With respect to a year  
13 for which a county or area is identified under  
14 this paragraph, the Secretary shall identify  
15 such counties or areas as part of the proposed  
16 and final rule to implement the physician fee  
17 schedule under section 1848 for the applicable  
18 year. The Secretary shall post the list of coun-  
19 ties identified under this paragraph on the  
20 Internet website of the Centers for Medicare &  
21 Medicaid Services.”.

22 **SEC. 305. RECOMMENDATIONS ON REFINING THE PHYSI-**  
23 **CIAN FEE SCHEDULE.**

24 (a) RECOMMENDATIONS ON CONSOLIDATED CODING  
25 FOR SERVICES COMMONLY PERFORMED TOGETHER.—

1 Not later than December 31, 2008, the Comptroller Gen-  
2 eral of the United States shall—

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

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

11 (b) RECOMMENDATIONS ON INCREASED USE OF  
12 BUNDLED PAYMENTS.—Not later than December 31,  
13 2008, the Comptroller General of the United States  
14 shall—

15 (1) complete an analysis of those procedures  
16 under the Medicare physician fee schedule for which  
17 no global payment methodology is applied but for  
18 which a “bundled” payment methodology would be  
19 appropriate; and

20 (2) submit to Congress a report on such anal-  
21 ysis and include in the report recommendations on  
22 increasing the use of “bundled” payment method-  
23 ology under such schedule.

24 (c) MEDICARE PHYSICIAN FEE SCHEDULE.—In this  
25 section, the term “Medicare physician fee schedule” means

1 the fee schedule established under section 1848 of the So-  
2 cial Security Act (42 U.S.C. 1395w-4).

3 **SEC. 306. IMPROVED AND EXPANDED MEDICAL HOME DEM-**  
4 **ONSTRATION PROJECT.**

5 (a) IN GENERAL.—The Secretary of Health and  
6 Human Services (in this section referred to as the “Sec-  
7 retary”) shall establish under title XVIII of the Social Se-  
8 curity Act an expanded medical home demonstration  
9 project (in this section referred to as the “expanded  
10 project”) under this section. The expanded project super-  
11 sedes the project that was initiated under section 204 of  
12 the Medicare Improvement and Extension Act of 2006 (di-  
13 vision B of Public Law 109-432). The purpose of the ex-  
14 panded project is—

15 (1) to guide the redesign of the health care de-  
16 livery system to provide accessible, continuous, com-  
17 prehensive, and coordinated, care to Medicare bene-  
18 ficiaries; and

19 (2) to provide care management fees to per-  
20 sonal physicians delivering continuous and com-  
21 prehensive care in qualified medical homes.

22 (b) NATURE AND SCOPE OF PROJECT.—

23 (1) DURATION; SCOPE.—The expanded project  
24 shall operate during a period of three years, begin-  
25 ning not later than October 1, 2009, and shall in-

1       clude a nationally representative sample of physi-  
2       cians serving urban, rural, and underserved areas  
3       throughout the United States.

4               (2) ENCOURAGING PARTICIPATION OF SMALL  
5       PHYSICIAN PRACTICES.—

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

12              (B) TECHNICAL ASSISTANCE.— In order to  
13       facilitate the participation under the expanded  
14       project of physicians in such practices, the Sec-  
15       retary shall make available additional technical  
16       assistance to such practices during the first  
17       year of the expanded project.

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

22              (A) the selection of up to 100 HIT-en-  
23       hanced medical homes; and



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

4 (4) BENEFICIARY PARTICIPATION.—The Sec-  
5 retary shall establish a process for any Medicare  
6 beneficiary who is served by a medical home partici-  
7 pating in the expanded project to elect to participate  
8 in the project. Each beneficiary who elects to so par-  
9 ticipate shall be eligible—

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

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

17 The Secretary shall develop standard recruitment  
18 materials and election processes for Medicare bene-  
19 ficiaries who are electing to participate in the ex-  
20 panded project.

21 (c) STANDARDS FOR MEDICAL HOMES, HIT-EN-  
22 HANCED MEDICAL HOMES.—

23 (1) STANDARD SETTING AND CERTIFICATION  
24 PROCESS.—The Secretary shall establish a process

1 for selection of a qualified standard setting and cer-  
2 tification organization—

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

7 (B) to provide for the review and certifi-  
8 cation of medical practices as meeting such  
9 standards.

10 (2) BASIC STANDARDS FOR MEDICAL HOMES.—

11 For purposes of this subsection, the term “medical  
12 home” means a physician-directed practice that has  
13 been certified, under paragraph (1), as meeting the  
14 following standards:

15 (A) ACCESS AND COMMUNICATION WITH  
16 PATIENTS.—The practice applies standards for  
17 access to care and communication with partici-  
18 pating beneficiaries.

19 (B) MANAGING PATIENT INFORMATION  
20 AND USING INFORMATION IN MANAGEMENT TO  
21 SUPPORT PATIENT CARE.—The practice has  
22 readily accessible, clinically useful information  
23 on participating beneficiaries that enables the  
24 practice to treat such beneficiaries comprehen-  
25 sively and systematically.

1 (C) MANAGING AND COORDINATING CARE  
2 ACCORDING TO INDIVIDUAL NEEDS.—The prac-  
3 tice maintains continuous relationships with  
4 participating beneficiaries by implementing evi-  
5 dence-based guidelines and applying them to  
6 the identified needs of individual beneficiaries  
7 over time and with the intensity needed by such  
8 beneficiaries.

9 (D) PROVIDING ONGOING ASSISTANCE AND  
10 ENCOURAGEMENT IN PATIENT SELF-MANAGE-  
11 MENT.—The practice—

12 (i) collaborates with participating  
13 beneficiaries to pursue their goals for opti-  
14 mal achievable health; and

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

18 (E) RESOURCES TO MANAGE CARE.—The  
19 practice has in place the resources and proc-  
20 esses necessary to achieve improvements in the  
21 management and coordination of care for par-  
22 ticipating beneficiaries.

23 (F) MONITORING PERFORMANCE.—The  
24 practice monitors its clinical process and per-  
25 formance (including outcome measures) in

1 meeting the applicable standards under this  
2 subsection and provides information in a form  
3 and manner specified by the Secretary with re-  
4 spect to such process and performance.

5 (3) ADDITIONAL STANDARDS FOR HIT-EN-  
6 HANCED MEDICAL HOME.—For purposes of this sub-  
7 section, the term “HIT-enhanced medical home”  
8 means a medical home that has been certified, under  
9 paragraph (1), as using a health information tech-  
10 nology system that includes at least the following  
11 elements:

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

16 (i) The record—

17 (I) has the capability of inter-  
18 operability with secure data acquisi-  
19 tion from health information tech-  
20 nology systems of other health care  
21 providers in the area served by the  
22 home; or

23 (II) the capability to securely ac-  
24 quire clinical data delivered by such

1 other health care providers to a secure  
2 common data source.

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

5 (iii) The record has the capability to  
6 acquire, manage, and display all the types  
7 of clinical information commonly relevant  
8 to services furnished by the medical home,  
9 such as complete medical records, radio-  
10 graphic image retrieval, and clinical labora-  
11 tory information.

12 (iv) The record is integrated with de-  
13 cision support capacities that facilitate the  
14 use of evidence-based medicine and clinical  
15 decision support tools to guide decision-  
16 making at the point-of-care based on pa-  
17 tient-specific factors.

18 (B) E-PRESCRIBING.—The system sup-  
19 ports e-prescribing and computerized physician  
20 order entry.

21 (C) OUTCOME MEASUREMENT.—The sys-  
22 tem supports the secure, confidential provision  
23 of clinical process and outcome measures ap-  
24 proved by the National Quality Forum to the  
25 Secretary for use in confidential manner for

1 provider feedback and peer review and for out-  
2 comes and clinical effectiveness research.

3 (D) PATIENT EDUCATION CAPABILITY.—

4 The system actively facilitates participating  
5 beneficiaries engaging in the management of  
6 their own health through education and support  
7 systems and tools for shared decision-making.

8 (E) SUPPORT OF BASIC STANDARDS.—

9 The elements of such system, such as the elec-  
10 tronic health record, email communications, pa-  
11 tient registries, and clinical-decision support  
12 tools, are integrated in a manner to better  
13 achieve the basic standards specified in para-  
14 graph (2) for a medical home.

15 (4) USE OF DATA.—The Secretary shall use the  
16 data submitted under paragraph (1)(F) in a con-  
17 fidential manner for feedback and peer review for  
18 medical homes and for outcomes and clinical effec-  
19 tiveness research. After the first two years of the ex-  
20 panded project, these data may be used for adjust-  
21 ment in the monthly medical home care management  
22 fee under subsection (d)(2)(E).

23 (d) MONTHLY MEDICAL HOME CARE MANAGEMENT  
24 FEE.—

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

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

8                   (A) OPERATING EXPENSES.—The addi-  
9                   tional practice expenses for the delivery of serv-  
10                  ices through a medical home, taking into ac-  
11                  count the additional expenses for an HIT-en-  
12                  hanced medical home. Such expenses include  
13                  costs associated with—

14                           (i) structural expenses, such as equip-  
15                           ment, maintenance, and training costs;

16                           (ii) enhanced access and communica-  
17                           tion functions;

18                           (iii) population management and reg-  
19                           istry functions;

20                           (iv) patient medical data and referral  
21                           tracking functions;

22                           (v) provision of evidence-based care;

23                           (vi) implementation and maintenance  
24                           of health information technology;

1 (vii) reporting on performance and  
2 improvement conditions; and

3 (viii) patient education and patient  
4 decision support, including print and elec-  
5 tronic patient education materials.

6 (B) ADDED VALUE SERVICES.—The value  
7 of additional physician work, such as aug-  
8 mented care plan oversight, expanded e-mail  
9 and telephonic consultations, extended patient  
10 medical data review (including data stored and  
11 transmitted electronically), and physician super-  
12 vision of enhanced self management education,  
13 and expanded follow-up accomplished by non-  
14 physician personnel, in a medical home that is  
15 not adequately taken into account in the estab-  
16 lishment of the physician fee schedule under  
17 section 1848 of the Social Security Act.

18 (C) RISK ADJUSTMENT.—The development  
19 of an appropriate risk adjustment mechanism  
20 to account for the varying costs of medical  
21 homes based upon characteristics of partici-  
22 pating beneficiaries.

23 (D) HIT ADJUSTMENT.—Variation of the  
24 fee based on the extensiveness of use of the



1 health information technology in the medical  
2 home.

3 (E) PERFORMANCE-BASED.—After the  
4 first two years of the expanded project, an ad-  
5 justment of the fee based on performance of the  
6 medical home in achieving quality or outcomes  
7 standards.

8 (3) PERSONAL PHYSICIAN DEFINED.—For pur-  
9 poses of this subsection, the term “personal physi-  
10 cian” means, with respect to a participating Medi-  
11 care beneficiary, a physician (as defined in section  
12 1861(r)(1) of the Social Security Act (42 U.S.C.  
13 1395x(r)(1)) who provides accessible, continuous, co-  
14 ordinated, and comprehensive care for the bene-  
15 ficiary as part of a medical practice that is a quali-  
16 fied medical home. Such a physician may be a spe-  
17 cialist for a beneficiary requiring ongoing care for a  
18 chronic condition or multiple chronic conditions  
19 (such as severe asthma, complex diabetes, cardio-  
20 vascular disease, rheumatologic disorder) or for a  
21 beneficiary with a prolonged illness.

22 (e) FUNDING.—

23 (1) USE OF CURRENT PROJECT FUNDING.—  
24 Funds otherwise applied to the demonstration under  
25 section 204 of the Medicare Improvement and Ex-

1       tension Act of 2006 (division B of Public Law 109–  
2       432) shall be available to carry out the expanded  
3       project.

4               (2) ADDITIONAL FUNDING FROM SMI TRUST  
5       FUND.—

6               (A) IN GENERAL.—In addition to the  
7       funds provided under paragraph (1), there shall  
8       be available, from the Federal Supplementary  
9       Medical Insurance Trust Fund (under section  
10       1841 of the Social Security Act), the amount of  
11       \$500,000,000 to carry out the expanded  
12       project, including payments to of monthly med-  
13       ical home care management fees under sub-  
14       section (d), reductions in coinsurance for par-  
15       ticipating beneficiaries under subsection  
16       (b)(4)(B), and funds for the design, implemen-  
17       tation, and evaluation of the expanded project.

18              (B) MONITORING EXPENDITURES; EARLY  
19       TERMINATION.—The Secretary shall monitor  
20       the expenditures under the expanded project  
21       and may terminate the project early in order  
22       that expenditures not exceed the amount of  
23       funding provided for the project under subpara-  
24       graph (A).

25              (f) EVALUATIONS AND REPORTS.—

1           (1) ANNUAL INTERIM EVALUATIONS AND RE-  
 2           PORTS.—For each year of the expanded project, the  
 3           Secretary shall provide for an evaluation of the  
 4           project and shall submit to Congress, by a date spec-  
 5           ified by the Secretary, a report on the project and  
 6           on the evaluation of the project for each such year.

7           (2) FINAL EVALUATION AND REPORT.—The  
 8           Secretary shall provide for an evaluation of the ex-  
 9           panded project and shall submit to Congress, not  
 10          later than 18 months after the date of completion of  
 11          the project, a report on the project and on the eval-  
 12          uation of the project.

13 **SEC. 307. REPEAL OF PHYSICIAN ASSISTANCE AND QUAL-**  
 14 **ITY INITIATIVE FUND.**

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

17 **SEC. 308. ADJUSTMENT TO MEDICARE PAYMENT LOCAL-**  
 18 **ITIES.**

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

22                   “(6) FEE SCHEDULE GEOGRAPHIC AREAS.—

23                           “(A) IN GENERAL.—

24                                   “(i) REVISION.—Subject to clause (ii),  
 25                                   for services furnished on or after January

1           1, 2008, the Secretary shall revise the fee  
2           schedule areas used for payment under  
3           this section applicable to the State of Cali-  
4           fornia using the county-based geographic  
5           adjustment factor as specified in option 3  
6           (table 9) in the proposed rule for the 2008  
7           physician fee schedule published at 72  
8           Fed. Reg. 38,122 (July 12, 2007).

9           “(ii) TRANSITION.—For services fur-  
10          nished during the period beginning Janu-  
11          ary 1, 2008, and ending December 31,  
12          2010, after calculating the work, practice  
13          expense, and malpractice geographic indi-  
14          ces described in clauses (i), (ii), and (iii) of  
15          paragraph (1)(A) that would otherwise  
16          apply, the Secretary shall increase any  
17          such geographic index for any county in  
18          California that is lower than the geo-  
19          graphic index used for payment for serv-  
20          ices under this section as of December 31,  
21          2007, in such county to such geographic  
22          index level.

23          “(B) SUBSEQUENT REVISIONS.—

24                 “(i) TIMING.—Not later than January  
25                 1, 2011, the Secretary shall review and

1 make revisions to fee schedule areas in all  
2 States for which more than one fee sched-  
3 ule area is used for payment of services  
4 under this section. The Secretary may re-  
5 vise fee schedule areas in States in which  
6 a single fee schedule area is used for pay-  
7 ment for services under this section using  
8 the same methodology applied in the pre-  
9 vious sentence.

10 “(ii) LINK WITH GEOGRAPHIC INDEX  
11 DATA REVISION.—The revision described in  
12 clause (i) shall be made effective concur-  
13 rently with the application of the periodic  
14 review of geographic adjustment factors re-  
15 quired under paragraph (1)(C) for 2011  
16 and subsequent periods.”.

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

18 (a) PAYMENT UNDER PART B OF THE MEDICARE  
19 PROGRAM FOR DIAGNOSTIC IMAGING SERVICES FUR-  
20 NISHED IN FACILITIES CONDITIONED ON ACCREDITATION  
21 OF FACILITIES.—

22 (1) SPECIAL PAYMENT RULE.—

23 (A) IN GENERAL.—Section 1848(b)(4) of  
24 the Social Security Act (42 U.S.C. 1395w-  
25 4(b)(4)) is amended—

1 (i) in the heading, by striking “RULE”  
2 and inserting “RULES”;

3 (ii) in subparagraph (A), by striking  
4 “IN GENERAL” and inserting “LIMITA-  
5 TION”; and

6 (iii) by adding at the end the fol-  
7 lowing new subparagraph:

8 “(C) PAYMENT ONLY FOR SERVICES PRO-  
9 VIDED IN ACCREDITED FACILITIES.—

10 “(i) IN GENERAL.—In the case of im-  
11 aging services that are diagnostic imaging  
12 services described in clause (ii), the pay-  
13 ment amount for the technical component  
14 and the professional component of the  
15 services established for a year under the  
16 fee schedule described in paragraph (1)  
17 shall each be zero, unless the services are  
18 furnished at a diagnostic imaging services  
19 facility that meets the certificate require-  
20 ment described in section 354(b)(1) of the  
21 Public Health Service Act, as applied  
22 under subsection (m). The previous sen-  
23 tence shall not apply with respect to the  
24 technical component if the imaging equip-  
25 ment meets certification standards and the

1 professional component of a diagnostic im-  
2 aging service that is furnished by a physi-  
3 cian.

4 “(ii) DIAGNOSTIC IMAGING SERV-  
5 ICES.—For purposes of clause (i) and sub-  
6 section (m), the term ‘diagnostic imaging  
7 services’ means all imaging modalities, in-  
8 cluding diagnostic magnetic resonance im-  
9 aging (‘MRI’), computed tomography  
10 (‘CT’), positron emission tomography  
11 (‘PET’), nuclear medicine procedures, x-  
12 rays, sonograms, ultrasounds, echocardi-  
13 grams, and such emerging diagnostic im-  
14 aging technologies as specified by the Sec-  
15 retary.”.

16 (B) EFFECTIVE DATE.—

17 (i) IN GENERAL.—Subject to clause  
18 (ii), the amendments made by subpara-  
19 graph (A) shall apply to diagnostic imag-  
20 ing services furnished on or after January  
21 1, 2010.

22 (ii) EXTENSION FOR ULTRASOUND  
23 SERVICES.—The amendments made by  
24 subparagraph (A) shall apply to diagnostic

1                   imaging services that are ultrasound serv-  
2                   ices on or after January 1, 2012.

3                   (2) CERTIFICATION OF FACILITIES THAT FUR-  
4                   NISH DIAGNOSTIC IMAGING SERVICES.—Section  
5                   1848 of the Social Security Act (42 U.S.C. 1395w-  
6                   4) is amended by adding at the end the following  
7                   new subsection:

8                   “(m) CERTIFICATION OF FACILITIES THAT FURNISH  
9                   DIAGNOSTIC IMAGING SERVICES.—

10                   “(1) IN GENERAL.—For purposes of subsection  
11                   (b)(4)(C)(i), except as provided under paragraphs  
12                   (2) through (8), the provisions of section 354 of the  
13                   Public Health Service Act (as in effect as of June  
14                   1, 2007), relating to the certification of mammog-  
15                   raphy facilities, shall apply, with respect to the pro-  
16                   vision of diagnostic imaging services (as defined in  
17                   subsection (b)(4)(C)(ii)) and to a diagnostic imaging  
18                   services facility defined in paragraph (8) (and to the  
19                   process of accrediting such facilities) in the same  
20                   manner that such provisions apply, with respect to  
21                   the provision of mammograms and to a facility de-  
22                   fined in subsection (a)(3) of such section (and to the  
23                   process of accrediting such mammography facilities).



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

4           “(A) any reference to ‘mammography’, or  
5 ‘breast imaging’ is deemed a reference to ‘diag-  
6 nostic imaging services (as defined in section  
7 1848(b)(4)(C)(ii) of the Social Security Act)’;

8           “(B) any reference to a mammogram or  
9 film is deemed a reference to an image, as de-  
10 fined in paragraph (8);

11           “(C) any reference to ‘mammography facil-  
12 ity’ or to a ‘facility’ under such section 354 is  
13 deemed a reference to a diagnostic imaging  
14 services facility, as defined in paragraph (8);

15           “(D) any reference to radiological equip-  
16 ment used to image the breast is deemed a ref-  
17 erence to medical imaging equipment used to  
18 provide diagnostic imaging services;

19           “(E) any reference to radiological proce-  
20 dures or radiological is deemed a reference to  
21 medical imaging services, as defined in para-  
22 graph (8) or medical imaging, respectively;

23           “(F) any reference to an inspection (as de-  
24 fined in subsection (a)(4) of such section) or in-  
25 spector is deemed a reference to an audit (as

1 defined in paragraph (8)) or auditor, respec-  
2 tively;

3 “(G) any reference to a medical physicist  
4 (as described in subsection (f)(1)(E) of such  
5 section) is deemed to include a reference to a  
6 magnetic resonance scientist or the appropriate  
7 qualified expert as determined by the accred-  
8 iting body;

9 “(H) in applying subsection (d)(1)(A)(i) of  
10 such section, the reference to ‘type of each x-  
11 ray machine, image receptor, and processor’ is  
12 deemed a reference to ‘type of imaging equip-  
13 ment’;

14 “(I) in applying subsection (d)(1)(B) of  
15 such section, the reference that ‘the person or  
16 agent submits to the Secretary’ is deemed a ref-  
17 erence that ‘the person or agent submits to the  
18 Secretary, through the appropriate accredita-  
19 tion body’;

20 “(J) in applying subsection (d)(1)(B)(i) of  
21 such section, the reference to standards estab-  
22 lished by the Secretary is deemed a reference to  
23 standards established by an accreditation body  
24 and approved by the Secretary;

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

3           “(i) in paragraph (1)(A), the ref-  
4 erence to ‘may’ is deemed a reference to  
5 ‘shall’;

6           “(ii) in paragraph (1)(B)(i)(II), the  
7 reference to ‘a random sample of clinical  
8 images from such facilities’ is deemed a  
9 reference to ‘a statistically significant ran-  
10 dom sample of clinical images from a sta-  
11 tistically significant random sample of fa-  
12 cilities’;

13           “(iii) in paragraph (3)(A) of such sec-  
14 tion—

15           “(I) the reference to ‘paragraph  
16 (1)(B)’ in such subsection is deemed  
17 to be a reference to ‘paragraph (1)(B)  
18 and subsection (f)’; and

19           “(II) the reference to the ‘Sec-  
20 retary’ is deemed a reference to ‘an  
21 accreditation body, with the approval  
22 of the Secretary’; and

23           “(iv) in paragraph (6)(B), the ref-  
24 erence to the Committee on Labor and  
25 Human Resources of the Senate is deemed

1 to be the Committee on Finance of the  
2 Senate and the reference to the Committee  
3 on Energy and Commerce of the House of  
4 Representatives is deemed to include a ref-  
5 erence to the Committee on Ways and  
6 Means of the House of Representatives;

7 “(L) in applying subsection (f), relating to  
8 quality standards—

9 “(i) each reference to standards estab-  
10 lished by the Secretary is deemed a ref-  
11 erence to standards established by an ac-  
12 creditation body involved and approved by  
13 the Secretary under subsection (d)(1)(B)(i)  
14 of such section;

15 “(ii) in paragraph (1)(A), the ref-  
16 erence to ‘radiation dose’ is deemed a ref-  
17 erence to ‘radiation dose, as appropriate’;

18 “(iii) in paragraph (1)(B), the ref-  
19 erence to ‘radiological standards’ is deemed  
20 a reference to ‘medical imaging standards,  
21 as appropriate’;

22 “(iv) in paragraphs (1)(D)(ii) and  
23 (1)(E)(iii), the reference to ‘the Secretary’  
24 is deemed a reference to ‘an accreditation  
25 body with the approval of the Secretary’;

1           “(v) in each of subclauses (III) and  
2           (IV) of paragraph (1)(G)(ii), each ref-  
3           erence to ‘patient’ is deemed a reference to  
4           ‘patient, if requested by the patient’; and  
5           “(M) in applying subsection (g), relating to  
6           inspections—

7           “(i) each reference to the ‘Secretary  
8           or State or local agency acting on behalf of  
9           the Secretary’ is deemed to include a ref-  
10          erence to an accreditation body involved;

11          “(ii) in the first sentence of para-  
12          graph (1)(F), the reference to ‘annual in-  
13          spections required under this paragraph’ is  
14          deemed a reference to ‘the audits carried  
15          out in facilities at least every three years  
16          from the date of initial accreditation under  
17          this paragraph’; and

18          “(iii) in the second sentence of para-  
19          graph (1)(F), the reference to ‘inspections  
20          carried out under this paragraph’ is  
21          deemed a reference to ‘audits conducted  
22          under this paragraph during the previous  
23          year’.

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

4           “(A) IN GENERAL.—Except as provided in  
5 subparagraph (B)—

6           “(i) any reference to ‘October 1,  
7 1994’ shall be deemed a reference to ‘Jan-  
8 uary 1, 2010’;

9           “(ii) the reference to ‘the date of the  
10 enactment of this section’ in each of sub-  
11 sections (e)(1)(D) and (f)(1)(E)(iii) is  
12 deemed to be a reference to ‘the date of  
13 the enactment of the Children’s Health  
14 and Medicare Protection Act of 2007’;

15           “(iii) the reference to ‘annually’ in  
16 subsection (g)(1)(E) is deemed a reference  
17 to ‘every three years’;

18           “(iv) the reference to ‘October 1,  
19 1996’ in subsection (l) is deemed to be a  
20 reference to ‘January 1, 2011’;

21           “(v) the reference to ‘October 1,  
22 1999’ in subsection (n)(3)(H) is deemed to  
23 be a reference to ‘January 1, 2012’; and

24           “(vi) the reference to ‘October 1,  
25 1993’ in the matter following paragraph

1           (3)(J) of subsection (n) is deemed to be a  
2           reference ‘January 1, 2010’.

3           “(B) ULTRASOUND SERVICES.—With re-  
4           spect to diagnostic imaging services that are  
5           ultrasounds—

6                   “(i) any reference to ‘October 1,  
7                   1994’ shall be deemed a reference to ‘Jan-  
8                   uary 1, 2012’;

9                   “(ii) the reference to ‘the date of the  
10                  enactment of this section’ in subsection  
11                  (f)(1)(E)(iii) is deemed to be a reference to  
12                  ‘7 years after the date of the enactment of  
13                  the Children’s Health and Medicare Pro-  
14                  tection Act of 2007’;

15                  “(iii) the reference to ‘October 1,  
16                  1996’ in subsection (l) is deemed to be a  
17                  reference to ‘January 1, 2013’;

18           “(4) PROVISIONS NOT APPLICABLE.—For pur-  
19           poses of paragraph (1), in applying section 354 of  
20           the Public Health Service Act, the following provi-  
21           sion shall not apply:

22                   “(A) Subsections (e) and (f) of such sec-  
23                   tion, in so far as the respective subsection im-  
24                   poses any requirement for a physician to be cer-  
25                   tified, accredited, or otherwise meet require-

1           ments, with respect to the provision of any di-  
2           agnostic imaging services, as a condition of pay-  
3           ment under subsection (b)(4)(C)(i), with re-  
4           spect to the professional or technical compo-  
5           nent, for such service.

6           “(B) Subsection (e)(1)(B)(v).

7           “(C) Subsection (f)(1)(H) of such section,  
8           relating to standards for special techniques for  
9           mammograms of patients with breast implants.

10          “(D) Subsection (g)(6) of such section, re-  
11          lating to an inspection demonstration program.

12          “(E) Subsection (n) of such section, relat-  
13          ing to the national advisory committee.

14          “(F) Subsection (p) of such section, relat-  
15          ing to breast cancer screening surveillance re-  
16          search grants.

17          “(G) Paragraphs (1)(B) and (2) of sub-  
18          section (r) of such section, related to funding.

19          “(5) ACCREDITATION BODIES.—For purposes  
20          of paragraph (1), in applying section 354(e)(1) of  
21          the Public Health Service, the following shall apply:

22                 “(A) APPROVAL OF TWO ACCREDITATION  
23                 BODIES FOR EACH TREATMENT MODALITY.—In  
24                 the case that there is more than one accredita-  
25                 tion body for a treatment modality that quali-



1           fies for approval under this subsection, the Sec-  
2           retary shall approve at least two accreditation  
3           bodies for such treatment modality.

4           “(B) ADDITIONAL ACCREDITATION BODY  
5           STANDARDS.—In addition to the standards de-  
6           scribed in subparagraph (B) of such section for  
7           accreditation bodies, the Secretary shall estab-  
8           lish standards that require—

9                   “(i) the timely integration of new  
10                   technology by accreditation bodies for pur-  
11                   poses of accrediting facilities under this  
12                   subsection; and

13                   “(ii) the accreditation body involved to  
14                   evaluate the annual medical physicist sur-  
15                   vey (or annual medical survey of another  
16                   appropriate qualified expert chosen by the  
17                   accreditation body) of a facility upon on-  
18                   site review of such facility.

19           “(6) ADDITIONAL QUALITY STANDARDS.—For  
20           purposes of paragraph (1), in applying subsection  
21           (f)(1) of section 354 of the Public Health Service—

22                   “(A) the quality standards under such sub-  
23                   section shall, with respect to a facility include—

24                   “(i) standards for qualifications of  
25                   medical personnel who are not physicians

1 and who perform diagnostic imaging serv-  
2 ices at the facility that require such per-  
3 sonnel to ensure that individuals, prior to  
4 performing medical imaging, demonstrate  
5 compliance with the standards established  
6 under subsection (a) through successful  
7 completion of certification by a nationally  
8 recognized professional organization, licen-  
9 sure, completion of an examination, perti-  
10 nent coursework or degree program,  
11 verified pertinent experience, or through  
12 other ways determined appropriate by an  
13 accreditation body (with the approval of  
14 the Secretary, or through some combina-  
15 tion thereof);

16 “(ii) standards requiring the facility  
17 to maintain records of the credentials of  
18 physicians and other medical personnel de-  
19 scribed in clause (i);

20 “(iii) standards for qualifications and  
21 responsibilities of medical directors and  
22 other personnel with supervising roles at  
23 the facility;

1           “(iv) standards that require the facil-  
2           ity has procedures to ensure the safety of  
3           patients of the facility; and

4           “(v) standards for the establishment  
5           of a quality control program at the facility  
6           to be implemented as described in subpara-  
7           graph (E) of such subsection;

8           “(B) the quality standards described in  
9           subparagraph (B) of such subsection shall be  
10          deemed to include standards that require the  
11          establishment and maintenance of a quality as-  
12          surance and quality control program at each fa-  
13          cility that is adequate and appropriate to en-  
14          sure the reliability, clarity, and accuracy of the  
15          technical quality of diagnostic images produced  
16          at such facilities; and

17          “(C) the quality standard described in sub-  
18          paragraph (C) of such subsection, relating to a  
19          requirement for personnel who perform speci-  
20          fied services, shall include in such requirement  
21          that such personnel must meet continuing med-  
22          ical education standards as specified by an ac-  
23          creditation body (with the approval of the Sec-  
24          retary) and update such standards at least once  
25          every three years.

1           “(7) ADDITIONAL REQUIREMENTS.—Notwith-  
2 standing any provision of section 354 of the Public  
3 Health Service Act, the following shall apply to the  
4 accreditation process under this subsection for pur-  
5 poses of subsection (b)(4)(C)(i):

6           “(A) Any diagnostic imaging services facil-  
7 ity accredited before January 1, 2010 (or Janu-  
8 ary 1, 2012, in the case of ultrasounds), by an  
9 accrediting body approved by the Secretary  
10 shall be deemed a facility accredited by an ap-  
11 proved accreditation body for purposes of such  
12 subsection as of such date if the facility submits  
13 to the Secretary proof of such accreditation by  
14 transmittal of the certificate of accreditation,  
15 including by electronic means.

16           “(B) The Secretary may require the ac-  
17 creditation under this subsection of an emerg-  
18 ing technology used in the provision of a diag-  
19 nostic imaging service as a condition of pay-  
20 ment under subsection (b)(4)(C)(i) for such  
21 service at such time as the Secretary deter-  
22 mines there is sufficient empirical and scientific  
23 information to properly carry out the accredita-  
24 tion process for such technology.

1           “(8) DEFINITIONS.—For purposes of this sub-  
2 section:

3           “(A) AUDIT.—The term ‘audit’ means an  
4 onsite evaluation, with respect to a diagnostic  
5 imaging services facility, by the Secretary, State  
6 or local agency on behalf of the Secretary, or  
7 accreditation body approved under this sub-  
8 section that includes the following:

9                   “(i) Equipment verification.

10                   “(ii) Evaluation of policies and proce-  
11 dures for compliance with accreditation re-  
12 quirements.

13                   “(iii) Evaluation of personnel quali-  
14 fications and credentialing.

15                   “(iv) Evaluation of the technical qual-  
16 ity of images.

17                   “(v) Evaluation of patient reports.

18                   “(vi) Evaluation of peer-review mech-  
19 anisms and other quality assurance activi-  
20 ties.

21                   “(vii) Evaluation of quality control  
22 procedures, results, and follow-up actions.

23                   “(viii) Evaluation of medical physi-  
24 cists (or other appropriate professionals

1 chosen by the accreditation body) and  
2 magnetic resonance scientist surveys.

3 “(ix) Evaluation of consumer com-  
4 plaint mechanisms.

5 “(x) Provision of recommendations for  
6 improvement based on findings with re-  
7 spect to clauses (i) through (ix).

8 “(B) DIAGNOSTIC IMAGING SERVICES FA-  
9 CILITY.—The term ‘diagnostic imaging services  
10 facility’ has the meaning given the term ‘facil-  
11 ity’ in section 354(a)(3) of the Public Health  
12 Service Act (42 U.S.C. 263b(a)(3)) subject to  
13 the reference changes specified in paragraph  
14 (2), but does not include any facility that does  
15 not furnish diagnostic imaging services for  
16 which payment may be made under this section.

17 “(C) IMAGE.—The term ‘image’ means the  
18 portrayal of internal structures of the human  
19 body for the purpose of detecting and deter-  
20 mining the presence or extent of disease or in-  
21 jury and may be produced through various  
22 techniques or modalities, including radiant en-  
23 ergy or ionizing radiation and ultrasound and  
24 magnetic resonance. Such term does not include  
25 image guided procedures.

1           “(D) MEDICAL IMAGING SERVICE.—The  
2           term ‘medical imaging service’ means a service  
3           that involves the science of an image.”.

4           (b) ADJUSTMENT IN PRACTICE EXPENSE TO RE-  
5 FLECT HIGHER PRESUMED UTILIZATION.—Section 1848  
6 of the Social Security Act (42 U.S.C. 1395w) is amend-  
7 ed—

8           (1) in subsection (b)(4)—

9           (A) in subparagraph (B), by striking “sub-  
10           paragraph (A)” and inserting “this paragraph”;  
11           and

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

14           “(D) ADJUSTMENT IN PRACTICE EXPENSE  
15           TO REFLECT HIGHER PRESUMED UTILIZA-  
16           TION.—In computing the number of practice  
17           expense relative value units under subsection  
18           (c)(2)(C)(ii) with respect to imaging services  
19           described in subparagraph (B), the Secretary  
20           shall adjust such number of units so it reflects  
21           a 75 percent (rather than 50 percent) presumed  
22           rate of utilization of imaging equipment.”; and

23           (2) in subsection (c)(2)(B)(v)(II), by inserting  
24           “AND OTHER PROVISIONS” after “OPD PAYMENT  
25           CAP”.

1           (c) ADJUSTMENT IN TECHNICAL COMPONENT “DIS-  
2 COUNT” ON SINGLE-SESSION IMAGING TO CONSECUTIVE  
3 BODY PARTS.—Section 1848(b)(4) of such Act is further  
4 amended by adding at the end the following new subpara-  
5 graph:

6                   “(E) ADJUSTMENT IN TECHNICAL COMPO-  
7                   NENT DISCOUNT ON SINGLE-SESSION IMAGING  
8                   INVOLVING CONSECUTIVE BODY PARTS.—The  
9                   Secretary shall increase the reduction in ex-  
10                  penditures attributable to the multiple proce-  
11                  dure payment reduction applicable to the tech-  
12                  nical component for imaging under the final  
13                  rule published by the Secretary in the Federal  
14                  Register on November 21, 2005 (42 CFR 405,  
15                  et al.) from 25 percent to 50 percent.”.

16           (d) ADJUSTMENT IN ASSUMED INTEREST RATE FOR  
17 CAPITAL PURCHASES.—Section 1848(b)(4) of such Act is  
18 further amended by adding at the end the following new  
19 subparagraph:

20                   “(F) ADJUSTMENT IN ASSUMED INTEREST  
21                   RATE FOR CAPITAL PURCHASES.—In computing  
22                   the practice expense component for imaging  
23                   services under this section, the Secretary shall  
24                   change the interest rate assumption for capital  
25                   purchases of imaging devices to reflect the pre-



1 vailing rate in the market, but in no case higher  
2 than 11 percent.”.

3 (e) **DISALLOWANCE OF GLOBAL BILLING.**—Effective  
4 for claims filed for imaging services (as defined in sub-  
5 section (b)(4)(B) of section 1848 of the Social Security  
6 Act) furnished on or after the first day of the first month  
7 that begins more than 1 year after the date of the enact-  
8 ment of this Act, the Secretary of Health and Human  
9 Services shall not accept (or pay) a claim under such sec-  
10 tion unless the claim is made separately for each compo-  
11 nent of such services.

12 (f) **EFFECTIVE DATE.**—Except as otherwise pro-  
13 vided, this section, and the amendments made by this sec-  
14 tion, shall apply to services furnished on or after January  
15 1, 2008.

16 **SEC. 310. REDUCING FREQUENCY OF MEETINGS OF THE**  
17 **PRACTICING PHYSICIANS ADVISORY COUN-**  
18 **CIL.**

19 Section 1868(a)(2) of the Social Security Act (42  
20 U.S.C. 1395ee(a)(2)) is amended by striking “once during  
21 each calendar quarter” and inserting “once each year (and  
22 at such other times as the Secretary may specify)”.

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

**SEC. 401. EQUALIZING PAYMENTS BETWEEN MEDICARE AD-  
 VANTAGE PLANS AND FEE-FOR-SERVICE  
 MEDICARE.**

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

(1) in subsection (j)(1)(A)—

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

(B) by inserting after “(k)(1)” the following: “, or, beginning with 2009,  $\frac{1}{12}$  of the blended benchmark amount determined under subsection (l)(1)”; and

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

“(l) DETERMINATION OF BLENDED BENCHMARK AMOUNT.—

“(1) IN GENERAL.—For purposes of subsection (j), subject to paragraphs (2) and (3), the term ‘blended benchmark amount’ means for an area—

“(A) for 2009 the sum of—

1 “(i)  $\frac{2}{3}$  of the applicable amount (as  
2 defined in subsection (k)(1)) for the area  
3 and year; and

4 “(ii)  $\frac{1}{3}$  of the amount specified in  
5 subsection (c)(1)(D)(i) for the area and  
6 year;

7 “(B) for 2010 the sum of—

8 “(i)  $\frac{1}{3}$  of the applicable amount for  
9 the area and year; and

10 “(ii)  $\frac{2}{3}$  of the amount specified in  
11 subsection (c)(1)(D)(i) for the area and  
12 year; and

13 “(C) for a subsequent year the amount  
14 specified in subsection (c)(1)(D)(i) for the area  
15 and year.

16 “(2) FEE-FOR-SERVICE PAYMENT FLOOR.—In  
17 no case shall the blended benchmark amount for an  
18 area and year be less than the amount specified in  
19 subsection (c)(1)(D)(i) for the area and year.

20 “(3) EXCEPTION FOR PACE PLANS.—This sub-  
21 section shall not apply to payments to a PACE pro-  
22 gram under section 1894.”.

23 (b) PHASE IN OF PAYMENT BASED ON IME  
24 COSTS.—

1           (1) IN GENERAL.—Section 1853(c)(1)(D)(i) of  
2 such Act (42 U.S.C. 1395w–23(c)(1)(D)(i)) is  
3 amended by inserting “and costs attributable to pay-  
4 ments under section 1886(d)(5)(B)” after  
5 “1886(h)”.

6           (2) EFFECTIVE DATE.—The amendment made  
7 by paragraph (1) shall apply to the capitation rate  
8 for years beginning with 2009.

9           (c) LIMITATION ON PLAN ENROLLMENT IN CASES OF  
10 EXCESS BIDS FOR 2009 AND 2010.—

11           (1) IN GENERAL.—In the case of a Medicare  
12 Part C organization that offers a Medicare Part C  
13 plan in the 50 States or the District of Columbia for  
14 which—

15                   (A) bid amount described in paragraph (2)  
16 for a Medicare Part C plan for 2009 or 2010,  
17 exceeds

18                   (B) the percent specified in paragraph (4)  
19 of the fee-for-service amount described in para-  
20 graph (3),

21 the Medicare Part C plan may not enroll any new  
22 enrollees in the plan during the annual, coordinated  
23 election period (under section 1851(e)(3)(B) of such  
24 Act (42 U.S.C. 1395w–21(e)(3)(B)) for the year or

1 during the year (if the enrollment becomes effective  
2 during the year).

3 (2) BID AMOUNT FOR PART A AND B SERV-  
4 ICES.—

5 (A) IN GENERAL.—Except as provided in  
6 subparagraph (B), the bid amount described in  
7 this paragraph is the unadjusted Medicare Part  
8 C statutory non-drug monthly bid amount (as  
9 defined in section 1854(b)(2)(E) of the Social  
10 Security Act (42 U.S.C. 1395w–24(b)(2)(E)).

11 (B) TREATMENT OF MSA PLANS.—In the  
12 case of an MSA plan (as defined in section  
13 1859(b)(3) of the Social Security Act, 42  
14 U.S.C. 1935w–28(b)(3)), the bid amount de-  
15 scribed in this paragraph is the amount de-  
16 scribed in section 1854(a)(3)(A) of such Act  
17 (42 U.S.C. 1395w–24(a)(3)(A)).

18 (3) FEE-FOR-SERVICE AMOUNT DESCRIBED.—

19 (A) IN GENERAL.—Subject to subpara-  
20 graph (B), the fee-for-service amount described  
21 in this paragraph for an Medicare Part C local  
22 area is the amount described in section  
23 1853(c)(1)(D)(i) of the Social Security Act (42  
24 U.S.C. 1395w–23) for such area.

1           (B) TREATMENT OF MULTI-COUNTY  
2 PLANS.—In the case of an MA plan the service  
3 area for which covers more than one Medicare  
4 Part C local area, the fee-for-service amount  
5 described in this paragraph is the amount de-  
6 scribed in section 1853(c)(1)(D)(i) of the Social  
7 Security Act for each such area served, weight-  
8 ed for each such area by the proportion of the  
9 enrollment of the plan that resides in the coun-  
10 ty (as determined based on amounts posted by  
11 the Administrator of the Centers for Medicare  
12 & Medicaid Services in the April bid notice for  
13 the year involved).

14           (4) PERCENTAGE PHASE DOWN.—For purposes  
15 of paragraph (1), the percentage specified in this  
16 paragraph—

17                   (A) for 2009 is 106 percent; and

18                   (B) for 2010 is 103 percent.

19           (5) EXEMPTION OF AGE-INS.—For purposes of  
20 paragraph (1), the term “new enrollee” with respect  
21 to a Medicare Part C plan offered by a Medicare  
22 Part C organization, does not include an individual  
23 who was enrolled in a plan offered by the organiza-  
24 tion in the month immediately before the month in

1 which the individual was eligible to enroll in such a  
 2 Medicare Part C plan offered by the organization.

3 (d) ANNUAL REBASING OF FEE-FOR-SERVICE  
 4 RATES.—Section 1853(c)(1)(D)(ii) of the Social Security  
 5 Act (42 U.S.C. 1395w–23(c)(1)(D)(ii)) is amended—

6 (1) by inserting “(before 2009)” after “for sub-  
 7 sequent years”; and

8 (2) by inserting before the period at the end the  
 9 following: “and for each year beginning with 2009”.

10 (e) REPEAL OF PPO STABILIZATION FUND.—Sec-  
 11 tion 1858 of the Social Security Act (42 U.S.C. 1395) is  
 12 amended—

13 (1) by striking subsection (e); and

14 (2) in subsection (f)(1), by striking “subject to  
 15 subsection (e),”.

## 16 **Subtitle B—Beneficiary Protections**

### 17 **SEC. 411. NAIC DEVELOPMENT OF MARKETING, ADVER-** 18 **TISING, AND RELATED PROTECTIONS.**

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

22 “(m) APPLICATION OF MODEL MARKETING AND EN-  
 23 ROLLMENT STANDARDS.—

24 “(1) IN GENERAL.—The National Association  
 25 of Insurance Commissioners (in this subsection re-

1       ferred to as the ‘NAIC’) is requested to develop, and  
2       to submit to the Secretary of Health and Human  
3       Services not later than 12 months after the date of  
4       the enactment of this Act, model regulations (in this  
5       section referred to as ‘model regulations’) regarding  
6       Medicare plan marketing, enrollment, broker and  
7       agent training and certification, agent and broker  
8       commissions, and market conduct by plans, agents  
9       and brokers for implementation (under paragraph  
10      (7)) under this part and part D, including for en-  
11      forcement by States under section 1856(b)(3).

12           “(2) **MARKETING GUIDELINES.**—

13           “(A) **IN GENERAL.**—The model regulations  
14           shall address the sales and advertising tech-  
15           niques used by Medicare private plans, agents  
16           and brokers in selling plans, including defining  
17           and prohibiting cold calls, unsolicited door-to-  
18           door sales, cross-selling, and co-branding.

19           “(B) **SPECIAL CONSIDERATIONS.**—The  
20           model regulations shall specifically address the  
21           marketing—

22           “(i) of plans to full benefit dual-eli-  
23           ble individuals and qualified medicare  
24           beneficiaries;



1                   “(ii) of plans to populations with lim-  
2                   ited English proficiency;

3                   “(iii) of plans to beneficiaries in sen-  
4                   ior living facilities; and

5                   “(iv) of plans at educational events.

6                   “(3) ENROLLMENT GUIDELINES.—

7                   “(A) IN GENERAL.—The model regulations  
8                   shall address the disclosures Medicare private  
9                   plans, agents, and brokers must make when en-  
10                  rolling beneficiaries, and a process—

11                  “(i) for affirmative beneficiary sign  
12                  off before enrollment in a plan; and

13                  “(ii) in the case of Medicare Part C  
14                  plans, for plans to conduct a beneficiary  
15                  call-back to confirm beneficiary sign off  
16                  and enrollment.

17                  “(B) SPECIFIC CONSIDERATIONS.—The  
18                  model regulations shall specially address bene-  
19                  ficiary understanding of the Medicare plan  
20                  through required disclosure (or beneficiary  
21                  verification) of each of the following:

22                  “(i) The type of Medicare private plan  
23                  involved.

24                  “(ii) Attributes of the plan, including  
25                  premiums, cost sharing, formularies (if ap-

1                   plicable), benefits, and provider access lim-  
2                   itations in the plan.

3                   “(iii) Comparative quality of the plan.

4                   “(iv) The fact that plan attributes  
5                   may change annually.

6                   “(4) APPOINTMENT, CERTIFICATION AND  
7                   TRAINING OF AGENTS AND BROKERS.—The model  
8                   regulations shall establish procedures and require-  
9                   ments for appointment, certification (and periodic  
10                  recertification), and training of agents and brokers  
11                  that market or sell Medicare private plans consistent  
12                  with existing State appointment and certification  
13                  procedures and with this paragraph.

14                  “(5) AGENT AND BROKER COMMISSIONS.—

15                  “(A) IN GENERAL.—The model regulations  
16                  shall establish standards for fair and appro-  
17                  priate commissions for agents and brokers con-  
18                  sistent with this paragraph.

19                  “(B) LIMITATION ON TYPES OF COMMIS-  
20                  SION.—The model regulations shall specifically  
21                  prohibit the following:

22                  “(i) Differential commissions—

23                          “(I) for Medicare Part C plans  
24                          based on the type of Medicare private  
25                          plan; or

1                   “(II) prescription drug plans  
2                   under part D based on the type of  
3                   prescription drug plan.

4                   “(ii) Commissions in the first year  
5                   that are more than 200 percent of subse-  
6                   quent year commissions.

7                   “(iii) The payment of extra bonuses  
8                   or incentives (such as trips, gifts, and  
9                   other non-commission cash payments).

10                  “(C) AGENT DISCLOSURE.—In developing  
11                  the model regulations, the NAIC shall consider  
12                  requiring agents and brokers to disclose com-  
13                  missions to a beneficiary upon request of the  
14                  beneficiary before enrollment.

15                  “(D) PREVENTION OF FRAUD.—The model  
16                  regulations shall consider the opportunity for  
17                  fraud and abuse and beneficiary steering in set-  
18                  ting standards under this paragraph and shall  
19                  provide for the ability of State commissioners to  
20                  investigate commission structures.

21                  “(6) MARKET CONDUCT.—

22                  “(A) IN GENERAL.—The model regulations  
23                  shall establish standards for the market con-  
24                  duct of organizations offering Medicare private  
25                  plans, and of agents and brokers selling such

1 plans, and for State review of plan market con-  
2 duct.

3 “(B) MATTERS TO BE INCLUDED.—Such  
4 standards shall include standards for—

5 “(i) timely payment of claims;

6 “(ii) beneficiary complaint reporting  
7 and disclosure; and

8 “(iii) State reporting of market con-  
9 duct violations and sanctions.

10 “(7) IMPLEMENTATION.—

11 “(A) PUBLICATION OF NAIC MODEL REGU-  
12 LATIONS.—If the model regulations are sub-  
13 mitted on a timely basis under paragraph (1)—

14 “(i) the Secretary shall publish them  
15 in the Federal Register upon receipt and  
16 request public comment on the issue of  
17 whether such regulations are consistent  
18 with the requirements established in this  
19 subsection for such regulations;

20 “(ii) not later than 6 months after the  
21 date of such publication, the Secretary  
22 shall determine whether such regulations  
23 are so consistent with such requirements  
24 and shall publish notice of such determina-  
25 tion in the Federal Register;

1           “(iii) if the Secretary makes the de-  
2           termination under clause (ii) that such reg-  
3           ulations are consistent with such require-  
4           ments, in the notice published under clause  
5           (ii) the Secretary shall publish notice of  
6           adoption of such model regulations as con-  
7           stituting the marketing and enrollment  
8           standards adopted under this subsection to  
9           be applied under this title; and

10           “(iv) if the Secretary makes the deter-  
11           mination under such clause that such regu-  
12           lations are not consistent with such re-  
13           quirements, the procedures of clauses (ii)  
14           and (iii) of subparagraph (B) shall apply  
15           (in relation to the notice published under  
16           clause (ii)), in the same manner as such  
17           clauses would apply in the case of publica-  
18           tion of a notice under subparagraph (B)(i).

19           “(B) NO MODEL REGULATIONS.—If the  
20           model regulations are not submitted on a timely  
21           basis under paragraph (1)—

22           “(i) the Secretary shall publish notice  
23           of such fact in the Federal Register;

24           “(ii) not later than 6 months after the  
25           date of publication of such notice, the Sec-

1           retary shall propose regulations that pro-  
2           vide for marketing and enrollment stand-  
3           ards that incorporate the requirements of  
4           this subsection for the model regulations  
5           and request public comments on such pro-  
6           posed regulations; and

7                   “(iii) not later than 6 months after  
8           the date of publication of such proposed  
9           regulations, the Secretary shall publish  
10          final regulations that shall constitute the  
11          marketing and enrollment standards  
12          adopted under this subsection to be applied  
13          under this title.

14                   “(C) REFERENCES TO MARKETING AND  
15          ENROLLMENT STANDARDS.—In this title, a ref-  
16          erence to marketing and enrollment standards  
17          adopted under this subsection is deemed a ref-  
18          erence to the regulations constituting such  
19          standards adopted under subparagraph (A) or  
20          (B), as the case may be.

21                   “(D) EFFECTIVE DATE OF STANDARDS.—  
22          In order to provide for the orderly and timely  
23          implementation of marketing and enrollment  
24          standards adopted under this subsection, the  
25          Secretary, in consultation with the NAIC, shall

1 specify (by program instruction or otherwise)  
2 effective dates with respect to all components of  
3 such standards consistent with the following:

4 “(i) In the case of components that  
5 relate predominantly to operations in rela-  
6 tion to Medicare private plans, the effective  
7 date shall be for plan years beginning on  
8 or after such date (not later than 1 year  
9 after the date of promulgation of the  
10 standards) as the Secretary specifies.

11 “(ii) In the case of other components,  
12 the effective date shall be such date, not  
13 later than 1 year after the date of promul-  
14 gation of the standards, as the Secretary  
15 specifies.

16 “(E) CONSULTATION.— In promulgating  
17 marketing and enrollment standards under this  
18 paragraph, the NAIC or Secretary shall consult  
19 with a working group composed of representa-  
20 tives of issuers of Medicare private plans, con-  
21 sumer groups, medicare beneficiaries, State  
22 Health Insurance Assistance Programs, and  
23 other qualified individuals. Such representatives  
24 shall be selected in a manner so as to assure

1 balanced representation among the interested  
2 groups.

3 “(8) ENFORCEMENT.—

4 “(A) IN GENERAL.—Any Medicare private  
5 plan that violates marketing and enrollment  
6 standards is subject to sanctions under section  
7 1857(g).

8 “(B) STATE RESPONSIBILITIES.—Nothing  
9 in this subsection or section 1857(g) shall pro-  
10 hibit States from imposing sanctions against  
11 Medicare private plans, agents, or brokers for  
12 violations of the marketing and enrollment  
13 standards adopted under section 1852(m).  
14 States shall have the sole authority to regulate  
15 agents and brokers.

16 “(9) MEDICARE PRIVATE PLAN DEFINED.—In  
17 this subsection, the term ‘Medicare private plan’  
18 means a Medicare Part C plan and a prescription  
19 drug plan under part D.”.

20 (b) EXPANSION OF EXCEPTION TO PREEMPTION OF  
21 STATE ROLE.—

22 (1) IN GENERAL.—Section 1856(b)(3) of the  
23 Social Security Act (42 U.S.C. 1395w–26(b)(3)) is  
24 amended by striking “(other than State licensing  
25 laws or State laws relating to plan solvency)” and



1 inserting “(other than State laws relating to licens-  
2 ing or plan solvency and State laws or regulations  
3 adopting the marketing and enrollment standards  
4 adopted under section 1852(m))”.

5 (2) EFFECTIVE DATE.—The amendment made  
6 by paragraph (1) shall apply to plans offered on or  
7 after July 1, 2008.

8 (c) APPLICATION TO PRESCRIPTION DRUG PLANS.—

9 (1) IN GENERAL.—Section 1860D–1 of such  
10 Act is amended by adding at the end the following  
11 new subsection:

12 “(d) APPLICATION OF MARKETING AND ENROLL-  
13 MENT STANDARDS.—The marketing and enrollment  
14 standards adopted under section 1852(m) shall apply to  
15 prescription drug plans (and sponsors of such plans) in  
16 the same manner as they apply to Medicare Part C plans  
17 and organizations offering such plans.”.

18 (2) REFERENCE TO CURRENT LAW PROVI-  
19 SIONS.—The amendment made by subsection (a)  
20 and (b) apply, pursuant to section 1860D–  
21 1(b)(1)(B)(ii) of the Social Security Act (42 U.S.C.  
22 1395w–101(b)(1)(B)(ii)), to prescription drug plans  
23 under part D of title XVIII of such Act.

24 (d) CONTRACT REQUIREMENT TO MEET MARKETING  
25 AND ADVERTISING STANDARDS.—

1           (1) IN GENERAL.—Section 1857(d) of the So-  
2           cial Security Act (42 U.S.C. 1395w–27(d)), as  
3           amended by subsection (b)(1), is further amended by  
4           adding at the end the following new paragraph:

5           “(7) MARKETING AND ADVERTISING STAND-  
6           ARDS.—The contract shall require the organization  
7           to meet all standards adopted under section  
8           1852(m) (including those enforced by the State in-  
9           volved pursuant to section 1856(b)(3)) relating to  
10          marketing and advertising conduct.”.

11          (2) EFFECTIVE DATE.—The amendment made  
12          by paragraph (1) shall apply to contracts for plan  
13          years beginning on or after January 1, 2011.

14          (e) APPLICATION OF SANCTIONS.—

15          (1) APPLICATION TO VIOLATION OF MARKETING  
16          AND ENROLLMENT STANDARDS.—Section  
17          1857(g)(1) of such Act (42 U.S.C. 1395w–27(g)(1)),  
18          as amended by the preceding provisions of this Act,  
19          is further amended—

20                  (A) by striking “and” at the end of sub-  
21                  paragraph (G);

22                  (B) by adding “and” at the end of sub-  
23                  paragraph (H); and

24                  (C) by inserting after subparagraph (H)  
25                  the following new subparagraph:

1           “(I) violates marketing and enrollment  
2 standards adopted under section 1852(m);”.

3           (2) ENHANCED CIVIL MONEY SANCTIONS.—

4           Such section is further amended—

5           (A) in paragraph (2)(A), by striking  
6 “\$25,000”, “\$100,000”, and “\$15,000” and  
7 inserting “\$50,000”, “\$200,000”, and  
8 “\$30,000”, respectively; and

9           (B) in subparagraphs (A), (B), and (D) of  
10 paragraph (3), by striking “\$25,000”,  
11 “\$10,000”, and “\$100,000”, respectively, and  
12 inserting “\$50,000”, “\$20,000”, and  
13 “\$200,000”, respectively.

14           (3) EFFECTIVE DATE.—The amendments made  
15 by paragraph (2) shall apply to violations occurring  
16 on or after the date of the enactment of this Act.

17           (f) DISCLOSURE OF MARKET AND ADVERTISING  
18 CONTRACT VIOLATIONS AND IMPOSED SANCTIONS.—Sec-  
19 tion 1857 of such Act is amended by adding at the end  
20 the following new subsection:

21           “(j) DISCLOSURE OF MARKET AND ADVERTISING  
22 CONTRACT VIOLATIONS AND IMPOSED SANCTIONS.—For  
23 years beginning with 2009, the Secretary shall post on its  
24 public website for the Medicare program an annual report  
25 that—

1           “(1) lists each MA organization for which the  
2           Secretary made during the year a determination  
3           under subsection (c)(2) the basis of which is de-  
4           scribed in paragraph (1)(E); and

5           “(2) that describes any applicable sanctions  
6           under subsection (g) applied to such organization  
7           pursuant to such determination.”.

8           (g) STANDARD DEFINITIONS OF BENEFITS AND  
9           FORMATS FOR USE IN MARKETING MATERIALS.—Section  
10          1851(h) of such Act (42 U.S.C. 1395w–21(h)) is amended  
11          by adding at the end the following new paragraph:

12           “(6) STANDARD DEFINITIONS OF BENEFITS  
13           AND FORMATS FOR USE IN MARKETING MATE-  
14           RIALS.—

15           “(A) IN GENERAL.—Not later than Janu-  
16           ary 1, 2010, the Secretary, in consultation with  
17           the National Association of Insurance Commis-  
18           sioners and a working group of the type de-  
19           scribed in section 1852(m)(7)(E), shall develop  
20           standard descriptions and definitions for bene-  
21           fits under this title for use in marketing mate-  
22           rial distributed by Medicare Part C organiza-  
23           tions and formats for including such descrip-  
24           tions in such marketing material.

1           “(B) REQUIRED USE OF STANDARD DEFINITIONS.— For plan years beginning on or  
2           after January 1, 2011, the Secretary shall dis-  
3           approve the distribution of marketing material  
4           under paragraph (1)(B) if such marketing ma-  
5           terial does not use, without modification, the  
6           applicable descriptions and formats specified  
7           under subparagraph (A).”

9           (h) SUPPORT FOR STATE HEALTH INSURANCE AS-  
10          SISTANCE PROGRAMS (SHIPS).—Section 1857(e)(2) of  
11          the Social Security Act (42 U.S.C. 1395w–27(e)(2)) is  
12          amended—

13                 (1) in subparagraph (B), by adding at the end  
14                 the following: “Of the amounts so collected, no less  
15                 than \$55,000,000 for fiscal year 2009, \$65,000,000  
16                 for fiscal year 2010, \$75,000,000 for fiscal year  
17                 2011, and \$85,000,000 for fiscal year 2012 and  
18                 each succeeding fiscal year shall be used to support  
19                 Medicare Part C and Part D counseling and assist-  
20                 ance provided by State Health Insurance Assistance  
21                 Programs.”;

22                 (2) in subparagraph (C)—

23                         (A) by striking “and” after  
24                         “\$100,000,000,”; and

1 (B) by striking “an amount equal to  
2 \$200,000,000” and inserting “and ending with  
3 fiscal year 2008 an amount equal to  
4 \$200,000,000, for fiscal year 2009 an amount  
5 equal to \$255,000,000, for fiscal year 2010 an  
6 amount equal to \$265,000,000, for fiscal year  
7 2011 an amount equal to \$275,000,000, and  
8 for fiscal year 2012 and each succeeding fiscal  
9 year an amount equal to \$285,000,000”; and

10 (3) in subparagraph (D)(ii)—

11 (A) by striking “and” at the end of sub-  
12 clause (IV);

13 (B) in subclause (V), by striking the period  
14 at the end and inserting “before fiscal year  
15 2009; and”; and

16 (C) by adding at the end the following new  
17 subclause:

18 “(VI) for fiscal year 2009 and each  
19 succeeding fiscal year the applicable por-  
20 tion (as so defined) of the amount specified  
21 in subparagraph (C) for that fiscal year.”.

22 **SEC. 412. LIMITATION ON OUT-OF-POCKET COSTS FOR INDI-**  
23 **VIDUAL HEALTH SERVICES.**

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

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

6           (2) in subparagraph (B)(i), by striking “or an  
7 actuarially equivalent level of cost-sharing as deter-  
8 mined in this part”; and

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

11                   “(ii) PERMITTING USE OF FLAT CO-  
12 PAYMENT OR PER DIEM RATE.—Nothing in  
13 clause (i) shall be construed as prohibiting  
14 a Medicare part C plan from using a flat  
15 copayment or per diem rate, in lieu of the  
16 cost-sharing that would be imposed under  
17 part A or B, so long as the amount of the  
18 cost-sharing imposed does not exceed the  
19 amount of the cost-sharing that would be  
20 imposed under the respective part if the in-  
21 dividual were not enrolled in a plan under  
22 this part.”.

23           (b) LIMITATION FOR DUAL ELIGIBLES AND QUALI-  
24 FIED MEDICARE BENEFICIARIES.—Section 1852(a) of

1 such Act is amended by adding at the end the following  
2 new paragraph:

3           “(7) LIMITATION ON COST-SHARING FOR DUAL  
4           ELIGIBLES AND QUALIFIED MEDICARE BENE-  
5           FICIARIES.—In the case of a individual who is a full-  
6           benefit dual eligible individual (as defined in section  
7           1935(e)(6)) or a qualified medicare beneficiary (as  
8           defined in section 1905(p)(1)) who is enrolled in a  
9           Medicare Part C plan, the plan may not impose  
10          cost-sharing that exceeds the amount of cost-sharing  
11          that would be permitted with respect to the indi-  
12          vidual under this title and title XIX if the individual  
13          were not enrolled with such plan.”.

14          (c) EFFECTIVE DATES.—

15               (1) The amendments made by subsection (a)  
16               shall apply to plan years beginning on or after Janu-  
17               ary 1, 2009.

18               (2) The amendments made by subsection (b)  
19               shall apply to plan years beginning on or after Janu-  
20               ary 1, 2008.

21 **SEC. 413. MA PLAN ENROLLMENT MODIFICATIONS.**

22          (a)           IMPROVED           PLAN           ENROLLMENT,  
23          DISENROLLMENT, AND CHANGE OF ENROLLMENT.—

24               (1) CONTINUOUS OPEN ENROLLMENT FOR  
25               FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS AND



1 QUALIFIED MEDICARE BENEFICIARIES (QMB).—Sec-  
2 tion 1851(e)(2)(D) of the Social Security Act (42  
3 U.S.C. 1395w–21(e)(2)(D)) is amended—

4 (A) in the heading, by inserting “, FULL-  
5 BENEFIT DUAL ELIGIBLE INDIVIDUALS, AND  
6 QUALIFIED MEDICARE BENEFICIARIES” after  
7 “INSTITUTIONALIZED INDIVIDUALS”;

8 (B) in the matter before clause (i), by in-  
9 serting “, a full-benefit dual eligible individual  
10 (as defined in section 1935(c)(6)), or a quali-  
11 fied medicare beneficiary (as defined in section  
12 1905(p)(1))” after “institutionalized (as defined  
13 by the Secretary)”; and

14 (C) in clause (i), by inserting “or  
15 disenroll” after “enroll”.

16 (2) SPECIAL ELECTION PERIODS FOR ADDI-  
17 TIONAL CATEGORIES OF INDIVIDUALS.—Section  
18 1851(e)(4) of such Act (42 U.S.C. 1395w(e)(4)) is  
19 amended—

20 (A) in subparagraph (C), by striking at the  
21 end “or”;

22 (B) in subparagraph (D), by inserting “,  
23 taking into account the health or well-being of  
24 the individual” before the period and redesign-

1 nating such subparagraph as subparagraph (F);  
2 and

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

5 “(D) the individual is described in section  
6 1902(a)(10)(E)(iii) (relating to specified low-in-  
7 come medicare beneficiaries);

8 “(E) the individual is enrolled in an MA  
9 plan and enrollment in the plan is suspended  
10 under paragraph (2)(B) or (3)(C) of section  
11 1857(g) because of a failure of the plan to meet  
12 applicable requirements; or”.

13 (3) EFFECTIVE DATE.—The amendments made  
14 by this subsection shall take effect on the date of the  
15 enactment of this Act.

16 (b) ACCESS TO MEDIGAP COVERAGE FOR INDIVID-  
17 UALS WHO LEAVE MA PLANS.—

18 (1) IN GENERAL.—Section 1882(s)(3) of the  
19 Social Security Act (42 U.S.C. 1395ss(s)(3)) is  
20 amended—

21 (A) in each of clauses (v)(III) and (vi) of  
22 subparagraph (B), by striking “12 months”  
23 and inserting “24 months”; and

1           (B) in each of subclauses (I) and (II) of  
2           subparagraph (F)(i), by striking “12 months”  
3           and inserting “24 months”.

4           (2) EFFECTIVE DATE.—The amendments made  
5           by paragraph (1) shall apply to terminations of en-  
6           rollments in MA plans occurring on or after the date  
7           of the enactment of this Act.

8           (c) IMPROVED ENROLLMENT POLICIES.—

9           (1) NO AUTO-ENROLLMENT OF MEDICAID  
10          BENEFICIARIES.—

11           (A) IN GENERAL.—Section 1851(e) of such  
12          Act (42 U.S.C. 1395w–21(e)) is amended by  
13          adding at the end the following new paragraph:

14          “(7) NO AUTO-ENROLLMENT OF MEDICAID  
15          BENEFICIARIES.—In no case may the Secretary pro-  
16          vide for the enrollment in a MA plan of a Medicare  
17          Advantage eligible individual who is eligible to re-  
18          ceive medical assistance under title XIX as a full-  
19          benefit dual eligible individual or a qualified medi-  
20          care beneficiary, without the affirmative application  
21          of such individual (or authorized representative of  
22          the individual) to be enrolled in such plan.”.

23           (B) NO APPLICATION TO PRESCRIPTION  
24          DRUG PLANS.—Section 1860D–1(b)(1)(B)(iii)

1 of such Act (42 U.S.C. 1395w-  
2 101(b)(1)(B)(iii)) is amended—

3 (i) by striking “paragraph (2) and”  
4 and by inserting “paragraph (2),”; and

5 (ii) by inserting “, and paragraph  
6 (7),” after “paragraph (4)”.

7 (C) EFFECTIVE DATE.—The amendments  
8 made by this paragraph shall apply to enroll-  
9 ments that are effective on or after the date of  
10 the enactment of this Act.

11 **SEC. 414. INFORMATION FOR BENEFICIARIES ON MA PLAN**  
12 **ADMINISTRATIVE COSTS.**

13 (a) DISCLOSURE OF MEDICAL LOSS RATIOS AND  
14 OTHER EXPENSE DATA.—Section 1851 of the Social Se-  
15 curity Act (42 U.S.C. 1395w-21) is amended by adding  
16 at the end the following new subsection:

17 “(j) PUBLICATION OF MEDICAL LOSS RATIOS AND  
18 OTHER COST-RELATED INFORMATION.—

19 “(1) IN GENERAL.—The Secretary shall pub-  
20 lish, not later than October 1 of each year (begin-  
21 ning with 2009), for each Medicare Part C plan con-  
22 tract, the following:

23 “(A) The medical loss ratio of the plan in  
24 the previous year.

1           “(B) The per enrollee payment under this  
2 part to the plan, as adjusted to reflect a risk  
3 score (based on factors described in section  
4 1853(a)(1)(C)(i)) of 1.0.

5           “(C) The average risk score (as so based).

6           “(2) SUBMISSION OF DATA.—

7           “(A) IN GENERAL.—Each Medicare Part C  
8 organization shall submit to the Secretary, in a  
9 form and manner specified by the Secretary,  
10 data necessary for the Secretary to publish the  
11 information described in paragraph (1) on a  
12 timely basis, including the information de-  
13 scribed in paragraph (3).

14           “(B) DATA FOR 2008 AND 2009.—The data  
15 submitted under subparagraph (A) for 2008  
16 and for 2009 shall be consistent in content with  
17 the data reported as part of the Medicare Part  
18 C plan bid in June 2007 for 2008.

19           “(C) MEDICAL LOSS RATIO DATA.—The  
20 data to be submitted under subparagraph (A)  
21 relating to medical loss ratio for a year—

22                   “(i) shall be submitted not later than  
23 June 1 of the following year; and

24                   “(ii) beginning with 2010, shall be  
25 submitted based on the standardized ele-

1           ments and definitions developed under  
2           paragraph (4).

3           “(D) AUDITED DATA.—Data submitted  
4           under this paragraph shall be data that has  
5           been audited by an independent third party  
6           auditor.

7           “(3) MLR INFORMATION.—The information de-  
8           scribed in this paragraph with respect to a Medicare  
9           Part C plan for a year is as follows:

10           “(A) The costs for the plan in the previous  
11           year for each of the following:

12           “(i) Total medical expenses, sepa-  
13           rately indicated for benefits for the original  
14           medicare fee-for-service program option  
15           and for supplemental benefits.

16           “(ii) Non-medical expenses, shown  
17           separately for each of the following cat-  
18           egories of expenses:

19           “(I) Marketing and sales.

20           “(II) Direct administration.

21           “(III) Indirect administration.

22           “(IV) Net cost of private reinsur-  
23           ance.

24           “(B) Gain or loss margin.

1           “(C) Total revenue requirement, computed  
2           as the total of medical and nonmedical expenses  
3           and gain or loss margin, multiplied by the gain  
4           or loss margin.

5           “(D) Percent of revenue ratio, computed  
6           as the total revenue requirement expressed as a  
7           percentage of revenue.

8           “(4) DEVELOPMENT OF DATA REPORTING  
9           STANDARDS.—

10           “(A) IN GENERAL.—The Secretary shall  
11           develop and implement standardized data ele-  
12           ments and definitions for reporting under this  
13           subsection, for contract years beginning with  
14           2010, of data necessary for the calculation of  
15           the medical loss ratio for Medicare Part C  
16           plans. Not later than December 31, 2008, the  
17           Secretary shall publish a report describing the  
18           elements and definitions so developed.

19           “(B) CONSULTATION.—The Secretary  
20           shall consult with representatives of Medicare  
21           Part C organizations, experts on health plan ac-  
22           counting systems, and representatives of the  
23           National Association of Insurance Commis-  
24           sioners, in the development of such data ele-  
25           ments and definitions.

1           “(5) MEDICAL LOSS RATIO DEFINED.—For  
2 purposes of this part, the term ‘medical loss ratio’  
3 means, with respect to an MA plan for a year, the  
4 ratio of—

5                   “(A) the aggregate benefits (excluding  
6 nonmedical expenses described in paragraph  
7 (3)(A)(ii)) paid under the plan for the year, to

8                   “(B) the aggregate amount of premiums  
9 (including basic and supplemental beneficiary  
10 premiums) and payments made under sections  
11 1853 and 1860D–15) collected for the plan and  
12 year.

13 Such ratio shall be computed without regard to  
14 whether the benefits or premiums are for required or  
15 supplemental benefits under the plan.”.

16 (b) AUDIT OF ADMINISTRATIVE COSTS AND COMPLI-  
17 ANCE WITH THE FEDERAL ACQUISITION REGULATION.—

18           (1) IN GENERAL.—Section 1857(d)(2)(B) of  
19 such Act (42 U.S.C. 1395w–27(d)(2)(B)) is amend-  
20 ed—

21                   (A) by striking “or (ii)” and inserting  
22 “(ii)”; and

23                   (B) by inserting before the period at the  
24 end the following: “, or (iii) to compliance with  
25 the requirements of subsection (e)(4) and the



1 extent to which administrative costs comply  
2 with the applicable requirements for such costs  
3 under the Federal Acquisition Regulation”.

4 (2) EFFECTIVE DATE.—The amendments made  
5 by this subsection shall apply for contract years be-  
6 ginning after the date of the enactment of this Act.

7 (c) MINIMUM MEDICAL LOSS RATIO.—Section  
8 1857(e) of the Social Security Act (42 U.S.C. 1395w-  
9 27(e)) is amended by adding at the end the following new  
10 paragraph:

11 “(4) REQUIREMENT FOR MINIMUM MEDICAL  
12 LOSS RATIO.—If the Secretary determines for a con-  
13 tract year (beginning with 2010) that an MA plan  
14 has failed to have a medical loss ratio (as defined in  
15 section 1851(j)(4)) of at least .85—

16 “(A) for that contract year, the Secretary  
17 shall reduce the blended benchmark amount  
18 under subsection (l) for the second succeeding  
19 contract year by the number of percentage  
20 points by which such loss ratio was less than 85  
21 percent;

22 “(B) for 3 consecutive contract years, the  
23 Secretary shall not permit the enrollment of  
24 new enrollees under the plan for coverage dur-  
25 ing the second succeeding contract year; and

1           “(C) the Secretary shall terminate the plan  
2           contract if the plan fails to have such a medical  
3           loss ratio for 5 consecutive contract years.”.

4           (d) INFORMATION ON MEDICARE PART C PLAN EN-  
5 ROLLMENT AND SERVICES.—Section 1851 of such Act, as  
6 amended by subsection (a), is further amended by adding  
7 at the end the following new subsection:

8           “(k) PUBLICATION OF ENROLLMENT AND OTHER IN-  
9 FORMATION.—

10           “(1) MONTHLY PUBLICATION OF PLAN-SPE-  
11 CIFIC ENROLLMENT DATA.—The Secretary shall  
12 publish (on the public website of the Centers for  
13 Medicare & Medicaid Services or otherwise) not later  
14 than 30 days after the end of each month (beginning  
15 with January 2008) on the actual enrollment in each  
16 Medicare Part C plan by contract and by county.

17           “(2) AVAILABILITY OF OTHER INFORMATION.—  
18 The Secretary shall make publicly available data and  
19 other information in a format that may be readily  
20 used for analysis of the Medicare Part C program  
21 under this part and will contribute to the under-  
22 standing of the organization and operation of such  
23 program.”.

24           (e) MEDPAC REPORT ON VARYING MINIMUM MED-  
25 ICAL LOSS RATIOS.—

1           (1) STUDY.—The Medicare Payment Advisory  
2 Commission shall conduct a study of the need and  
3 feasibility of providing for different minimum med-  
4 ical loss ratios for different types of Medicare Part  
5 C plans, including coordinated care plans, group  
6 model plans, coordinated care independent practice  
7 association plans, preferred provider organization  
8 plans, and private fee-for-services plans.

9           (2) REPORT.—Not later than 1 year after the  
10 date of the enactment of this Act, submit to Con-  
11 gress a report on the study conducted under para-  
12 graph (1).

## 13           **Subtitle C—Quality and Other** 14           **Provisions**

### 15   **SEC. 421. REQUIRING ALL MA PLANS TO MEET EQUAL** 16           **STANDARDS.**

17           (a) COLLECTION AND REPORTING OF INFORMA-  
18 TION.—

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

23           (2) REPORTING FOR PRIVATE FEE-FOR-SERV-  
24 ICES AND MSA PLANS.—Section 1852(e)(3) of such

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

3 “(C) DATA COLLECTION REQUIREMENTS  
4 BY PRIVATE FEE-FOR-SERVICE PLANS AND MSA  
5 PLANS.—

6 “(i) USING MEASURES FOR PPOS FOR  
7 CONTRACT YEAR 2009.—For contract year  
8 2009, the Medicare Part C organization of-  
9 fering a private fee-for-service plan or an  
10 MSA plan shall submit to the Secretary for  
11 such plan the same information on the  
12 same performance measures for which such  
13 information is required to be submitted for  
14 Medicare Part C plans that are preferred  
15 provider organization plans for that year.

16 “(ii) APPLICATION OF SAME MEAS-  
17 URES AS COORDINATED CARE PLANS BE-  
18 GINNING IN CONTRACT YEAR 2010.—For a  
19 contract year beginning with 2010, a Medi-  
20 care Part C organization offering a private  
21 fee-for-service plan or an MSA plan shall  
22 submit to the Secretary for such plan the  
23 same information on the same performance  
24 measures for which such information is re-  
25 quired to be submitted for such contract

1           year Medicare Part C plans described in  
2           section 1851(a)(2)(A)(i) for contract year  
3           such contract year.”.

4           (3) EFFECTIVE DATE.—The amendment made  
5           by paragraph (1) shall apply to contract years begin-  
6           ning on or after January 1, 2009.

7           (b) EMPLOYER PLANS.—

8           (1) IN GENERAL.—The first sentence of para-  
9           graph (2) of section 1857(i) of such Act (42 U.S.C.  
10          1395w–27(i)) is amended by inserting before the pe-  
11          riod at the end the following: “, but only if 90 per-  
12          cent of the Medicare part C eligible individuals en-  
13          rolled under such plan reside in a county in which  
14          the Medicare Part C organization offers a Medicare  
15          Part C local plan”.

16          (2) LIMITATION ON APPLICATION OF WAIVER  
17          AUTHORITY.—Paragraphs (1) and (2) of such sec-  
18          tion are each amended by inserting “that were in ef-  
19          fect before the date of the enactment of the Chil-  
20          dren’s Health and Medicare Protection Act of 2007”  
21          after “waive or modify requirements”.

22          (3) EFFECTIVE DATES.—The amendment made  
23          by paragraph (1) shall apply for plan years begin-  
24          ning on or after January 1, 2009, and the amend-

1       ments made by paragraph (2) shall take effect on  
2       the date of the enactment of this Act.

3 **SEC. 422. DEVELOPMENT OF NEW QUALITY REPORTING**  
4       **MEASURES ON RACIAL DISPARITIES.**

5       (a) NEW QUALITY REPORTING MEASURES.—

6           (1) IN GENERAL.—Section 1852(e)(3) of the  
7       Social Security Act (42 U.S.C. 1395w-22(e)(3)), as  
8       amended by section 421(a)(2), is amended—

9           (A) in subparagraph (B)—

10               (i) in clause (i), by striking “The Sec-  
11               retary” and inserting “Subject to subpara-  
12               graph (D), the Secretary”; and

13               (ii) in clause (ii), by striking “sub-  
14               clause (iii)” and inserting “clause (iii) and  
15               subparagraph (C)”; and

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

18               “(D) ADDITIONAL QUALITY REPORTING  
19       MEASURES.—

20               “(i) IN GENERAL.—The Secretary  
21               shall develop by October 1, 2009, quality  
22               measures for Medicare Part C plans that  
23               measure disparities in the amount and  
24               quality of health services provided to racial  
25               and ethnic minorities.

1                   “(ii) DATA TO MEASURE RACIAL AND  
2                   ETHNIC DISPARITIES IN THE AMOUNT AND  
3                   QUALITY OF CARE PROVIDED TO ENROLL-  
4                   EES.—The Secretary shall provide for  
5                   Medicare Part C organizations to submit  
6                   data under this paragraph, including data  
7                   similar to those submitted for other quality  
8                   measures, that permits analysis of dispari-  
9                   ties among racial and ethnic minorities in  
10                  health services, quality of care, and health  
11                  status among Medicare Part C plan enroll-  
12                  ees for use in submitting the reports under  
13                  paragraph (5).”.

14                  (2) EFFECTIVE DATE.—The amendments made  
15                  by this subsection shall apply to reporting of quality  
16                  measures for plan years beginning on or after Janu-  
17                  ary 1, 2010.

18                  (b) BIENNIAL REPORT ON RACIAL AND ETHNIC MI-  
19                  NORITIES.—Section 1852(e) of such Act (42 U.S.C.  
20                  1395w–22(e)) is amended by adding at the end the fol-  
21                  lowing new paragraph:

22                         “(5) REPORT TO CONGRESS.—

23                                 “(A) IN GENERAL.—Not later than 2 years  
24                                 after the date of the enactment of this para-  
25                                 graph, and biennially thereafter, the Secretary

1 shall submit to Congress a report regarding  
2 how quality assurance programs conducted  
3 under this subsection measure and report on  
4 disparities in the amount and quality of health  
5 care services furnished to racial and ethnic mi-  
6 norities.

7 “(B) CONTENTS OF REPORT.—Each such  
8 report shall include the following:

9 “(i) A description of the means by  
10 which such programs focus on such racial  
11 and ethnic minorities.

12 “(ii) An evaluation of the impact of  
13 such programs on eliminating health dis-  
14 parities and on improving health outcomes,  
15 continuity and coordination of care, man-  
16 agement of chronic conditions, and con-  
17 sumer satisfaction.

18 “(iii) Recommendations on ways to re-  
19 duce clinical outcome disparities among ra-  
20 cial and ethnic minorities.

21 “(iv) Data for each MA plan from  
22 HEDIS and other source reporting the dis-  
23 parities in the amount and quality of  
24 health services furnished to racial and eth-  
25 nic minorities.”.



1 **SEC. 423. STRENGTHENING AUDIT AUTHORITY.**

2 (a) FOR PART C PAYMENTS RISK ADJUSTMENT.—  
3 Section 1857(d)(1) of the Social Security Act (42 U.S.C.  
4 1395w–27(d)(1)) is amended by inserting after “section  
5 1858(c)” the following: “, and data submitted with re-  
6 spect to risk adjustment under section 1853(a)(3)”.

7 (b) ENFORCEMENT OF AUDITS AND DEFICI-  
8 CIENCIES.—

9 (1) IN GENERAL.—Section 1857(e) of such Act  
10 is amended by adding at the end the following new  
11 paragraph:

12 “(5) ENFORCEMENT OF AUDITS AND DEFICI-  
13 CIENCIES.—

14 “(A) INFORMATION IN CONTRACT.—The  
15 Secretary shall require that each contract with  
16 a Medicare Part C organization under this sec-  
17 tion shall include terms that inform the organi-  
18 zation of the provisions in subsection (d).

19 “(B) ENFORCEMENT AUTHORITY.—The  
20 Secretary is authorized, in connection with con-  
21 ducting audits and other activities under sub-  
22 section (d), to take such actions, including pur-  
23 suit of financial recoveries, necessary to address  
24 deficiencies identified in such audits or other  
25 activities.”.

1           (2) APPLICATION UNDER PART D.—For provi-  
2           sion applying the amendment made by paragraph  
3           (1) to prescription drug plans under part D, see sec-  
4           tion 1860D–12(b)(3)(D) of the Social Security Act.

5           (c) EFFECTIVE DATE.—The amendments made by  
6           this section shall take effect the date of the enactment  
7           of this Act and shall apply to audits and activities con-  
8           ducted for contract years beginning on or after January  
9           1, 2009.

10 **SEC. 424. IMPROVING RISK ADJUSTMENT FOR MA PAY-**  
11 **MENTS.**

12           (a) IN GENERAL.—Not later than 1 year after the  
13           date of the enactment of this Act, the Secretary of Health  
14           and Human Services shall submit to Congress a report  
15           that evaluates the adequacy of the Medicare Advantage  
16           risk adjustment system under section 1853(a)(1)(C) of the  
17           Social Security Act (42 U.S.C. 1395–23(a)(1)(C)).

18           (b) PARTICULARS.—The report under subsection (a)  
19           shall include an evaluation of at least the following:

20                   (1) The need and feasibility of improving the  
21                   adequacy of the risk adjustment system in predicting  
22                   costs for beneficiaries with co-morbid conditions and  
23                   associated cognitive impairments.

1           (2) The need and feasibility of including further  
2           gradations of diseases and conditions (such as the  
3           degree of severity of congestive heart failure).

4           (3) The feasibility of measuring difference in  
5           coding over time between Medicare part C plans and  
6           the medicare traditional fee-for-service program and,  
7           to the extent this difference exists, the options for  
8           addressing it.

9           (4) The feasibility and value of including part  
10          D and other drug utilization data in the risk adjust-  
11          ment model.

12 **SEC. 425. ELIMINATING SPECIAL TREATMENT OF PRIVATE**  
13 **FEE-FOR-SERVICE PLANS.**

14          (a) **ELIMINATION OF EXTRA BILLING PROVISION.**—  
15 Section 1852(k)(2) of the Social Security Act (42 U.S.C.  
16 1395w–22(k)(2)) is amended—

17           (1) in subparagraph (A)(i), by striking “115  
18           percent” and inserting “100 percent”; and

19           (2) in subparagraph (C)(i), by striking “includ-  
20           ing any liability for balance billing consistent with  
21           this subsection”).

22          (b) **REVIEW OF BID INFORMATION.**—Section  
23 1854(a)(6)(B) of such Act (42 U.S.C. 1395w–  
24 24(a)(6)(B)) is amended—

1           (1) in clause (i), by striking “clauses (iii) and  
2           (iv)” and inserting “clause (iii)”; and

3           (2) by striking clause (iv).

4           (c) EFFECTIVE DATE.—The amendments made by  
5 this section shall apply to contract years beginning with  
6 2009.

7 **SEC. 426. RENAMING OF MEDICARE ADVANTAGE PROGRAM.**

8           (a) IN GENERAL.—The program under part C of title  
9 XVIII of the Social Security Act is henceforth to be known  
10 as the “Medicare Part C program”.

11          (b) CHANGE IN REFERENCES.—

12           (1) AMENDING SOCIAL SECURITY ACT.—The  
13 Social Security Act is amended by striking “Medi-  
14 care Advantage”, “MA”, and “Medicare+Choice”  
15 and inserting “Medicare Part C” each place it ap-  
16 pears, with the appropriate, respective typographic  
17 formatting, including typeface and capitalization.

18           (2) ADDITIONAL REFERENCES.—Notwith-  
19 standing section 201(b) of the Medicare Prescription  
20 Drug, Improvement, and Modernization Act of 2003  
21 (Public Law 108–173), any reference to the pro-  
22 gram under part C of title XVIII of the Social Secu-  
23 rity Act shall be deemed a reference to the “Medi-  
24 care Part C” program and, with respect to such  
25 part, any reference to “Medicare+Choice”. “Medi-

1 care Advantage”, or “MA” is deemed a reference to  
2 the program under such part.

### 3 **Subtitle D—Extension of** 4 **Authorities**

#### 5 **SEC. 431. EXTENSION AND REVISION OF AUTHORITY FOR** 6 **SPECIAL NEEDS PLANS (SNPS).**

7 (a) EXTENDING RESTRICTION ON ENROLLMENT AU-  
8 THORITY FOR SNPS FOR 3 YEARS.—Subsection (f) of sec-  
9 tion 1859 of the Social Security Act (42 U.S.C. 1395w-  
10 28) is amended by striking “2009” and inserting “2012”.

11 (b) STRUCTURE OF AUTHORITY FOR SNPS.—

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

14 (A) in subsection (b)(6)(A), by striking all  
15 that follows “means” and inserting the fol-  
16 lowing: “an MA plan—

17 “(i) that serves special needs individ-  
18 uals (as defined in subparagraph (B));

19 “(ii) as of January 1, 2009—

20 “(I) at least 90 percent of the  
21 enrollees which are described in sub-  
22 paragraph (B)(i), as determined  
23 under regulations in effect as of July  
24 1, 2007;

1 “(II) at least 90 percent of the  
2 enrollees in which are described in  
3 subparagraph (B)(ii) and are full-ben-  
4 efit dual eligible individuals (as de-  
5 fined in section 1935(c)(6)) or quali-  
6 fied medicare beneficiaries (as defined  
7 in section 1905(p)(1)); or

8 “(III) at least 90 percent of the  
9 enrollees in which have a severe or  
10 disabling chronic condition of the type  
11 that the plan is committed to serve as  
12 indicated by the data submitted for  
13 the risk-adjustment of plan payments;  
14 and

15 “(iii) as of January 1, 2009, meets  
16 the applicable requirements of paragraph  
17 (2) or (3) of subsection (f), as the case  
18 may be.”; and

19 (B) in subsection (f)—

20 (i) by amending the heading to read  
21 as follows: “REQUIREMENTS FOR ENROLL-  
22 MENT IN PART C PLANS FOR SPECIAL  
23 NEEDS BENEFICIARIES”;

24 (ii) by designating the sentence begin-  
25 ning “In the case of” as paragraph (1)

1 with the heading “REQUIREMENTS FOR  
2 ENROLLMENT.—” and with appropriate in-  
3 dentation; and

4 (iii) by adding at the end the fol-  
5 lowing new paragraphs:

6 “(2) ADDITIONAL REQUIREMENTS FOR INSTI-  
7 TUTIONAL SNPS.—In the case of a specialized MA  
8 plan for special needs individuals described in sub-  
9 section (b)(6)(A)(ii)(I), the applicable requirements  
10 of this subsection are as follows:

11 “(A) The plan has an agreement with the  
12 State that includes provisions regarding co-  
13 operation on the coordination of care for such  
14 individuals. Such agreement shall include a de-  
15 scription of the manner that the State Medicaid  
16 program under title XIX will pay for the costs  
17 of services for individuals eligible under such  
18 title for medical assistance for acute care and  
19 long-term care services.

20 “(B) The plan has a contract with long-  
21 term care facilities and other providers in the  
22 area sufficient to provide care for enrollees de-  
23 scribed in subsection (b)(6)(B)(i).

24 “(C) The plan reports to the Secretary in-  
25 formation on additional quality measures speci-

1           fied by the Secretary under section  
2           1852(e)(3)(D)(iv)(I) for such plans.

3           “(3) ADDITIONAL REQUIREMENTS FOR DUAL  
4           SNPS.—In the case of a specialized MA plan for spe-  
5           cial needs individuals described in subsection  
6           (b)(6)(A)(ii)(II), the applicable requirements of this  
7           subsection are as follows:

8                   “(A) The plan has an agreement with the  
9                   State Medicaid agency that—

10                           “(i) includes provisions regarding co-  
11                           operation on the coordination of the fi-  
12                           nancing of care for such individuals;

13                           “(ii) includes a description of the  
14                           manner that the State Medicaid program  
15                           under title XIX will pay for the costs of  
16                           cost-sharing and supplemental services for  
17                           individuals enrolled in the plan eligible  
18                           under such title for medical assistance for  
19                           acute and long-term care services; and

20                           “(iii) effective January 1, 2011, pro-  
21                           vides for capitation payments to cover  
22                           costs of supplemental benefits for individ-  
23                           uals described in subsection  
24                           (b)(6)(A)(ii)(II).



1           “(B) The out-of-pocket costs for services  
2           under parts A and B that are charged to enroll-  
3           ees may not exceed the out-of-pocket costs for  
4           same services permitted for such individuals  
5           under title XIX.

6           “(C) The plan reports to the Secretary in-  
7           formation on additional quality measures speci-  
8           fied by the Secretary under section  
9           1852(e)(3)(D)(iv)(II) for such plans.

10          “(4) ADDITIONAL REQUIREMENTS FOR SEVERE  
11          OR DISABLING CHRONIC CONDITION SNPS.—In the  
12          case of a specialized MA plan for special needs indi-  
13          viduals described in subsection (b)(6)(A)(ii)(III), the  
14          applicable requirements of this subsection are as fol-  
15          lows:

16                 “(A) The plan is designated to serve, and  
17                 serves, Medicare beneficiaries with one or more  
18                 of the following specific severe or disabling  
19                 chronic conditions:

20                         “(i) Cardiovascular.

21                         “(ii) Cerebrovascular.

22                         “(iii) Congestive health failure.

23                         “(iv) Diabetes.

24                         “(v) Chronic obstructive pulmonary  
25                         disease.

1 “(vi) HIV/AIDS.

2 “(B) The plan has an average risk score  
3 under section 1853(a)(1)(C) of 1.35 or greater.

4 “(C) The plan has established and actively  
5 manages a chronic care improvement program  
6 under section 1852(e)(2) for each of the condi-  
7 tions that it serves under subparagraph (A)  
8 that significantly exceeds the features and re-  
9 sults of such programs established and man-  
10 aged by Medicare Part C plans that are not  
11 specialized Medicare Part C plans for special  
12 needs individuals of the type described in this  
13 paragraph.

14 “(D) The plan has a network of a suffi-  
15 cient number of primary care and specialty phy-  
16 sicians, hospitals, and other health care pro-  
17 viders under contract to the plan so that the  
18 plan can clearly meet the routine and specialty  
19 needs of the severely ill and disabled enrollees  
20 of the plan throughout the service area of the  
21 plan.

22 “(E) The plan reports to the Secretary in-  
23 formation on additional quality measures speci-  
24 fied by the Secretary under section  
25 1852(e)(3)(D)(iv)(III) for such plans.”.

1           (2) QUALITY STANDARDS AND QUALITY RE-  
2           PORTING.—Section 1852(e)(3) of such Act (42  
3           U.S.C. 1395w–22(e)(3) is amended—

4           (A) in subparagraph (A)(i), by adding at  
5           the end the following: “In the case of a special-  
6           ized Medicare Part C plan for special needs in-  
7           dividuals described in paragraph (2), (3), or (4)  
8           of section 1859(f), the organization shall pro-  
9           vide for the reporting on quality measures de-  
10          veloped for the plan under subparagraph  
11          (D)(iii).”; and

12          (B) in subparagraph (D), as added by sec-  
13          tion 422(a)(1), by adding at the end the fol-  
14          lowing new clause:

15                 “(iii) SPECIFICATION OF ADDITIONAL  
16                 QUALITY MEASUREMENTS FOR SPECIAL-  
17                 IZED PART C PLANS.—For implementation  
18                 for plan years beginning not later than  
19                 January 1, 2010, the Secretary shall de-  
20                 velop new quality measures appropriate to  
21                 meeting the needs of—

22                         “(I) beneficiaries enrolled in spe-  
23                         cialized Medicare Part C plans for  
24                         special needs individuals (described in  
25                         section 1859(b)(6)(A)(ii)(I)) that

1 serve predominantly individuals who  
2 are dual-eligible individuals eligible for  
3 medical assistance under title XIX by  
4 measuring the special needs for care  
5 of individuals who are both Medicare  
6 and Medicaid beneficiaries;

7 “(II) beneficiaries enrolled in  
8 specialized Medicare Part C plans for  
9 special needs individuals (described in  
10 section 1859(b)(6)(A)(ii)(II)) that  
11 serve predominantly institutionalized  
12 individuals by measuring the special  
13 needs for care of individuals who are  
14 a resident in long-term care institu-  
15 tion; and

16 “(III) beneficiaries enrolled in  
17 specialized Medicare Part C plans for  
18 special needs individuals (described in  
19 section 1859(b)(6)(A)(ii)(III)) that  
20 serve predominantly individuals with  
21 severe or disabling chronic conditions  
22 by measuring the special needs for  
23 care of such individuals.”.

24 (3) EFFECTIVE DATE; GRANDFATHER.—The  
25 amendments made by paragraph (1) shall take effect

1 for enrollments occurring on or after January 1,  
2 2009, and shall not apply—

3 (A) to a Medicare Advantage plan with a  
4 contract with a State Medicaid integrated Medi-  
5 care-Medicaid plan program that had been ap-  
6 proved by the Centers for Medicare & Medicaid  
7 Services as of January 1, 2004; and

8 (B) to plans that are operational as of the  
9 date of the enactment of this Act as approved  
10 Medicare demonstration projects and that pro-  
11 vide services predominantly to individuals with  
12 end-stage renal disease.

13 (4) TRANSITION FOR NON-QUALIFYING SNPS.—

14 (A) RESTRICTIONS IN 2008 FOR CHRONIC  
15 CARE SNPS.—In the case of a specialized MA  
16 plan for special needs individuals (as defined in  
17 section 1859(b)(6)(A) of the Social Security Act  
18 (42 U.S.C. 1395w–28(b)(6)(A)) that, as of De-  
19 cember 31, 2007, is not described in either sub-  
20 clause (I) or subclause (II) of clause (ii) of such  
21 section, as amended by paragraph (1), then as  
22 of January 1, 2008—

23 (i) the plan may not be offered unless  
24 it was offered before such date;

1 (ii) no new members may be enrolled  
2 with the plan; and

3 (iii) there may be no expansion of the  
4 service area of such plan.

5 (B) TRANSITION OF ENROLLEES.—The  
6 Secretary of Health and Human Services shall  
7 provide for an orderly transition of those spe-  
8 cialized MA plans for special needs individuals  
9 (as defined in section 1859(b)(6)(A) of the So-  
10 cial Security Act (42 U.S.C. 1395w-  
11 28(b)(6)(A)), as of the date of the enactment of  
12 this Act), and their enrollees, that no longer  
13 qualify as such plans under such section, as  
14 amended by this subsection.

15 (c) SUNSET OF ADDITIONAL DESIGNATION AUTHOR-  
16 ITY.—

17 (1) IN GENERAL.—Subsection (d) of section  
18 231 of the Medicare Prescription Drug, Improve-  
19 ment, and Modernization Act of 2003 (Public Law  
20 108–173) is repealed.

21 (2) EFFECTIVE DATE.—The repeal made by  
22 paragraph (1) shall take effect on January 1, 2009,  
23 and shall apply to plans offered on or after such  
24 date.

1 **SEC. 432. EXTENSION AND REVISION OF AUTHORITY FOR**  
2 **MEDICARE REASONABLE COST CONTRACTS.**

3 (a) EXTENSION FOR 3 YEARS OF PERIOD REASON-  
4 ABLE COST PLANS CAN REMAIN IN THE MARKET.—Sec-  
5 tion 1876(h)(5)(C)(ii) of the Social Security Act (42  
6 U.S.C. 1395mm(h)(5)(C)(ii)) is amended, in the matter  
7 preceding subclause (I), by striking “January 1, 2008”  
8 and inserting “January 1, 2011”.

9 (b) APPLICATION OF CERTAIN MEDICARE ADVAN-  
10 TAGE REQUIREMENTS TO COST CONTRACTS EXTENDED  
11 OR RENEWED AFTER ENACTMENT.—Section 1876(h) of  
12 such Act (42 U.S.C. 1395mm(h)), as amended by sub-  
13 section (a), is amended—

14 (1) by redesignating paragraph (5) as para-  
15 graph (6); and

16 (2) by inserting after paragraph (4) the fol-  
17 lowing new paragraph:

18 “(5)(A) Any reasonable cost reimbursement  
19 contract with an eligible organization under this sub-  
20 section that is extended or renewed on or after the  
21 date of enactment of the Children’s Health and  
22 Medicare Protection Act of 2007 shall provide that  
23 the provisions of the Medicare Part C program de-  
24 scribed in subparagraph (B) shall apply to such or-  
25 ganization and such contract in a substantially simi-  
26 lar manner as such provisions apply to Medicare

1 Part C organizations and Medicare Part C plans  
2 under part C.

3 “(B) The provisions described in this sub-  
4 paragraph are as follows:

5 “(i) Section 1851(h) (relating to the  
6 approval of marketing material and appli-  
7 cation forms).

8 “(ii) Section 1852(e) (relating to the  
9 requirement of having an ongoing quality  
10 improvement program and treatment of ac-  
11 creditation in the same manner as such  
12 provisions apply to Medicare Part C local  
13 plans that are preferred provider organiza-  
14 tion plans).

15 “(iii) Section 1852(f) (relating to  
16 grievance mechanisms).

17 “(iv) Section 1852(g) (relating to cov-  
18 erage determinations, reconsiderations, and  
19 appeals).

20 “(v) Section 1852(j)(4) (relating to  
21 limitations on physician incentive plans).

22 “(vi) Section 1854(c) (relating to the  
23 requirement of uniform premiums among  
24 individuals enrolled in the plan).



1           “(vii) Section 1854(g) (relating to re-  
2           strictions on imposition of premium taxes  
3           with respect to payments to organizations).

4           “(viii) Section 1856(b)(3) (relating to  
5           relation to State laws).

6           “(ix) The provisions of part C relating  
7           to timelines for contract renewal and bene-  
8           ficiary notification.”.

9   **TITLE V—PROVISIONS RELAT-**  
10 **ING TO MEDICARE PART A**

11 **SEC. 501. INPATIENT HOSPITAL PAYMENT UPDATES.**

12       (a) FOR ACUTE HOSPITALS.—Clause (i) of section  
13 1886(b)(3)(B) of the Social Security Act (42 U.S.C.  
14 1395ww(b)(3)(B)) is amended—

15           (1) in subclause (XIX), by striking “and”;

16           (2) by redesignating subclause (XX) as sub-  
17           clause (XXII); and

18           (3) by inserting after subclause (XIX) the fol-  
19           lowing new subclauses:

20           “(XX) for fiscal year 2007, subject to clause  
21           (viii), the market basket percentage increase for hos-  
22           pitals in all areas,

23           “(XXI) for fiscal year 2008, subject to clause  
24           (viii), the market basket percentage increase minus

1       0.25 percentage point for hospitals in all areas,  
2       and”.

3       (b) FOR OTHER HOSPITALS.—Clause (ii) of such sec-  
4       tion is amended—

5             (1) in subclause (VII) by striking “and”;

6             (2) by redesignating subclause (VIII) as sub-  
7       clause (X); and

8             (3) by inserting after subclause (VII) the fol-  
9       lowing new subclauses:

10            “(VIII) fiscal years 2003 through 2007, is the  
11       market basket percentage increase,

12            “(IX) fiscal year 2008, is the market basket  
13       percentage increase minus 0.25 percentage point,  
14       and”.

15       (c) DELAYED EFFECTIVE DATE.—

16            (1) ACUTE CARE HOSPITALS.—The amend-  
17       ments made by subsection (a) shall not apply to dis-  
18       charges occurring before January 1, 2008.

19            (2) OTHER HOSPITALS.—The amendments  
20       made by subsection (b) shall be applied, only with  
21       respect to cost reporting periods beginning during  
22       fiscal year 2008 and not with respect to the com-  
23       putation for any succeeding cost reporting period, by  
24       substituting “0.1875 percentage point” for “0.25  
25       percentage point”.

1 **SEC. 502. PAYMENT FOR INPATIENT REHABILITATION FA-**  
2 **CILITY (IRF) SERVICES.**

3 (a) PAYMENT UPDATE.—

4 (1) IN GENERAL.—Section 1886(j)(3)(C) of the  
5 Social Security Act (42 U.S.C. 1395ww(j)(3)(C)) is  
6 amended by adding at the end the following: “The  
7 increase factor to be applied under this subpara-  
8 graph for fiscal year 2008 shall be 1 percent.”.

9 (2) DELAYED EFFECTIVE DATE.—The amend-  
10 ment made by paragraph (1) shall not apply to pay-  
11 ment units occurring before January 1, 2008.

12 (b) INPATIENT REHABILITATION FACILITY CLASSI-  
13 FICATION CRITERIA.—

14 (1) IN GENERAL.—Section 5005 of the Deficit  
15 Reduction Act of 2005 (Public Law 109–171) is  
16 amended—

17 (A) in subsection (a), by striking “apply  
18 the applicable percent specified in subsection  
19 (b)” and inserting “require a compliance rate  
20 that is no greater than the 60 percent compli-  
21 ance rate that became effective for cost report-  
22 ing periods beginning on or after July 1,  
23 2006,”; and

24 (B) by amending subsection (b) to read as  
25 follows:

1       “(b) CONTINUED USE OF COMORBIDITIES.—For por-  
2 tions of cost reporting periods occurring on or after the  
3 date of the enactment of the Children’s Health and Medi-  
4 care Protection Act of 2007, the Secretary shall include  
5 patients with comorbidities as described in section  
6 412.23(b)(2)(i) of title 42, Code of Federal Regulations  
7 (as in effect as of January 1, 2007), in the inpatient popu-  
8 lation that counts towards the percent specified in sub-  
9 section (a).”.

10           (2) EFFECTIVE DATE.—The amendment made  
11 by paragraph (1)(A) shall apply to portions of cost  
12 reporting periods beginning on or after the date of  
13 the enactment of this Act.

14       (c) PAYMENT FOR CERTAIN MEDICAL CONDITIONS  
15 TREATED IN INPATIENT REHABILITATION FACILITIES.—

16           (1) IN GENERAL.—Section 1886(j) of the Social  
17 Security Act (42 U.S.C. 1395ww(j)) is amended—

18                   (A) by redesignating paragraph (7) as  
19 paragraph (8);

20                   (B) by inserting after paragraph (6) the  
21 following new paragraph:

22                   “(7) SPECIAL PAYMENT RULE FOR CERTAIN  
23 MEDICAL CONDITIONS.—

24                           “(A) IN GENERAL.—Subject to subpara-  
25 graph (H), in the case of discharges occurring

1 on or after October 1, 2008, in lieu of the  
2 standardized payment amount (as determined  
3 pursuant to the preceding provisions of this  
4 subsection) that would otherwise be applicable  
5 under this subsection, the Secretary shall sub-  
6 stitute, for payment units with respect to an  
7 applicable medical condition (as defined in sub-  
8 paragraph (G)(i)) that is treated in an inpa-  
9 tient rehabilitation facility, the modified stand-  
10 ardized payment amount determined under sub-  
11 paragraph (B).

12 “(B) MODIFIED STANDARDIZED PAYMENT  
13 AMOUNT.—The modified standardized payment  
14 amount for an applicable medical condition  
15 shall be based on the amount determined under  
16 subparagraph (C) for such condition, as ad-  
17 justed under subparagraphs (D), (E), and (F).

18 “(C) AMOUNT DETERMINED.—

19 “(i) IN GENERAL.—The amount de-  
20 termined under this subparagraph for an  
21 applicable medical condition shall be based  
22 on the sum of the following:

23 “(I) An amount equal to the av-  
24 erage per stay skilled nursing facility  
25 payment rate for the applicable med-

1 ical condition (as determined under  
2 clause (ii)).

3 “(II) An amount equal to 25 per-  
4 cent of the difference between the  
5 overhead costs (as defined in subpara-  
6 graph (G)(ii)) component of the aver-  
7 age inpatient rehabilitation facility per  
8 stay payment amount for the applica-  
9 ble medical condition (as determined  
10 under the preceding paragraphs of  
11 this subsection) and the overhead  
12 costs component of the average per  
13 stay skilled nursing facility payment  
14 rate for such condition (as determined  
15 under clause (ii)).

16 “(III) An amount equal to 33  
17 percent of the difference between the  
18 patient care costs (as defined in sub-  
19 paragraph (G)(iii)) component of the  
20 average inpatient rehabilitation facil-  
21 ity per stay payment amount for the  
22 applicable medical condition (as deter-  
23 mined under the preceding para-  
24 graphs of this subsection) and the pa-  
25 tient care costs component of the av-

1                   erage per stay skilled nursing facility  
2                   payment rate for such condition (as  
3                   determined under clause (ii)).

4                   “(ii) DETERMINATION OF AVERAGE  
5                   PER STAY SKILLED NURSING FACILITY  
6                   PAYMENT RATE.—For purposes of clause  
7                   (i), the Secretary shall convert skilled  
8                   nursing facility payment rates for applica-  
9                   ble medical conditions, as determined  
10                  under section 1888(e), to average per stay  
11                  skilled nursing facility payment rates for  
12                  each such condition.

13                  “(D) ADJUSTMENTS.—The Secretary shall  
14                  adjust the amount determined under subpara-  
15                  graph (C) for an applicable medical condition  
16                  using the adjustments to the prospective pay-  
17                  ment rates for inpatient rehabilitation facilities  
18                  described in paragraphs (2), (3), (4), and (6).

19                  “(E) UPDATE FOR INFLATION.—Except in  
20                  the case of a fiscal year for which the Secretary  
21                  rebases the amounts determined under subpara-  
22                  graph (C) for applicable medical conditions pur-  
23                  suant to subparagraph (F), the Secretary shall  
24                  annually update the amounts determined under  
25                  subparagraph (C) for each applicable medical

1 condition by the increase factor for inpatient re-  
2 habilitation facilities (as described in paragraph  
3 (3)(C)).

4 “(F) REBASING.—The Secretary shall pe-  
5 riodically (but in no case less than once every  
6 5 years) rebase the amounts determined under  
7 subparagraph (C) for applicable medical condi-  
8 tions using the methodology described in such  
9 subparagraph and the most recent and complete  
10 cost report and claims data available.

11 “(G) DEFINITIONS.—In this paragraph:

12 “(i) APPLICABLE MEDICAL CONDI-  
13 TION.—The term ‘applicable medical condi-  
14 tion’ means—

15 “(I) unilateral knee replacement;

16 “(II) unilateral hip replacement;

17 and

18 “(III) unilateral hip fracture.

19 “(ii) OVERHEAD COSTS.—The term  
20 ‘overhead costs’ means those Medicare-al-  
21 lowable costs that are contained in the  
22 General Service cost centers of the Medi-  
23 care cost reports for inpatient rehabilita-  
24 tion facilities and for skilled nursing facili-



1           ties, respectively, as determined by the  
2           Secretary.

3           “(iii) PATIENT CARE COSTS.—The  
4           term ‘patient care costs’ means total Medi-  
5           care-allowable costs minus overhead costs.

6           “(H) SUNSET.—The provisions of this  
7           paragraph shall cease to apply as of the date  
8           the Secretary implements an integrated, site-  
9           neutral payment methodology under this title  
10          for post-acute care.”; and

11          (C) in paragraph (8), as redesignated by  
12          paragraph (1)—

13               (i) in subparagraph (C), by striking  
14               “and” at the end;

15               (ii) in subparagraph (D), by striking  
16               the period at the end and inserting “,  
17               and”;

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

20               “(E) modified standardized payment  
21               amounts under paragraph (7).”.

22          (2) SPECIAL RULE FOR DISCHARGES OCCUR-  
23          RING IN THE SECOND HALF OF FISCAL YEAR 2008.—

24               (A) IN GENERAL.—In the case of dis-  
25               charges from an inpatient rehabilitation facility

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

1           (B) IMPLEMENTATION.—Notwithstanding  
2           any other provision of law, the Secretary of  
3           Health and Human Services may implement  
4           this subsection by program instruction or other-  
5           wise. Paragraph (8)(E) of such section 1886(j)  
6           of the Social Security Act, as added by para-  
7           graph (1)(C), shall apply for purposes of this  
8           subsection in the same manner as such para-  
9           graph applies for purposes of paragraph (7) of  
10          such section 1886(j).

11          (d) RECOMMENDATIONS FOR CLASSIFYING INPA-  
12          TIENT REHABILITATION HOSPITALS AND UNITS.—

13           (1) REPORT TO CONGRESS.—Not later than 12  
14          months after the date of the enactment of this Act,  
15          the Secretary of Health and Human Services, in  
16          consultation with physicians (including geriatricians  
17          and physiatrists), administrators of inpatient reha-  
18          bilitation, acute care hospitals, skilled nursing facili-  
19          ties, and other settings providing rehabilitation serv-  
20          ices, Medicare beneficiaries, trade organizations rep-  
21          resenting inpatient rehabilitation hospitals and units  
22          and skilled nursing facilities, and the Medicare Pay-  
23          ment Advisory Commission, shall submit to the  
24          Committee on Ways and Means of the House of

1 Representatives and the Committee on Finance of  
2 the Senate a report that includes—

3 (A) an examination of Medicare bene-  
4 ficiaries' access to medically necessary rehabili-  
5 tation services;

6 (B) alternatives or refinements to the 75  
7 percent rule policy for determining exclusion  
8 criteria for inpatient rehabilitation hospital and  
9 unit designation under the Medicare program,  
10 including determining clinical appropriateness  
11 of inpatient rehabilitation hospital and unit ad-  
12 missions and alternative criteria which would  
13 consider a patient's functional status, diagnosis,  
14 co-morbidities, and other relevant factors; and

15 (C) an examination that identifies any con-  
16 dition for which individuals are commonly ad-  
17 mitted to inpatient rehabilitation hospitals that  
18 is not included as a condition described in sec-  
19 tion 412.23(b)(2)(iii) of title 42, Code of Fed-  
20 eral Regulations, to determine the appropriate  
21 setting of care, and any variation in patient  
22 outcomes and costs, across settings of care, for  
23 treatment of such conditions.

24 For the purposes of this subsection, the term “75  
25 percent rule” means the requirement of section

1 412.23(b)(2) of title 42, Code of Federal Regula-  
2 tions, that 75 percent of the patients of a rehabilita-  
3 tion hospital or converted rehabilitation unit are in  
4 1 or more of 13 listed treatment categories.

5 (2) CONSIDERATIONS.—In developing the re-  
6 port described in paragraph (1), the Secretary shall  
7 include the following:

8 (A) The potential effect of the 75 percent  
9 rule on access to rehabilitation care by Medi-  
10 care beneficiaries for the treatment of a condi-  
11 tion, whether or not such condition is described  
12 in section 412.23(b)(2)(iii) of title 42, Code of  
13 Federal Regulations.

14 (B) An analysis of the effectiveness of re-  
15 habilitation care for the treatment of condi-  
16 tions, whether or not such conditions are de-  
17 scribed in section 412.23(b)(2)(iii) of title 42,  
18 Code of Federal Regulations, available to Medi-  
19 care beneficiaries in various health care set-  
20 tings, taking into account variation in patient  
21 outcomes and costs across different settings of  
22 care, and which may include whether the Medi-  
23 care program and Medicare beneficiaries may  
24 incur higher costs of care for the entire episode

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

3 **SEC. 503. LONG-TERM CARE HOSPITALS.**

4           (a) LONG-TERM CARE HOSPITAL PAYMENT UP-  
5 DATE.—

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

9           “(m) PROSPECTIVE PAYMENT FOR LONG-TERM  
10 CARE HOSPITALS.—

11           “(1) REFERENCE TO ESTABLISHMENT AND IM-  
12 PLEMENTATION OF SYSTEM.—For provisions related  
13 to the establishment and implementation of a pro-  
14 spective payment system for payments under this  
15 title for inpatient hospital services furnished by a  
16 long-term care hospital described in subsection  
17 (d)(1)(B)(iv), see section 123 of the Medicare, Med-  
18 icaid, and SCHIP Balanced Budget Refinement Act  
19 of 1999 and section 307(b) of Medicare, Medicaid,  
20 and SCHIP Benefits Improvement and Protection  
21 Act of 2000.

22           “(2) UPDATE FOR RATE YEAR 2008.—In imple-  
23 menting the system described in paragraph (1) for  
24 discharges occurring during the rate year ending in  
25 2008 for a hospital, the base rate for such dis-

1 charges for the hospital shall be the same as the  
2 base rate for discharges for the hospital occurring  
3 during the previous rate year.”.

4 (2) DELAYED EFFECTIVE DATE.—Subsection  
5 (m)(2) of section 1886 of the Social Security Act, as  
6 added by paragraph (1), shall not apply to dis-  
7 charges occurring on or after July 1, 2007, and be-  
8 fore January 1, 2008.

9 (b) PAYMENT FOR LONG-TERM CARE HOSPITAL  
10 SERVICES; PATIENT AND FACILITY CRITERIA.—

11 (1) DEFINITION OF LONG-TERM CARE HOS-  
12 PITAL.—

13 (A) DEFINITION.—Section 1861 of the So-  
14 cial Security Act (42 U.S.C. 1395x), as amend-  
15 ed by section 201(a)(2), is amended by adding  
16 at the end the following new subsection:

17 “Long-Term Care Hospital

18 “(ddd) The term ‘long-term care hospital’ means an  
19 institution which—

20 “(1) is primarily engaged in providing inpatient  
21 services, by or under the supervision of a physician,  
22 to Medicare beneficiaries whose medically complex  
23 conditions require a long hospital stay and programs  
24 of care provided by a long-term care hospital;

1           “(2) has an average inpatient length of stay (as  
2           determined by the Secretary) for Medicare bene-  
3           ficiaries of greater than 25 days, or as otherwise de-  
4           fined in section 1886(d)(1)(B)(iv);

5           “(3) satisfies the requirements of subsection  
6           (e);

7           “(4) meets the following facility criteria:

8           “(A) the institution has a patient review  
9           process, documented in the patient medical  
10          record, that screens patients prior to admission  
11          for appropriateness of admission to a long-term  
12          care hospital, validates within 48 hours of ad-  
13          mission that patients meet admission criteria  
14          for long-term care hospitals, regularly evaluates  
15          patients throughout their stay for continuation  
16          of care in a long-term care hospital, and as-  
17          sesses the available discharge options when pa-  
18          tients no longer meet such continued stay cri-  
19          teria;

20          “(B) the institution has active physician  
21          involvement with patients during their treat-  
22          ment through an organized medical staff, physi-  
23          cian-directed treatment with physician on-site  
24          availability on a daily basis to review patient  
25          progress, and consulting physicians on call and



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

4 “(C) the institution has interdisciplinary  
5 team treatment for patients, requiring inter-  
6 disciplinary teams of health care professionals,  
7 including physicians, to prepare and carry out  
8 an individualized treatment plan for each pa-  
9 tient; and

10 “(5) meets patient criteria relating to patient  
11 mix and severity appropriate to the medically com-  
12 plex cases that long-term care hospitals are designed  
13 to treat, as measured under section 1886(n).”.

14 (B) NEW PATIENT CRITERIA FOR LONG-  
15 TERM CARE HOSPITAL PROSPECTIVE PAY-  
16 MENT.—Section 1886 of such Act (42 U.S.C.  
17 1395ww), as amended by subsection (a), is fur-  
18 ther amended by adding at the end the fol-  
19 lowing new subsection:

20 “(n) PATIENT CRITERIA FOR PROSPECTIVE PAY-  
21 MENT TO LONG-TERM CARE HOSPITALS.—

22 “(1) IN GENERAL.—To be eligible for prospec-  
23 tive payment under this section as a long-term care  
24 hospital, a long-term care hospital must admit not  
25 less than a majority of patients who have a high

1 level of severity, as defined by the Secretary, and  
2 who are assigned to one or more of the following  
3 major diagnostic categories:

4 “(A) Circulatory diagnoses.

5 “(B) Digestive, endocrine, and metabolic  
6 diagnoses.

7 “(C) Infection disease diagnoses.

8 “(D) Neurological diagnoses.

9 “(E) Renal diagnoses.

10 “(F) Respiratory diagnoses.

11 “(G) Skin diagnoses.

12 “(H) Other major diagnostic categories as  
13 selected by the Secretary.

14 “(2) MAJOR DIAGNOSTIC CATEGORY DE-  
15 FINED.—In paragraph (1), the term ‘major diag-  
16 nostic category’ means the medical categories formed  
17 by dividing all possible principle diagnosis into mu-  
18 tually exclusive diagnosis areas which are referred to  
19 in 67 Federal Register 49985 (August 1, 2002).”.

20 (C) ESTABLISHMENT OF REHABILITATION  
21 UNITS WITHIN CERTAIN LONG-TERM CARE HOS-  
22 PITALS.—If the Secretary of Health and  
23 Human Services does not include rehabilitation  
24 services within a major diagnostic category  
25 under section 1886(n)(2) of the Social Security

1 Act, as added by subparagraph (B), the Sec-  
2 retary shall approve for purposes of title XVIII  
3 of such Act distinct part inpatient rehabilitation  
4 hospital units in long-term care hospitals con-  
5 sistent with the following:

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

1           riod described in section 412.30(c) of title  
2           42, Code of Federal Regulations, applica-  
3           ble to the conversion of hospital beds into  
4           a distinct-part rehabilitation unit shall not  
5           apply to such units.

6           (ii) Services provided in inpatient re-  
7           habilitation units established under clause  
8           (i) shall not be reimbursed as long-term  
9           care hospital services under section 1886  
10          of such Act and shall be subject to pay-  
11          ment policies established by the Secretary  
12          to reimburse services provided by inpatient  
13          hospital rehabilitation units.

14          (D) EFFECTIVE DATE.—The amendments  
15          made by subparagraphs (A) and (B), and the  
16          provisions of subparagraph (C), shall apply to  
17          discharges occurring on or after January 1,  
18          2008.

19          (2) IMPLEMENTATION OF FACILITY AND PA-  
20          TIENT CRITERIA.—

21               (A) REPORT.—No later than 1 year after  
22               the date of the enactment of this Act, the Sec-  
23               retary of Health and Human Services (in this  
24               section referred to as the “Secretary”) shall  
25               submit to the appropriate committees of Con-

1           gress a report containing recommendations re-  
2           garding the promulgation of the national long-  
3           term care hospital facility and patient criteria  
4           for application under paragraphs (4) and (5) of  
5           section 1861(ccc) and section 1886(n) of the  
6           Social Security Act, as added by subparagraphs  
7           (A) and (B), respectively, of paragraph (1). In  
8           the report, the Secretary shall consider rec-  
9           ommendations contained in a report to Con-  
10          gress by the Medicare Payment Advisory Com-  
11          mission in June 2004 for long-term care hos-  
12          pital-specific facility and patient criteria to en-  
13          sure that patients admitted to long-term care  
14          hospitals are medically complex and appropriate  
15          to receive long-term care hospital services.

16                 (B) IMPLEMENTATION.—No later than 1  
17          year after the date of submittal of the report  
18          under subparagraph (A), the Secretary shall,  
19          after rulemaking, implement the national long-  
20          term care hospital facility and patient criteria  
21          referred to in such subparagraph. Such long-  
22          term care hospital facility and patient criteria  
23          shall be used to screen patients in determining  
24          the medical necessity and appropriateness of a  
25          Medicare beneficiary's admission to, continued

1 stay at, and discharge from, long-term care hos-  
2 pitals under the Medicare program and shall  
3 take into account the medical judgment of the  
4 patient's physician, as provided for under sec-  
5 tions 1814(a)(3) and 1835(a)(2)(B) of the So-  
6 cial Security Act (42 U.S.C. 1395f(a)(3),  
7 1395n(a)(2)(B)).

8 (3) EXPANDED REVIEW OF MEDICAL NECES-  
9 SITY.—

10 (A) IN GENERAL.—The Secretary of  
11 Health and Human Services shall provide,  
12 under contracts with one or more appropriate  
13 fiscal intermediaries or medicare administrative  
14 contractors under section 1874A(a)(4)(G) of  
15 the Social Security Act (42 U.S.C.  
16 1395kk(a)(4)(G)), for reviews of the medical  
17 necessity of admissions to long-term care hos-  
18 pitals (described in section 1886(d)(1)(B)(iv) of  
19 such Act) and continued stay at such hospitals,  
20 of individuals entitled to, or enrolled for, bene-  
21 fits under part A of title XVIII of such Act on  
22 a hospital-specific basis consistent with this  
23 paragraph. Such reviews shall be made for dis-  
24 charges occurring on or after October 1, 2007.

1 (B) REVIEW METHODOLOGY.—The medical  
2 necessity reviews under paragraph (A) shall be  
3 conducted for each such long-term care hospital  
4 on an annual basis in accordance with rules (in-  
5 cluding a sample methodology) specified by the  
6 Secretary. Such sample methodology shall—

7 (i) provide for a statistically valid and  
8 representative sample of admissions of  
9 such individuals sufficient to provide re-  
10 sults at a 95 percent confidence interval;  
11 and

12 (ii) guarantee that at least 75 percent  
13 of overpayments received by long-term care  
14 hospitals for medically unnecessary admis-  
15 sions and continued stays of individuals in  
16 long-term care hospitals will be identified  
17 and recovered and that related days of care  
18 will not be counted toward the length of  
19 stay requirement contained in section  
20 1886(d)(1)(B)(iv) of the Social Security  
21 Act (42 U.S.C. 1395ww(d)(1)(B)(iv)).

22 (C) CONTINUATION OF REVIEWS.—Under  
23 contracts under this paragraph, the Secretary  
24 shall establish a denial rate with respect to such  
25 reviews that, if exceeded, could require further

1 review of the medical necessity of admissions  
2 and continued stay in the hospital involved.

3 (D) TERMINATION OF REQUIRED RE-  
4 VIEWS.—

5 (i) IN GENERAL.—Subject to clause  
6 (iii), the previous provisions of this sub-  
7 section shall cease to apply as of the date  
8 specified in clause (ii).

9 (ii) DATE SPECIFIED.—The date spec-  
10 ified in this clause is the later of January  
11 1, 2013, or the date of implementation of  
12 national long-term care hospital facility  
13 and patient criteria under section para-  
14 graph (2)(B).

15 (iii) CONTINUATION.—As of the date  
16 specified in clause (ii), the Secretary shall  
17 determine whether to continue to guar-  
18 antee, through continued medical review  
19 and sampling under this paragraph, recov-  
20 ery of at least 75 percent of overpayments  
21 received by long-term care hospitals due to  
22 medically unnecessary admissions and con-  
23 tinued stays.

24 (E) FUNDING.—The costs to fiscal inter-  
25 mediaries or medicare administrative contrac-



1           tors conducting the medical necessity reviews  
2           under subparagraph (A) shall be funded from  
3           the aggregate overpayments recouped by the  
4           Secretary of Health and Human Services from  
5           long-term care hospitals due to medically un-  
6           necessary admissions and continued stays. The  
7           Secretary may use an amount not in excess of  
8           40 percent of the overpayments recouped under  
9           this paragraph to compensate the fiscal inter-  
10          mediaries or Medicare administrative contrac-  
11          tors for the costs of services performed.

12           (4) LIMITED, QUALIFIED MORATORIUM OF  
13          LONG-TERM CARE HOSPITALS.—

14           (A) IN GENERAL.—Subject to subpara-  
15          graph (B), the Secretary shall impose a tem-  
16          porary moratorium on the certification of new  
17          long-term care hospitals (and satellite facilities),  
18          and new long-term care hospital and satellite  
19          facility beds, for purposes of the Medicare pro-  
20          gram under title XVIII of the Social Security  
21          Act. The moratorium shall terminate at the end  
22          of the 4-year period beginning on the date of  
23          the enactment of this Act.

24           (B) EXCEPTIONS.—

1 (i) IN GENERAL.—The moratorium  
2 under subparagraph (A) shall not apply as  
3 follows:

4 (I) To a long-term care hospital,  
5 satellite facility, or additional beds  
6 under development as of the date of  
7 the enactment of this Act.

8 (II) To an existing long-term  
9 care hospital that requests to increase  
10 its number of long-term care hospital  
11 beds, if the Secretary determines  
12 there is a need at the long-term care  
13 hospital for additional beds to accom-  
14 modate—

15 (aa) infectious disease issues  
16 for isolation of patients;

17 (bb) bedside dialysis serv-  
18 ices;

19 (cc) single-sex accommoda-  
20 tion issues;

21 (dd) behavioral issues; or

22 (ee) any requirements of  
23 State or local law.

24 (III) To an existing long-term  
25 care hospital that requests an increase

1 in beds because of the closure of a  
2 long-term care hospital or significant  
3 decrease in the number of long-term  
4 care hospital beds, in a State where  
5 there is only one other long-term care  
6 hospital.

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

10 (ii) “UNDER DEVELOPMENT” DE-  
11 FINED.—For purposes of clause (i)(I), a  
12 long-term care hospital or satellite facility  
13 is considered to be “under development” as  
14 of a date if any of the following have oc-  
15 curred on or before such date:

16 (I) The hospital or a related  
17 party has a binding written agreement  
18 with an outside, unrelated party for  
19 the construction, reconstruction, lease,  
20 rental, or financing of the long-term  
21 care hospital and the hospital has ex-  
22 pended, before the date of the enact-  
23 ment of this Act, at least 10 percent  
24 of the estimated cost of the project  
25 (or, if less, \$2,500,000).

1 (II) Actual construction, renova-  
2 tion or demolition for the long-term  
3 care hospital has begun and the hos-  
4 pital has expended, before the date of  
5 the enactment of this Act, at least 10  
6 percent of the estimated cost of the  
7 project (or, if less, \$2,500,000).

8 (III) A certificate of need has  
9 been approved in a State where one is  
10 required or other necessary approvals  
11 from appropriate State agencies have  
12 been received for the operation of the  
13 hospital.

14 (IV) The hospital documents  
15 that, within 3 months after the date  
16 of the enactment of this Act, it is  
17 within a 6-month long-term care hos-  
18 pital demonstration period required by  
19 section 412.23(e)(1)–(3) of title 42,  
20 Code of Federal Regulations, to dem-  
21 onstrate that it has a greater than 25  
22 day average length of stay.

23 (5) NO APPLICATION OF 25 PERCENT PATIENT  
24 THRESHOLD PAYMENT ADJUSTMENT TO FREE-  
25 STANDING AND GRANDFATHERED LTCHS.—The Sec-

1       retary shall not apply, during the 5-year period be-  
2       ginning on the date of the enactment of this Act,  
3       section 412.536 of title 42, Code of Federal Regula-  
4       tions, or any similar provision, to freestanding long-  
5       term care hospitals and the Secretary shall not apply  
6       such section or section 412.534 of title 42, Code of  
7       Federal Regulations, or any similar provisions, to a  
8       long-term care hospital identified by section 4417(a)  
9       of the Balanced Budget Act of 1997 (Public Law  
10      105–33). A long-term care hospital identified by  
11      such section 4417(a) shall be deemed to be a free-  
12      standing long-term care hospital for the purpose of  
13      this section. Section 412.536 of title 42, Code of  
14      Federal Regulations, shall be void and of no effect.

15               (6) PAYMENT FOR HOSPITALS-WITHIN-HOS-  
16      PITALS.—

17                       (A) IN GENERAL.—Payments to an appli-  
18                      cable long-term care hospital or satellite facility  
19                      which is located in a rural area or which is co-  
20                      located with an urban single or MSA dominant  
21                      hospital under paragraphs (d)(1), (e)(1), and  
22                      (e)(4) of section 412.534 of title 42, Code of  
23                      Federal Regulations, shall not be subject to any  
24                      payment adjustment under such section if no  
25                      more than 75 percent of the hospital’s Medicare

1 discharges (other than discharges described in  
2 paragraph (d)(2) or (e)(3) of such section) are  
3 admitted from a co-located hospital.

4 (B) CO-LOCATED LONG-TERM CARE HOS-  
5 PITALS AND SATELLITE FACILITIES.—

6 (i) IN GENERAL.—Payment to an ap-  
7 plicable long-term care hospital or satellite  
8 facility which is co-located with another  
9 hospital shall not be subject to any pay-  
10 ment adjustment under section 412.534 of  
11 title 42, Code of Federal Regulations, if no  
12 more than 50 percent of the hospital’s  
13 Medicare discharges (other than discharges  
14 described in section 412.534(c)(3) of such  
15 title) are admitted from a co-located hos-  
16 pital.

17 (ii) APPLICABLE LONG-TERM CARE  
18 HOSPITAL OR SATELLITE FACILITY DE-  
19 FINED.—In this paragraph, the term “ap-  
20 plicable long-term care hospital or satellite  
21 facility” means a hospital or satellite facil-  
22 ity that is subject to the transition rules  
23 under section 412.534(g) of title 42, Code  
24 of Federal Regulations.

1 (C) EFFECTIVE DATE.—Subparagraphs  
2 (A) and (B) shall apply to discharges occurring  
3 on or after October 1, 2007, and before October  
4 1, 2012.

5 (7) NO APPLICATION OF VERY SHORT-STAY  
6 OUTLIER POLICY.—The Secretary shall not apply,  
7 during the 5-year period beginning on the date of  
8 the enactment of this Act, the amendments finalized  
9 on May 11, 2007 (72 Federal Register 26904) made  
10 to the short-stay outlier payment provision for long-  
11 term care hospitals contained in section  
12 412.529(e)(3)(i) of title 42, Code of Federal Regula-  
13 tions, or any similar provision.

14 (8) NO APPLICATION OF ONE TIME ADJUST-  
15 MENT TO STANDARD AMOUNT.—The Secretary shall  
16 not, during the 5-year period beginning on the date  
17 of the enactment of this Act, make the one-time pro-  
18 spective adjustment to long-term care hospital pro-  
19 spective payment rates provided for in section  
20 412.523(d)(3) of title 42, Code of Federal Regula-  
21 tions, or any similar provision.

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

1           (1) IN GENERAL.—Subsection (d)(1)(B) of sec-  
2           tion 1886 of the Social Security Act (42 U.S.C.  
3           1395ww) is amended—

4           (A) in clause (iv)—

5           (i) in subclause (I), by striking  
6           “(iv)(I)” and inserting “(iv)” and by strik-  
7           ing “or” at the end; and

8           (ii) in subclause (II)—

9           (I) by striking “, or” at the end  
10           and inserting a semicolon; and

11           (II) by redesignating such sub-  
12           clause as clause (vi) and by moving it  
13           to immediately follow clause (v); and

14           (B) in clause (v), by striking the semicolon  
15           at the end and inserting “, or”.

16           (2) CONFORMING PAYMENT REFERENCES.—  
17           Subsection (b) of such section is amended—

18           (A) in paragraph (2)(E)(ii), by adding at  
19           the end the following new subclause:

20           “(III) Hospitals described in clause (vi) of such  
21           subsection.”;

22           (B) in paragraph (3)(F)(iii), by adding at  
23           the end the following new subclause:

24           “(VI) Hospitals described in clause (vi) of such  
25           subsection.”;



1 (C) in paragraphs (3)(G)(ii), (3)(H)(i),  
2 and (3)(H)(ii)(I), by inserting “or (vi)” after  
3 “clause (iv)” each place it appears;

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

6 “(IV) Hospitals described in clause (vi) of such  
7 subsection.”;

8 (E) in paragraph (3)(J), by striking “sub-  
9 section (d)(1)(B)(iv)” and inserting “clause (iv)  
10 or (vi) of subsection (d)(1)(B)”;

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

13 “(iv) Hospitals described in clause (vi) of such  
14 subsection.”.

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

18 (A) by inserting “(as in effect as of such  
19 date)” after “clause (iv)”;

20 (B) by inserting “(or, in the case of a hos-  
21 pital classified under clause (iv)(II), as so in ef-  
22 fect, shall be classified under clause (vi) on and  
23 after the effective date of such clause)” after  
24 “so classified”.

1           (4) IN GENERAL.—In the case of a hospital  
2 that is classified under clause (iv)(II) of section  
3 1886(d)(1)(B) of the Social Security Act imme-  
4 diately before the date of the enactment of this Act  
5 and which is classified under clause (vi) of such sec-  
6 tion after such date of enactment, payments under  
7 section 1886 of such Act for cost reporting periods  
8 beginning after the date of the enactment of this Act  
9 shall be based upon payment rates in effect for the  
10 cost reporting period for such hospital beginning  
11 during fiscal year 2001, increased for each suc-  
12 ceeding cost reporting period (beginning before the  
13 date of the enactment of this Act) by the applicable  
14 percentage increase under section 1886(b)(3)(B)(ii)  
15 of such Act.

16           (5) CLARIFICATION OF TREATMENT OF SAT-  
17 ELLITE FACILITIES AND REMOTE LOCATIONS.—A  
18 long-stay cancer hospital described in section  
19 1886(d)(1)(B)(vi) of the Social Security Act, as des-  
20 ignated under paragraph (1), shall include satellites  
21 or remote site locations for such hospital established  
22 before or after the date of the enactment of this Act  
23 without regard to section 412.22(h)(2)(i) of title 42,  
24 Code of Federal Regulations, if the provider-based  
25 requirements under section 413.65 of such title, ap-

1 applicable certification requirements under title XVIII  
2 of the Social Security Act, and such other applicable  
3 State licensure and certificate of need requirements  
4 are met with respect to such satellites or remote site  
5 locations.

6 **SEC. 504. INCREASING THE DSH ADJUSTMENT CAP.**

7 (a) IN GENERAL.—Section 1886(d)(5)(F)(xiv) of the  
8 Social Security Act (42 U.S.C. 1395ww(d)(5)(F)(xiv)) is  
9 amended—

10 (1) in subclause (II), by striking “12 percent”  
11 and inserting “the percent specified in subclause  
12 (III)”; and

13 (2) by adding at the end the following new sub-  
14 clause:

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

17 “(a) before October 1, 2007, 12 percent;

18 “(b) during fiscal year 2008, 16 percent;

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

20 “(d) on or after October 1, 2009, 12 percent.”.

21 (b) SPECIAL RULE IN COMPUTING DISPROPOR-  
22 TIONATE PATIENT PERCENTAGE.—

23 (1) IN GENERAL.—Section 1886(d)(5)(F)(vi) of  
24 such Act (42 U.S.C. 1395ww(d)(5)(F)(vi)) is  
25 amended by adding at the end the following: “In ap-

1       plying this clause in the case of hospitals located in  
2       Puerto Rico, the Secretary shall substitute for the  
3       fraction described in subclause (I) one-half of the  
4       national average of such fraction for all subsection  
5       (d) hospitals, as estimated by the Secretary.”.

6               (2) EFFECTIVE DATE.—The amendment made  
7       by paragraph (1) shall apply to discharges in cost  
8       reporting periods of hospitals beginning on or after  
9       January 1, 2008.

10 **SEC. 505. PPS-EXEMPT CANCER HOSPITALS.**

11       (a) AUTHORIZING REBASING FOR PPS-EXEMPT  
12       CANCER HOSPITALS.—Section 1886(b)(3)(F) of the So-  
13       cial Security Act (42 U.S.C. 1395ww(b)(3)(F)) is amend-  
14       ed by adding at the end the following new clause:

15               “(iv) In the case of a hospital (or unit  
16               described in the matter following clause (v)  
17               of subsection (d)(1)(B)) that received pay-  
18               ment under this subsection for inpatient  
19               hospital services furnished during cost re-  
20               porting periods beginning before October  
21               1, 1999, that is within a class of hospital  
22               described in clause (iii) (other than sub-  
23               clause (IV), relating to long-term care hos-  
24               pitals, and that requests the Secretary (in  
25               a form and manner specified by the Sec-

1           retary) to effect a rebasing under this  
2           clause for the hospital, the Secretary may  
3           compute the target amount for the hos-  
4           pital’s 12-month cost reporting period be-  
5           ginning during fiscal year 2008 as an  
6           amount equal to the average described in  
7           clause (ii) but determined as if any ref-  
8           erence in such clause to ‘the date of the  
9           enactment of this subparagraph’ were a  
10          reference to ‘the date of the enactment of  
11          this clause’.”.

12          (b) ADDITIONAL CANCER HOSPITAL PROVISIONS.—

13           (1) IN GENERAL.—Section 1886(d)(1) of the  
14          Social Security Act (42 U.S.C. 1395ww(d)(1)) is  
15          amended—

16           (A) in subparagraph (B)(v)—

17           (i) by striking “or” at the end of sub-  
18          clause (II); and

19           (ii) by adding at the end the fol-  
20          lowing:

21           “(IV) a hospital that is a nonprofit corporation,  
22          the sole member of which is affiliated with a univer-  
23          sity that has been the recipient of a cancer center  
24          support grant from the National Cancer Institute of  
25          the National Institutes of Health, and which sole

1 member (or its predecessors or such university) was  
2 recognized as a comprehensive cancer center by the  
3 National Cancer Institute of the National Institutes  
4 of Health as of April 20, 1983, if the hospital's arti-  
5 cles of incorporation specify that at least 50 percent  
6 of its total discharges have a principal finding of  
7 neoplastic disease (as defined in subparagraph (E))  
8 and if, of December 31, 2005, the hospital was li-  
9 censed for less than 150 acute care beds, or

10 “(V) a hospital (aa) that the Secretary has de-  
11 termined to be, at any time on or before December  
12 31, 2011, a hospital involved extensively in treat-  
13 ment for, or research on, cancer, (bb) that is (as of  
14 the date of such determination) a free-standing facil-  
15 ity, (cc) for which the hospital's predecessor provider  
16 entity was University Hospitals of Cleveland with  
17 medicare provider number 36-0137;”;

18 (B) in subparagraph (B), by inserting  
19 after clause (vi), as redesignated by section  
20 503(c)(1)(A)(ii)(II), the following new clause:

21 “(vii) a hospital that—

22 “(I) is located in a State that as of Decem-  
23 ber 31, 2006, had only one center under section  
24 414 of the Public Health Service Act that has  
25 been designated by the National Cancer Insti-

1           tute as a comprehensive center currently serv-  
2           ing all 21 counties in the most densely popu-  
3           lated State in the nation (U.S. Census estimate  
4           for 2005: 8,717,925 persons; 1,134.5 persons  
5           per square mile), serving more than 70,000 pa-  
6           tient visits annually;

7           “(II) as of December 31, 2006, served as  
8           the teaching and clinical care, research and  
9           training hospital for the Center described in  
10          subclause (II), providing significant financial  
11          and operational support to such Center;

12          “(III) as of December 31, 2006, served as  
13          a core and essential element in such Center  
14          which conducts more than 130 clinical trial ac-  
15          tivities, national cooperative group studies, in-  
16          vestigator-initiated and peer review studies and  
17          has received as of 2005 at least \$93,000,000 in  
18          research grant awards;

19          “(IV) as of December 31, 2006, includes  
20          dedicated patient care units organized primarily  
21          for the treatment of and research on cancer  
22          with approximately 125 beds, 75 percent of  
23          which are dedicated to cancer patients, and con-  
24          tains a radiation oncology department as well

1 as specialized emergency services for oncology  
2 patients; and

3 “(V) as of December 31, 2004, is identi-  
4 fied as the focus of the Center’s inpatient ac-  
5 tivities in the Center’s application as a NCI-  
6 designated comprehensive cancer center and  
7 shares the NCI comprehensive cancer designa-  
8 tion with the Center;” and

9 (C) in subparagraph (E)—

10 (i) by striking “subclauses (II) and  
11 (III)” and inserting “subclauses (II), (III),  
12 and (IV)”; and

13 (ii) by inserting “and subparagraph  
14 (B)(vi)” after “subparagraph (B)(v)”.

15 (2) EFFECTIVE DATES; PAYMENTS.—

16 (A) APPLICATION TO COST REPORTING PE-  
17 RIODS.—

18 (i) Any classification by reason of sec-  
19 tion 1886(d)(1)(B)(vi) of the Social Secu-  
20 rity Act (42 U.S.C. 1395ww(d)(1)(B)(vi)),  
21 as inserted by paragraph (1), shall apply  
22 to cost reporting periods beginning on or  
23 after January 1, 2006.

24 (ii) The provisions of section  
25 1886(d)(1)(B)(v)(IV) of the Social Secu-



1           rity Act, as added by paragraph (1), shall  
2           take effect on January 1, 2008.

3           (B) BASE TARGET AMOUNT.—Notwith-  
4           standing subsection (b)(3)(E) of section 1886  
5           of the Social Security Act (42 U.S.C. 1395ww),  
6           in the case of a hospital described in subsection  
7           (d)(1)(B)(vi) of such section, as inserted by  
8           paragraph (1)—

9                   (i) the hospital shall be permitted to  
10                  resubmit the 2006 Medicare 2552 cost re-  
11                  port incorporating a cancer hospital sub-  
12                  provider number and to apply the Medicare  
13                  ratio-of-cost-to-charge settlement method-  
14                  ology for outpatient cancer services; and

15                   (ii) the hospital's target amount under  
16                  subsection (b)(3)(E)(i) of such section for  
17                  the first cost reporting period beginning on  
18                  or after January 1, 2006, shall be the al-  
19                  lowable operating costs of inpatient hos-  
20                  pital services (referred to in subclause (I)  
21                  of such subsection) for such first cost re-  
22                  porting period.

23           (C) DEADLINE FOR PAYMENTS.—Any pay-  
24           ments owed to a hospital as a result of this sub-  
25           section for periods occurring before the date of

1 the enactment of this Act shall be made expedi-  
2 tiously, but in no event later than 1 year after  
3 such date of enactment.

4 (3) APPLICATION TO CERTAIN HOSPITALS.—

5 (A) INAPPLICABILITY OF CERTAIN RE-  
6 QUIREMENTS.—The provisions of section  
7 412.22(e) of title 42, Code of Federal Regula-  
8 tions, shall not apply to a hospital described in  
9 section 1886(d)(1)(B)(v)(V) of the Social Secu-  
10 rity Act, as added by paragraph (1).

11 (B) APPLICATION TO COST REPORTING PE-  
12 RIODS.—If the Secretary makes a determina-  
13 tion that a hospital is described in section  
14 1886(d)(1)(B)(v)(V) of the Social Security Act,  
15 as added by paragraph (1), such determination  
16 shall apply as of the first cost reporting period  
17 beginning on or after the date of such deter-  
18 mination.

19 (C) BASE PERIOD.—Notwithstanding the  
20 provisions of section 1886(b)(3)(E) of the So-  
21 cial Security Act (42 U.S.C. 1395ww(b)(3)(E))  
22 or any other provision of law, the base cost re-  
23 porting period for purposes of determining the  
24 target amount for any hospital for which a de-  
25 termination described in subparagraph (B) has

1           been made shall be the first full 12-month cost  
2           reporting period beginning on or after the date  
3           of such determination.

4           (D) RULE.—A hospital described in sub-  
5           clause (V) of section 1886(b)(1)(B)(v) of the  
6           Social Security Act, as added by paragraph (1),  
7           shall not qualify as a hospital described in such  
8           subclause for any cost reporting period in which  
9           less than 50 percent of its total discharges have  
10          a principal finding of neoplastic disease. With  
11          respect to the first cost reporting period for  
12          which a determination described in subpara-  
13          graph (B) has been made, the Secretary shall  
14          accept a self-certification by the hospital, which  
15          shall be applicable to such first cost reporting  
16          period, that the hospital intends to have total  
17          discharges during such first cost reporting pe-  
18          riod of which 50 percent or more have a prin-  
19          cipal finding of neoplastic disease.

20          (c) MEDPAC REPORT ON PPS-EXEMPT CANCER  
21          HOSPITALS.—Not later than March 1, 2009, the Medicare  
22          Payment Advisory Commission (established under section  
23          1805 of the Social Security Act (42 U.S.C. 1395b–6))  
24          shall submit to the Secretary and Congress a report evalu-  
25          ating the following:

1           (1) Measures of payment adequacy and Medi-  
2           care margins for PPS-exempt cancer hospitals, as  
3           established under section 1886(d)(1)(B)(v) of the  
4           Social Security Act (42 U.S.C.  
5           1395ww(d)(1)(B)(v)).

6           (2) To the extent a PPS-exempt cancer hospital  
7           was previously affiliated with another hospital, the  
8           margins of the PPS-exempt hospital and the other  
9           hospital as separate entities and the margins of such  
10          hospitals that existed when the hospitals were pre-  
11          viously affiliated.

12          (3) Payment adequacy for cancer discharges  
13          under the Medicare inpatient hospital prospective  
14          payment system.

15 **SEC. 506. SKILLED NURSING FACILITY PAYMENT UPDATE.**

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

19               (1) in subclause (III), by striking “and” at the  
20               end;

21               (2) by redesignating subclause (IV) as sub-  
22               clause (VI); and

23               (3) by inserting after subclause (III) the fol-  
24               lowing new subclauses:

1                   “(IV) for each of fiscal years  
2                   2004, 2005, 2006, and 2007, the rate  
3                   computed for the previous fiscal year  
4                   increased by the skilled nursing facil-  
5                   ity market basket percentage change  
6                   for the fiscal year involved;

7                   “(V) for fiscal year 2008, the  
8                   rate computed for the previous fiscal  
9                   year; and”.

10           (b)     DELAYED     EFFECTIVE     DATE.—Section  
11 1888(e)(4)(E)(ii)(V) of the Social Security Act, as in-  
12 serted by subsection (a)(3), shall not apply to payment  
13 for days before January 1, 2008.

14 **SEC. 507. REVOCATION OF UNIQUE DEEMING AUTHORITY**  
15                   **OF THE JOINT COMMISSION FOR THE AC-**  
16                   **CREDITATION OF HEALTHCARE ORGANIZA-**  
17                   **TIONS.**

18           (a) REVOCATION.—Section 1865 of the Social Secu-  
19 rity Act (42 U.S.C. 1395bb) is amended—

20                   (1) by striking subsection (a); and

21                   (2) by redesignating subsections (b), (c), (d),  
22 and (e) as subsections (a), (b), (c), and (d), respec-  
23 tively.

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

1 (A) in subsection (a)(1), as so redesignig-  
2 nated, by striking “In addition, if” and insert-  
3 ing “If”;

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

5 (i) by striking “released to him by the  
6 Joint Commission on Accreditation of Hos-  
7 pitals,” and inserting “released to the Sec-  
8 retary by”; and

9 (ii) by striking the comma after “As-  
10 sociation”;

11 (C) in subsection (c), as so redesignated,  
12 by striking “pursuant to subsection (a) or  
13 (b)(1)” and inserting “pursuant to subsection  
14 (a)(1)”; and

15 (D) in subsection (d), as so redesignated,  
16 by striking “pursuant to subsection (a) or  
17 (b)(1)” and inserting “pursuant to subsection  
18 (a)(1)”.

19 (2) Section 1861(e) of such Act (42 U.S.C.  
20 1395x(e)) is amended in the fourth sentence by  
21 striking “and (ii) is accredited by the Joint Commis-  
22 sion on Accreditation of Hospitals, or is accredited  
23 by or approved by a program of the country in which  
24 such institution is located if the Secretary finds the  
25 accreditation or comparable approval standards of

1 such program to be essentially equivalent to those of  
2 the Joint Commission on Accreditation of Hos-  
3 pitals.” and inserting “and (ii) is accredited by a na-  
4 tional accreditation body recognized by the Secretary  
5 under section 1865(a), or is accredited by or ap-  
6 proved by a program of the country in which such  
7 institution is located if the Secretary finds the ac-  
8 creditation or comparable approval standards of  
9 such program to be essentially equivalent to those of  
10 such a national accreditation body.”.

11 (3) Section 1864(c) of such Act (42 U.S.C.  
12 1395aa(c)) is amended by striking “pursuant to sub-  
13 section (a) or (b)(1) of section 1865” and inserting  
14 “pursuant to section 1865(a)(1)”.

15 (4) Section 1875(b) of such Act (42 U.S.C.  
16 1395ll(b)) is amended by striking “the Joint Com-  
17 mission on Accreditation of Hospitals,” and insert-  
18 ing “national accreditation bodies under section  
19 1865(a)”.

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

23 (6) Section 1852(e)(4)(C) of such Act (42  
24 U.S.C. 1395w-22(e)(4)(C)) is amended by striking

1 “section 1865(b)(2)” and inserting “section  
2 1865(a)(2)”.

3 (c) AUTHORITY TO RECOGNIZE JCAHO AS A NA-  
4 TIONAL ACCREDITATION BODY.—The Secretary of Health  
5 and Human Services may recognize the Joint Commission  
6 on Accreditation of Healthcare Organizations as a na-  
7 tional accreditation body under section 1865 of the Social  
8 Security Act (42 U.S.C. 1395bb), as amended by this sec-  
9 tion, upon such terms and conditions, and upon submis-  
10 sion of such information, as the Secretary may require.

11 (d) EFFECTIVE DATE; TRANSITION RULE.—(1) Sub-  
12 ject to paragraph (2), the amendments made by this sec-  
13 tion shall apply with respect to accreditations of hospitals  
14 granted on or after the date that is 18 months after the  
15 date of the enactment of this Act.

16 (2) For purposes of title XVIII of the Social Security  
17 Act (42 U.S.C. 1395 et seq.), the amendments made by  
18 this section shall not effect the accreditation of a hospital  
19 by the Joint Commission on Accreditation of Healthcare  
20 Organizations, or under accreditation or comparable ap-  
21 proval standards found to be essentially equivalent to ac-  
22 creditation or approval standards of the Joint Commission  
23 on Accreditation of Healthcare Organizations, for the pe-  
24 riod of time applicable under such accreditation.



1 **SEC. 508. TREATMENT OF MEDICARE HOSPITAL RECLASSI-**  
2 **FICATIONS.**

3 (a) EXTENDING CERTAIN MEDICARE HOSPITAL  
4 WAGE INDEX RECLASSIFICATIONS THROUGH FISCAL  
5 YEAR 2009.—

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, 2009”.

11 (2) SPECIAL EXCEPTION RECLASSIFICATIONS.—  
12 The Secretary of Health and Human Services shall  
13 extend for discharges occurring through September  
14 30, 2009, the special exception reclassification made  
15 under the authority of section 1886(d)(5)(I)(i) of  
16 the Social Security Act (42 U.S.C.  
17 1395ww(d)(5)(I)(i)) and contained in the final rule  
18 promulgated by the Secretary in the Federal Reg-  
19 ister on August 11, 2004 (69 Fed. Reg. 49105,  
20 49107).

21 (b) DISREGARDING SECTION 508 HOSPITAL RECLAS-  
22 SIFICATIONS FOR PURPOSES OF GROUP RECLASSIFICA-  
23 TIONS.—Section 508 of the Medicare Prescription Drug,  
24 Improvement, and Modernization Act of 2003 (Public Law  
25 108–173, 42 U.S.C. 1395ww note) is amended by adding  
26 at the end the following new subsection:

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

11       (c) OTHER HOSPITAL RECLASSIFICATION PROVI-  
12 SIONS.—Notwithstanding any other provision of law—

13           (1) In the case of a subsection (d) hospital (as  
14 defined for purposes of section 1886 of the Social  
15 Security Act (42 U.S.C. 1395ww)) located in Put-  
16 nam County, Tennessee with respect to which a re-  
17 classification of its wage index for purposes of such  
18 section would (but for this subsection) expire on  
19 September 30, 2007, such reclassification of such  
20 hospital shall be extended through September 30,  
21 2008.

22           (2) For purposes of making payments under  
23 section 1886(d) of the Social Security Act (42  
24 U.S.C. 1395ww(d)), the Secretary of Health and  
25 Human Services shall classify any hospital located in

1 Orange County, New York that was reclassified  
2 under the authority of section 508 of the Medicare  
3 Prescription Drug, Improvement and Modernization  
4 Act of 2003 (Public Law 108–173) as being located  
5 in the New York-White Plains-Wayne, NY–NJ Core  
6 Based Statistical Area. Any reclassification under  
7 this subsection shall be treated as a reclassification  
8 under section 1886(d)(8) of such Act.

9 (3) For purposes of making payments under  
10 section 1886(d) of the Social Security Act (42  
11 U.S.C. 1395ww(d)), the large urban area of New  
12 York, New York is deemed to include hospitals, re-  
13 quired by State law enacted prior to June 30, 2007,  
14 to join under a single unified governance structure  
15 if—

16 (A) such hospitals are located in a city  
17 with a population of no less than 20,000 and no  
18 greater than 30,000; and

19 (B) such hospitals are less than 3/4 miles  
20 apart.

21 (4) For purposes of making payments under  
22 section 1886(d) of the Social Security Act (42  
23 U.S.C. 1395ww(d)) the large urban area of Buffalo-  
24 Niagara Falls, New York is deemed to include Chau-  
25 tauqua County, New York. In no case shall there be

1 a reduction in the hospital wage index for Erie  
2 County, New York, or any adjoining county, as a re-  
3 sult of the application of this paragraph (other than  
4 as a result of a general reduction required to carry  
5 out paragraph (8)(D) of that section).

6 (5) For purposes of making payments under  
7 section 1886(d) of the Social Security Act (42  
8 U.S.C. 1395ww(d)) a hospital shall be reclassified  
9 into the New York-White Plains-Wayne, New York-  
10 New Jersey core based statistical area (CBSA code  
11 35644) if the hospital is a subsection (d) hospital  
12 (as defined in section 1886(d)(1)(B) of the Social  
13 Security Act (42 U.S.C. 1395ww(d)(1)(B)) that—

14 (A) is licensed by the State in which it is  
15 located as a specialty hospital;

16 (B) specializes in the treatment of cardiac,  
17 vascular, and pulmonary diseases;

18 (C) provides at least 100 beds; and

19 (D) is located in Burlington County, New  
20 Jersey.

21 (6)(A) Any hospital described in subparagraph  
22 (B) shall be treated as located in the core based sta-  
23 tistical area described in subparagraph (C) for pur-  
24 poses of making payments under section 1886(d) of  
25 the Social Security Act (42 U.S.C. 1395ww(d)).

1           (B) A hospital described in this subparagraph  
2 is any hospital that—

3           (i) is located in a core based statistical  
4 area (CBSA) that—

5           (I) had a population (as reported in  
6 the decennial census for the year 2000) of  
7 at least 500,000, but not more than  
8 750,000;

9           (II) had a population (as reported in  
10 such census) that was at least 10,000  
11 below the population for the area as re-  
12 ported in the previous decennial census;  
13 and

14           (III) has as of January 1, 2006, at  
15 least 5, and no more than 7, subsection (d)  
16 hospitals; and

17           (ii) demonstrates that its average hourly  
18 wage amount (as determined consistent with  
19 section 1886(d)(10)(D)(vi) of the Social Secu-  
20 rity Act is not less than 96 percent of such av-  
21 erage hourly wage amount rate for all sub-  
22 section (d) hospitals located in same core base  
23 statistical area of the hospital.

1           (C) The area described in this subparagraph,  
2 with respect to a hospital described in subparagraph  
3 (B), is the core based statistical area that—

4           (i) is within the same State as, and is ad-  
5 jacent to, the core based statistical area in  
6 which the hospital is located; and

7           (ii) has an average hourly wage amount  
8 (described in subparagraph (B)(ii)) that is clos-  
9 est to (but does not exceed) such average hourly  
10 wage amount of the hospital.

11           (7) For purposes of making payments under  
12 section 1886(d) of the Social Security Act (42  
13 U.S.C. 1395ww(d)), the large urban area of Hart-  
14 ford, Connecticut is deemed to include Albany, Sche-  
15 nectady, and Rensselaer Counties, New York.

16           (8) For purposes of making payment under sec-  
17 tion 1886(d) of the Social Security Act (42 U.S.C.  
18 1395ww(d)), the Nashville-Davidson-Murfreesboro  
19 core based statistical area is deemed to include  
20 Cumberland County, Tennessee.

21           (9) For purposes of making payment under sec-  
22 tion 1886(d) of the Social Security Act (42 U.S.C.  
23 1395ww(d)), any hospital that is co-located in  
24 Marinette, Wisconsin and the Menominee, Michigan  
25 is deemed to be located in Chicago, Illinois.

1           (10) In the case of a hospital located in Massa-  
2 chusetts or Clinton County, New York, that is re-  
3 classified based on wages under paragraph (8) or  
4 (10) of section 1886(d) of the Social Security Act  
5 into an area the area wage index for which is in-  
6 creased under section 4410(a) of the Balanced  
7 Budget Act of 1997 (Public Law 10533), such in-  
8 creased area wage index shall also apply to such hos-  
9 pital under such section 1886(d).

10           (11) For purposes of applying the area wage  
11 index under section 1886(d) of the Social Security  
12 Act (42 U.S.C. 1395ww(d)), hospital provider num-  
13 bers 360112 and 23005 shall be treated as located  
14 in the same urban area as Ann Arbor, Michigan.

15           (12) For purposes of making payment under  
16 section 1886(d) of the Social Security Act (42  
17 U.S.C. 1395ww(d)), any hospital that is located in  
18 Columbia County, New York, with less 250 beds is  
19 deemed to be located in the New York-White Plains-  
20 Wayne, NY–NJ core based statistical area.

21           (13) For purposes of the previous provisions of  
22 this subsection (other than paragraph (1))—

23                   (A) any reclassification effected under such  
24 provisions shall be treated as a decision of the  
25 Medicare Geographic Classification Review

1 Board under section 1886(d) of the Social Se-  
2 curity Act and subject to budget neutrality  
3 under paragraph (8)(D) of such section; and

4 (B) such provisions shall only apply to dis-  
5 charges occurring on or after October 1, 2008,  
6 during the 3-year reclassification period begin-  
7 ning on such date.

8 **SEC. 509. MEDICARE CRITICAL ACCESS HOSPITAL DES-**  
9 **IGNATIONS.**

10 (a) IN GENERAL.—

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

15 “(3) EXCEPTION.—

16 “(A) IN GENERAL.—The amendment made  
17 by paragraph (1) shall not apply to the certifi-  
18 cation by the State of Minnesota on or after  
19 January 1, 2006, under section  
20 1820(c)(2)(B)(i)(II) of the Social Security Act  
21 (42 U.S.C. 1395i–4(c)(2)(B)(i)(II)) of one hos-  
22 pital that meets the criteria described in sub-  
23 paragraph (B) and is located in Cass County,  
24 Minnesota, as a necessary provider of health



1 care services to residents in the area of the hos-  
2 pital.

3 “(B) CRITERIA DESCRIBED.—A hospital  
4 meets the criteria described in this subpara-  
5 graph if the hospital—

6 “(i) has been granted an exception by  
7 the State to an otherwise applicable statu-  
8 tory restriction on hospital construction or  
9 licensing prior to the date of enactment of  
10 this subparagraph; and

11 “(ii) is located on property which the  
12 State has approved for conveyance to a  
13 county within the State prior to such date  
14 of enactment.”.

15 (2) Section 1820(c)(2)(B)(i)(I) of the Social Se-  
16 curity Act (42 U.S.C. 1395i-4(c)(2)(B)(i)(I)) is  
17 amended by striking “or,” and inserting “or, in the  
18 case of a hospital that is located in the county seat  
19 of Butler, Alabama, a 32-mile drive, or,”.

20 (b) EFFECTIVE DATE.—The amendment made by  
21 subsection (a)(2) shall apply to cost reporting periods be-  
22 ginning on or after the date of the enactment of this Act.

1 **TITLE VI—OTHER PROVISIONS**  
2 **RELATING TO MEDICARE**  
3 **PART B**

4 **Subtitle A—Payment and Coverage**  
5 **Improvements**

6 **SEC. 601. PAYMENT FOR THERAPY SERVICES.**

7 (a) EXTENSION OF EXCEPTIONS PROCESS FOR  
8 MEDICARE THERAPY CAPS.—Section 1833(g)(5) of the  
9 Social Security Act (42 U.S.C. 1395l(g)(5)), as amended  
10 by section 201 of the Medicare Improvements and Exten-  
11 sion Act of 2006 (division B of Public Law 109–432), is  
12 amended by striking “2007” and inserting “2009”.

13 (b) STUDY AND REPORT.—

14 (1) STUDY.—The Secretary of Health and  
15 Human Services, in consultation with appropriate  
16 stakeholders, shall conduct a study on refined and  
17 alternative payment systems to the Medicare pay-  
18 ment cap under section 1833(g) of the Social Secu-  
19 rity Act (42 U.S.C. 1395l(g)) for physical therapy  
20 services and speech-language pathology services, de-  
21 scribed in paragraph (1) of such section and occupa-  
22 tional therapy services described in paragraph (3) of  
23 such section. Such study shall consider, with respect  
24 to payment amounts under Medicare, the following:

1 (A) The creation of multiple payment caps  
2 for such services to better reflect costs associ-  
3 ated with specific health conditions.

4 (B) The development of a prospective pay-  
5 ment system, including an episode-based system  
6 of payments, for such services.

7 (C) The data needed for the development  
8 of a system of multiple payment caps (or an al-  
9 ternative payment methodology) for such serv-  
10 ices and the availability of such data.

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

14 **SEC. 602. MEDICARE SEPARATE DEFINITION OF OUT-**  
15 **PATIENT SPEECH-LANGUAGE PATHOLOGY**  
16 **SERVICES.**

17 (a) IN GENERAL.—Section 1861(ll) of the Social Se-  
18 curity Act (42 U.S.C. 1395x(ll)) is amended—

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

21 (2) by inserting after paragraph (1) the fol-  
22 lowing new paragraph:

23 “(2) The term ‘outpatient speech-language pathology  
24 services’ has the meaning given the term ‘outpatient phys-

1 ical therapy services’ in subsection (p), except that in ap-  
2 plying such subsection—

3 “(A) ‘speech-language pathology’ shall be sub-  
4 stituted for ‘physical therapy’ each place it appears;  
5 and

6 “(B) ‘speech-language pathologist’ shall be sub-  
7 stituted for ‘physical therapist’ each place it ap-  
8 pears.”.

9 (b) CONFORMING AMENDMENTS.—

10 (1) Section 1832(a)(2)(C) of the Social Security  
11 Act (42 U.S.C. 1395k(a)(2)(C)) is amended—

12 (A) by striking “and outpatient” and in-  
13 serting “, outpatient”; and

14 (B) by inserting before the semicolon at  
15 the end the following: “, and outpatient speech-  
16 language pathology services (other than services  
17 to which the second sentence of section 1861(p)  
18 applies through the application of section  
19 1861(l)(2))”.

20 (2) Subparagraphs (A) and (B) of section  
21 1833(a)(8) of such Act (42 U.S.C. 1395l(a)(8)) are  
22 each amended by striking “(which includes out-  
23 patient speech-language pathology services)” and in-  
24 serting “, outpatient speech-language pathology  
25 services,”.

1           (3) Section 1833(g)(1) of such Act (42 U.S.C.  
2 1395l(g)(1)) is amended—

3           (A) by inserting “and speech-language pa-  
4 thology services of the type described in such  
5 section through the application of section  
6 1861(ll)(2)” after “1861(p)”; and

7           (B) by inserting “and speech-language pa-  
8 thology services” after “and physical therapy  
9 services”.

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

12          (A) by striking “section 1861(g)” and in-  
13 serting “subsection (g) or (ll)(2) of section  
14 1861” each place it appears; and

15          (B) by inserting “or outpatient speech-lan-  
16 guage pathology services, respectively” after  
17 “occupational therapy services”.

18          (5) Section 1861(p) of such Act (42 U.S.C.  
19 1395x(p)) is amended by striking the fourth sen-  
20 tence.

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

1           (7) Section 1862(a)(20) of such Act (42 U.S.C.  
2 1395y(a)(20)) is amended—

3           (A) by striking “outpatient occupational  
4 therapy services or outpatient physical therapy  
5 services” and inserting “outpatient physical  
6 therapy services, outpatient speech-language pa-  
7 thology services, or outpatient occupational  
8 therapy services”; and

9           (B) by striking “section 1861(g)” and in-  
10 sserting “subsection (g) or (ll)(2) of section  
11 1861”.

12          (8) Section 1866(e)(1) of such Act (42 U.S.C.  
13 1395cc(e)(1)) is amended—

14           (A) by striking “section 1861(g)” and in-  
15 sserting “subsection (g) or (ll)(2) of section  
16 1861” the first two places it appears;

17           (B) by striking “defined) or” and inserting  
18 “defined),”; and

19           (C) by inserting before the semicolon at  
20 the end the following: “, or (through the oper-  
21 ation of section 1861(ll)(2)) with respect to the  
22 furnishing of outpatient speech-language pa-  
23 thology”.

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

4 (d) CONSTRUCTION.—Nothing in this section shall be  
5 construed to affect existing regulations and policies of the  
6 Centers for Medicare & Medicaid Services that require  
7 physician oversight of care as a condition of payment for  
8 speech-language pathology services under part B of the  
9 medicare program.

10 **SEC. 603. INCREASED REIMBURSEMENT RATE FOR CER-**  
11 **TIFIED NURSE-MIDWIVES.**

12 (a) IN GENERAL.—Section 1833(a)(1)(K) of the So-  
13 cial Security Act (42 U.S.C.1395l(a)(1)(K)) is amended  
14 by striking “(but in no event” and all that follows through  
15 “performed by a physician)”.

16 (b) EFFECTIVE DATE.—The amendment made by  
17 subsection (a) shall apply to services furnished on or after  
18 April 1, 2008.

19 **SEC. 604. ADJUSTMENT IN OUTPATIENT HOSPITAL FEE**  
20 **SCHEDULE INCREASE FACTOR.**

21 The first sentence of section 1833(t)(3)(C)(iv) of the  
22 Social Security Act (42 U.S.C. 1395l(t)(3)(C)(iv)) is  
23 amended by inserting before the period at the end the fol-  
24 lowing: “and reduced by 0.25 percentage point for such  
25 factor for such services furnished in 2008”.

1 **SEC. 605. EXCEPTION TO 60-DAY LIMIT ON MEDICARE SUB-**  
2 **STITUTE BILLING ARRANGEMENTS IN CASE**  
3 **OF PHYSICIANS ORDERED TO ACTIVE DUTY**  
4 **IN THE ARMED FORCES.**

5 (a) IN GENERAL.—Section 1842(b)(6)(D)(iii) of the  
6 Social Security Act (42 U.S.C. 1395u(b)(6)(D)(iii)) is  
7 amended by inserting after “of more than 60 days” the  
8 following: “or are provided over a longer continuous period  
9 during all of which the first physician has been called or  
10 ordered to active duty as a member of a reserve component  
11 of the Armed Forces”.

12 (b) EFFECTIVE DATE.—The amendment made by  
13 subsection (a) shall apply to services furnished on or after  
14 the date of the enactment of this section.

15 **SEC. 606. EXCLUDING CLINICAL SOCIAL WORKER SERVICES**  
16 **FROM COVERAGE UNDER THE MEDICARE**  
17 **SKILLED NURSING FACILITY PROSPECTIVE**  
18 **PAYMENT SYSTEM AND CONSOLIDATED PAY-**  
19 **MENT.**

20 (a) IN GENERAL.—Section 1888(e)(2)(A)(ii) of the  
21 Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)) is  
22 amended by inserting “clinical social worker services,”  
23 after “qualified psychologist services,”.

24 (b) CONFORMING AMENDMENT.—Section  
25 1861(hh)(2) of the Social Security Act (42 U.S.C.  
26 1395x(hh)(2)) is amended by striking “and other than



1 services furnished to an inpatient of a skilled nursing facil-  
 2 ity which the facility is required to provide as a require-  
 3 ment for participation”.

4 (c) EFFECTIVE DATE.—The amendments made by  
 5 this section shall apply to items and services furnished on  
 6 or after January 1, 2008.

7 **SEC. 607. COVERAGE OF MARRIAGE AND FAMILY THERA-**  
 8 **PIST SERVICES AND MENTAL HEALTH COUN-**  
 9 **SELOR SERVICES.**

10 (a) COVERAGE OF MARRIAGE AND FAMILY THERA-  
 11 PIST SERVICES.—

12 (1) COVERAGE OF SERVICES.—Section  
 13 1861(s)(2) of the Social Security Act (42 U.S.C.  
 14 1395x(s)(2)), as amended by section 201(a)(1), is  
 15 amended—

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

18 (B) in subparagraph (BB), by adding  
 19 “and” at the end; and

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

22 “(CC) marriage and family therapist services  
 23 (as defined in subsection (eee));”.

24 (2) DEFINITION.—Section 1861 of the Social  
 25 Security Act (42 U.S.C. 1395x), as amended by sec-

1        tions 201(a)(2) and 503(b)(1), is amended by add-  
2        ing at the end the following new subsection:

3            “Marriage and Family Therapist Services

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

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

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

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

1           “(C) is licensed or certified as a marriage and  
2 family therapist in the State in which marriage and  
3 family therapist services are performed.”.

4           (3) PROVISION FOR PAYMENT UNDER PART  
5 B.—Section 1832(a)(2)(B) of the Social Security  
6 Act (42 U.S.C. 1395k(a)(2)(B)) is amended by add-  
7 ing at the end the following new clause:

8                   “(v) marriage and family therapist  
9 services;”.

10          (4) AMOUNT OF PAYMENT.—

11           (A) IN GENERAL.—Section 1833(a)(1) of  
12 the Social Security Act (42 U.S.C.  
13 1395l(a)(1)), as amended by section 201(b)(1),  
14 is amended—

15                   (i) by striking “and” before “(W)”;

16                   and

17                   (ii) by inserting before the semicolon  
18 at the end the following: “, and (X) with  
19 respect to marriage and family therapist  
20 services under section 1861(s)(2)(CC), the  
21 amounts paid shall be 80 percent of the  
22 lesser of: (i) the actual charge for the serv-  
23 ices; or (ii) 75 percent of the amount de-  
24 termined for payment of a psychologist  
25 under subparagraph (L)”.

1 (B) DEVELOPMENT OF CRITERIA WITH RE-  
2 SPECT TO CONSULTATION WITH A PHYSICIAN.—

3 The Secretary of Health and Human Services  
4 shall, taking into consideration concerns for pa-  
5 tient confidentiality, develop criteria with re-  
6 spect to payment for marriage and family ther-  
7 apist services for which payment may be made  
8 directly to the marriage and family therapist  
9 under part B of title XVIII of the Social Secu-  
10 rity Act (42 U.S.C. 1395j et seq.) under which  
11 such a therapist must agree to consult with a  
12 patient's attending or primary care physician in  
13 accordance with such criteria.

14 (5) EXCLUSION OF MARRIAGE AND FAMILY  
15 THERAPIST SERVICES FROM SKILLED NURSING FA-  
16 CILITY PROSPECTIVE PAYMENT SYSTEM.—Section  
17 1888(e)(2)(A)(ii) of the Social Security Act (42  
18 U.S.C. 1395yy(e)(2)(A)(ii)), is amended by inserting  
19 “marriage and family therapist services (as defined  
20 in subsection (eee)(1)),” after “qualified psychologist  
21 services,”.

22 (6) COVERAGE OF MARRIAGE AND FAMILY  
23 THERAPIST SERVICES PROVIDED IN RURAL HEALTH  
24 CLINICS AND FEDERALLY QUALIFIED HEALTH CEN-  
25 TERS.—Section 1861(aa)(1)(B) of the Social Secu-

1 rity Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by  
2 striking “or by a clinical social worker (as defined  
3 in subsection (hh)(1)),” and inserting “, by a clinical  
4 social worker (as defined in subsection (hh)(1)), or  
5 by a marriage and family therapist (as defined in  
6 subsection (eee)(2)),”.

7 (7) INCLUSION OF MARRIAGE AND FAMILY  
8 THERAPISTS AS PRACTITIONERS FOR ASSIGNMENT  
9 OF CLAIMS.—Section 1842(b)(18)(C) of the Social  
10 Security Act (42 U.S.C. 1395u(b)(18)(C)) is amend-  
11 ed by adding at the end the following new clause:

12 “(vii) A marriage and family therapist (as de-  
13 fined in section 1861(eee)(2)).”.

14 (b) COVERAGE OF MENTAL HEALTH COUNSELOR  
15 SERVICES.—

16 (1) COVERAGE OF SERVICES.—Section  
17 1861(s)(2) of the Social Security Act (42 U.S.C.  
18 1395x(s)(2)), as amended by subsection (a)(1), is  
19 further amended—

20 (A) in subparagraph (BB), by striking

21 “and” at the end;

22 (B) in subparagraph (CC), by inserting

23 “and” at the end; and

24 (C) by adding at the end the following new

25 subparagraph:

1 “(DD) mental health counselor services (as de-  
2 fined in subsection (fff)(2));”.

3 (2) DEFINITION.—Section 1861 of the Social  
4 Security Act (42 U.S.C. 1395x), as amended by sec-  
5 tions 201(a)(2) and 503(b)(1) and subsection (a)(2),  
6 is amended by adding at the end the following new  
7 subsection:

8 “Mental Health Counselor; Mental Health Counselor  
9 Services

10 “(fff)(1) The term ‘mental health counselor’ means  
11 an individual who—

12 “(A) possesses a master’s or doctor’s degree  
13 which qualifies the individual for licensure or certifi-  
14 cation for the practice of mental health counseling in  
15 the State in which the services are performed;

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

19 “(C) is licensed or certified as a mental health  
20 counselor or professional counselor by the State in  
21 which the services are performed.

22 “(2) The term ‘mental health counselor services’  
23 means services performed by a mental health counselor (as  
24 defined in paragraph (1)) for the diagnosis and treatment  
25 of mental illnesses which the mental health counselor is

1 legally authorized to perform under State law (or the  
2 State regulatory mechanism provided by the State law) of  
3 the State in which such services are performed, provided  
4 such services are covered under this title, as would other-  
5 wise be covered if furnished by a physician or as incident  
6 to a physician’s professional service, but only if no facility  
7 or other provider charges or is paid any amounts with re-  
8 spect to the furnishing of such services.”.

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

14                       “(vi) mental health counselor serv-  
15                       ices;”.

16           (4) AMOUNT OF PAYMENT.—

17           (A) IN GENERAL.—Section 1833(a)(1) of  
18       the Social Security Act (42 U.S.C.  
19       1395l(a)(1)), as amended by subsection (a)(4),  
20       is further amended—

21                       (i) by striking “and” before “(X)”;

22                       and

23                       (ii) by inserting before the semicolon  
24                       at the end the following: “, and (Y) with  
25                       respect to mental health counselor services

1           under section 1861(s)(2)(DD), the  
2           amounts paid shall be 80 percent of the  
3           lesser of: (i) the actual charge for the serv-  
4           ices; or (ii) 75 percent of the amount de-  
5           termined for payment of a psychologist  
6           under subparagraph (L)”.

7           (B) DEVELOPMENT OF CRITERIA WITH RE-  
8           SPECT TO CONSULTATION WITH A PHYSICIAN.—  
9           The Secretary of Health and Human Services  
10          shall, taking into consideration concerns for pa-  
11          tient confidentiality, develop criteria with re-  
12          spect to payment for mental health counselor  
13          services for which payment may be made di-  
14          rectly to the mental health counselor under part  
15          B of title XVIII of the Social Security Act (42  
16          U.S.C. 1395j et seq.) under which such a coun-  
17          selor must agree to consult with a patient’s at-  
18          tending or primary care physician in accordance  
19          with such criteria.

20          (5) EXCLUSION OF MENTAL HEALTH COUN-  
21          SELOR SERVICES FROM SKILLED NURSING FACILITY  
22          PROSPECTIVE PAYMENT SYSTEM.—Section  
23          1888(e)(2)(A)(ii) of the Social Security Act (42  
24          U.S.C. 1395yy(e)(2)(A)(ii)), as amended by sub-  
25          section (a)(5), is amended by inserting “mental



1 health counselor services (as defined in section  
2 1861(ddd)(2)),” after “marriage and family thera-  
3 pist services (as defined in subsection (eee)(1)),”.

4 (6) COVERAGE OF MENTAL HEALTH COUN-  
5 SELOR SERVICES PROVIDED IN RURAL HEALTH  
6 CLINICS AND FEDERALLY QUALIFIED HEALTH CEN-  
7 TERS.—Section 1861(aa)(1)(B) of the Social Secu-  
8 rity Act (42 U.S.C. 1395x(aa)(1)(B)), as amended  
9 by subsection (a)(6), is amended by striking “or by  
10 a marriage and family therapist (as defined in sub-  
11 section (eee)(2)),” and inserting “by a marriage and  
12 family therapist (as defined in subsection (eee)(2)),  
13 or a mental health counselor (as defined in sub-  
14 section (fff)(1)),”.

15 (7) INCLUSION OF MENTAL HEALTH COUN-  
16 SELORS AS PRACTITIONERS FOR ASSIGNMENT OF  
17 CLAIMS.—Section 1842(b)(18)(C) of the Social Se-  
18 curity Act (42 U.S.C. 1395u(b)(18)(C)), as amended  
19 by subsection (a)(7), is amended by adding at the  
20 end the following new clause:

21 “(viii) A mental health counselor (as defined in  
22 section 1861(fff)(1)).”.

23 (c) EFFECTIVE DATE.—The amendments made by  
24 this section shall apply to items and services furnished on  
25 or after January 1, 2008.

1 **SEC. 608. RENTAL AND PURCHASE OF POWER-DRIVEN**  
2 **WHEELCHAIRS.**

3 (a) IN GENERAL.—Section 1834(a)(7) of the Social  
4 Security Act (42 U.S.C. 1395m(a)(7)) is amended—

5 (1) in subparagraph (A)—

6 (A) in clause (i)(I), by striking “Except as  
7 provided in clause (iii), payment” and inserting  
8 “Payment”;

9 (B) by striking clause (iii); and

10 (C) in clause (iv)—

11 (i) by redesignating such clause as  
12 clause (iii); and

13 (ii) by striking “or in the case of a  
14 power-driven wheelchair for which a pur-  
15 chase agreement has been entered into  
16 under clause (iii)”;

17 (2) in subparagraph (C)(ii)(II), by striking “or  
18 (A)(iii)”.

19 (b) EFFECTIVE DATE.—

20 (1) IN GENERAL.—Subject to paragraph (1),  
21 the amendments made by subsection (a) shall take  
22 effect on January 1, 2008, and shall apply to power-  
23 driven wheelchairs furnished on or after such date.

24 (2) APPLICATION TO COMPETITIVE ACQUISI-  
25 TION.—The amendments made by subsection (a)  
26 shall not apply to contracts entered into under sec-

1       tion 1847 of the Social Security Act (42 U.S.C.  
2       1395w-3) pursuant to a bid submitted under such  
3       section before October 1, 2007.

4 **SEC. 609. RENTAL AND PURCHASE OF OXYGEN EQUIPMENT.**

5       (a) IN GENERAL.—Section 1834(a)(5)(F) of the So-  
6       cial Security Act (42 U.S.C. 1395m(a)(5)(F)) is amend-  
7       ed—

8               (1) in clause (i)—

9                       (A) by striking “Payment” and inserting  
10                      “Subject to clause (iii), payment”; and

11                      (B) by striking “36 months” and inserting  
12                      “18 months”;

13               (2) in clause (ii)(I), by striking “36th contin-  
14       uous month” and inserting “18th continuous  
15       month”; and

16               (3) by adding at the end the following new  
17       clause:

18                               “(iii) SPECIAL RULE FOR OXYGEN  
19                               GENERATING PORTABLE EQUIPMENT.—In  
20                               the case of oxygen generating portable  
21                               equipment referred to in the final rule pub-  
22                               lished in the Federal Register on Novem-  
23                               ber 9, 2006 (71 Fed. Reg. 65897–65899),  
24                               in applying clauses (i) and (ii)(I) each ref-

1                   erence to ‘18 months’ is deemed a ref-  
2                   erence to ‘36 months’.”.

3           (b) EFFECTIVE DATE.—

4               (1) IN GENERAL.—Subject to paragraph (3),  
5               the amendments made by subsection (a) shall apply  
6               to oxygen equipment furnished on or after January  
7               1, 2008.

8               (2) TRANSITION.—In the case of an individual  
9               receiving oxygen equipment on December 31, 2007,  
10              for which payment is made under section 1834(a) of  
11              the Social Security Act (42 U.S.C. 1395m(a)), the  
12              18-month period described in paragraph (5)(F)(i) of  
13              such section, as amended by subsection (a), shall  
14              begin on January 1, 2008, but in no case shall the  
15              rental period for such equipment exceed 36 months.

16              (3) APPLICATION TO COMPETITIVE ACQUI-  
17              TION.—The amendments made by subsection (a)  
18              shall not apply to contracts entered into under sec-  
19              tion 1847 of the Social Security Act (42 U.S.C.  
20              1395w-3) pursuant to a bid submitted under such  
21              section before October 1, 2007.

22           (c) STUDY AND REPORT.—

23               (1) STUDY.—The Secretary of Health and  
24               Human Services shall conduct a study to examine  
25               the service component and the equipment component

1 of the provision of oxygen to Medicare beneficiaries.

2 The study shall assess—

3 (A) the type of services provided and vari-  
4 ation across suppliers in providing such serv-  
5 ices;

6 (B) whether the services are medically nec-  
7 essary or affect patient outcomes;

8 (C) whether the Medicare program pays  
9 appropriately for equipment in connection with  
10 the provision of oxygen;

11 (D) whether such program pays appro-  
12 priately for necessary services;

13 (E) whether such payment in connection  
14 with the provision of oxygen should be divided  
15 between equipment and services, and if so, how;  
16 and

17 (F) how such payment rate compares to a  
18 competitively bid rate.

19 (2) REPORT.—Not later than 18 months after  
20 the date of the enactment of this Act, the Secretary  
21 of Health and Human Services shall submit to Con-  
22 gress a report on the study conducted under para-  
23 graph (1).

1 **SEC. 610. ADJUSTMENT FOR MEDICARE MENTAL HEALTH**  
2 **SERVICES.**

3 (a) IN GENERAL.—For purposes of payment for serv-  
4 ices furnished under the physician fee schedule under sec-  
5 tion 1848 of the Social Security Act (42 U.S.C. 1395w-  
6 4) during the applicable period, the Secretary of Health  
7 and Human Services shall increase the amount otherwise  
8 payable for applicable services by 5 percent.

9 (b) DEFINITIONS.—For purposes of subsection (a):

10 (1) APPLICABLE PERIOD.—The term “applica-  
11 ble period” means the period beginning on January  
12 1, 2008, and ending on December 31 of the year be-  
13 fore the effective date of the first review after Janu-  
14 ary 1, 2008, of work relative value units conducted  
15 under section 1848(c)(2)(B)(i) of the Social Security  
16 Act.

17 (2) APPLICABLE SERVICES.—The term “appli-  
18 cable services” means procedure codes for services—

19 (A) in the categories of psychiatric thera-  
20 peutic procedures furnished in office or other  
21 outpatient facility settings, or inpatient hos-  
22 pital, partial hospital or residential care facility  
23 settings; and

24 (B) which cover insight oriented, behavior  
25 modifying, or supportive psychotherapy and  
26 interactive psychotherapy services in the

1 Healthcare Common Procedure Coding System  
2 established by the Secretary of Health and  
3 Human Services under section 1848(c)(5) of  
4 such Act.

5 (c) IMPLEMENTATION.—Notwithstanding any other  
6 provision of law, the Secretary of Health and Human  
7 Services may implement this section by program instruc-  
8 tion or otherwise.

9 **SEC. 611. EXTENSION OF BRACHYTHERAPY SPECIAL RULE.**

10 Section 1833(t)(16)(C) of the Social Security Act (42  
11 U.S.C. 1395l(t)(16)(C)) is amended by striking “2008”  
12 and inserting “2009”.

13 **SEC. 612. PAYMENT FOR PART B DRUGS.**

14 (a) APPLICATION OF CONSISTENT VOLUME  
15 WEIGHTING IN COMPUTATION OF ASP.—In order to as-  
16 sure that payments for drugs and biologicals under section  
17 1847A of the Social Security Act (42 U.S.C. 1395w–3a)  
18 are correct and consistent with law, the Secretary of  
19 Health and Human Services shall, for payment for drugs  
20 and biologicals furnished on or after July 1, 2008, com-  
21 pute the volume-weighted average sales price using equa-  
22 tion #2 (specified in appendix A of the report of the In-  
23 spector General of the Department of Health and Human  
24 Services on “Calculation of Volume-Weighted Average  
25 Sales Price for Medicare Part B Prescription Drugs”

1 (February 2006; OEI-03-05-00310)) used by the Office  
2 of Inspector General to calculate a volume-weighted ASP.

3 (b) IMPROVEMENTS IN THE COMPETITIVE ACQUISITION PROGRAM (CAP).—  
4

5 (1) CONTINUOUS OPEN ENROLLMENT; AUTO-  
6 MATIC REENROLLMENT WITHOUT NEED FOR RE-  
7 APPLICATION.—Subsection (a)(1)(A) of section  
8 1847B of the Social Security Act (42 U.S.C.  
9 1395w-3b) is amended—

10 (A) in clause (ii), by striking “annually”  
11 and inserting “on an ongoing basis”;

12 (B) in clause (iii), by striking “an annual  
13 selection” and inserting “a selection (which  
14 may be changed on an annual basis)”; and

15 (C) by adding at the end the following:  
16 “An election and selection described in clauses  
17 (ii) and (iii) shall continue to be effective with-  
18 out the need for any periodic reelection or re-  
19 application or selection.”.

20 (2) PERMITTING APPROPRIATE DELIVERY AND  
21 TRANSPORT OF DRUGS.—Subsection (b)(4)(E) of  
22 such section is amended—

23 (A) by striking “or” at the end of clause  
24 (i);



1 (B) by striking the period at the end of  
2 clause (ii) and inserting a semicolon; and

3 (C) by adding at the end the following new  
4 clauses:

5 “(iii) prevent a contractor from deliv-  
6 ering drugs to a satellite office designated  
7 by the prescribing physician; or

8 “(iv) prevent a contractor from allow-  
9 ing a selecting physician to transport  
10 drugs or biologicals to the site of adminis-  
11 tration consistent with State law and other  
12 applicable laws and regulations.”.

13 (3) PHYSICIAN OUTREACH AND EDUCATION.—  
14 Subsection (a)(1) of such section is amended by add-  
15 ing at the end the following new subparagraph:

16 “(E) PHYSICIAN OUTREACH AND EDU-  
17 CATION.—The Secretary shall conduct a pro-  
18 gram of outreach to education physicians con-  
19 cerning the program and the ongoing oppor-  
20 tunity of physicians to elect to obtain drugs and  
21 biologicals under the program.”.

22 (4) REBIDDING OF CONTRACTS.—The Secretary  
23 of Health and Human Services shall provide for the  
24 rebidding of contracts under section 1847B(c) of the  
25 Social Security Act (42 U.S.C. 1395w–3b(c)) only

1 for periods on or after the expiration of the contract  
2 in effect under such section as of the date of the en-  
3 actment of this Act, except in the case of a con-  
4 tractor terminated as a result of the application of  
5 section 1847B(b)(2)(B) of such Act.

6 (c) TREATMENT OF CERTAIN DRUGS.—Section  
7 1847A(b) of the Social Security Act (42 U.S.C. 1395w-  
8 3a(b)) is amended—

9 (1) in paragraph (1), by inserting “paragraph  
10 (6) and” after “Subject to”; and

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

13 “(6) SPECIAL RULE.—Beginning with January  
14 1, 2008, the payment amount for—

15 “(A) each single source drug or biological  
16 described in section 1842(o)(1)(G) (including a  
17 single source drug or biological that is treated  
18 as a multiple source drug because of the appli-  
19 cation of subsection (c)(6)(C)(ii)) is the lower  
20 of—

21 “(i) the payment amount that would  
22 be determined for such drug or biological  
23 applying such subsection; or

24 “(ii) the payment amount that would  
25 have been determined for such drug or bio-

1           logical if such subsection were not applied;  
2           and

3           “(B) a multiple source drug (excluding a  
4           drug or biological that is treated as a multiple  
5           source drug because of the application of such  
6           subsection) is the lower of—

7                   “(i) the payment amount that would  
8                   be determined for such drug or biological  
9                   taking into account the application of such  
10                  subsection; or

11                   “(ii) the payment amount that would  
12                   have been determined for such drug or bio-  
13                   logical if such subsection were not ap-  
14                   plied.”.

15       (d) EFFECTIVE DATE.—Except as otherwise pro-  
16       vided, the amendments made by this section shall apply  
17       to drugs furnished on or after January 1, 2008.

## 18       **Subtitle B—Extension of Medicare**

### 19           **Rural Access Protections**

#### 20       **SEC. 621. 2-YEAR EXTENSION OF FLOOR ON MEDICARE**

##### 21           **WORK GEOGRAPHIC ADJUSTMENT.**

22       Section 1848(e)(1)(E) of such Act (42 U.S.C.  
23       1395w–4(e)(1)(E)) is amended by striking “2008” and in-  
24       serting “2010”.

1 **SEC. 622. 2-YEAR EXTENSION OF SPECIAL TREATMENT OF**  
2 **CERTAIN PHYSICIAN PATHOLOGY SERVICES**  
3 **UNDER MEDICARE.**

4 Section 542(c) of the Medicare, Medicaid, and  
5 SCHIP Benefits Improvement and Protection Act of  
6 2000, as amended by section 732 of the Medicare Pre-  
7 scription Drug, Improvement, and Modernization Act of  
8 2003, and section 104 of the Medicare Improvements and  
9 Extension Act of 2006 (division B of Public Law 109-  
10 432), is amended by striking “and 2007” and inserting  
11 “2007, 2008, and 2009”.

12 **SEC. 623. 2-YEAR EXTENSION OF MEDICARE REASONABLE**  
13 **COSTS PAYMENTS FOR CERTAIN CLINICAL**  
14 **DIAGNOSTIC LABORATORY TESTS FUR-**  
15 **NISHED TO HOSPITAL PATIENTS IN CERTAIN**  
16 **RURAL AREAS.**

17 Section 416(b) of the Medicare Prescription Drug,  
18 Improvement, and Modernization Act of 2003 (Public Law  
19 108-173; 117 Stat. 2282; 42 U.S.C. 1395l-4(b)), as  
20 amended by section 105 of the Medicare Improvement and  
21 Extension Act of 2006 (division B of Public Law 109-  
22 432), is amended by striking “3-year” and inserting “5-  
23 year”.

1 **SEC. 624. 2-YEAR EXTENSION OF MEDICARE INCENTIVE**  
2 **PAYMENT PROGRAM FOR PHYSICIAN SCAR-**  
3 **CITY AREAS.**

4 (a) IN GENERAL.—Section 1833(u)(1) of the Social  
5 Security Act (42 U.S.C. 1395l(u)(1)) is amended by strik-  
6 ing “2008” and inserting “2010”.

7 (b) TRANSITION.—With respect to physicians’ serv-  
8 ices furnished during 2008 and 2009, for purposes of sub-  
9 section (a), the Secretary of Health and Human Services  
10 shall use the primary care scarcity areas and the specialty  
11 care scarcity areas (as identified in section 1833(u)(4))  
12 that the Secretary was using under such subsection with  
13 respect to physicians’ services furnished on December 31,  
14 2007.

15 **SEC. 625. 2-YEAR EXTENSION OF MEDICARE INCREASE PAY-**  
16 **MENTS FOR GROUND AMBULANCE SERVICES**  
17 **IN RURAL AREAS.**

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

20 (1) in subparagraph (A)—

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

24 (B) in clause (i), by inserting “for services  
25 furnished on or after July 1, 2004, and before  
26 January 1, 2007, and on or after January 1,

1           2008, and before January 1, 2010,” after “in  
2           such paragraph,”; and

3           (C) in clause (ii), by inserting “for services  
4           furnished on or after July 1, 2004, and before  
5           January 1, 2007,” after “in clause (i),”; and  
6           (2) in subparagraph (B)—

7           (A) in the heading, by striking “AFTER  
8           2006” and inserting “FOR SUBSEQUENT PERI-  
9           ODS”;

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

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

14 **SEC. 626. EXTENDING HOLD HARMLESS FOR SMALL RURAL**  
15 **HOSPITALS UNDER THE HOPD PROSPECTIVE**  
16 **PAYMENT SYSTEM.**

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

19          (1) by striking “January 1, 2009” and insert-  
20          ing “January 1, 2010”;

21          (2) by striking “2007, or 2008,”; and

22          (3) by striking “90 percent, and 85 percent, re-  
23          spectively.” and inserting “and with respect to such  
24          services furnished after 2006 the applicable percent-  
25          age shall be 90 percent.”.

1           **Subtitle C—End Stage Renal**  
2                   **Disease Program**

3 **SEC. 631. CHRONIC KIDNEY DISEASE DEMONSTRATION**  
4                   **PROJECTS.**

5           (a) IN GENERAL.—The Secretary of Health and  
6 Human Services (in this section referred to as the “Sec-  
7 retary”), acting through the Director of the National In-  
8 stitutes of Health, shall establish demonstration projects  
9 to—

10                   (1) increase public and medical community  
11 awareness (particularly of those who treat patients  
12 with diabetes and hypertension) about the factors  
13 that lead to chronic kidney disease, how to prevent  
14 it, how to diagnose it, and how to treat it;

15                   (2) increase screening and use of prevention  
16 techniques for chronic kidney disease for Medicare  
17 beneficiaries and the general public (particularly  
18 among patients with diabetes and hypertension,  
19 where prevention techniques are well established and  
20 early detection makes prevention possible); and

21                   (3) enhance surveillance systems and expand re-  
22 search to better assess the prevalence and incidence  
23 of chronic kidney disease, (building on work done by  
24 Centers for Disease Control and Prevention).

25           (b) SCOPE AND DURATION.—

1           (1) SCOPE.—The Secretary shall select at least  
2           3 States in which to conduct demonstration projects  
3           under this section. In selecting the States under this  
4           paragraph, the Secretary shall take into account the  
5           size of the population of individuals with end-stage  
6           renal disease who are enrolled in part B of title  
7           XVIII of the Social Security Act and ensure the par-  
8           ticipation of individuals who reside in rural and  
9           urban areas.

10           (2) DURATION.—The demonstration projects  
11           under this section shall be conducted for a period  
12           that is not longer than 5 years and shall begin on  
13           January 1, 2009.

14           (c) EVALUATION AND REPORT.—

15           (1) EVALUATION.—The Secretary shall conduct  
16           an evaluation of the demonstration projects con-  
17           ducted under this section.

18           (2) REPORT.—Not later than 12 months after  
19           the date on which the demonstration projects under  
20           this section are completed, the Secretary shall sub-  
21           mit to Congress a report on the evaluation con-  
22           ducted under paragraph (1) together with rec-  
23           ommendations for such legislation and administra-  
24           tive action as the Secretary determines appropriate.



1 **SEC. 632. MEDICARE COVERAGE OF KIDNEY DISEASE PA-**  
2 **TIENT EDUCATION SERVICES.**

3 (a) COVERAGE OF KIDNEY DISEASE EDUCATION  
4 SERVICES.—

5 (1) COVERAGE.—Section 1861(s)(2) of the So-  
6 cial Security Act (42 U.S.C. 1395x(s)(2)), as  
7 amended by sections 201(a)(1), 607(a)(1), and  
8 607(b)(1), is amended—

9 (A) in subparagraph (CC), by striking  
10 “and” after the semicolon at the end;

11 (B) in subparagraph (DD), by adding  
12 “and” after the semicolon at the end; and

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

15 “(EE) kidney disease education services (as de-  
16 fined in subsection (ggg));”.

17 (2) SERVICES DESCRIBED.—Section 1861 of  
18 the Social Security Act (42 U.S.C. 1395x), as  
19 amended by sections 201(a)(2), 503(b)(1),  
20 607(a)(2), and 607(b)(2), is amended by adding at  
21 the end the following new subsection:

22 “Kidney Disease Education Services

23 “(ggg)(1) The term ‘kidney disease education serv-  
24 ices’ means educational services that are—

25 “(A) furnished to an individual with stage IV  
26 chronic kidney disease who, according to accepted

1 clinical guidelines identified by the Secretary, will re-  
2 quire dialysis or a kidney transplant;

3 “(B) furnished, upon the referral of the physi-  
4 cian managing the individual’s kidney condition, by  
5 a qualified person (as defined in paragraph (2)); and

6 “(C) designed—

7 “(i) to provide comprehensive information  
8 (consistent with the standards developed under  
9 paragraph (3)) regarding—

10 “(I) the management of comorbidities,  
11 including for purposes of delaying the need  
12 for dialysis;

13 “(II) the prevention of uremic com-  
14 plications; and

15 “(III) each option for renal replace-  
16 ment therapy (including hemodialysis and  
17 peritoneal dialysis at home and in-center  
18 as well as vascular access options and  
19 transplantation);

20 “(ii) to ensure that the individual has the  
21 opportunity to actively participate in the choice  
22 of therapy; and

23 “(iii) to be tailored to meet the needs of  
24 the individual involved.

1           “(2) The term ‘qualified person’ means a physician,  
2 physician assistant, nurse practitioner, or clinical nurse  
3 specialist who furnishes services for which payment may  
4 be made under the fee schedule established under section  
5 1848. Such term does not include a renal dialysis facility.

6           “(3) The Secretary shall set standards for the con-  
7 tent of such information to be provided under paragraph  
8 (1)(C)(i) after consulting with physicians, other health  
9 professionals, health educators, professional organizations,  
10 accrediting organizations, kidney patient organizations, di-  
11 alysis facilities, transplant centers, network organizations  
12 described in section 1881(c)(2), and other knowledgeable  
13 persons. To the extent possible the Secretary shall consult  
14 with a person or entity described in the previous sentence,  
15 other than a dialysis facility, that has not received indus-  
16 try funding from a drug or biological manufacturer or di-  
17 alysis facility.

18           “(4) In promulgating regulations to carry out this  
19 subsection, the Secretary shall ensure that each individual  
20 who is eligible for benefits for kidney disease education  
21 services under this title receives such services in a timely  
22 manner to maximize the benefit of those services.

23           “(5) The Secretary shall monitor the implementation  
24 of this subsection to ensure that individuals who are eligi-  
25 ble for benefits for kidney disease education services re-

1 ceive such services in the manner described in paragraph  
2 (4).

3 “(6) No individual shall be eligible to be provided  
4 more than 6 sessions of kidney disease education services  
5 under this title.”.

6 (3) PAYMENT UNDER THE PHYSICIAN FEE  
7 SCHEDULE.—Section 1848(j)(3) of the Social Secu-  
8 rity Act (42 U.S.C. 1395w-4(j)(3)) is amended by  
9 inserting “(2)(DD),” after “(2)(AA),”.

10 (4) LIMITATION ON NUMBER OF SESSIONS.—  
11 Section 1862(a)(1) of the Social Security Act (42  
12 U.S.C. 1395y(a)(1)) is amended—

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

15 (B) in subparagraph (N), by striking the  
16 semicolon at the end and inserting “, and”; and

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

19 “(O) in the case of kidney disease education  
20 services (as defined in section 1861(ggg)), which are  
21 furnished in excess of the number of sessions cov-  
22 ered under such section;”.

23 (5) GAO REPORT.—Not later than September  
24 1, 2010, the Comptroller General of the United

1 States shall submit to Congress a report on the fol-  
2 lowing:

3 (A) The number of Medicare beneficiaries  
4 who are eligible to receive benefits for kidney  
5 disease education services (as defined in section  
6 1861(ggg) of the Social Security Act, as added  
7 by paragraph (2)) under title XVIII of such Act  
8 and who receive such services.

9 (B) The extent to which there is a suffi-  
10 cient amount of physicians, physician assist-  
11 ants, nurse practitioners, and clinical nurse spe-  
12 cialists to furnish kidney disease education serv-  
13 ices (as so defined) under such title and wheth-  
14 er or not renal dialysis facilities (and appro-  
15 priate employees of such facilities) should be in-  
16 cluded as an entity eligible under such section  
17 to furnish such services.

18 (C) Recommendations, if appropriate, for  
19 renal dialysis facilities (and appropriate employ-  
20 ees of such facilities) to structure kidney dis-  
21 ease education services (as so defined) in a  
22 manner that is objective and unbiased and that  
23 provides a range of options and alternative loca-  
24 tions for renal replacement therapy and man-

1           agement of co-morbidities that may delay the  
2           need for dialysis.

3           (b) **EFFECTIVE DATE.**—The amendments made by  
4 this section shall apply to services furnished on or after  
5 January 1, 2009.

6 **SEC. 633. REQUIRED TRAINING FOR PATIENT CARE DIALY-**  
7                                   **SIS TECHNICIANS.**

8           Section 1881 of the Social Security Act (42 U.S.C.  
9 1395rr) is amended by adding the following new sub-  
10 section:

11           “(h)(1) Except as provided in paragraph (2), a pro-  
12 vider of services or a renal dialysis facility may not use,  
13 for more than 12 months during 2009, or for any period  
14 beginning on January 1, 2010, any individual as a patient  
15 care dialysis technician unless the individual—

16                       “(A) has completed a training program in the  
17 care and treatment of an individual with chronic  
18 kidney failure who is undergoing dialysis treatment;  
19 and

20                       “(B) has been certified by a nationally recog-  
21 nized certification entity for dialysis technicians.

22           “(2)(A) A provider of services or a renal dialysis facil-  
23 ity may permit an individual enrolled in a training pro-  
24 gram described in paragraph (1)(A) to serve as a patient  
25 care dialysis technician while they are so enrolled.

1 “(B) The requirements described in subparagraphs  
2 (A), (B), and (C) of paragraph (1) do not apply to an  
3 individual who has performed dialysis-related services for  
4 at least 5 years.

5 “(3) For purposes of paragraph (1), if, since the most  
6 recent completion by an individual of a training program  
7 described in paragraph (1)(A), there has been a period  
8 of 24 consecutive months during which the individual has  
9 not furnished dialysis-related services for monetary com-  
10 pensation, such individual shall be required to complete  
11 a new training program or become recertified as described  
12 in paragraph (1)(B).

13 “(4) A provider of services or a renal dialysis facility  
14 shall provide such regular performance review and regular  
15 in-service education as assures that individuals serving as  
16 patient care dialysis technicians for the provider or facility  
17 are competent to perform dialysis-related services.”.

18 **SEC. 634. MEDPAC REPORT ON TREATMENT MODALITIES**

19 **FOR PATIENTS WITH KIDNEY FAILURE.**

20 (a) EVALUATION.—

21 (1) IN GENERAL.—Not later than March 1,  
22 2009, the Medicare Payment Advisory Commission  
23 (established under section 1805 of the Social Secu-  
24 rity Act) shall submit to the Secretary and Congress  
25 a report evaluating the barriers that exist to increas-

1       ing the number of individuals with end-stage renal  
2       disease who elect to receive home dialysis services  
3       under the Medicare program under title XVIII of  
4       the Social Security Act (42 U.S.C. 1395 et seq.).

5               (2) REPORT DETAILS.—The report shall include  
6       the following:

7               (A) A review of Medicare home dialysis  
8       demonstration projects initiated before the date  
9       of the enactment of this Act, and the results of  
10      such demonstration projects and recommenda-  
11      tions for future Medicare home dialysis dem-  
12      onstration projects or Medicare program  
13      changes that will test models that can improve  
14      Medicare beneficiary access to home dialysis.

15              (B) A comparison of current Medicare  
16      home dialysis costs and payments with current  
17      in-center and hospital dialysis costs and pay-  
18      ments.

19              (C) An analysis of the adequacy of Medi-  
20      care reimbursement for patient training for  
21      home dialysis (including hemodialysis and peri-  
22      toneal dialysis) and recommendations for ensur-  
23      ing appropriate payment for such home dialysis  
24      training.



1           (D) A catalogue and evaluation of the in-  
2           centives and disincentives in the current reim-  
3           bursement system that influence whether pa-  
4           tients receive home dialysis services or other  
5           treatment modalities.

6           (E) An evaluation of patient education  
7           services and how such services impact the treat-  
8           ment choices made by patients.

9           (F) Recommendations for implementing in-  
10          centives to encourage patients to elect to receive  
11          home dialysis services or other treatment mo-  
12          dalities under the Medicare program.

13          (3) SCOPE OF REVIEW.—In preparing the re-  
14          port under paragraph (1), the Medicare Payment  
15          Advisory Commission shall consider a variety of per-  
16          spectives, including the perspectives of physicians,  
17          other health care professionals, hospitals, dialysis fa-  
18          cilities, health plans, purchasers, and patients.

19 **SEC. 635. ADJUSTMENT FOR ERYTHROPOIETIN STIMU-**  
20 **LATING AGENTS (ESAS).**

21          (a) IN GENERAL.—Subsection (b)(13) of section  
22 1881 of the Social Security Act (42 U.S.C. 1395rr) is  
23 amended—

1           (1) in subparagraph (A)(iii), by striking “For  
2           such drugs” and inserting “Subject to subparagraph  
3           (C), for such drugs”; and

4           (2) by adding at the end the following new sub-  
5           paragraph:

6           “(C)(i) The payment amounts under this title for  
7           erythropoietin furnished during 2008 or 2009 to an indi-  
8           vidual with end stage renal disease by a large dialysis fa-  
9           cility (as defined in subparagraph (D)) (whether to indi-  
10          viduals in the facility or at home), in an amount equal  
11          to \$8.75 per thousand units (rounded to the nearest 100  
12          units) or, if less, 102 percent of the average sales price  
13          (as determined under section 1847A) for such drug or bio-  
14          logical.

15          “(ii) The payment amounts under this title for  
16          darbepoetin alfa furnished during 2008 or 2009 to an in-  
17          dividual with end stage renal disease by a large dialysis  
18          facility (as defined in clause (iii)) (whether to individuals  
19          in the facility or at home), in an amount equal to \$2.92  
20          per microgram or, if less, 102 percent of the average sales  
21          price (as determined under section 1847A) for such drug  
22          or biological.

23          “(iii) For purposes of this subparagraph, the term  
24          ‘large dialysis facility’ means a provider of services or  
25          renal dialysis facility that is owned or managed by a cor-

1 porate entity that, as of July 24, 2007, owns or manages  
2 300 or more such providers or facilities, and includes a  
3 successor to such a corporate entity.”.

4 (b) NO IMPACT ON DRUG ADD-ON PAYMENT.—Noth-  
5 ing in the amendments made by subsection (a) shall be  
6 construed to affect the amount of any payment adjust-  
7 ment made under section 1881(b)(12)(B)(ii) of the Social  
8 Security Act (42 U.S.C. 1395rr(b)(12)(B)(ii)).

9 **SEC. 636. SITE NEUTRAL COMPOSITE RATE.**

10 Subsection (b)(12)(A) of section 1881 of the Social  
11 Security Act (42 U.S.C. 1395rr) is amended by adding  
12 at the end the following new sentence: “Under such sys-  
13 tem the payment rate for dialysis services furnished on  
14 or after January 1, 2008, by providers of such services  
15 for hospital-based facilities shall be the same as the pay-  
16 ment rate (computed without regard to this sentence) for  
17 such services furnished by renal dialysis facilities that are  
18 not hospital-based, except that in applying the geographic  
19 index under subparagraph (D) to hospital-based facilities,  
20 the labor share shall be based on the labor share otherwise  
21 applied for such facilities.”.

1 **SEC. 637. DEVELOPMENT OF ESRD BUNDLING SYSTEM AND**  
2 **QUALITY INCENTIVE PAYMENTS.**

3 (a) DEVELOPMENT OF ESRD BUNDLING SYSTEM.—  
4 Subsection (b) of section 1881 of the Social Security Act  
5 (42 U.S.C. 1395rr) is further amended—

6 (1) in paragraph (12)(A), by striking “In lieu  
7 of payment” and inserting “Subject to paragraph  
8 (14), in lieu of payment”;

9 (2) in the second sentence of paragraph  
10 (12)(F)—

11 (A) by inserting “or paragraph (14)” after  
12 “this paragraph”; and

13 (B) by inserting “or under the system  
14 under paragraph (14)” after “subparagraph  
15 (B)”;

16 (3) in paragraph (12)(H)—

17 (A) by inserting “or paragraph (14)” after  
18 “under this paragraph” the first place it ap-  
19 pears; and

20 (B) by inserting before the period at the  
21 end the following: “or, under paragraph (14),  
22 the identification of renal dialysis services in-  
23 cluded in the bundled payment, the adjustment  
24 for outliers, the identification of facilities to  
25 which the phase-in may apply, and the deter-  
26 mination of payment amounts under subpara-

1 graph (A) under such paragraph, and the appli-  
2 cation of paragraph (13)(C)(iii)”;

3 (4) in paragraph (13)—

4 (A) in subparagraph (A), by striking “The  
5 payment amounts” and inserting “subject to  
6 paragraph (14), the payment amounts”; and

7 (B) in subparagraph (B)—

8 (i) in clause (i), by striking “(i)” after  
9 “(B)” and by inserting “, subject to para-  
10 graph (14)” before the period at the end;

11 and

12 (ii) by striking clause (ii); and

13 (5) by adding at the end the following new  
14 paragraph:

15 “(14)(A) Subject to subparagraph (E), for services  
16 furnished on or after January 1, 2010, the Secretary shall  
17 implement a payment system under which a single pay-  
18 ment is made under this title for renal dialysis services  
19 (as defined in subparagraph (B)) in lieu of any other pay-  
20 ment (including a payment adjustment under paragraph  
21 (12)(B)(ii)) for such services and items furnished pursu-  
22 ant to paragraph (4). In implementing the system the Sec-  
23 retary shall ensure that the estimated total amount of pay-  
24 ments under this title for 2010 for renal dialysis services  
25 shall equal 96 percent of the estimated amount of pay-

1 ments for such services, including payments under para-  
2 graph (12)(B)(ii), that would have been made if such sys-  
3 tem had not been implemented.

4 “(B) For purposes of this paragraph, the term ‘renal  
5 dialysis services’ includes—

6 “(i) items and services included in the  
7 composite rate for renal dialysis services as of  
8 December 31, 2009;

9 “(ii) erythropoietin stimulating agents fur-  
10 nished to individuals with end stage renal dis-  
11 ease;

12 “(iii) other drugs and biologicals and diag-  
13 nostic laboratory tests, that the Secretary iden-  
14 tifies as commonly used in the treatment of  
15 such patients and for which payment was (be-  
16 fore the application of this paragraph) made  
17 separately under this title, and any oral equiva-  
18 lent form of such drugs and biologicals or of  
19 drugs and biologicals described in clause (ii);  
20 and

21 “(iv) home dialysis training for which pay-  
22 ment was (before the application of this para-  
23 graph) made separately under this section.

24 Such term does not include vaccines.

1       “(C) The system under this paragraph may provide  
2 for payment on the basis of services furnished during a  
3 week or month or such other appropriate unit of payment  
4 as the Secretary specifies.

5       “(D) Such system—

6           “(i) shall include a payment adjustment based  
7 on case mix that may take into account patient  
8 weight, body mass index, comorbidities, length of  
9 time on dialysis, age, race, ethnicity, and other ap-  
10 appropriate factors;

11           “(ii) shall include a payment adjustment for  
12 high cost outliers due to unusual variations in the  
13 type or amount of medically necessary care, includ-  
14 ing variations in the amount of erythropoietin stimu-  
15 lating agents necessary for anemia management; and

16           “(iii) may include such other payment adjust-  
17 ments as the Secretary determines appropriate, such  
18 as a payment adjustment—

19           “(I) by a geographic index, such as the  
20 index referred to in paragraph (12)(D), as the  
21 Secretary determines to be appropriate;

22           “(II) for pediatric providers of services and  
23 renal dialysis facilities;

24           “(III) for low volume providers of services  
25 and renal dialysis facilities;

1           “(IV) for providers of services or renal di-  
2           alysis facilities located in rural areas; and

3           “(V) for providers of services or renal di-  
4           alysis facilities that are not large dialysis facili-  
5           ties.

6           “(E) The Secretary may provide for a phase-in of the  
7           payment system described in subparagraph (A) for serv-  
8           ices furnished by a provider of services or renal dialysis  
9           facility described in any of subclauses (II) through (V) of  
10          subparagraph (D)(iii), but such payment system shall be  
11          fully implemented for services furnished in the case of any  
12          such provider or facility on or after January 1, 2013.

13          “(F) The Secretary shall apply the annual increase  
14          that would otherwise apply under subparagraph (F) of  
15          paragraph (12) to payment amounts established under  
16          such paragraph (if this paragraph did not apply) in an  
17          appropriate manner under this paragraph.”.

18          (b) PROHIBITION OF UNBUNDLING.—Section  
19          1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

20                 (1) by striking “or” at the end of paragraph  
21                 (21);

22                 (2) by striking the period at the end of para-  
23                 graph (22) and inserting “; or”; and

24                 (3) by inserting after paragraph (22) the fol-  
25                 lowing new paragraph:



1           “(23) where such expenses are for renal dialysis  
2 services (as defined in subparagraph (B) of section  
3 1881(b)(14)) for which payment is made under such  
4 section (other than under subparagraph (E) of such  
5 section) unless such payment is made under such  
6 section to a provider of services or a renal dialysis  
7 facility for such services.”.

8           (c) QUALITY INCENTIVE PAYMENTS.—Section 1881  
9 of such Act is amended by adding at the end the following  
10 new subsection:

11           “(i) QUALITY INCENTIVE PAYMENTS IN THE END-  
12 STAGE RENAL DISEASE PROGRAM.—

13           “(1) QUALITY INCENTIVE PAYMENTS FOR  
14 SERVICES FURNISHED IN 2008, 2009, AND 2010.—

15           “(A) IN GENERAL.—With respect to renal  
16 dialysis services furnished during a performance  
17 period (as defined in subparagraph (B)) by a  
18 provider of services or renal dialysis facility that  
19 the Secretary determines meets the applicable  
20 performance standard for the period under sub-  
21 paragraph (C) and reports on measures for  
22 2009 and 2010 under subparagraph (D) for  
23 such services, in addition to the amount other-  
24 wise paid under this section, subject to sub-  
25 paragraph (G), there also shall be paid to the

1 provider or facility an amount equal to the ap-  
2 plicable percentage (specified in subparagraph  
3 (E) for the period) of the Secretary's estimate  
4 (based on claims submitted not later than two  
5 months after the end of the performance pe-  
6 riod) of the amount specified in subparagraph  
7 (F) for such period.

8 “(B) PERFORMANCE PERIOD.—In this  
9 paragraph, the term ‘performance period’  
10 means each of the following:

11 “(i) The period beginning on July 1,  
12 2008, and ending on December 31, 2008.

13 “(ii) 2009.

14 “(iii) 2010.

15 “(C) PERFORMANCE STANDARD.—

16 “(i) 2008.—For the performance pe-  
17 riod occurring in 2008, the applicable per-  
18 formance standards for a provider or facil-  
19 ity under this subparagraph are—

20 “(I) 92 percent or more of indi-  
21 viduals with end stage renal disease  
22 receiving erythropoetin stimulating  
23 agents who have an average hemato-  
24 crit of 33.0 percent or more; and

1           “(II) less than a percentage,  
2           specified by the Secretary, of individ-  
3           uals with end stage renal disease re-  
4           ceiving erythropoietin stimulating  
5           agents who have an average hemato-  
6           crit of 39.0 percent or more.

7           “(ii) 2009 AND 2010.—For the 2009  
8           and 2010 performance periods, the appli-  
9           cable performance standard for a provider  
10          or facility under this subparagraph is suc-  
11          cessful performance (relative to national  
12          average) on—

13           “(I) such measures of anemia  
14           management as the Secretary shall  
15           specify, including measures of hemo-  
16           globin levels or hematocrit levels for  
17           erythropoietin stimulating agents that  
18           are consistent with the labeling for  
19           dosage of erythropoietin stimulating  
20           agents approved by the Food and  
21           Drug Administration for treatment of  
22           anemia in patients with end stage  
23           renal disease, taking into account  
24           variations in hemoglobin ranges or  
25           hematocrit levels of patients; and

1                   “(II) such other measures, relat-  
2                   ing to subjects described in subpara-  
3                   graph (D)(i), as the Secretary may  
4                   specify.

5                   “(D) REPORTING PERFORMANCE MEAS-  
6                   URES.—The performance measures under this  
7                   subparagraph to be reported shall include—

8                   “(i) such measures as the Secretary  
9                   specifies, before the beginning of the per-  
10                  formance period involved and taking into  
11                  account measures endorsed by the Na-  
12                  tional Quality Forum, including, to the ex-  
13                  tent feasible measures on—

14                   “(I) iron management;

15                   “(II) dialysis adequacy; and

16                   “(III) vascular access, including  
17                  for maximizing the placement of arte-  
18                  rial venous fistula; and

19                   “(ii) to the extent feasible, such meas-  
20                  ure (or measures) of patient satisfaction as  
21                  the Secretary shall specify.

22                  The provider or facility submitting information  
23                  on such measures shall attest to the complete-  
24                  ness and accuracy of such information.

1           “(E) APPLICABLE PERCENTAGE.—The ap-  
2           plicable percentage specified in this subpara-  
3           graph for—

4                   “(i) the performance period occurring  
5                   in 2008, is 1.0 percent;

6                   “(ii) the 2009 performance period, is  
7                   2.0 percent; and

8                   “(iii) the 2010 performance period, is  
9                   3.0 percent.

10           In the case of any performance period which is  
11           less than an entire year, the applicable percent-  
12           age specified in this subparagraph shall be mul-  
13           tplied by the ratio of the number of months in  
14           the year to the number of months in such per-  
15           formance period. In the case of 2010, the appli-  
16           cable percentage specified in this subparagraph  
17           shall be multiplied by the Secretary’s estimate  
18           of the ratio of the aggregate payment amount  
19           described in subparagraph (F)(i) that would  
20           apply in 2010 if paragraph (14) did not apply,  
21           to the aggregate payment base under subpara-  
22           graph (F)(ii) for 2010.

23           “(F) PAYMENT BASE.—The payment base  
24           described in this subparagraph for a provider or  
25           facility is—

1           “(i) for performance periods before  
2           2010, the payment amount determined  
3           under paragraph (12) for services fur-  
4           nished by the provider or facility during  
5           the performance period, including the drug  
6           payment adjustment described in subpara-  
7           graph (B)(ii) of such paragraph; and

8           “(ii) for the 2010 performance period  
9           is the amount determined under paragraph  
10          (14) for services furnished by the provider  
11          or facility during the period.

12          “(G) LIMITATION ON FUNDING.—

13                 “(i) IN GENERAL.—If the Secretary  
14                 determines that the total payments under  
15                 this paragraph for a performance period is  
16                 projected to exceed the dollar amount spec-  
17                 ified in clause (ii) for such period, the Sec-  
18                 retary shall reduce, in a pro rata manner,  
19                 the amount of such payments for each pro-  
20                 vider or facility for such period to elimi-  
21                 nate any such projected excess for the pe-  
22                 riod.

23                 “(ii) DOLLAR AMOUNT.—The dollar  
24                 amount specified in this clause—

1                   “(I) for the performance period  
2                   occurring in 2008, is \$50,000,000;

3                   “(II) for the 2009 performance  
4                   period is \$100,000,000; and

5                   “(III) for the 2010 performance  
6                   period is \$150,000,000.

7                   “(H) FORM OF PAYMENT.—The payment  
8                   under this paragraph shall be in the form of a  
9                   single consolidated payment.

10                   “(2) QUALITY INCENTIVE PAYMENTS FOR FA-  
11                   CILITIES AND PROVIDERS FOR 2011.—

12                   “(A) INCREASED PAYMENT.—For 2011, in  
13                   the case of a provider or facility that, for the  
14                   performance period (as defined in subparagraph  
15                   (B))—

16                   “(i) meets (or exceeds) the perform-  
17                   ance standard for anemia management  
18                   specified in paragraph (1)(C)(ii)(I);

19                   “(ii) has substantially improved per-  
20                   formance or exceeds a performance stand-  
21                   ard (as determined under subparagraph  
22                   (E)); and

23                   “(iii) reports measures specified in  
24                   paragraph (1)(D),

1 with respect to renal dialysis services furnished  
2 by the provider or facility during the quality  
3 bonus payment period (as specified in subpara-  
4 graph (C)) the payment amount otherwise made  
5 to such provider or facility under subsection  
6 (b)(14) shall be increased, subject to subpara-  
7 graph (F), by the applicable percentage speci-  
8 fied in subparagraph (D). Payment amounts  
9 under paragraph (1) shall not be counted for  
10 purposes of applying the previous sentence.

11 “(B) PERFORMANCE PERIOD.—In this  
12 paragraph, the term ‘performance period’  
13 means a multi-month period specified by the  
14 Secretary.

15 “(C) QUALITY BONUS PAYMENT PERIOD.—  
16 In this paragraph, the term ‘quality bonus pay-  
17 ment period’ means, with respect to a perform-  
18 ance period, a multi-month period beginning on  
19 January 1, 2011, specified by the Secretary  
20 that begins at least 3 months (but not more  
21 than 9 months) after the end of the perform-  
22 ance period.

23 “(D) APPLICABLE PERCENTAGE.—The ap-  
24 plicable percentage specified in this subpara-  
25 graph is a percentage, not to exceed the 4.0



1 percent, specified by the Secretary consistent  
2 with subparagraph (F). Such percentage may  
3 vary based on the level of performance and im-  
4 provement. The applicable percentage specified  
5 in this subparagraph shall be multiplied by the  
6 ratio applied under the third sentence of para-  
7 graph (1)(E) for 2010.

8 “(E) PERFORMANCE STANDARD.—Based  
9 on performance of a provider of services or a  
10 renal dialysis facility on performance measures  
11 described in paragraph (1)(D) for a perform-  
12 ance period, the Secretary shall determine a  
13 composite score for such period.

14 “(F) LIMITATION ON FUNDING.—If the  
15 Secretary determines that the total amount to  
16 be paid under this paragraph for a quality  
17 bonus payment period is projected to exceed  
18 \$200,000,000, the Secretary shall reduce, in a  
19 uniform manner, the applicable percentage oth-  
20 erwise applied under subparagraph (D) for  
21 services furnished during the period to elimi-  
22 nate any such projected excess.

23 “(3) APPLICATION.—

24 “(A) IMPLEMENTATION.—Notwithstanding  
25 any other provision of law, the Secretary may

1           implement by program instruction or otherwise  
2           this subsection.

3           “(B) LIMITATIONS ON REVIEW.—

4                   “(i) IN GENERAL.—There shall be no  
5           administrative or judicial review under sec-  
6           tion 1869 or 1878 or otherwise of—

7                           “(I) the determination of per-  
8                           formance measures and standards  
9                           under this subsection;

10                           “(II) the determination of suc-  
11                           cessful reporting, including a deter-  
12                           mination of composite scores; and

13                           “(III) the determination of the  
14                           quality incentive payments made  
15                           under this subsection.

16                   “(ii) TREATMENT OF DETERMINA-  
17           TIONS.—A determination under this sub-  
18           paragraph shall not be treated as a deter-  
19           mination for purposes of section 1869.

20           “(4) TECHNICAL ASSISTANCE.—The Secretary  
21           shall identify or establish an appropriately skilled  
22           group or organization, such as the ESRD Networks,  
23           to provide technical assistance to consistently low-  
24           performing facilities or providers that are in the bot-  
25           tom quintile.

1 “(5) PUBLIC REPORTING.—

2 “(A) ANNUAL NOTICE.—The Secretary  
3 shall provide an annual written notification to  
4 each individual who is receiving renal dialysis  
5 services from a provider of services or renal di-  
6 alysis facility that—

7 “(i) informs such individual of the  
8 composite scores described in subpara-  
9 graph (A) and other relevant quality meas-  
10 ures with respect to providers of services  
11 or renal dialysis facilities in the local area;

12 “(ii) compares such scores and meas-  
13 ures to the average local and national  
14 scores and measures; and

15 “(iii) provides information on how to  
16 access additional information on quality of  
17 such services furnished and options for al-  
18 ternative providers and facilities.

19 “(B) CERTIFICATES.—The Secretary shall  
20 provide certificates to facilities and providers  
21 who provide services to individuals with end-  
22 stage renal disease under this title to display in  
23 patient areas. The certificate shall indicate the  
24 composite score obtained by the facility or pro-  
25 vider under the quality initiative.

1           “(C) WEB-BASED QUALITY LIST.—The  
2           Secretary shall establish a web-based list of fa-  
3           cilities and providers who furnish renal dialysis  
4           services under this section that indicates their  
5           composite score of each provider and facility.

6           “(6) RECOMMENDATIONS FOR REPORTING AND  
7           QUALITY INCENTIVE INITIATIVE FOR PHYSICIANS.—  
8           The Secretary shall develop recommendations for ap-  
9           plying quality incentive payments under this sub-  
10          section to physicians who receive the monthly  
11          capitated payment under this title. Such rec-  
12          ommendations shall include the following:

13                 “(A) Recommendations to include pediatric  
14                 specific measures for physicians with at least  
15                 50 percent of their patients with end stage  
16                 renal disease being individuals under 18 years  
17                 of age.

18                 “(B) Recommendations on how to struc-  
19                 ture quality incentive payments for physicians  
20                 who demonstrate improvements in quality or  
21                 who attain quality standards, as specified by  
22                 the Secretary.

23           “(7) REPORTS.—

24                 “(A) INITIAL REPORT.—Not later than  
25                 January 1, 2013, the Secretary shall submit to

1 Congress a report on the implementation of the  
2 bundled payment system under subsection  
3 (b)(14) and the quality initiative under this  
4 subsection. Such report shall include the fol-  
5 lowing information:

6 “(i) A comparison of the aggregate  
7 payments under subsection (b)(14) for  
8 items and services to the cost of such items  
9 and services.

10 “(ii) The changes in utilization rates  
11 for erythropoietin stimulating agents.

12 “(iii) The mode of administering such  
13 agents, including information on the pro-  
14 portion of such individuals receiving such  
15 agents intravenously as compared to  
16 subcutaneously.

17 “(iv) The frequency of dialysis.

18 “(v) Other differences in practice pat-  
19 terns, such as the adoption of new tech-  
20 nology, different modes of practice, and  
21 variations in use of drugs other than drugs  
22 described in clause (iii).

23 “(vi) The performance of facilities and  
24 providers under paragraph (2).

1           “(vii) Other recommendations for leg-  
2           islative and administrative actions deter-  
3           mined appropriate by the Secretary.

4           “(B) SUBSEQUENT REPORT.—Not later  
5           than January 1, 2015, the Secretary shall sub-  
6           mit to Congress a report that contains the in-  
7           formation described in each of clauses (ii)  
8           through (vii) of subparagraph (A) and a com-  
9           parison of the results of the payment system  
10          under subsection (b)(14) for renal dialysis serv-  
11          ices furnished during the 2-year period begin-  
12          ning on January 1, 2013, and the results of  
13          such payment system for such services fur-  
14          nished during the previous two-year period.”.

15 **SEC. 638. MEDPAC REPORT ON ESRD BUNDLING SYSTEM.**

16          Not later than March 1, 2012, the Medicare Payment  
17          Advisory Commission (established under section 1805 of  
18          the Social Security Act) shall submit to Congress a report  
19          on the implementation of the payment system under sec-  
20          tion 1881(b)(14) of the Social Security Act (as added by  
21          section 7) for renal dialysis services and related services  
22          (defined in subparagraph (B) of such section). Such report  
23          shall include, with respect to such payment system for  
24          such services, an analysis of each of the following:

1           (1) An analysis of the overall adequacy of pay-  
2           ment under such system for all such services.

3           (2) An analysis that compares the adequacy of  
4           payment under such system for services furnished  
5           by—

6                   (A) a provider of services or renal dialysis  
7                   facility that is described in section  
8                   1881(b)(13)(C)(iv) of the Social Security Act;

9                   (B) a provider of services or renal dialysis  
10                  facility not described in such section;

11                  (C) a hospital-based facility;

12                  (D) a freestanding renal dialysis facility;

13                  (E) a renal dialysis facility located in an  
14                  urban area; and

15                  (F) a renal dialysis facility located in a  
16                  rural area.

17           (3) An analysis of the financial status of pro-  
18           viders of such services and renal dialysis facilities,  
19           including access to capital, return on equity, and re-  
20           turn on capital.

21           (4) An analysis of the adequacy of payment  
22           under such method and the adequacy of the quality  
23           improvement payments under section 1881(i) of the  
24           Social Security Act in ensuring that payments for

1 such services under the Medicare program are con-  
2 sistent with costs for such services.

3 (5) Recommendations, if appropriate, for modi-  
4 fications to such payment system.

5 **SEC. 639. OIG STUDY AND REPORT ON ERYTHROPOIETIN.**

6 (a) STUDY.—The Inspector General of the Depart-  
7 ment of Health and Human Services shall conduct a study  
8 on the following:

9 (1) The dosing guidelines, standards, protocols,  
10 and algorithms for erythropoietin stimulating agents  
11 recommended or used by providers of services and  
12 renal dialysis facilities that are described in section  
13 1881(b)(13)(C)(iv) of the Social Security Act and  
14 providers and facilities that are not described in  
15 such section.

16 (2) The extent to which such guidelines, stand-  
17 ards, protocols, and algorithms are consistent with  
18 the labeling of the Food and Drug Administration  
19 for such agents.

20 (3) The extent to which physicians sign stand-  
21 ing orders for such agents that are consistent with  
22 such guidelines, standards, protocols, and algorithms  
23 recommended or used by the provider or facility in-  
24 volved.



1           (4) The extent to which the prescribing deci-  
2           sions of physicians, with respect to such agents, are  
3           independent of—

4                   (A) such relevant guidelines, standards,  
5                   protocols, and algorithms; or

6                   (B) recommendations of an anemia man-  
7                   agement nurse or other appropriate employee of  
8                   the provider or facility involved.

9           (5) The role of medical directors of providers of  
10           services and renal dialysis facilities and the financial  
11           relationships between such providers and facilities  
12           and the physicians hired as medical directors of such  
13           providers and facilities, respectively.

14           (b) REPORT.—Not later than January 1, 2009, the  
15           Inspector General of the Department of Health and  
16           Human Services shall submit to Congress a report on the  
17           study conducted under subsection (a), together with such  
18           recommendations as the Inspector General determines ap-  
19           propriate.

## 20                   **Subtitle D—Miscellaneous**

### 21           **SEC. 651. LIMITATION ON EXCEPTION TO THE PROHIBI-** 22                   **TION ON CERTAIN PHYSICIAN REFERRALS** 23                   **FOR HOSPITALS.**

24           (a) IN GENERAL.—Section 1877 of the Social Secu-  
25           rity Act (42 U.S.C. 1395) is amended—

1 (1) in subsection (d)(2)—

2 (A) in subparagraph (A), by striking  
3 “and” at the end;

4 (B) in subparagraph (B), by striking the  
5 period at the end and inserting “; and”; and

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

8 “(C) if the entity is a hospital, the hospital  
9 meets the requirements of paragraph (3)(D).”;

10 (2) in subsection (d)(3)—

11 (A) in subparagraph (B), by striking  
12 “and” at the end;

13 (B) in subparagraph (C), by striking the  
14 period at the end and inserting “; and”; and

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

17 “(D) the hospital meets the requirements  
18 described in subsection (i)(1) not later than 18  
19 months after the date of the enactment of this  
20 subparagraph.”; and

21 (3) by adding at the end the following new sub-  
22 section:

23 “(i) REQUIREMENTS FOR HOSPITALS TO QUALIFY  
24 FOR HOSPITAL EXCEPTION TO OWNERSHIP OR INVEST-  
25 MENT PROHIBITION.—

1           “(1) REQUIREMENTS DESCRIBED.—For pur-  
2           poses of paragraphs subsection (d)(3)(D), the re-  
3           quirements described in this paragraph for a hos-  
4           pital are as follows:

5                   “(A) PROVIDER AGREEMENT.—The hos-  
6                   pital had a provider agreement under section  
7                   1866 in effect on July 24, 2007.

8                   “(B) PROHIBITION OF EXPANSION OF FA-  
9                   CILITY CAPACITY.—The number of operating  
10                  rooms and beds of the hospital at any time on  
11                  or after the date of the enactment of this sub-  
12                  section are no greater than the number of oper-  
13                  ating rooms and beds as of such date.

14                  “(C) PREVENTING CONFLICTS OF INTER-  
15                  EST.—

16                           “(i) The hospital submits to the Sec-  
17                           retary an annual report containing a de-  
18                           tailed description of—

19                                   “(I) the identity of each physi-  
20                                   cian owner and any other owners of  
21                                   the hospital; and

22                                   “(II) the nature and extent of all  
23                                   ownership interests in the hospital.

24                           “(ii) The hospital has procedures in  
25                           place to require that any referring physi-

1           cian owner discloses to the patient being  
2           referred, by a time that permits the pa-  
3           tient to make a meaningful decision re-  
4           garding the receipt of care, as determined  
5           by the Secretary—

6                       “(I) the ownership interest of  
7                       such referring physician in the hos-  
8                       pital; and

9                       “(II) if applicable, any such own-  
10                      ership interest of the treating physi-  
11                      cian.

12                     “(iii) The hospital does not condition  
13                     any physician ownership interests either di-  
14                     rectly or indirectly on the physician owner  
15                     making or influencing referrals to the hos-  
16                     pital or otherwise generating business for  
17                     the hospital.

18                     “(D) ENSURING BONA FIDE INVEST-  
19                     MENT.—

20                     “(i) Physician owners in the aggregate  
21                     do not own more than 40 percent of the  
22                     total value of the investment interests held  
23                     in the hospital or in an entity whose assets  
24                     include the hospital.

1           “(ii) The investment interest of any  
2 individual physician owner does not exceed  
3 2 percent of the total value of the invest-  
4 ment interests held in the hospital or in an  
5 entity whose assets include the hospital.

6           “(iii) Any ownership or investment in-  
7 terests that the hospital offers to a physi-  
8 cian owner are not offered on more favor-  
9 able terms than the terms offered to a per-  
10 son who is not a physician owner.

11           “(iv) The hospital does not directly or  
12 indirectly provide loans or financing for  
13 any physician owner investments in the  
14 hospital.

15           “(v) The hospital does not directly or  
16 indirectly guarantee a loan, make a pay-  
17 ment toward a loan, or otherwise subsidize  
18 a loan, for any individual physician owner  
19 or group of physician owners that is re-  
20 lated to acquiring any ownership interest  
21 in the hospital.

22           “(vi) Investment returns are distrib-  
23 uted to investors in the hospital in an  
24 amount that is directly proportional to the

1 investment of capital by the physician  
2 owner in the hospital.

3 “(vii) Physician owners do not receive,  
4 directly or indirectly, any guaranteed re-  
5 ceipt of or right to purchase other business  
6 interests related to the hospital, including  
7 the purchase or lease of any property  
8 under the control of other investors in the  
9 hospital or located near the premises of the  
10 hospital.

11 “(viii) The hospital does not offer a  
12 physician owner the opportunity to pur-  
13 chase or lease any property under the con-  
14 trol of the hospital or any other investor in  
15 the hospital on more favorable terms than  
16 the terms offered to an individual who is  
17 not a physician owner.

18 “(E) PATIENT SAFETY.—

19 “(i) Insofar as the hospital admits a  
20 patient and does not have any physician  
21 available on the premises to provide serv-  
22 ices during all hours in which the hospital  
23 is providing services to such patient, before  
24 admitting the patient—

1                   “(I) the hospital discloses such  
2 fact to a patient; and

3                   “(II) following such disclosure,  
4 the hospital receives from the patient  
5 a signed acknowledgment that the pa-  
6 tient understands such fact.

7                   “(ii) The hospital has the capacity  
8 to—

9                   “(I) provide assessment and ini-  
10 tial treatment for patients; and

11                   “(II) refer and transfer patients  
12 to hospitals with the capability to  
13 treat the needs of the patient in-  
14 volved.

15                   “(2) PUBLICATION OF INFORMATION RE-  
16 PORTED.—The Secretary shall publish, and update  
17 on an annual basis, the information submitted by  
18 hospitals under paragraph (1)(C)(i) on the public  
19 Internet website of the Centers for Medicare & Med-  
20 icaid Services.

21                   “(3) COLLECTION OF OWNERSHIP AND INVEST-  
22 MENT INFORMATION.—For purposes of clauses (i)  
23 and (ii) of paragraph (1)(D), the Secretary shall col-  
24 lect physician ownership and investment information

1 for each hospital as it existed on the date of the en-  
2 actment of this subsection.

3 “(4) PHYSICIAN OWNER DEFINED.—For pur-  
4 poses of this subsection, the term ‘physician owner’  
5 means a physician (or an immediate family member  
6 of such physician) with a direct or an indirect own-  
7 ership interest in the hospital.”.

8 (b) ENFORCEMENT.—

9 (1) ENSURING COMPLIANCE.—The Secretary of  
10 Health and Human Services shall establish policies  
11 and procedures to ensure compliance with the re-  
12 quirements described in such section 1877(i)(1) of  
13 the Social Security Act, as added by subsection  
14 (a)(3), beginning on the date such requirements first  
15 apply. Such policies and procedures may include un-  
16 announced site reviews of hospitals.

17 (2) AUDITS.—Beginning not later than 18  
18 months after the date of the enactment of this Act,  
19 the Secretary of Health and Human Services shall  
20 conduct audits to determine if hospitals violate the  
21 requirements referred to in paragraph (1).



1 **TITLE VII—PROVISIONS RELAT-**  
2 **ING TO MEDICARE PARTS A**  
3 **AND B**

4 **SEC. 701. HOME HEALTH PAYMENT UPDATE FOR 2008.**

5 Section 1895(b)(3)(B)(ii) of the Social Security Act  
6 (42 U.S.C. 1395fff(b)(3)(B)(ii)) is amended—

7 (1) in subclause (IV) at the end, by striking  
8 “and”;

9 (2) by redesignating subclause (V) as subclause  
10 (VII); and

11 (3) by inserting after subclause (IV) the fol-  
12 lowing new subclauses:

13 “(V) 2007, subject to clause (v),  
14 the home health market basket per-  
15 centage increase;

16 “(VI) 2008, subject to clause (v),  
17 0 percent; and”.

18 **SEC. 702. 2-YEAR EXTENSION OF TEMPORARY MEDICARE**  
19 **PAYMENT INCREASE FOR HOME HEALTH**  
20 **SERVICES FURNISHED IN A RURAL AREA.**

21 Section 421 of the Medicare Prescription Drug, Im-  
22 provement, and Modernization Act of 2003 (Public Law  
23 108–173; 117 Stat. 2283; 42 U.S.C. 1395fff note), as  
24 amended by section 5201(b) of the Deficit Reduction Act  
25 of 2005, is amended—

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

3 (2) in subsection (a), by striking “and episodes  
 4 and visits beginning on or after January 1, 2006,  
 5 and before January 1, 2007” and inserting “epi-  
 6 sodes and visits beginning on or after January 1,  
 7 2006, and before January 1, 2007, and episodes and  
 8 visits beginning on or after January 1, 2008, and  
 9 before January 1, 2010”.

10 **SEC. 703. EXTENSION OF MEDICARE SECONDARY PAYER**  
 11 **FOR BENEFICIARIES WITH END STAGE**  
 12 **RENAL DISEASE FOR LARGE GROUP PLANS.**

13 (a) IN GENERAL.—Section 1862(b)(1)(C) of the So-  
 14 cial Security Act (42 U.S.C. 1395y(b)(1)(C)) is amend-  
 15 ed—

16 (1) by redesignating clauses (i) and (ii) as sub-  
 17 clauses (I) and (II), respectively, and indenting ac-  
 18 cordingly;

19 (2) by amending the text preceding subclause  
 20 (I), as so redesignated, to read as follows:

21 “(C) INDIVIDUALS WITH END STAGE  
 22 RENAL DISEASE.—

23 “(i) IN GENERAL.—A group health  
 24 plan (as defined in subparagraph  
 25 (A)(v))—”;

1           (3) in the matter following subclause (II), as so  
2 redesignated—

3           (A) by striking “clause (i)” and inserting  
4 “subclause (I)”;

5           (B) by striking “clause (ii)” and inserting  
6 “subclause (II)”;

7           (C) by striking “clauses (i) and (ii)” and  
8 inserting “subclauses (I) and (II)”; and

9           (D) in the last sentence, by striking “Ef-  
10 fective for items” and inserting “Subject to  
11 clause (ii), effective for items”; and

12          (4) by adding at the end the following new  
13 clause:

14           “(ii) SPECIAL RULE FOR LARGE  
15 GROUP PLANS.—In applying clause (i) to  
16 a large group health plan (as defined in  
17 subparagraph (B)(iii)). effective for items  
18 and services furnished on or after January  
19 1, 2008, (with respect to periods beginning  
20 on or after the date that is 30 months  
21 prior to January 1, 2008), subclauses (I)  
22 and (II) of such clause shall be applied by  
23 substituting ‘42-month’ for ‘12-month’  
24 each place it appears.”.

1 **SEC. 704. PLAN FOR MEDICARE PAYMENT ADJUSTMENTS**  
2 **FOR NEVER EVENTS.**

3 (a) IN GENERAL.—The Secretary of Health and  
4 Human Services (in this section referred to as the “Sec-  
5 retary”) shall develop a plan (in this section referred to  
6 as the “never events plan”) to implement, beginning in  
7 fiscal year 2010, a policy to reduce or eliminate payments  
8 under title XVIII of the Social Security Act for never  
9 events.

10 (b) NEVER EVENT DEFINED.—For purposes of this  
11 section, the term “never event” means an event involving  
12 the delivery of (or failure to deliver) physicians’ services,  
13 inpatient or outpatient hospital services, or facility serv-  
14 ices furnished in an ambulatory surgical facility in which  
15 there is an error in medical care that is clearly identifiable,  
16 usually preventable, and serious in consequences to pa-  
17 tients, and that indicates a deficiency in the safety and  
18 process controls of the services furnished with respect to  
19 the physician, hospital, or ambulatory surgical center in-  
20 volved.

21 (c) PLAN DETAILS.—

22 (1) DEFINING NEVER EVENTS.—With respect  
23 to criteria for identifying never events under the  
24 never events plan, the Secretary should consider  
25 whether the event meets the following characteris-  
26 tics:

1 (A) CLEARLY IDENTIFIABLE.—The event  
2 is clearly identifiable and measurable and fea-  
3 sible to include in a reporting system for never  
4 events.

5 (B) USUALLY PREVENTABLE.—The event  
6 is usually preventable taking into consideration  
7 that, because of the complexity of medical care,  
8 certain medical events are not always avoidable.

9 (C) SERIOUS.—The event is serious and  
10 could result in death or loss of a body part, dis-  
11 ability, or more than transient loss of a body  
12 function.

13 (D) DEFICIENCY IN SAFETY AND PROCESS  
14 CONTROLS.—The event is indicative of a prob-  
15 lem in safety systems and process controls used  
16 by the physician, hospital, or ambulatory sur-  
17 gical center involved and is indicative of the re-  
18 liability of the quality of services provided by  
19 the physician, hospital, or ambulatory surgical  
20 center, respectively.

21 (2) IDENTIFICATION AND PAYMENT ISSUES.—  
22 With respect to policies under the never events plan  
23 for identifying and reducing (or eliminating) pay-  
24 ment for never events, the Secretary shall consider—

1 (A) mechanisms used by hospitals and  
2 physicians in reporting and coding of services  
3 that would reliably identify never events; and

4 (B) modifications in billing and payment  
5 mechanisms that would enable the Secretary to  
6 efficiently and accurately reduce or eliminate  
7 payments for never events.

8 (3) PRIORITIES.—Under the never events plan  
9 the Secretary shall identify priorities regarding the  
10 services to focus on and, among those, the never  
11 events for which payments should be reduced or  
12 eliminated.

13 (4) CONSULTATION.—In developing the never  
14 events plan, the Secretary shall consult with affected  
15 parties that are relevant to payment reductions in  
16 response to never events.

17 (d) CONGRESSIONAL REPORT.—By not later than  
18 June 1, 2008, the Secretary shall submit a report to Con-  
19 gress on the never events plan developed under this sub-  
20 section and shall include in the report recommendations  
21 on specific methods for implementation of the plan on a  
22 timely basis.

23 **SEC. 705. REINSTATEMENT OF RESIDENCY SLOTS.**

24 (a) IN GENERAL.—Section 1886(h) of the Social Se-  
25 curity Act (42 U.S.C. 1395ww(h)) is amended—

1           (1) in paragraph (4)(H), by adding at the end  
2           the following new clauses:

3                   “(v) INCREASE IN RESIDENT LIMIT  
4                   DUE TO CLOSURE OF OTHER HOSPITALS.—

5                   If one or more hospitals with approved  
6                   medical residency training programs, which  
7                   are located within the same metropolitan  
8                   statistical area as of January 1, 2001,  
9                   closed, the Secretary shall increase by not  
10                  more than 10 (subject to the limitation  
11                  set forth in the last sentence of this clause)  
12                  the otherwise applicable resident limit  
13                  under subparagraph (F) for each hospital  
14                  within the same metropolitan statistical  
15                  area that meets all the following criteria:

16                   “(I) The hospital is described in  
17                   subsection (d)(5)(F)(i).

18                   “(II) The hospital instituted a  
19                   medical residency training program in  
20                   internal medicine that was accredited  
21                   by the American Osteopathic Association  
22                   on or after January 1, 2004.

23                   “(III) The hospital had a pro-  
24                   vider number and a resident limit as

1 of January 1, 2000, and remained  
2 open as of October 1, 2007.

3 “(IV) The hospital did not re-  
4 ceive an increase in its resident limit  
5 under paragraph (7)(B).

6 “(V) The hospital maintains no  
7 more than 400 beds.

8 In no event may the resident limit for any  
9 hospital be increased above 50 through ap-  
10 plication of this clause and in no event  
11 may the total of the residency positions  
12 added by this clause for all hospitals ex-  
13 ceed 10.

14 “(vi) INCREASE IN RESIDENCY  
15 SLOTS.—In the case of a hospital located  
16 in Peoria County, Illinois, that has more  
17 than 500 beds, the Secretary shall increase  
18 by two the otherwise applicable resident  
19 limit under subparagraph (F) for such hos-  
20 pital.”; and

21 (2) in paragraph (7)—

22 (A) by redesignating subparagraph (D) as  
23 subparagraph (E); and

24 (B) by inserting after subparagraph (C)  
25 the following new subparagraph:



1           “(D) ADJUSTMENT BASED ON SETTLED  
2 COST REPORT.—In the case of a hospital with  
3 a dual accredited osteopathic and allopathic  
4 family practice program for which—

5           “(i) the otherwise applicable resident  
6 limit was reduced under subparagraph  
7 (A)(i)(I); and

8           “(ii) such reduction was based on a  
9 reference resident level that was deter-  
10 mined using a cost report and where a re-  
11 vised or corrected notice of program reim-  
12 bursement was issued between September  
13 1, 2006 and September 15, 2006, whether  
14 as a result of an appeal or otherwise, and  
15 the reference resident level under such set-  
16 tled cost report is higher than the level  
17 used for the reduction under subparagraph  
18 (A)(i)(I);

19 the Secretary shall apply subparagraph  
20 (A)(i)(I) using the higher resident reference  
21 level and make any necessary adjustments to  
22 such reduction. Any such necessary adjustments  
23 shall be effective for portions of cost reporting  
24 periods occurring on or after July 1, 2005.”.

1 (b) EFFECTIVE DATES.—The amendment made by  
2 paragraph (1) shall be effective for cost reporting periods  
3 beginning on or after October 1, 2007, and the amend-  
4 ments made by paragraph (2) shall take effect as if in-  
5 cluded in the enactment of section 422 of the Medicare  
6 Prescription Drug, Improvement, and Modernization Act  
7 of 2003 (Public Law 108–173).

8 **SEC. 706. STUDIES RELATING TO HOME HEALTH.**

9 (a) IN GENERAL.—The Medicare Payment Advisory  
10 Commission shall conduct a study of Medicare bene-  
11 ficiaries utilizing home health care services to determine—

12 (1) the impact that remote monitoring equip-  
13 ment and related services have on improving health  
14 care outcomes in the home health care setting for  
15 beneficiaries with chronic conditions;

16 (2) the differences in the percentage of inpa-  
17 tient hospital admissions and emergency room visits  
18 for beneficiaries with a similar health care risk pro-  
19 file who utilize remote monitoring equipment and  
20 services compared to those who do not use such  
21 equipment and services;

22 (3) the percentage of Medicare beneficiaries  
23 currently utilizing remote monitoring equipment and  
24 related services;

1           (4) the estimated reduction in aggregate ex-  
2           penditures under parts A and B of title XVIII of the  
3           Social Security Act expenditures if home health  
4           agencies increased their utilization of remote moni-  
5           toring equipment and related services for patients  
6           with chronic disease conditions; and

7           (5) the variation of utilization of remote moni-  
8           toring equipment and related services within geo-  
9           graphic regions and by size of home health agency.

10          (b) DATA COLLECTION.—As a condition of a home  
11          health agency’s participation in the program under title  
12          XVIII of the Social Security Act, beginning no later than  
13          January 1, 2008, the Secretary of Health and Human  
14          Services shall require such agencies to collect, in a form  
15          and manner determined by the Secretary, the following  
16          data:

17               (1) The extent of home health agency’s usage  
18               of remote monitoring equipment and related services  
19               for beneficiaries with chronic conditions.

20               (2) Whether such equipment and services are  
21               used to monitor patients’ with chronic conditions  
22               vital signs on a daily basis.

23               (3) Whether standing physician orders accom-  
24               pany the use of remote monitoring equipment and  
25               services.

1           (4) The costs of remote monitoring equipment  
2           and related services.

3           (c) **REPORT TO CONGRESS.**—Not later than June 1,  
4 2010, the Commission shall report to Congress on its find-  
5 ings on the study conducted under subsection (a). Such  
6 report shall include recommendations regarding how Con-  
7 gress may enact reimbursement policies that increase the  
8 appropriate utilization of remote monitoring equipment  
9 and services under the home health program for Medicare  
10 beneficiaries with chronic conditions in a manner that fa-  
11 cilitates health care outcomes and leads to the long-term  
12 reduction of aggregate expenditures under the Medicare  
13 program.

14 **SEC. 707. RURAL HOME HEALTH QUALITY DEMONSTRATION PROJECTS.**  
15

16           (a) **IN GENERAL.**—Not later than 180 days after the  
17 date of the enactment of this Act, the Secretary of Health  
18 and Human Services (in this section referred to as the  
19 “Secretary”) shall make grants to eligible entities for dem-  
20 onstration projects to assist home health agencies to better  
21 serve their Medicare populations while aiming to reduce  
22 costs to the Medicare program through utilization of tech-  
23 nologies, including telemonitoring and other telehealth  
24 technologies, health information technologies, and tele-  
25 communications technologies that—

1           (1) implement procedures and standards that  
2           reduce the need for inpatient hospital services and  
3           health center visits; and

4           (2) address the aims of safety, effectiveness,  
5           patient- or community-centeredness, timeliness, effi-  
6           ciency, and equity identified by the Institute of Med-  
7           icine of the National Academies in its report entitled  
8           “Crossing the Quality Chasm: A New Health System  
9           for the 21st Century” released on March 1, 2001,  
10          when determining when and what care is needed.

11          (b) ELIGIBLE ENTITIES.—In this section, the term  
12          “eligible entity” means a State that includes—

13               (1) a rural academic medical center;

14               (2) no urban regional medical center; and

15               (3) a Medicare population whose enrollees in  
16          the Medicare Part C program is less than 3 percent.

17          (c) CONSULTATION.—In developing the program for  
18          awarding grants under this section, the Secretary shall  
19          consult with the Administrator of the Centers for Medi-  
20          care & Medicaid Services, home health agencies, rural  
21          health care researchers, and private and non-profit groups  
22          (including national associations) which are undertaking  
23          similar efforts.

24          (d) DURATION.—Each demonstration project under  
25          this section shall be for a period of 2 years.

1 (e) REPORT.—Not later than one year after the con-  
2 clusion of all of the demonstration projects funded under  
3 this section, the Secretary shall submit a report to the  
4 Congress on the results of such projects. The report shall  
5 include—

6 (1) an evaluation of technologies utilized and  
7 effects on patient access to home health care, patient  
8 outcomes, and an analysis of the cost effectiveness  
9 of each such project; and

10 (2) recommendations on Federal legislation,  
11 regulations, or administrative policies to enhance  
12 rural home health quality and outcomes.

13 (f) FUNDING.— Out of any funds in the Treasury  
14 not otherwise appropriated, there are appropriated to the  
15 Secretary for fiscal year 2008, \$3,000,000 to carry out  
16 this section. Funds appropriated under this subsection  
17 shall remain available until expended.

18 **TITLE VIII—MEDICAID**  
19 **Subtitle A—Protecting Existing**  
20 **Coverage**

21 **SEC. 801. MODERNIZING TRANSITIONAL MEDICAID.**

22 (a) FOUR-YEAR EXTENSION.—

23 (1) IN GENERAL.—Sections 1902(e)(1)(B) and  
24 1925(f) of the Social Security Act (42 U.S.C.  
25 1396a(e)(1)(B), 1396r–6(f)) are each amended by

1 striking “September 30, 2003” and inserting “Sep-  
2 tember 30, 2011”.

3 (2) EFFECTIVE DATE.—The amendments made  
4 by this subsection shall take effect on October 1,  
5 2007.

6 (b) STATE OPTION OF INITIAL 12-MONTH ELIGI-  
7 BILITY.—Section 1925 of the Social Security Act (42  
8 U.S.C. 1396r-6) is amended—

9 (1) in subsection (a)(1), by inserting “but sub-  
10 ject to paragraph (5)” after “Notwithstanding any  
11 other provision of this title”;

12 (2) by adding at the end of subsection (a) the  
13 following:

14 “(5) OPTION OF 12-MONTH INITIAL ELIGIBILITY  
15 PERIOD.—A State may elect to treat any reference  
16 in this subsection to a 6-month period (or 6 months)  
17 as a reference to a 12-month period (or 12 months).  
18 In the case of such an election, subsection (b) shall  
19 not apply.”; and

20 (3) in subsection (b)(1), by inserting “but sub-  
21 ject to subsection (a)(5)” after “Notwithstanding  
22 any other provision of this title”.

23 (c) REMOVAL OF REQUIREMENT FOR PREVIOUS RE-  
24 CEIPT OF MEDICAL ASSISTANCE.—Section 1925(a)(1) of

1 such Act (42 U.S.C. 1396r-6(a)(1)), as amended by sub-  
2 section (b)(1), is further amended—

3 (1) by inserting “subparagraph (B) and” before  
4 “paragraph (5)”;

5 (2) by redesignating the matter after “RE-  
6 QUIREMENT.—” as a subparagraph (A) with the  
7 heading “IN GENERAL.—” and with the same inden-  
8 tation as subparagraph (B) (as added by paragraph  
9 (3)); and

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

11 “(B) STATE OPTION TO WAIVE REQUIRE-  
12 MENT FOR 3 MONTHS BEFORE RECEIPT OF  
13 MEDICAL ASSISTANCE.—A State may, at its op-  
14 tion, elect also to apply subparagraph (A) in  
15 the case of a family that was receiving such aid  
16 for fewer than three months or that had applied  
17 for and was eligible for such aid for fewer than  
18 3 months during the 6 immediately preceding  
19 months described in such subparagraph.”.

20 (d) CMS REPORT ON ENROLLMENT AND PARTICIPA-  
21 TION RATES UNDER TMA.—Section 1925 of such Act (42  
22 U.S.C. 1396r-6), as amended by this section, is further  
23 amended by adding at the end the following new sub-  
24 section:



1       “(g) COLLECTION AND REPORTING OF PARTICIPA-  
2 TION INFORMATION.—

3               “(1) COLLECTION OF INFORMATION FROM  
4 STATES.—Each State shall collect and submit to the  
5 Secretary (and make publicly available), in a format  
6 specified by the Secretary, information on average  
7 monthly enrollment and average monthly participa-  
8 tion rates for adults and children under this section  
9 and of the number and percentage of children who  
10 become ineligible for medical assistance under this  
11 section whose medical assistance is continued under  
12 another eligibility category or who are enrolled under  
13 the State’s child health plan under title XXI. Such  
14 information shall be submitted at the same time and  
15 frequency in which other enrollment information  
16 under this title is submitted to the Secretary.

17               “(2) ANNUAL REPORTS TO CONGRESS.—Using  
18 the information submitted under paragraph (1), the  
19 Secretary shall submit to Congress annual reports  
20 concerning enrollment and participation rates de-  
21 scribed in such paragraph.”.

22       (e) EFFECTIVE DATE.—The amendments made by  
23 subsections (b) through (d) shall take effect on the date  
24 of the enactment of this Act.

1 **SEC. 802. FAMILY PLANNING SERVICES.**

2 (a) COVERAGE AS OPTIONAL CATEGORICALLY  
3 NEEDY GROUP.—

4 (1) IN GENERAL.—Section 1902(a)(10)(A)(ii)  
5 of the Social Security Act (42 U.S.C.  
6 1396a(a)(10)(A)(ii)) is amended—

7 (A) in subclause (XVIII), by striking “or”  
8 at the end;

9 (B) in subclause (XIX), by adding “or” at  
10 the end; and

11 (C) by adding at the end the following new  
12 subclause:

13 “(XX) who are described in subsection (ee) (re-  
14 lating to individuals who meet certain income stand-  
15 ards);”.

16 (2) GROUP DESCRIBED.—Section 1902 of the  
17 Social Security Act (42 U.S.C. 1396a), as amended  
18 by section 112(c), is amended by adding at the end  
19 the following new subsection:

20 “(ee)(1) Individuals described in this subsection are  
21 individuals—

22 “(A) whose income does not exceed an in-  
23 come eligibility level established by the State  
24 that does not exceed the highest income eligi-  
25 bility level established under the State plan

1 under this title (or under its State child health  
2 plan under title XXI) for pregnant women; and

3 “(B) who are not pregnant.

4 “(2) At the option of a State, individuals de-  
5 scribed in this subsection may include individuals  
6 who are determined to meet the eligibility require-  
7 ments referred to in paragraph (1) under the terms,  
8 conditions, and procedures applicable to making eli-  
9 gibility determinations for medical assistance under  
10 this title under a waiver to provide the benefits de-  
11 scribed in clause (XV) of the matter following sub-  
12 paragraph (G) of section 1902(a)(10) granted to the  
13 State under section 1115 as of January 1, 2007.”.

14 (3) LIMITATION ON BENEFITS.—Section  
15 1902(a)(10) of the Social Security Act (42 U.S.C.  
16 1396a(a)(10)) is amended in the matter following  
17 subparagraph (G)—

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

20 (B) by inserting “, and (XV) the medical  
21 assistance made available to an individual de-  
22 scribed in subsection (ee) shall be limited to  
23 family planning services and supplies described  
24 in section 1905(a)(4)(C) including medical di-  
25 agnosis or treatment services that are provided

1           pursuant to a family planning service in a fam-  
2           ily planning setting provided during the period  
3           in which such an individual is eligible” after  
4           “cervical cancer”.

5           (4) CONFORMING AMENDMENTS.—Section  
6           1905(a) of the Social Security Act (42 U.S.C.  
7           1396d(a)) is amended in the matter preceding para-  
8           graph (1)—

9                   (A) in clause (xii), by striking “or” at the  
10           end;

11                   (B) in clause (xiii), by adding “or” at the  
12           end; and

13                   (C) by inserting after clause (xiii) the fol-  
14           lowing:

15                           “(xiv) individuals described in section  
16                           1902(ee),”.

17           (b) PRESUMPTIVE ELIGIBILITY.—

18                   (1) IN GENERAL.—Title XIX of the Social Se-  
19           curity Act (42 U.S.C. 1396 et seq.) is amended by  
20           inserting after section 1920B the following:

21           “PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING  
22   SERVICES

23                   “SEC. 1920C. (a) STATE OPTION.—State plan ap-  
24           proved under section 1902 may provide for making med-  
25           ical assistance available to an individual described in sec-  
26           tion 1902(ee) (relating to individuals who meet certain in-

1 come eligibility standard) during a presumptive eligibility  
2 period. In the case of an individual described in section  
3 1902(ee), such medical assistance shall be limited to fam-  
4 ily planning services and supplies described in  
5 1905(a)(4)(C) and, at the State’s option, medical diag-  
6 nosis or treatment services that are provided in conjunc-  
7 tion with a family planning service in a family planning  
8 setting provided during the period in which such an indi-  
9 vidual is eligible.

10 “(b) DEFINITIONS.—For purposes of this section:

11 “(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The  
12 term ‘presumptive eligibility period’ means, with re-  
13 spect to an individual described in subsection (a),  
14 the period that—

15 “(A) begins with the date on which a  
16 qualified entity determines, on the basis of pre-  
17 liminary information, that the individual is de-  
18 scribed in section 1902(ee); and

19 “(B) ends with (and includes) the earlier  
20 of—

21 “(i) the day on which a determination  
22 is made with respect to the eligibility of  
23 such individual for services under the State  
24 plan; or

1           “(ii) in the case of such an individual  
2           who does not file an application by the last  
3           day of the month following the month dur-  
4           ing which the entity makes the determina-  
5           tion referred to in subparagraph (A), such  
6           last day.

7           “(2) QUALIFIED ENTITY.—

8           “(A) IN GENERAL.—Subject to subpara-  
9           graph (B), the term ‘qualified entity’ means  
10          any entity that—

11                  “(i) is eligible for payments under a  
12                  State plan approved under this title; and

13                  “(ii) is determined by the State agen-  
14                  cy to be capable of making determinations  
15                  of the type described in paragraph (1)(A).

16           “(B) RULE OF CONSTRUCTION.—Nothing  
17           in this paragraph shall be construed as pre-  
18           venting a State from limiting the classes of en-  
19           tities that may become qualified entities in  
20           order to prevent fraud and abuse.

21           “(c) ADMINISTRATION.—

22                  “(1) IN GENERAL.—The State agency shall pro-  
23                  vide qualified entities with—

24                          “(A) such forms as are necessary for an  
25                          application to be made by an individual de-

1           scribed in subsection (a) for medical assistance  
2           under the State plan; and

3           “(B) information on how to assist such in-  
4           dividuals in completing and filing such forms.

5           “(2) NOTIFICATION REQUIREMENTS.—A quali-  
6           fied entity that determines under subsection  
7           (b)(1)(A) that an individual described in subsection  
8           (a) is presumptively eligible for medical assistance  
9           under a State plan shall—

10           “(A) notify the State agency of the deter-  
11           mination within 5 working days after the date  
12           on which determination is made; and

13           “(B) inform such individual at the time  
14           the determination is made that an application  
15           for medical assistance is required to be made by  
16           not later than the last day of the month fol-  
17           lowing the month during which the determina-  
18           tion is made.

19           “(3) APPLICATION FOR MEDICAL ASSIST-  
20           ANCE.—In the case of an individual described in  
21           subsection (a) who is determined by a qualified enti-  
22           ty to be presumptively eligible for medical assistance  
23           under a State plan, the individual shall apply for  
24           medical assistance by not later than the last day of

1 the month following the month during which the de-  
2 termination is made.

3 “(d) PAYMENT.—Notwithstanding any other provi-  
4 sion of this title, medical assistance that—

5 “(1) is furnished to an individual described in  
6 subsection (a)—

7 “(A) during a presumptive eligibility pe-  
8 riod;

9 “(B) by a entity that is eligible for pay-  
10 ments under the State plan; and

11 “(2) is included in the care and services covered  
12 by the State plan, shall be treated as medical assist-  
13 ance provided by such plan for purposes of clause  
14 (4) of the first sentence of section 1905(b).”.

15 (2) CONFORMING AMENDMENTS.—

16 (A) Section 1902(a)(47) of the Social Se-  
17 curity Act (42 U.S.C. 1396a(a)(47)) is amend-  
18 ed by inserting before the semicolon at the end  
19 the following: “and provide for making medical  
20 assistance available to individuals described in  
21 subsection (a) of section 1920C during a pre-  
22 sumptive eligibility period in accordance with  
23 such section”.

24 (B) Section 1903(u)(1)(D)(v) of such Act  
25 (42 U.S.C. 1396b(u)(1)(D)(v)) is amended—



1 (i) by striking “or for” and inserting  
2 “for”; and

3 (ii) by inserting before the period the  
4 following: “, or for medical assistance pro-  
5 vided to an individual described in sub-  
6 section (a) of section 1920C during a pre-  
7 sumptive eligibility period under such sec-  
8 tion”.

9 (e) CLARIFICATION OF COVERAGE OF FAMILY PLAN-  
10 NING SERVICES AND SUPPLIES.—Section 1937(b) of the  
11 Social Security Act (42 U.S.C. 1396u–7(b)) is amended  
12 by adding at the end the following:

13 “(5) COVERAGE OF FAMILY PLANNING SERV-  
14 ICES AND SUPPLIES.—Notwithstanding the previous  
15 provisions of this section, a State may not provide  
16 for medical assistance through enrollment of an indi-  
17 vidual with benchmark coverage or benchmark-equiv-  
18 alent coverage under this section unless such cov-  
19 erage includes for any individual described in section  
20 1905(a)(4)(C), medical assistance for family plan-  
21 ning services and supplies in accordance with such  
22 section.”.

23 (f) EFFECTIVE DATE.—The amendments made by  
24 this section take effect on October 1, 2007.

1 **SEC. 803. AUTHORITY TO CONTINUE PROVIDING ADULT**  
2 **DAY HEALTH SERVICES APPROVED UNDER A**  
3 **STATE MEDICAID PLAN.**

4 (a) **IN GENERAL.**—During the period described in  
5 subsection (b), the Secretary of Health and Human Serv-  
6 ices shall not—

7 (1) withhold, suspend, disallow, or otherwise  
8 deny Federal financial participation under section  
9 1903(a) of the Social Security Act (42 U.S.C.  
10 1396b(a)) for the provision of adult day health care  
11 services, day activity and health services, or adult  
12 medical day care services, as defined under a State  
13 Medicaid plan approved during or before 1994, dur-  
14 ing such period if such services are provided con-  
15 sistent with such definition and the requirements of  
16 such plan; or

17 (2) withdraw Federal approval of any such  
18 State plan or part thereof regarding the provision of  
19 such services (by regulation or otherwise).

20 (b) **PERIOD DESCRIBED.**—The period described in  
21 this subsection is the period that begins on November 3,  
22 2005, and ends on March 1, 2009.

1 **SEC. 804. STATE OPTION TO PROTECT COMMUNITY**  
2 **SPOUSES OF INDIVIDUALS WITH DISABIL-**  
3 **ITIES.**

4 Section 1924(h)(1)(A) of the Social Security Act (42  
5 U.S.C. 1396r-5(h)(1)(A)) is amended by striking “is de-  
6 scribed in section 1902(a)(10)(A)(ii)(VI)” and inserting  
7 “is being provided medical assistance for home and com-  
8 munity-based services under subsection (c), (d), (e), (i),  
9 or (j) of section 1915 or pursuant to section 1115”.

10 **SEC. 805. COUNTY MEDICAID HEALTH INSURING ORGANI-**  
11 **ZATIONS .**

12 (a) IN GENERAL.—Section 9517(c)(3) of the Consoli-  
13 dated Omnibus Budget Reconciliation Act of 1985 (42  
14 U.S.C. 1396b note), as added by section 4734 of the Om-  
15 nibus Budget Reconciliation Act of 1990 and as amended  
16 by section 704 of the Medicare, Medicaid, and SCHIP  
17 Benefits Improvement and Protection Act of 2000, is  
18 amended—

19 (1) in subparagraph (A), by inserting “, in the  
20 case of any health insuring organization described in  
21 such subparagraph that is operated by a public enti-  
22 ty established by Ventura County, and in the case  
23 of any health insuring organization described in such  
24 subparagraph that is operated by a public entity es-  
25 tablished by Merced County” after “described in  
26 subparagraph (B)”; and

1           (2) in subparagraph (C), by striking “14 per-  
2           cent” and inserting “16 percent”.

3           (b) EFFECTIVE DATE.—The amendments made by  
4 subsection (a) shall take effect on the date of the enact-  
5 ment of this Act.

## 6                           **Subtitle B—Payments**

### 7   **SEC. 811. PAYMENTS FOR PUERTO RICO AND TERRITORIES.**

8           (a) PAYMENT CEILING.—Section 1108(g) of the So-  
9 cial Security Act (42 U.S.C. 1308(g)) is amended—

10           (1) in paragraph (2), by striking “paragraph  
11           (3)” and inserting “paragraphs (3) and (4)”; and

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

14           “(4) FISCAL YEARS 2009 THROUGH 2012 FOR  
15 CERTAIN INSULAR AREAS.—The amounts otherwise  
16 determined under this subsection for Puerto Rico,  
17 the Virgin Islands, Guam, the Northern Mariana Is-  
18 lands, and American Samoa for fiscal years 2009  
19 through 2012 shall be increased by the following  
20 amounts:

21           “(A) PUERTO RICO.—For Puerto Rico,  
22           \$250,000,000   for   fiscal   year   2009,  
23           \$350,000,000   for   fiscal   year   2010,  
24           \$500,000,000   for   fiscal   year   2011,   and  
25           \$600,000,000 for fiscal year 2012.

1           “(B) VIRGIN ISLANDS.—For the Virgin Is-  
2           lands, \$5,000,000 for each of fiscal years 2009  
3           through 2012.

4           “(C) GUAM .—For Guam, \$5,000,000 for  
5           each of fiscal years 2009 through 2012.

6           “(D) NORTHERN MARIANA ISLANDS.—For  
7           the Northern Mariana Islands, \$4,000,000 for  
8           each of fiscal years 2009 through 2012.

9           “(E) AMERICAN SAMOA.—For American  
10          Samoa, \$4,000,000 for each of fiscal years  
11          2009 through 2012.

12          Such amounts shall not be taken into account in ap-  
13          plying paragraph (2) for fiscal years 2009 through  
14          2012 but shall be taken into account in applying  
15          such paragraph for fiscal year 2013 and subsequent  
16          fiscal years.”.

17          (b) REMOVAL OF FEDERAL MATCHING PAYMENTS  
18          FOR IMPROVING DATA REPORTING SYSTEMS FROM THE  
19          OVERALL LIMIT ON PAYMENTS TO TERRITORIES UNDER  
20          TITLE XIX.—Such section is further amended by adding  
21          at the end the following new paragraph:

22                 “(5) EXCLUSION OF CERTAIN EXPENDITURES  
23                 FROM PAYMENT LIMITS.—With respect to fiscal year  
24                 2008 and each fiscal year thereafter, if Puerto Rico,  
25                 the Virgin Islands, Guam, the Northern Mariana Is-

1 lands, or American Samoa qualify for a payment  
2 under subparagraph (A)(i) or (B) of section  
3 1903(a)(3) for a calendar quarter of such fiscal year  
4 with respect to expenditures for improvements in  
5 data reporting systems described in such subpara-  
6 graph, the limitation on expenditures under title  
7 XIX for such commonwealth or territory otherwise  
8 determined under subsection (f) and this subsection  
9 for such fiscal year shall be determined without re-  
10 gard to payment for such expenditures.”.

11 **SEC. 812. MEDICAID DRUG REBATE.**

12 Paragraph (1)(B)(i) of section 1927(c) of the Social  
13 Security Act (42 U.S.C. 1396r–8(c)) is amended—

14 (1) by striking “and” at the end of subclause  
15 (IV);

16 (2) in subclause (V)—

17 (A) by inserting “and before January 1,  
18 2008,” after “December 31, 1995,”; and

19 (B) by striking the period at the end and  
20 inserting “; and”; and

21 (3) by adding at the end the following new sub-  
22 clause:

23 “(VI) after December 31, 2007,  
24 is 22.1 percent.”.

1 **SEC. 813. ADJUSTMENT IN COMPUTATION OF MEDICAID**  
2 **FMAP TO DISREGARD AN EXTRAORDINARY**  
3 **EMPLOYER PENSION CONTRIBUTION.**

4 (a) IN GENERAL.—Only for purposes of computing  
5 the Federal medical assistance percentage under section  
6 1905(b) of the Social Security Act (42 U.S.C. 1396d(b))  
7 for a State for a fiscal year (beginning with fiscal year  
8 2006), any significantly disproportionate employer pension  
9 contribution described in subsection (b) shall be dis-  
10 regarded in computing the per capita income of such  
11 State, but shall not be disregarded in computing the per  
12 capita income for the continental United States (and Alas-  
13 ka) and Hawaii.

14 (b) SIGNIFICANTLY DISPROPORTIONATE EMPLOYER  
15 PENSION CONTRIBUTION.—For purposes of subsection  
16 (a), a significantly disproportionate employer pension con-  
17 tribution described in this subsection with respect to a  
18 State for a fiscal year is an employer contribution towards  
19 pensions that is allocated to such State for a period if the  
20 aggregate amount so allocated exceeds 25 percent of the  
21 total increase in personal income in that State for the pe-  
22 riod involved.

23 **SEC. 814. MORATORIUM ON CERTAIN PAYMENT RESTRIC-**  
24 **TIONS.**

25 Notwithstanding any other provision of law, the Sec-  
26 retary of Health and Human Services shall not, prior to

1 the date that is 1 year after the date of enactment of this  
2 Act, take any action (through promulgation of regulation,  
3 issuance of regulatory guidance, use of federal payment  
4 audit procedures, or other administrative action, policy, or  
5 practice, including a Medical Assistance Manual trans-  
6 mittal or letter to State Medicaid directors) to restrict cov-  
7 erage or payment under title XIX of the Social Security  
8 Act for rehabilitation services, or school-based administra-  
9 tion, transportation, or medical services if such restric-  
10 tions are more restrictive in any aspect than those applied  
11 to such coverage or payment as of July 1, 2007.

12 **SEC. 815. TENNESSEE DSH.**

13       The DSH allotments for Tennessee for each fiscal  
14 year beginning with fiscal year 2008 under subsection  
15 (f)(3) of section 1923 of the Social Security Act (42  
16 U.S.C. 13961396r-4) are deemed to be \$30,000,000. The  
17 Secretary of Health and Human Services may impose a  
18 limitation on the total amount of payments made to hos-  
19 pitals under the TennCare Section 1115 waiver only to  
20 the extent that such limitation is necessary to ensure that  
21 a hospital does not receive payment in excess of the  
22 amounts described in subsection (f) of such section or as  
23 necessary to ensure that the waiver remains budget neu-  
24 tral.



1 **SEC. 816. CLARIFICATION TREATMENT OF REGIONAL MED-**  
2 **ICAL CENTER.**

3 (a) IN GENERAL.—Nothing in section 1903(w) of the  
4 Social Security Act (42 U.S.C. 1396b(w)) shall be con-  
5 strued by the Secretary of Health and Human Services  
6 as prohibiting a State’s use of funds as the non-Federal  
7 share of expenditures under title XIX of such Act where  
8 such funds are transferred from or certified by a publicly-  
9 owned regional medical center located in another State  
10 and described in subsection (b), so long as the Secretary  
11 determines that such use of funds is proper and in the  
12 interest of the program under title XIX.

13 (b) CENTER DESCRIBED.—A center described in this  
14 subsection is a publicly-owned regional medical center  
15 that—

16 (1) provides level 1 trauma and burn care serv-  
17 ices;

18 (2) provides level 3 neonatal care services;

19 (3) is obligated to serve all patients, regardless  
20 of ability to pay;

21 (4) is located within a Standard Metropolitan  
22 Statistical Area (SMSA) that includes at least 3  
23 States;

24 (5) provides services as a tertiary care provider  
25 for patients residing within a 125-mile radius; and

1           (6) meets the criteria for a disproportionate  
2           share hospital under section 1923 of such Act (42  
3           U.S.C. 1396r-4) in at least one State other than the  
4           State in which the center is located.

5 **SEC. 817. EXTENSION OF SSI WEB-BASED ASSET DEM-**  
6                   **ONSTRATION PROJECT TO THE MEDICAID**  
7                   **PROGRAM.**

8           (a) IN GENERAL.—The Secretary of Health and  
9           Human Services shall provide for the application to asset  
10           eligibility determinations under the Medicaid program  
11           under title XIX of the Social Security Act of the auto-  
12           mated, secure, web-based asset verification request and re-  
13           sponse process being applied for determining eligibility for  
14           benefits under the Supplemental Security Income (SSI)  
15           program under title XVI of such Act under a demonstra-  
16           tion project conducted under the authority of section  
17           1631(e)(1)(B)(ii) of such Act (42 U.S.C.  
18           1383(e)(1)(B)(ii)).

19           (b) LIMITATION.—Such application shall only extend  
20           to those States in which such demonstration project is op-  
21           erating and only for the period in which such project is  
22           otherwise provided.

23           (c) RULES OF APPLICATION.—For purposes of car-  
24           rying out subsection (a), notwithstanding any other provi-  
25           sion of law, information obtained from a financial institu-

1 tion that is used for purposes of eligibility determinations  
 2 under such demonstration project with respect to the Sec-  
 3 retary of Health and Human Services under the SSI pro-  
 4 gram may also be shared and used by States for purposes  
 5 of eligibility determinations under the Medicaid program.  
 6 In applying section 1631(e)(1)(B)(ii) of the Social Secu-  
 7 rity Act under this subsection, references to the Commis-  
 8 sioner of Social Security and benefits under title XVI of  
 9 such Act shall be treated as including a reference to a  
 10 State described in subsection (b) and medical assistance  
 11 under title XIX of such Act provided by such a State.

## 12 **Subtitle C—Miscellaneous**

### 13 **SEC. 821. DEMONSTRATION PROJECT FOR EMPLOYER BUY-** 14 **IN.**

15 Title XXI of the Social Security Act, as amended by  
 16 section 133(a)(1), is further amended by adding at the  
 17 end the following new section:

### 18 **“SEC. 2112. DEMONSTRATION PROJECT FOR EMPLOYER** 19 **BUY-IN.**

20 “(a) **AUTHORITY.**—

21 “(1) **IN GENERAL.**—The Secretary shall estab-  
 22 lish a demonstration project under which up to 10  
 23 States (each referred to in this section as a ‘parti-  
 24 cipating State’) that meets the conditions of para-  
 25 graph (2) may provide, under its State child health

1 plan (notwithstanding section 2102(b)(3)(C)) for a  
2 period of 5 years, for child health assistance in rela-  
3 tion to family coverage described in subsection (d)  
4 for children who would be targeted low-income chil-  
5 dren but for coverage as beneficiaries under a group  
6 health plan as the children of participants by virtue  
7 of a qualifying employer's contribution under sub-  
8 section (b)(2).

9 “(2) CONDITIONS.—The conditions described in  
10 this paragraph for a State are as follows:

11 “(A) NO WAITING LISTS.—The State does  
12 not impose any waiting list, enrollment cap, or  
13 similar limitation on enrollment of targeted low-  
14 income children under the State child health  
15 plan.

16 “(B) ELIGIBILITY OF ALL CHILDREN  
17 UNDER 200 PERCENT OF POVERTY LINE.—The  
18 State is applying an income eligibility level  
19 under section 2110(b)(1)(B)(ii)(I) that is at  
20 least 200 percent of the poverty line.

21 “(3) QUALIFYING EMPLOYER DEFINED.—In  
22 this section, the term ‘qualifying employer’ means an  
23 employer that has a majority of its workforce com-  
24 posed of full-time workers with family incomes rea-  
25 sonably estimated by the employer (based on wage

1 information available to the employer) at or below  
2 200 percent of the poverty line. In applying the pre-  
3 vious sentence, two part-time workers shall be treat-  
4 ed as a single full-time worker.

5 “(b) FUNDING.—A demonstration project under this  
6 section in a participating State shall be funded, with re-  
7 spect to assistance provided to children described in sub-  
8 section (a)(1), consistent with the following:

9 “(1) LIMITED FAMILY CONTRIBUTION.—The  
10 family involved shall be responsible for providing  
11 payment towards the premium for such assistance of  
12 such amount as the State may specify, except that  
13 the limitations on cost-sharing (including premiums)  
14 under paragraphs (2) and (3) of section 2103(e)  
15 shall apply to all cost-sharing of such family under  
16 this section.

17 “(2) MINIMUM EMPLOYER CONTRIBUTION.—  
18 The qualifying employer involved shall be responsible  
19 for providing payment to the State child health plan  
20 in the State of at least 50 percent of the portion of  
21 the cost (as determined by the State) of the family  
22 coverage in which the employer is enrolling the fam-  
23 ily that exceeds the amount of the family contribu-  
24 tion under paragraph (1) applied towards such cov-  
25 erage.

1           “(3) LIMITATION ON FEDERAL FINANCIAL PAR-  
2           TICIPATION.—In no case shall the Federal financial  
3           participation under section 2105 with respect to a  
4           demonstration project under this section be made for  
5           any portion of the costs of family coverage described  
6           in subsection (d) (including the costs of administra-  
7           tion of such coverage) that are not attributable to  
8           children described in subsection (a)(1).

9           “(c) UNIFORM ELIGIBILITY RULES.—In providing  
10          assistance under a demonstration project under this sec-  
11          tion—

12           “(1) a State shall establish uniform rules of eli-  
13          gibility for families to participate; and

14           “(2) a State shall not permit a qualifying em-  
15          ployer to select, within those families that meet such  
16          eligibility rules, which families may participate.

17          “(d) TERMS AND CONDITIONS.—The family coverage  
18          offered to families of qualifying employers under a dem-  
19          onstration project under this section in a State shall be  
20          the same as the coverage and benefits provided under the  
21          State child health plan in the State for targeted low-in-  
22          come children with the highest family income level per-  
23          mitted.”.

1 **SEC. 822. DIABETES GRANTS.**

2 Section 2104 of the Social Security Act (42 U.S.C.  
3 1397dd), as amended by section 101, is further amend-  
4 ed—

5 (1) in subsection (a)(11), by inserting before  
6 the period at the end the following: “plus for fiscal  
7 year 2009 the total of the amount specified in sub-  
8 section (j)”;

9 (2) by adding at the end the following new sub-  
10 section:

11 “(j) FUNDING FOR DIABETES GRANTS.—From the  
12 amounts appropriated under subsection (a)(11), for fiscal  
13 year 2009 from the amounts—

14 “(1) \$150,000,000 is hereby transferred and  
15 made available in such fiscal year for grants under  
16 section 330B of the Public Health Service Act; and

17 “(2) \$150,000,000 is hereby transferred and  
18 made available in such fiscal year for grants under  
19 section 330C of such Act.”.

20 **SEC. 823. TECHNICAL CORRECTION.**

21 (a) CORRECTION OF REFERENCE TO CHILDREN IN  
22 FOSTER CARE RECEIVING CHILD WELFARE SERVICES.—  
23 Section 1937(a)(2)(B)(viii) of the Social Security Act (42  
24 U.S.C. 1396u–7(a)(2)(B) is amended by striking “aid or  
25 assistance is made available under part B of title IV to  
26 children in foster care” and inserting “child welfare serv-

1 ices are made available under part B of title IV on the  
2 basis of being a child in foster care”.

3 (b) **EFFECTIVE DATE.**—The amendment made by  
4 subsection (a) shall take effect as if included in the  
5 amendment made by section 6044(a) of the Deficit Reduc-  
6 tion Act of 2005.

## 7 **TITLE IX—MISCELLANEOUS**

### 8 **SEC. 901. MEDICARE PAYMENT ADVISORY COMMISSION** 9 **STATUS.**

10 Section 1805(a) of the Social Security Act (42 U.S.C.  
11 1395b–6(a)) is amended by inserting “as an agency of  
12 Congress” after “established”.

### 13 **SEC. 902. REPEAL OF TRIGGER PROVISION.**

14 Subtitle A of title VIII of the Medicare Prescription  
15 Drug, Improvement, and Modernization Act of 2003 (Pub-  
16 lic Law 108–173) is repealed and the provisions of law  
17 amended by such subtitle are restored as if such subtitle  
18 had never been enacted.

### 19 **SEC. 903. REPEAL OF COMPARATIVE COST ADJUSTMENT** 20 **(CCA) PROGRAM.**

21 Section 1860C–1 of the Social Security Act (42  
22 U.S.C. 1395w–29), as added by section 241(a) of the  
23 Medicare Prescription Drug, Improvement, and Mod-  
24 ernization Act of 2003 (Public Law 108–173), is repealed.



1 **SEC. 904. COMPARATIVE EFFECTIVENESS RESEARCH.**

2 (a) IN GENERAL.—Part A of title XVIII of the Social  
3 Security Act is amended by adding at the end the fol-  
4 lowing new section:

5 “COMPARATIVE EFFECTIVENESS RESEARCH

6 “SEC. 1822. (a) CENTER FOR COMPARATIVE EFFEC-  
7 TIVENESS RESEARCH ESTABLISHED.—

8 “(1) IN GENERAL.—The Secretary shall estab-  
9 lish within the Agency of Healthcare Research and  
10 Quality a Center for Comparative Effectiveness Re-  
11 search (in this section referred to as the ‘Center’) to  
12 conduct, support, and synthesize research (including  
13 research conducted or supported under section 1013  
14 of the Medicare Prescription Drug, Improvement,  
15 and Modernization Act of 2003) with respect to the  
16 outcomes, effectiveness, and appropriateness of  
17 health care services and procedures in order to iden-  
18 tify the manner in which diseases, disorders, and  
19 other health conditions can most effectively and ap-  
20 propriately be prevented, diagnosed, treated, and  
21 managed clinically.

22 “(2) DUTIES.—The Center shall—

23 “(A) conduct, support, and synthesize re-  
24 search relevant to the comparative clinical effec-  
25 tiveness of the full spectrum of health care  
26 treatments, including pharmaceuticals, medical

1 devices, medical and surgical procedures, and  
2 other medical interventions;

3 “(B) conduct and support systematic re-  
4 views of clinical research, including original re-  
5 search conducted subsequent to the date of the  
6 enactment of this section;

7 “(C) use methodologies such as random-  
8 ized controlled clinical trials as well as other  
9 various types of clinical research, such as obser-  
10 vational studies;

11 “(D) submit to the Comparative Effective-  
12 ness Research Commission, the Secretary, and  
13 Congress appropriate relevant reports described  
14 in subsection (d)(2);

15 “(E) encourage, as appropriate, the devel-  
16 opment and use of clinical registries and the de-  
17 velopment of clinical effectiveness research data  
18 networks from electronic health records, post  
19 marketing drug and medical device surveillance  
20 efforts, and other forms of electronic health  
21 data; and

22 “(F) not later than 180 days after the  
23 date of the enactment of this section, develop  
24 methodological standards to be used when con-  
25 ducting studies of comparative clinical effective-

1           ness and value (and procedures for use of such  
2           standards) in order to help ensure accurate and  
3           effective comparisons and update such stand-  
4           ards at least biennially.

5           “(b) OVERSIGHT BY COMPARATIVE EFFECTIVENESS  
6 RESEARCH COMMISSION.—

7           “(1) IN GENERAL.—The Secretary shall estab-  
8           lish an independent Comparative Effectiveness Re-  
9           search Commission (in this section referred to as the  
10          ‘Commission’) to oversee and evaluate the activities  
11          carried out by the Center under subsection (a) to en-  
12          sure such activities result in highly credible research  
13          and information resulting from such research.

14          “(2) DUTIES.—The Commission shall—

15                 “(A) determine national priorities for re-  
16                 search described in subsection (a) and in mak-  
17                 ing such determinations consult with patients  
18                 and health care providers and payers;

19                 “(B) monitor the appropriateness of use of  
20                 the CERTF described in subsection (f) with re-  
21                 spect to the timely production of comparative  
22                 effectiveness research determined to be a na-  
23                 tional priority under subparagraph (A);

1           “(C) identify highly credible research  
2 methods and standards of evidence for such re-  
3 search to be considered by the Center;

4           “(D) review and approve the methodo-  
5 logical standards (and updates to such stand-  
6 ards) developed by the Center under subsection  
7 (a)(2)(F);

8           “(E) enter into an arrangement under  
9 which the Institute of Medicine of the National  
10 Academy of Sciences shall conduct an evalua-  
11 tion and report on standards of evidence for  
12 such research;

13           “(F) support forums to increase stake-  
14 holder awareness and permit stakeholder feed-  
15 back on the efforts of the Agency of Healthcare  
16 Research and Quality to advance methods and  
17 standards that promote highly credible re-  
18 search;

19           “(G) make recommendations for public  
20 data access policies of the Center that would  
21 allow for access of such data by the public while  
22 ensuring the information produced from re-  
23 search involved is timely and credible;

24           “(H) appoint a clinical perspective advisory  
25 panel for each research priority determined

1 under subparagraph (A), which shall frame the  
2 specific research inquiry to be examined with  
3 respect to such priority to ensure that the infor-  
4 mation produced from such research is clinically  
5 relevant to decisions made by clinicians and pa-  
6 tients at the point of care;

7 “(I) make recommendations for the pri-  
8 ority for periodic reviews of previous compara-  
9 tive effectiveness research and studies con-  
10 ducted by the Center under subsection (a);

11 “(J) routinely review processes of the Cen-  
12 ter with respect to such research to confirm  
13 that the information produced by such research  
14 is objective, credible, consistent with standards  
15 of evidence established under this section, and  
16 developed through a transparent process that  
17 includes consultations with appropriate stake-  
18 holders;

19 “(K) at least annually, provide guidance or  
20 recommendations to health care providers and  
21 consumers for the use of information on the  
22 comparative effectiveness of health care services  
23 by consumers, providers (as defined for pur-  
24 poses of regulations promulgated under section  
25 264(c) of the Health Insurance Portability and

1 Accountability Act of 1996) and public and pri-  
2 vate purchasers;

3 “(L) make recommendations for a strategy  
4 to disseminate the findings of research con-  
5 ducted and supported under this section that  
6 enables clinicians to improve performance, con-  
7 sumers to make more informed health care de-  
8 cisions, and payers to set medical policies that  
9 improve quality and value;

10 “(M) provide for the public disclosure of  
11 relevant reports described in subsection (d)(2);  
12 and

13 “(N) submit to Congress an annual report  
14 on the progress of the Center in achieving na-  
15 tional priorities determined under subparagraph  
16 (A) for the provision of credible comparative ef-  
17 fectiveness information produced from such re-  
18 search to all interested parties.

19 “(3) COMPOSITION OF COMMISSION.—

20 “(A) IN GENERAL.—The members of the  
21 Commission shall consist of—

22 “(i) the Director of the Agency for  
23 Healthcare Research and Quality;

1           “(ii) the Chief Medical Officer of the  
2           Centers for Medicare & Medicaid Services;  
3           and

4           “(iii) 15 additional members who shall  
5           represent broad constituencies of stake-  
6           holders including clinicians, patients, re-  
7           searchers, third-party payers, consumers of  
8           Federal and State beneficiary programs.

9           “(B) QUALIFICATIONS.—

10           “(i) DIVERSE REPRESENTATION OF  
11           PERSPECTIVES.—The members of the  
12           Commission shall represent a broad range  
13           of perspectives and shall collectively have  
14           experience in the following areas:

15                   “(I) Epidemiology.

16                   “(II) Health services research.

17                   “(III) Bioethics.

18                   “(IV) Decision sciences.

19                   “(V) Economics.

20           “(ii) DIVERSE REPRESENTATION OF  
21           HEALTH CARE COMMUNITY.—At least one  
22           member shall represent each of the fol-  
23           lowing health care communities:

24                   “(I) Consumers.

1                   “(II) Practicing physicians, in-  
2                   cluding surgeons.

3                   “(III) Employers.

4                   “(IV) Public payers.

5                   “(V) Insurance plans.

6                   “(VI) Clinical researchers who  
7                   conduct research on behalf of pharma-  
8                   ceutical or device manufacturers.

9                   “(4) APPOINTMENT.—The Comptroller General  
10                  of the United States, in consultation with the chairs  
11                  of the committees of jurisdiction of the House of  
12                  Representatives and the Senate, shall appoint the  
13                  members of the Commission.

14                  “(5) CHAIRMAN; VICE CHAIRMAN.—The Comp-  
15                  troller General of the United States shall designate  
16                  a member of the Commission, at the time of ap-  
17                  pointment of the member, as Chairman and a mem-  
18                  ber as Vice Chairman for that term of appointment,  
19                  except that in the case of vacancy of the Chairman-  
20                  ship or Vice Chairmanship, the Comptroller General  
21                  may designate another member for the remainder of  
22                  that member’s term.

23                  “(6) TERMS.—

24                         “(A) IN GENERAL.—Except as provided in  
25                         subparagraph (B), each member of the Com-



1 mission shall be appointed for a term of 4  
2 years.

3 “(B) TERMS OF INITIAL APPOINTEES.—Of  
4 the members first appointed—

5 “(i) 8 shall be appointed for a term of  
6 4 years; and

7 “(ii) 7 shall be appointed for a term  
8 of 3 years.

9 “(7) COORDINATION.—To enhance effectiveness  
10 and coordination, the Comptroller General is encour-  
11 aged, to the greatest extent possible, to seek coordi-  
12 nation between the Commission and the National  
13 Advisory Council of the Agency for Healthcare Re-  
14 search and Quality.

15 “(8) CONFLICTS OF INTEREST.—In appointing  
16 the members of the Commission or a clinical per-  
17 spective advisory panel described in paragraph  
18 (2)(H), the Comptroller General of the United  
19 States or the Commission, respectively, shall take  
20 into consideration any financial conflicts of interest.

21 “(9) COMPENSATION.—While serving on the  
22 business of the Commission (including travel time),  
23 a member of the Commission shall be entitled to  
24 compensation at the per diem equivalent of the rate  
25 provided for level IV of the Executive Schedule

1 under section 5315 of title 5, United States Code;  
2 and while so serving away from home and the mem-  
3 ber's regular place of business, a member may be al-  
4 lowed travel expenses, as authorized by the Director  
5 of the Commission.

6 “(10) AVAILABILITY OF REPORTS.—The Com-  
7 mission shall transmit to the Secretary a copy of  
8 each report submitted under this subsection and  
9 shall make such reports available to the public.

10 “(11) DIRECTOR AND STAFF; EXPERTS AND  
11 CONSULTANTS.—Subject to such review as the Sec-  
12 retary, in consultation with the Comptroller General  
13 deems necessary to assure the efficient administra-  
14 tion of the Commission, the Commission may—

15 “(A) employ and fix the compensation of  
16 an Executive Director (subject to the approval  
17 of the Secretary, in consultation with the  
18 Comptroller General) and such other personnel  
19 as may be necessary to carry out its duties  
20 (without regard to the provisions of title 5,  
21 United States Code, governing appointments in  
22 the competitive service);

23 “(B) seek such assistance and support as  
24 may be required in the performance of its du-

1           ties from appropriate Federal departments and  
2           agencies;

3           “(C) enter into contracts or make other ar-  
4           rangements, as may be necessary for the con-  
5           duct of the work of the Commission (without  
6           regard to section 3709 of the Revised Statutes  
7           (41 U.S.C. 5));

8           “(D) make advance, progress, and other  
9           payments which relate to the work of the Com-  
10          mission;

11          “(E) provide transportation and subsist-  
12          ence for persons serving without compensation;  
13          and

14          “(F) prescribe such rules and regulations  
15          as it deems necessary with respect to the inter-  
16          nal organization and operation of the Commis-  
17          sion.

18          “(12) POWERS.—

19                 “(A) OBTAINING OFFICIAL DATA.—The  
20                 Commission may secure directly from any de-  
21                 partment or agency of the United States infor-  
22                 mation necessary to enable it to carry out this  
23                 section. Upon request of the Executive Director,  
24                 the head of that department or agency shall

1 furnish that information to the Commission on  
2 an agreed upon schedule.

3 “(B) DATA COLLECTION.—In order to  
4 carry out its functions, the Commission shall—

5 “(i) utilize existing information, both  
6 published and unpublished, where possible,  
7 collected and assessed either by its own  
8 staff or under other arrangements made in  
9 accordance with this section,

10 “(ii) carry out, or award grants or  
11 contracts for, original research and experi-  
12 mentation, where existing information is  
13 inadequate, and

14 “(iii) adopt procedures allowing any  
15 interested party to submit information for  
16 the Commission’s use in making reports  
17 and recommendations.

18 “(C) ACCESS OF GAO TO INFORMATION.—  
19 The Comptroller General shall have unrestricted  
20 access to all deliberations, records, and non-  
21 proprietary data of the Commission, imme-  
22 diately upon request.

23 “(D) PERIODIC AUDIT.—The Commission  
24 shall be subject to periodic audit by the Comp-  
25 troller General.

1       “(c) RESEARCH REQUIREMENTS.—Any research con-  
2 ducted, supported, or synthesized under this section shall  
3 meet the following requirements:

4               “(1) ENSURING TRANSPARENCY, CREDIBILITY,  
5 AND ACCESS.—

6                       “(A) The establishment of the agenda and  
7 conduct of the research shall be insulated from  
8 inappropriate political or stakeholder influence.

9                       “(B) Methods of conducting such research  
10 shall be scientifically based.

11                      “(C) All aspects of the prioritization of re-  
12 search, conduct of the research, and develop-  
13 ment of conclusions based on the research shall  
14 be transparent to all stakeholders.

15                      “(D) The process and methods for con-  
16 ducting such research shall be publicly docu-  
17 mented and available to all stakeholders.

18                      “(E) Throughout the process of such re-  
19 search, the Center shall provide opportunities  
20 for all stakeholders involved to review and pro-  
21 vide comment on the methods and findings of  
22 such research.

23               “(2) USE OF CLINICAL PERSPECTIVE ADVISORY  
24 PANELS.—The research shall meet a national re-  
25 search priority determined under subsection

1 (b)(2)(A) and shall examine the specific research in-  
2 quiry framed by the clinical perspective advisory  
3 panel for the national research priority.

4 “(3) STAKEHOLDER INPUT.—The priorities of  
5 the research, the research, and the dissemination of  
6 the research shall involve the consultation of pa-  
7 tients, health care providers, and health care con-  
8 sumer representatives through transparent mecha-  
9 nisms recommended by the Commission.

10 “(d) PUBLIC ACCESS TO COMPARATIVE EFFECTIVE-  
11 NESS INFORMATION.—

12 “(1) IN GENERAL.—Not later than 90 days  
13 after receipt by the Center or Commission, as appli-  
14 cable, of a relevant report described in paragraph  
15 (2) made by the Center, Commission, or clinical per-  
16 spective advisory panel under this section, appro-  
17 priate information contained in such report shall be  
18 posted on the official public Internet site of the Cen-  
19 ter and of the Commission, as applicable.

20 “(2) RELEVANT REPORTS DESCRIBED.—For  
21 purposes of this section, a relevant report is each of  
22 the following submitted by a grantee or contractor  
23 of the Center:

24 “(A) An interim progress report.

1           “(B) A draft final comparative effective-  
2           ness review.

3           “(C) A final progress report on new re-  
4           search submitted for publication by a peer re-  
5           view journal.

6           “(D) Stakeholder comments.

7           “(E) A final report.

8           “(3) ACCESS BY CONGRESS AND THE COMMIS-  
9           SION TO THE CENTER’S INFORMATION.—Congress  
10          and the Commission shall each have unrestricted ac-  
11          cess to all deliberations, records, and nonproprietary  
12          data of the Center, immediately upon request.

13          “(e) DISSEMINATION AND INCORPORATION OF COM-  
14          PARATIVE EFFECTIVENESS INFORMATION.—

15               “(1) DISSEMINATION.—The Center shall pro-  
16          vide for the dissemination of appropriate findings  
17          produced by research supported, conducted, or syn-  
18          thesized under this section to health care providers,  
19          patients, vendors of health information technology  
20          focused on clinical decision support, appropriate pro-  
21          fessional associations, and Federal and private  
22          health plans.

23               “(2) INCORPORATION.—The Center shall assist  
24          users of health information technology focused on  
25          clinical decision support to promote the timely incor-

1 poration of the findings described in paragraph (1)  
2 into clinical practices and to promote the ease of use  
3 of such incorporation.

4 “(f) REPORTS TO CONGRESS.—

5 “(1) ANNUAL REPORTS.—Beginning not later  
6 than one year after the date of the enactment of this  
7 section, the Director of the Agency of Healthcare  
8 Research and Quality and the Commission shall sub-  
9 mit to Congress an annual report on the activities  
10 of the Center and the Commission, as well as the re-  
11 search, conducted under this section.

12 “(2) RECOMMENDATION FOR FAIR SHARE PER  
13 CAPITA AMOUNT FOR ALL-PAYER FINANCING.—Be-  
14 ginning not later than December 31, 2009, the Sec-  
15 retary shall submit to Congress an annual rec-  
16 ommendation for a fair share per capita amount de-  
17 scribed in subsection (c)(1) of section 9511 of the  
18 Internal Revenue Code of 1986 for purposes of  
19 funding the CERTF under such section.

20 “(3) ANALYSIS AND REVIEW.—Not later than  
21 December 31, 2011, the Secretary, in consultation  
22 with the Commission, shall submit to Congress a re-  
23 port on all activities conducted or supported under  
24 this section as of such date. Such report shall in-  
25 clude an evaluation of the return on investment re-



1 sulting from such activities, the overall costs of such  
2 activities, and an analysis of the backlog of any re-  
3 search proposals approved by the Commission but  
4 not funded. Such report shall also address whether  
5 Congress should expand the responsibilities of the  
6 Center and of the Commission to include studies of  
7 the effectiveness of various aspects of the health care  
8 delivery system, including health plans and delivery  
9 models, such as health plan features, benefit designs  
10 and performance, and the ways in which health serv-  
11 ices are organized, managed, and delivered.

12 “(g) COORDINATING COUNCIL FOR HEALTH SERV-  
13 ICES RESEARCH.—

14 “(1) ESTABLISHMENT.—The Secretary shall es-  
15 tablish a permanent council (in this section referred  
16 to as the ‘Council’) for the purpose of—

17 “(A) assisting the offices and agencies of  
18 the Department of Health and Human Services,  
19 the Department of Veterans Affairs, the De-  
20 partment of Defense, and any other Federal de-  
21 partment or agency to coordinate the conduct  
22 or support of health services research; and

23 “(B) advising the President and Congress  
24 on—

1           “(i) the national health services re-  
2           search agenda;

3           “(ii) strategies with respect to infra-  
4           structure needs of health services research;  
5           and

6           “(iii) appropriate organizational ex-  
7           penditures in health services research by  
8           relevant Federal departments and agen-  
9           cies.

10          “(2) MEMBERSHIP.—

11           “(A) NUMBER AND APPOINTMENT.—The  
12          Council shall be composed of 20 members. One  
13          member shall be the Director of the Agency for  
14          Healthcare Research and Quality. The Director  
15          shall appoint the other members not later than  
16          30 days after the enactment of this Act.

17           “(B) TERMS.—

18           “(i) IN GENERAL.—Except as pro-  
19          vided in clause (ii), each member of the  
20          Council shall be appointed for a term of 4  
21          years.

22           “(ii) TERMS OF INITIAL AP-  
23          POINTEES.—Of the members first ap-  
24          pointed—

1                   “(I) 10 shall be appointed for a  
2                   term of 4 years; and

3                   “(II) 9 shall be appointed for a  
4                   term of 3 years.

5                   “(iii) VACANCIES.—Any vacancies  
6                   shall not affect the power and duties of the  
7                   Council and shall be filled in the same  
8                   manner as the original appointment.

9                   “(C) QUALIFICATIONS.—

10                   “(i) IN GENERAL.—The members of  
11                   the Council shall include one senior official  
12                   from each of the following agencies:

13                   “(I) The Veterans Health Ad-  
14                   ministration.

15                   “(II) The Department of Defense  
16                   Military Health Care System.

17                   “(III) The Centers for Disease  
18                   Control and Prevention.

19                   “(IV) The National Center for  
20                   Health Statistics.

21                   “(V) The National Institutes of  
22                   Health.

23                   “(VI) The Center for Medicare &  
24                   Medicaid Services.

1                   “(VII) The Federal Employees  
2                   Health Benefits Program.

3                   “(ii) NATIONAL, PHILANTHROPIC  
4                   FOUNDATIONS.—The members of the  
5                   Council shall include 4 senior leaders from  
6                   major national, philanthropic foundations  
7                   that fund and use health services research.

8                   “(iii) STAKEHOLDERS.—The remain-  
9                   ing members of the Council shall be rep-  
10                  resentatives of other stakeholders in health  
11                  services research, including private pur-  
12                  chasers, health plans, hospitals and other  
13                  health facilities, and health consumer  
14                  groups.

15                  “(3) ANNUAL REPORT.—The Council shall sub-  
16                  mit to Congress an annual report on the progress of  
17                  the implementation of the national health services  
18                  research agenda.

19                  “(h) FUNDING OF COMPARATIVE EFFECTIVENESS  
20                  RESEARCH.—For fiscal year 2008 and each subsequent  
21                  fiscal year, amounts in the Comparative Effectiveness Re-  
22                  search Trust Fund (referred to in this section as the  
23                  ‘CERTF’) under section 9511 of the Internal Revenue  
24                  Code of 1986 shall be available to the Secretary to carry  
25                  out this section.”.

1 (b) COMPARATIVE EFFECTIVENESS RESEARCH  
2 TRUST FUND; FINANCING FOR TRUST FUND.—

3 (1) ESTABLISHMENT OF TRUST FUND.—

4 (A) IN GENERAL.—Subchapter A of chap-  
5 ter 98 of the Internal Revenue Code of 1986  
6 (relating to trust fund code) is amended by  
7 adding at the end the following new section:

8 **“SEC. 9511. HEALTH CARE COMPARATIVE EFFECTIVENESS**  
9 **RESEARCH TRUST FUND.**

10 “(a) CREATION OF TRUST FUND.—There is estab-  
11 lished in the Treasury of the United States a trust fund  
12 to be known as the ‘Health Care Comparative Effective-  
13 ness Research Trust Fund’ (hereinafter in this section re-  
14 ferred to as the ‘CERTF’), consisting of such amounts  
15 as may be appropriated or credited to such Trust Fund  
16 as provided in this section and section 9602(b).

17 “(b) TRANSFERS TO FUND.—There are hereby ap-  
18 propriated to the Trust Fund the following:

19 “(1) For fiscal year 2008, \$90,000,000.

20 “(2) For fiscal year 2009, \$100,000,000.

21 “(3) For fiscal year 2010, \$110,000,000.

22 “(4) For each fiscal year beginning with fiscal  
23 year 2011—

24 “(A) an amount equivalent to the net reve-  
25 nues received in the Treasury from the fees im-

1           posed under subchapter B of chapter 34 (relat-  
2           ing to fees on health insurance and self-insured  
3           plans) for such fiscal year; and

4                   “(B) subject to subsection (c)(2), amounts  
5           determined by the Secretary of Health and  
6           Human Services to be equivalent to the fair  
7           share per capita amount computed under sub-  
8           section (c)(1) for the fiscal year multiplied by  
9           the average number of individuals entitled to  
10          benefits under part A, or enrolled under part B,  
11          of title XVIII of the Social Security Act during  
12          such fiscal year.

13   The amounts appropriated under paragraphs (1), (2), (3),  
14   and (4)(B) shall be transferred from the Federal Hospital  
15   Insurance Trust Fund and from the Federal Supple-  
16   mentary Medical Insurance Trust Fund (established  
17   under section 1841 of such Act), and from the Medicare  
18   Prescription Drug Account within such Trust Fund, in  
19   proportion (as estimated by the Secretary) to the total ex-  
20   penditures during such fiscal year that are made under  
21   title XVIII of such Act from the respective trust fund or  
22   account.

23           “(c) FAIR SHARE PER CAPITA AMOUNT.—

24                   “(1) COMPUTATION.—

1           “(A) IN GENERAL.—Subject to subpara-  
2 graph (B), the fair share per capita amount  
3 under this paragraph for a fiscal year (begin-  
4 ning with fiscal year 2011) is an amount com-  
5 puted by the Secretary of Health and Human  
6 Services for such fiscal year that, when applied  
7 under this section and subchapter B of chapter  
8 34 of the Internal Revenue Code of 1986, will  
9 result in revenues to the CERTF of  
10 \$375,000,000 for the fiscal year.

11           “(B) ALTERNATIVE COMPUTATION.—

12           “(i) IN GENERAL.—If the Secretary is  
13 unable to compute the fair share per capita  
14 amount under subparagraph (A) for a fis-  
15 cal year, the fair share per capita amount  
16 under this paragraph for the fiscal year  
17 shall be the default amount determined  
18 under clause (ii) for the fiscal year.

19           “(ii) DEFAULT AMOUNT.—The default  
20 amount under this clause for—

21                   “(I) fiscal year 2011 is equal to  
22                   \$2; or

23                   “(II) a subsequent year is equal  
24                   to the default amount under this  
25                   clause for the preceding fiscal year in-

1                    increased by the annual percentage in-  
2                    crease in the medical care component  
3                    of the consumer price index (United  
4                    States city average) for the 12-month  
5                    period ending with April of the pre-  
6                    ceding fiscal year.

7                    Any amount determined under subclause  
8                    (II) shall be rounded to the nearest penny.

9                    “(2) LIMITATION ON MEDICARE FUNDING.—In  
10                   no case shall the amount transferred under sub-  
11                   section (b)(4)(B) for any fiscal year exceed  
12                   \$90,000,000.

13                   “(d) EXPENDITURES FROM FUND.—

14                   “(1) IN GENERAL.—Subject to paragraph (2),  
15                   amounts in the CERTF are available to the Sec-  
16                   retary of Health and Human Services for carrying  
17                   out section 1822 of the Social Security Act.

18                   “(2) ALLOCATION FOR COMMISSION.—Not less  
19                   than the following amounts in the CERTF for a fis-  
20                   cal year shall be available to carry out the activities  
21                   of the Comparative Effectiveness Research Commis-  
22                   sion established under section 1822(b) of the Social  
23                   Security Act for such fiscal year:

24                   “(A) For fiscal year 2008, \$7,000,000.

25                   “(B) For fiscal year 2009, \$9,000,000.



1           “(C) For each fiscal year beginning with  
2           2010, \$10,000,000.

3           Nothing in this paragraph shall be construed as pre-  
4           venting additional amounts in the CERTF from  
5           being made available to the Comparative Effective-  
6           ness Research Commission for such activities.

7           “(e) NET REVENUES.—For purposes of this section,  
8           the term ‘net revenues’ means the amount estimated by  
9           the Secretary based on the excess of—

10           “(1) the fees received in the Treasury under  
11           subchapter B of chapter 34, over

12           “(2) the decrease in the tax imposed by chapter  
13           1 resulting from the fees imposed by such sub-  
14           chapter.”.

15           (B) CLERICAL AMENDMENT.—The table of  
16           sections for such subchapter A is amended by  
17           adding at the end thereof the following new  
18           item:

“Sec. 9511. Health Care Comparative Effectiveness Research Trust Fund.”.

19           (2) FINANCING FOR FUND FROM FEES ON IN-  
20           SURED AND SELF-INSURED HEALTH PLANS.—

21           (A) GENERAL RULE.—Chapter 34 of the  
22           Internal Revenue Code of 1986 is amended by  
23           adding at the end the following new subchapter:

1     **“Subchapter B—Insured and Self-Insured**  
2                     **Health Plans**

“Sec. 4375. Health insurance.

“Sec. 4376. Self-insured health plans.

“Sec. 4377. Definitions and special rules.

3     **“SEC. 4375. HEALTH INSURANCE.**

4             “(a) IMPOSITION OF FEE.—There is hereby imposed  
5 on each specified health insurance policy for each policy  
6 year a fee equal to the fair share per capita amount deter-  
7 mined under section 9511(c)(1) multiplied by the average  
8 number of lives covered under the policy.

9             “(b) LIABILITY FOR FEE.—The fee imposed by sub-  
10 section (a) shall be paid by the issuer of the policy.

11            “(c) SPECIFIED HEALTH INSURANCE POLICY.—For  
12 purposes of this section:

13               “(1) IN GENERAL.—Except as otherwise pro-  
14 vided in this section, the term ‘specified health in-  
15 surance policy’ means any accident or health insur-  
16 ance policy issued with respect to individuals resid-  
17 ing in the United States.

18               “(2) EXEMPTION FOR CERTAIN POLICIES.—The  
19 term ‘specified health insurance policy’ does not in-  
20 clude any insurance if substantially all of its cov-  
21 erage is of excepted benefits described in section  
22 9832(e).

23               “(3) TREATMENT OF PREPAID HEALTH COV-  
24 ERAGE ARRANGEMENTS.—

1           “(A) IN GENERAL.—In the case of any ar-  
2           rangement described in subparagraph (B)—

3                   “(i) such arrangement shall be treated  
4                   as a specified health insurance policy, and

5                   “(ii) the person referred to in such  
6                   subparagraph shall be treated as the  
7                   issuer.

8           “(B) DESCRIPTION OF ARRANGEMENTS.—

9           An arrangement is described in this subpara-  
10          graph if under such arrangement fixed pay-  
11          ments or premiums are received as consider-  
12          ation for any person’s agreement to provide or  
13          arrange for the provision of accident or health  
14          coverage to residents of the United States, re-  
15          gardless of how such coverage is provided or ar-  
16          ranged to be provided.

17 **“SEC. 4376. SELF-INSURED HEALTH PLANS.**

18          “(a) IMPOSITION OF FEE.—In the case of any appli-  
19          cable self-insured health plan for each plan year, there is  
20          hereby imposed a fee equal to the fair share per capita  
21          amount determined under section 9511(c)(1) multiplied by  
22          the average number of lives covered under the plan.

23          “(b) LIABILITY FOR FEE.—

24                   “(1) IN GENERAL.—The fee imposed by sub-  
25                   section (a) shall be paid by the plan sponsor.

1           “(2) PLAN SPONSOR.—For purposes of para-  
2 graph (1) the term ‘plan sponsor’ means—

3           “(A) the employer in the case of a plan es-  
4 tablished or maintained by a single employer,

5           “(B) the employee organization in the case  
6 of a plan established or maintained by an em-  
7 ployee organization,

8           “(C) in the case of—

9           “(i) a plan established or maintained  
10 by 2 or more employers or jointly by 1 or  
11 more employers and 1 or more employee  
12 organizations,

13           “(ii) a multiple employer welfare ar-  
14 rangement, or

15           “(iii) a voluntary employees’ bene-  
16 ficiary association described in section  
17 501(c)(9),

18 the association, committee, joint board of trust-  
19 ees, or other similar group of representatives of  
20 the parties who establish or maintain the plan,  
21 or

22           “(D) the cooperative or association de-  
23 scribed in subsection (c)(2)(F) in the case of a  
24 plan established or maintained by such a coop-  
25 erative or association.

1       “(c) APPLICABLE SELF-INSURED HEALTH PLAN.—

2 For purposes of this section, the term ‘applicable self-in-  
3 sured health plan’ means any plan for providing accident  
4 or health coverage if—

5           “(1) any portion of such coverage is provided  
6 other than through an insurance policy, and

7           “(2) such plan is established or maintained—

8               “(A) by one or more employers for the  
9 benefit of their employees or former employees,

10               “(B) by one or more employee organiza-  
11 tions for the benefit of their members or former  
12 members,

13               “(C) jointly by 1 or more employers and 1  
14 or more employee organizations for the benefit  
15 of employees or former employees,

16               “(D) by a voluntary employees’ beneficiary  
17 association described in section 501(c)(9),

18               “(E) by any organization described in sec-  
19 tion 501(c)(6), or

20               “(F) in the case of a plan not described in  
21 the preceding subparagraphs, by a multiple em-  
22 ployer welfare arrangement (as defined in sec-  
23 tion 3(40) of Employee Retirement Income Se-  
24 curity Act of 1974), a rural electric cooperative  
25 (as defined in section 3(40)(B)(iv) of such Act),

1 or a rural telephone cooperative association (as  
2 defined in section 3(40)(B)(v) of such Act).

3 **“SEC. 4377. DEFINITIONS AND SPECIAL RULES.**

4 “(a) DEFINITIONS.—For purposes of this sub-  
5 chapter—

6 “(1) ACCIDENT AND HEALTH COVERAGE.—The  
7 term ‘accident and health coverage’ means any cov-  
8 erage which, if provided by an insurance policy,  
9 would cause such policy to be a specified health in-  
10 surance policy (as defined in section 4375(c)).

11 “(2) INSURANCE POLICY.—The term ‘insurance  
12 policy’ means any policy or other instrument where-  
13 by a contract of insurance is issued, renewed, or ex-  
14 tended.

15 “(3) UNITED STATES.—The term ‘United  
16 States’ includes any possession of the United States.

17 “(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

18 “(1) IN GENERAL.—For purposes of this sub-  
19 chapter—

20 “(A) the term ‘person’ includes any gov-  
21 ernmental entity, and

22 “(B) notwithstanding any other law or rule  
23 of law, governmental entities shall not be ex-  
24 empt from the fees imposed by this subchapter  
25 except as provided in paragraph (2).

1           “(2) TREATMENT OF EXEMPT GOVERNMENTAL  
2 PROGRAMS.—In the case of an exempt governmental  
3 program, no fee shall be imposed under section 4375  
4 or section 4376 on any covered life under such pro-  
5 gram.

6           “(3) EXEMPT GOVERNMENTAL PROGRAM DE-  
7 FINED.—For purposes of this subchapter, the term  
8 ‘exempt governmental program’ means—

9                   “(A) any insurance program established  
10 under title XVIII of the Social Security Act,

11                   “(B) the medical assistance program es-  
12 tablished by title XIX or XXI of the Social Se-  
13 curity Act,

14                   “(C) any program established by Federal  
15 law for providing medical care (other than  
16 through insurance policies) to individuals (or  
17 the spouses and dependents thereof) by reason  
18 of such individuals being—

19                           “(i) members of the Armed Forces of  
20 the United States, or

21                           “(ii) veterans, and

22                   “(D) any program established by Federal  
23 law for providing medical care (other than  
24 through insurance policies) to members of In-

1           dian tribes (as defined in section 4(d) of the In-  
2           dian Health Care Improvement Act).

3           “(c) TREATMENT AS TAX.—For purposes of subtitle  
4 F, the fees imposed by this subchapter shall be treated  
5 as if they were taxes.

6           “(d) NO COVER OVER TO POSSESSIONS.—Notwith-  
7 standing any other provision of law, no amount collected  
8 under this subchapter shall be covered over to any posses-  
9 sion of the United States.”.

10                   (B) CLERICAL AMENDMENTS.—

11                           (i) Chapter 34 of such Code is amend-  
12                           ed by striking the chapter heading and in-  
13                           serting the following:

14                   **“CHAPTER 34—TAXES ON CERTAIN**  
15                   **INSURANCE POLICIES**

                  “SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

                  “SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

16           **“Subchapter A—Policies Issued By Foreign**  
17           **Insurers”.**

18                           (ii) The table of chapters for subtitle  
19                           D of such Code is amended by striking the  
20                           item relating to chapter 34 and inserting  
21                           the following new item:

                  “CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES”.

22                   (C) EFFECTIVE DATE.—The amendments  
23                   made by this subsection shall apply with respect



1 to policies and plans for portions of policy or  
2 plan years beginning on or after October 1,  
3 2010.

4 **SEC. 905. IMPLEMENTATION OF HEALTH INFORMATION**  
5 **TECHNOLOGY (IT) UNDER MEDICARE.**

6 (a) IN GENERAL.—Not later than January 1, 2010,  
7 the Secretary of Health and Human Services shall submit  
8 to Congress a report that includes—

9 (1) a plan to develop and implement a health  
10 information technology (health IT) system for all  
11 health care providers under the Medicare program  
12 that meets the specifications described in subsection  
13 (b); and

14 (2) an analysis of the impact, feasibility, and  
15 costs associated with the use of health information  
16 technology in medically underserved communities.

17 (b) PLAN SPECIFICATION.—The specifications de-  
18 scribed in this subsection, with respect to a health infor-  
19 mation technology system described in subsection (a), are  
20 the following:

21 (1) The system protects the privacy and secu-  
22 rity of individually identifiable health information.

23 (2) The system maintains and provides per-  
24 mitted access to health information in an electronic

1 format (such as through computerized patient  
2 records or a clinical data repository).

3 (3) The system utilizes interface software that  
4 allows for interoperability.

5 (4) The system includes clinical decision sup-  
6 port.

7 (5) The system incorporates e-prescribing and  
8 computerized physician order entry.

9 (6) The system incorporates patient tracking  
10 and reminders.

11 (7) The system utilizes technology that is open  
12 source (if available) or technology that has been de-  
13 veloped by the government.

14 The report shall include an analysis of the financial and  
15 administrative resources necessary to develop such system  
16 and recommendations regarding the level of subsidies  
17 needed for all such health care providers to adopt the sys-  
18 tem.

19 **SEC. 906. DEVELOPMENT, REPORTING, AND USE OF**  
20 **HEALTH CARE MEASURES.**

21 (a) IN GENERAL.—Part E of title XVIII of the Social  
22 Security Act (42 U.S.C. 1395x et seq.) is amended by in-  
23 serting after section 1889 the following:

1 “DEVELOPMENT, REPORTING, AND USE OF HEALTH CARE  
2 MEASURES

3 “SEC. 1890. (a) FOSTERING DEVELOPMENT OF  
4 HEALTH CARE MEASURES.—The Secretary shall des-  
5 ignate, and have in effect an arrangement with, a single  
6 organization (such as the National Quality Forum) that  
7 meets the requirements described in subsection (c), under  
8 which such organization provides the Secretary with ad-  
9 vice on, and recommendations with respect to, the key ele-  
10 ments and priorities of a national system for establishing  
11 health care measures. The arrangement shall be effective  
12 beginning no sooner than January 1, 2008, and no later  
13 than September 30, 2008.

14 “(b) DUTIES.—The duties of the organization des-  
15 ignated under subsection (a) (in this title referred to as  
16 the ‘designated organization’) shall, in accordance with  
17 subsection (d), include—

18 “(1) establishing and managing an integrated  
19 national strategy and process for setting priorities  
20 and goals in establishing health care measures;

21 “(2) coordinating the development and speci-  
22 fications of such measures;

23 “(3) establishing standards for the development  
24 and testing of such measures;

1           “(4) endorsing national consensus health care  
2           measures; and

3           “(5) advancing the use of electronic health  
4           records for automating the collection, aggregation,  
5           and transmission of measurement information.

6           “(c) REQUIREMENTS DESCRIBED.—For purposes of  
7           subsection (a), the requirements described in this sub-  
8           section, with respect to an organization, are the following:

9           “(1) PRIVATE NONPROFIT.—The organization  
10          is a private nonprofit entity governed by a board and  
11          an individual designated as president and chief execu-  
12          tive officer.

13          “(2) BOARD MEMBERSHIP.—The members of  
14          the board of the organization include representatives  
15          of—

16                 “(A) health care providers or groups rep-  
17                 resenting such providers;

18                 “(B) health plans or groups representing  
19                 health plans;

20                 “(C) groups representing health care con-  
21                 sumers;

22                 “(D) health care purchasers and employers  
23                 or groups representing such purchasers or em-  
24                 ployers; and

1           “(E) health care practitioners or groups  
2           representing practitioners.

3           “(3) OTHER MEMBERSHIP REQUIREMENTS.—

4           The membership of the organization is representa-  
5           tive of individuals with experience with—

6           “(A) urban health care issues;

7           “(B) safety net health care issues;

8           “(C) rural and frontier health care issues;

9           and

10          “(D) health care quality and safety issues.

11          “(4) OPEN AND TRANSPARENT.—With respect

12          to matters related to the arrangement described in

13          subsection (a), the organization conducts its busi-

14          ness in an open and transparent manner and pro-

15          vides the opportunity for public comment.

16          “(5) VOLUNTARY CONSENSUS STANDARDS SET-

17          TING ORGANIZATION.—The organization operates as

18          a voluntary consensus standards setting organization

19          as defined for purposes of section 12(d) of the Na-

20          tional Technology Transfer and Advancement Act of

21          1995 (Public Law 104–113) and Office of Manage-

22          ment and Budget Revised Circular A–119 (published

23          in the Federal Register on February 10, 1998).

1           “(6) EXPERIENCE.—The organization has at  
2           least 7 years experience in establishing national con-  
3           sensus standards.

4           “(d) REQUIREMENTS FOR HEALTH CARE MEAS-  
5           URES.—In carrying out its duties under subsection (b),  
6           the designated organization shall ensure the following:

7           “(1) MEASURES.—The designated organization  
8           shall ensure that the measures established or en-  
9           dorsed under subsection (b) are evidence-based, reli-  
10          able, and valid; and include—

11                  “(A) measures of clinical processes and  
12                  outcomes, patient experience, efficiency, and eq-  
13                  uity;

14                  “(B) measures to assess effectiveness,  
15                  timeliness, patient self-management, patient  
16                  centeredness, and safety; and

17                  “(C) measures of under use and over use.

18          “(2) PRIORITIES.—

19                  “(A) IN GENERAL.—The designated orga-  
20                  nization shall ensure that priority is given to es-  
21                  tablishing and endorsing—

22                          “(i) measures with the greatest poten-  
23                          tial impact for improving the effectiveness  
24                          and efficiency of health care;

1           “(ii) measures that may be rapidly  
2 implemented by group health plans, health  
3 insurance issuers, physicians, hospitals,  
4 nursing homes, long-term care providers,  
5 and other providers;

6           “(iii) measures which may inform  
7 health care decisions made by consumers  
8 and patients; and

9           “(iv) measures that apply to multiple  
10 services furnished by different providers  
11 during an episode of care.

12           “(B) ANNUAL REPORT ON PRIORITIES;  
13 SECRETARIAL PUBLICATION AND COMMENT.—

14           “(i) ANNUAL REPORT.—The des-  
15 ignated organization shall issue and submit  
16 to the Secretary a report by March 31 of  
17 each year (beginning with 2009) on the or-  
18 ganization’s recommendations for priorities  
19 and goals in establishing and endorsing  
20 health care measures under this section  
21 over the next five years.

22           “(ii) SECRETARIAL REVIEW AND COM-  
23 MENT.—After receipt of the report under  
24 clause (i) for a year, the Secretary shall  
25 publish the report in the Federal Register,

1 including any comments of the Secretary  
2 on the priorities and goals set forth in the  
3 report.

4 “(3) RISK ADJUSTMENT.—The designated orga-  
5 nization, in consultation with health care measure  
6 developers and other stakeholders, shall establish  
7 procedures to assure that health care measures es-  
8 tablished and endorsed under this section account  
9 for differences in patient health status, patient char-  
10 acteristics, and geographic location, as appropriate.

11 “(4) MAINTENANCE.—The designated organiza-  
12 tion, in consultation with owners and developers of  
13 health care measures, shall require the owners or de-  
14 velopers of such measures to update and enhance  
15 such measures, including the development of more  
16 accurate and precise specifications, and retire exist-  
17 ing outdated measures. Such updating shall occur  
18 not more often than once during each 12-month pe-  
19 riod, except in the case of emergent circumstances  
20 requiring a more immediate update to a measure.

21 “(e) USE OF HEALTH CARE MEASURES; REPORT-  
22 ING.—

23 “(1) USE OF MEASURES.—For purposes of ac-  
24 tivities authorized or required under this title, the  
25 Secretary shall select from health care measures—



1           “(A) recommended by multi-stakeholder  
2 groups; and

3           “(B) endorsed by the designated organiza-  
4 tion under subsection (b)(4).

5           “(2) REPORTING.—The Secretary shall imple-  
6 ment procedures, consistent with generally accepted  
7 standards, to enable the Department of Health and  
8 Human Services to accept the electronic submission  
9 of data for purposes of—

10           “(A) effectiveness measurement using the  
11 health care measures developed pursuant to this  
12 section; and

13           “(B) reporting to the Secretary measures  
14 used to make value-based payments under this  
15 title.

16           “(f) CONTRACTS.—The Secretary, acting through the  
17 Agency for Healthcare Research and Quality, may con-  
18 tract with organizations to support the development and  
19 testing of health care measures meeting the standards es-  
20 tablished by the designated organization.

21           “(g) DISSEMINATION OF INFORMATION.—In order to  
22 make information on health care measures available to  
23 health care consumers, health professionals, public health  
24 officials, oversight organizations, researchers, and other  
25 appropriate individuals and entities, the Secretary shall

1 work with multi-stakeholder groups to provide for the dis-  
2 semination of information developed pursuant to this title.

3 “(h) FUNDING.—For purposes of carrying out sub-  
4 sections (a), (b), (c), and (d), including for expenses in-  
5 curred for the arrangement under subsection (a) with the  
6 designated organization, there is payable from the Federal  
7 Hospital Insurance Trust Fund (established under section  
8 1817) and the Federal Supplementary Medical Insurance  
9 Trust Fund (established under section 1841)—

10 “(1) for fiscal year 2008, \$15,000,000, multi-  
11 plied by the ratio of the total number of months in  
12 the year to the number of months (and portions of  
13 months) of such year during which the arrangement  
14 under subsection (a) is effective; and

15 “(2) for each of the fiscal years, 2009 through  
16 2012, \$15,000,000.”.

17 **SEC. 907. IMPROVEMENTS TO THE MEDIGAP PROGRAM.**

18 (a) IMPLEMENTATION OF NAIC RECOMMENDA-  
19 TIONS.—The Secretary of Health and Human Services  
20 shall provide, under subsections (p)(1)(E) of section 1882  
21 of the Social Security Act (42 U.S.C. 1395s), for imple-  
22 mentation of the changes in the NAIC model law and reg-  
23 ulations recommended by the National Association of In-  
24 surance Commissioners in its Model #651 (“Model Regu-  
25 lation to Implement the NAIC Medicare Supplement In-

1 surance Minimum Standards Model Act”) on March 11,  
2 2007, as modified to reflect the changes made under this  
3 Act. In carrying out the previous sentence, the benefit  
4 packages classified as “K” and “L” shall be eliminated  
5 and such NAIC recommendations shall be treated as hav-  
6 ing been adopted by such Association as of January 1,  
7 2008.

8 (b) REQUIRED OFFERING OF A RANGE OF POLI-  
9 CIES.—

10 (1) IN GENERAL.—Subsection (o) of such sec-  
11 tion is amended by adding at the end the following  
12 new paragraph:

13 “(4) In addition to the requirement of para-  
14 graph (2), the issuer of the policy must make avail-  
15 able to the individual at least medicare supplemental  
16 policies with benefit packages classified as ‘C’ or  
17 ‘F’.”.

18 (2) EFFECTIVE DATE.—The amendment made  
19 by paragraph (1) shall apply to medicare supple-  
20 mental policies issued on or after January 1, 2008.

21 (c) REMOVAL OF NEW BENEFIT PACKAGES.—Such  
22 section is further amended—

23 (1) in subsection (o)(1), by striking “(p), (v),  
24 and (w)” and inserting “(p) and (v)”;

1           (2) in subsection (v)(3)(A)(i), by striking “or a  
2           benefit package described in subparagraph (A) or  
3           (B) of subsection (w)(2)”;

4           (3) in subsection (w)—

5                 (A) by striking “POLICIES” and all that  
6                 follows through “The Secretary” and inserting  
7                 “POLICIES.—The Secretary”;

8                 (B) by striking the second sentence; and

9                 (C) by striking paragraph (2).

10 **SEC. 908. IMPLEMENTATION FUNDING.**

11           For purposes of implementing the provisions of this  
12 Act (other than title X), the Secretary of Health and  
13 Human Services shall provide for the transfer, from the  
14 Federal Supplementary Medical Insurance Trust Fund es-  
15 tablished under section 1841 of the Social Security Act  
16 (42 U.S.C. 1395t), of \$40,000,000 to the Centers for  
17 Medicare & Medicaid Services Program Management Ac-  
18 count for fiscal year 2008.

19 **SEC. 909. ACCESS TO DATA ON PRESCRIPTION DRUG PLANS**  
20 **AND MEDICARE ADVANTAGE PLANS.**

21           (a) IN GENERAL.—Section 1875 of the Social Secu-  
22 rity Act (42 U.S.C. 1395ll) is amended—

23                 (1) in the heading, by inserting “TO CONGRESS;  
24                 PROVIDING INFORMATION TO CONGRESSIONAL SUP-

1 PORT AGENCIES” after “AND RECOMMENDATIONS”;  
2 and

3 (2) by adding at the end the following new sub-  
4 section:

5 “(c) PROVIDING INFORMATION TO CONGRESSIONAL  
6 SUPPORT AGENCIES.—

7 “(1) IN GENERAL.—Notwithstanding any provi-  
8 sion under part D that limits the use of prescription  
9 drug data collected under such part, upon the re-  
10 quest of a Congressional support agency, the Sec-  
11 retary shall provide such agency with information  
12 submitted to, or compiled by, the Secretary under  
13 part D (subject to the restriction on disclosure under  
14 paragraph (2)), including—

15 “(A) only with respect to Congressional  
16 support agencies that make official baseline  
17 spending projections, conduct oversight studies  
18 mandated by Congress, or make official rec-  
19 ommendations on the program under this title  
20 to Congress—

21 “(i) aggregate negotiated prices for  
22 drugs covered under prescription drug  
23 plans and MA–PD plans;

24 “(ii) negotiated rebates, discounts,  
25 and other price concessions by drug and by

1 contract or plan (as reported under section  
2 1860D–2(d)(2));

3 “(iii) bid information (described in  
4 section 1860D–11(b)(2)(C)) submitted by  
5 such plans;

6 “(iv) data or a representative sample  
7 of data regarding drug claims and other  
8 data submitted under section 1860D–  
9 15(e)(1)(C) (as determined necessary and  
10 appropriate by the Congressional support  
11 agency to carry out the legislatively man-  
12 dated duties of the agency);

13 “(v) the amount of reinsurance pay-  
14 ments paid under section 1860D–15(a)(2),  
15 provided at the plan level; and

16 “(vi) the amount of any adjustments  
17 of payments made under subparagraph (B)  
18 or (C) of section 1860D–15(e)(2), provided  
19 at the plan level aggregate negotiated  
20 prices for drugs covered under prescription  
21 drug plans and MA–PD plans; and

22 “(B) access to drug event data submitted  
23 by such plans under section 1860D–  
24 15(d)(2)(A), except, with respect to data that  
25 reveals prices negotiated with drug manufactur-

1           ers, such data shall only be available to Con-  
2           gressional support agencies that make official  
3           baseline spending projections, conduct oversight  
4           studies mandated by Congress, or make official  
5           recommendations on the program under this  
6           title to Congress.

7           “(2) RESTRICTION ON DATA DISCLOSURE.—

8                 “(A) IN GENERAL.—Data provided to a  
9           Congressional support agency under this sub-  
10          section shall not be disclosed, reported, or re-  
11          leased in identifiable form.

12                “(B) IDENTIFIABLE FORM.—For purposes  
13          of subparagraph (A), the term ‘identifiable  
14          form’ means any representation of information  
15          that permits identification of a specific prescrip-  
16          tion drug plan, MA–PD plan, pharmacy benefit  
17          manager, drug manufacturer, drug wholesaler,  
18          or individual enrolled in a prescription drug  
19          plan or an MA–PD plan under part D.

20                “(3) TIMING.—The Secretary shall release data  
21          under this subsection in a timeframe that enables  
22          Congressional support agencies to complete congress-  
23          sional requests.

24                “(4) USE OF THE DATA PROVIDED.—Data pro-  
25          vided to a Congressional support agency under this

1 subsection shall only be used by such agency for car-  
2 rying out the functions and activities of the agency  
3 mandated by Congress.

4 “(5) CONFIDENTIALITY.—The Secretary shall  
5 establish safeguards to protect the confidentiality of  
6 data released under this subsection. Such safeguards  
7 shall not provide for greater disclosure than is per-  
8 mitted under any of the following:

9 “(A) The Federal regulations (concerning  
10 the privacy of individually identifiable health in-  
11 formation) promulgated under section 264(c) of  
12 the Health Insurance Portability and Account-  
13 ability Act of 1996.

14 “(B) Section 552 or 552a of title 5, United  
15 States Code, with regard to the privacy of indi-  
16 vidually identifiable beneficiary health informa-  
17 tion.

18 “(6) DEFINITIONS.—In this subsection:

19 “(A) CONGRESSIONAL SUPPORT AGEN-  
20 CY.—The term ‘Congressional support agency’  
21 means—

22 “(i) the Medicare Payment Advisory  
23 Commission;

24 “(ii) the Government Accountability  
25 Office; and



1 “(iii) the Congressional Budget Office.

2 “(B) MA–PD PLAN.—The term ‘MA–PD  
3 plan’ has the meaning given such term in sec-  
4 tion 1860D–1(a)(3)(C).

5 “(C) PRESCRIPTION DRUG PLAN.—The  
6 term ‘prescription drug plan’ has the meaning  
7 given such term in section 1860D–41(a)(14).”.

8 (b) CONFORMING AMENDMENT.—Section 1805(b)(2)  
9 of the Social Security Act (42 U.S.C. 1395b–6(b)(2)) is  
10 amended by adding at the end the following new subpara-  
11 graph:

12 “(D) PART D.—Specifically, the Commis-  
13 sion shall review payment policies with respect  
14 to the Voluntary Prescription Drug Benefit  
15 Program under part D, including—

16 “(i) the factors affecting expenditures;

17 “(ii) payment methodologies; and

18 “(iii) their relationship to access and  
19 quality of care for Medicare beneficiaries.”.

20 **SEC. 910. ABSTINENCE EDUCATION.**

21 Section 510 of the Social Security Act (42 U.S.C.  
22 710) is amended to read as follows:

1 **“SEC. 510. SEPARATE PROGRAM FOR ABSTINENCE EDU-**  
2 **CATION.**

3 “(a) IN GENERAL.—For the purpose described in  
4 subsection (b), the Secretary shall, for fiscal year 2008  
5 and fiscal year 2009, allot to each State which has trans-  
6 mitted an application for the fiscal year under section  
7 505(a) an amount equal to the product of—

8 “(1) the amount appropriated in subsection (d)  
9 for the fiscal year; and

10 “(2) the percentage determined for the State  
11 under section 502(c)(1)(B)(ii).

12 “(b) PURPOSE OF ALLOTMENT.—

13 “(1) PURPOSE.—The purpose of an allotment  
14 under subsection (a) to a State is to enable the  
15 State to provide abstinence education, and where ap-  
16 propriate, mentoring, counseling, and adult super-  
17 vision to promote abstinence from sexual activity,  
18 with a focus on those groups which are most likely  
19 to bear children out-of-wedlock.

20 “(2) DEFINITION; STATE OPTION.—For pur-  
21 poses of this section, the term ‘abstinence education’  
22 has, at the option of each State receiving an allot-  
23 ment under subsection (a), the meaning given such  
24 term in subparagraph (A), or the meaning given  
25 such term in subparagraph (B), as follows:

1           “(A) Such term means a medically and sci-  
2           entifically accurate educational or motivational  
3           program which—

4                   “(i) has as its exclusive purpose,  
5                   teaching the social, psychological, and  
6                   health gains to be realized by abstaining  
7                   from sexual activity;

8                   “(ii) teaches abstinence from sexual  
9                   activity outside marriage as the expected  
10                  standard for all school age children;

11                  “(iii) teaches that abstinence from  
12                  sexual activity is the only certain way to  
13                  avoid out-of-wedlock pregnancy, sexually  
14                  transmitted diseases, and other associated  
15                  health problems;

16                  “(iv) teaches that a mutually faithful  
17                  monogamous relationship in context of  
18                  marriage is the expected standard of  
19                  human sexual activity;

20                  “(v) teaches that sexual activity out-  
21                  side of the context of marriage is likely to  
22                  have harmful psychological and physical ef-  
23                  fects;

24                  “(vi) teaches that bearing children  
25                  out-of-wedlock is likely to have harmful

1 consequences for the child, the child's par-  
2 ents, and society;

3 “(vii) teaches young people how to re-  
4 ject sexual advances and how alcohol and  
5 drug use increases vulnerability to sexual  
6 advances; and

7 “(viii) teaches the importance of at-  
8 taining self-sufficiency before engaging in  
9 sexual activity.

10 “(B) Such term means a medically and sci-  
11 entifically accurate educational or motivational  
12 program which promotes abstinence and edu-  
13 cates those who are currently sexually active or  
14 at risk of sexual activity about additional meth-  
15 ods to prevent unintended pregnancy or reduce  
16 other health risks.

17 “(3) CERTAIN REQUIREMENTS.—

18 “(A) LIMITATION REGARDING INACCURATE  
19 INFORMATION.—None of the funds made avail-  
20 able under this section may be used to provide  
21 abstinence education that includes information  
22 that is medically and scientifically inaccurate.  
23 For purposes of this section, the term ‘medi-  
24 cally and scientifically inaccurate’ means infor-  
25 mation that is unsupported or contradicted by

1 a preponderance of peer-reviewed research by  
2 leading medical, psychological, psychiatric, and  
3 public health publications, organizations and  
4 agencies.

5 “(B) EFFECTIVENESS REGARDING CER-  
6 TAIN MATTERS.—None of the funds made avail-  
7 able under this section may be used for a pro-  
8 gram unless the program is based on a model  
9 that has been demonstrated to be effective in  
10 preventing unintended pregnancy, or in reduc-  
11 ing the transmission of a sexually transmitted  
12 disease, including the human immunodeficiency  
13 virus. The preceding sentence does not apply to  
14 any program that was approved and funded  
15 under this section on or before September 30,  
16 2007.

17 “(c) APPLICABILITY OF CERTAIN SECTIONS.—

18 “(1) REQUIREMENTS.—Sections 503, 507, and  
19 508 apply to allotments under subsection (a) to the  
20 same extent and in the same manner as such sec-  
21 tions apply to allotments under section 502(c).

22 “(2) DISCRETION OF SECRETARY.—Sections  
23 505 and 506 apply to allotments under subsection  
24 (a) to the extent determined by the Secretary to be  
25 appropriate.

1       “(d) AUTHORIZATION OF APPROPRIATIONS.—For the  
2 purpose of allotments under subsection (a), there is au-  
3 thorized to be appropriated \$50,000,000 for each of fiscal  
4 years 2008 and 2009.”.

## 5                   **TITLE X—REVENUES**

### 6   **SEC. 1001. INCREASE IN RATE OF EXCISE TAXES ON TO-** 7                   **BACCO PRODUCTS AND CIGARETTE PAPERS** 8                   **AND TUBES.**

9       (a) SMALL CIGARETTES.—Paragraph (1) of section  
10 5701(b) of the Internal Revenue Code of 1986 is amended  
11 by striking “\$19.50 per thousand (\$17 per thousand on  
12 cigarettes removed during 2000 or 2001)” and inserting  
13 “\$42 per thousand”.

14       (b) LARGE CIGARETTES.—Paragraph (2) of section  
15 5701(b) of such Code is amended by striking “\$40.95 per  
16 thousand (\$35.70 per thousand on cigarettes removed  
17 during 2000 or 2001)” and inserting “\$88.20 per thou-  
18 sand”.

19       (c) SMALL CIGARS.—Paragraph (1) of section  
20 5701(a) of such Code is amended by striking “\$1.828  
21 cents per thousand (\$1.594 cents per thousand on cigars  
22 removed during 2000 or 2001)” and inserting “\$42 per  
23 thousand”.

24       (d) LARGE CIGARS.—Paragraph (2) of section  
25 5701(a) of such Code is amended—

1           (1) by striking “20.719 percent (18.063 percent  
2           on cigars removed during 2000 or 2001)” and in-  
3           serting “40 percent (33 percent on cigars removed  
4           after December 31, 2007, and before October 1,  
5           2013)”, and

6           (2) by striking “\$48.75 per thousand (\$42.50  
7           per thousand on cigars removed during 2000 or  
8           2001)” and inserting “\$1 per cigar”.

9           (e) CIGARETTE PAPERS.—Subsection (c) of section  
10          5701 of such Code is amended by striking “1.22 cents  
11          (1.06 cents on cigarette papers removed during 2000 or  
12          2001)” and inserting “2.63 cents”.

13          (f) CIGARETTE TUBES.—Subsection (d) of section  
14          5701 of such Code is amended by striking “2.44 cents  
15          (2.13 cents on cigarette tubes removed during 2000 or  
16          2001)” and inserting “5.26 cents”.

17          (g) SNUFF.—Paragraph (1) of section 5701(e) of  
18          such Code is amended by striking “58.5 cents (51 cents  
19          on snuff removed during 2000 or 2001)” and inserting  
20          “\$1.26”.

21          (h) CHEWING TOBACCO.—Paragraph (2) of section  
22          5701(e) of such Code is amended by striking “19.5 cents  
23          (17 cents on chewing tobacco removed during 2000 or  
24          2001)” and inserting “42 cents”.

1 (i) PIPE TOBACCO.—Subsection (f) of section 5701  
2 of such Code is amended by striking “\$1.0969 cents  
3 (95.67 cents on pipe tobacco removed during 2000 or  
4 2001)” and inserting “\$2.36”.

5 (j) ROLL-YOUR-OWN TOBACCO.—

6 (1) IN GENERAL.—Subsection (g) of section  
7 5701 of such Code is amended by striking “\$1.0969  
8 cents (95.67 cents on roll-your-own tobacco removed  
9 during 2000 or 2001)” and inserting “\$7.4667”.

10 (2) INCLUSION OF CIGAR TOBACCO.—Sub-  
11 section (o) of section 5702 of such Code is amended  
12 by inserting “or cigars, or for use as wrappers for  
13 making cigars” before the period at the end.

14 (k) EFFECTIVE DATE.—The amendments made by  
15 this section shall apply to articles removed after December  
16 31, 2007.

17 (l) FLOOR STOCKS TAXES.—

18 (1) IMPOSITION OF TAX.—On cigarettes manu-  
19 factured in or imported into the United States which  
20 are removed before January 1, 2008, and held on  
21 such date for sale by any person, there is hereby im-  
22 posed a tax in an amount equal to the excess of—

23 (A) the tax which would be imposed under  
24 section 5701 of the Internal Revenue Code of



1           1986 on the article if the article had been re-  
2           moved on such date, over

3                   (B) the prior tax (if any) imposed under  
4           section 5701 of such Code on such article.

5           (2) AUTHORITY TO EXEMPT CIGARETTES HELD  
6           IN VENDING MACHINES.—To the extent provided in  
7           regulations prescribed by the Secretary, no tax shall  
8           be imposed by paragraph (1) on cigarettes held for  
9           retail sale on January 1, 2008, by any person in any  
10          vending machine. If the Secretary provides such a  
11          benefit with respect to any person, the Secretary  
12          may reduce the \$500 amount in paragraph (3) with  
13          respect to such person.

14          (3) CREDIT AGAINST TAX.—Each person shall  
15          be allowed as a credit against the taxes imposed by  
16          paragraph (1) an amount equal to \$500. Such credit  
17          shall not exceed the amount of taxes imposed by  
18          paragraph (1) for which such person is liable.

19          (4) LIABILITY FOR TAX AND METHOD OF PAY-  
20          MENT.—

21                   (A) LIABILITY FOR TAX.—A person hold-  
22           ing cigarettes on January 1, 2008, to which any  
23           tax imposed by paragraph (1) applies shall be  
24           liable for such tax.

1           (B) METHOD OF PAYMENT.—The tax im-  
2           posed by paragraph (1) shall be paid in such  
3           manner as the Secretary shall prescribe by reg-  
4           ulations.

5           (C) TIME FOR PAYMENT.—The tax im-  
6           posed by paragraph (1) shall be paid on or be-  
7           fore April 14, 2008.

8           (5) ARTICLES IN FOREIGN TRADE ZONES.—  
9           Notwithstanding the Act of June 18, 1934 (48 Stat.  
10          998, 19 U.S.C. 81a) and any other provision of law,  
11          any article which is located in a foreign trade zone  
12          on January 1, 2008, shall be subject to the tax im-  
13          posed by paragraph (1) if—

14                (A) internal revenue taxes have been deter-  
15                mined, or customs duties liquidated, with re-  
16                spect to such article before such date pursuant  
17                to a request made under the 1st proviso of sec-  
18                tion 3(a) of such Act, or

19                (B) such article is held on such date under  
20                the supervision of a customs officer pursuant to  
21                the 2d proviso of such section 3(a).

22          (6) DEFINITIONS.—For purposes of this sub-  
23          section—

24                (A) IN GENERAL.—Terms used in this sub-  
25                section which are also used in section 5702 of

1 the Internal Revenue Code of 1986 shall have  
2 the respective meanings such terms have in  
3 such section.

4 (B) SECRETARY.—The term “Secretary”  
5 means the Secretary of the Treasury or the  
6 Secretary’s delegate.

7 (7) CONTROLLED GROUPS.—Rules similar to  
8 the rules of section 5061(e)(3) of such Code shall  
9 apply for purposes of this subsection.

10 (8) OTHER LAWS APPLICABLE.—All provisions  
11 of law, including penalties, applicable with respect to  
12 the taxes imposed by section 5701 of such Code  
13 shall, insofar as applicable and not inconsistent with  
14 the provisions of this subsection, apply to the floor  
15 stocks taxes imposed by paragraph (1), to the same  
16 extent as if such taxes were imposed by such section  
17 5701. The Secretary may treat any person who bore  
18 the ultimate burden of the tax imposed by para-  
19 graph (1) as the person to whom a credit or refund  
20 under such provisions may be allowed or made.

21 **SEC. 1002. EXEMPTION FOR EMERGENCY MEDICAL SERV-**  
22 **ICES TRANSPORTATION.**

23 (a) IN GENERAL.—Subsection (l) of section 4041 of  
24 the Internal Revenue Code of 1986 is amended to read  
25 as follows:

1 “(l) EXEMPTION FOR CERTAIN USES.—

2 “(1) CERTAIN AIRCRAFT.—No tax shall be im-  
3 posed under this section on any liquid sold for use  
4 in, or used in, a helicopter or a fixed-wing aircraft  
5 for purposes of providing transportation with respect  
6 to which the requirements of subsection (f) or (g) of  
7 section 4261 are met.

8 “(2) EMERGENCY MEDICAL SERVICES.—No tax  
9 shall be imposed under this section on any liquid  
10 sold for use in, or used in, any ambulance for pur-  
11 poses of providing transportation for emergency  
12 medical services. The preceding sentence shall not  
13 apply to any liquid used after December 31, 2012.”.

14 (b) FUELS NOT USED FOR TAXABLE PURPOSES.—  
15 Section 6427 of such Code is amended by inserting after  
16 subsection (e) the following new subsection:

17 “(f) USE TO PROVIDE EMERGENCY MEDICAL SERV-  
18 ICES.—Except as provided in subsection (k), if any fuel  
19 on which tax was imposed by section 4081 or 4041 is used  
20 in an ambulance for a purpose described in section  
21 4041(l)(2), the Secretary shall pay (without interest) to  
22 the ultimate purchaser of such fuel an amount equal to  
23 the aggregate amount of the tax imposed on such fuel.  
24 The preceding sentence shall not apply to any liquid used  
25 after December 31, 2012.”.

1           (c) TIME FOR FILING CLAIMS; PERIOD COVERED.—  
2 Paragraphs (1) and (2)(A) of section 6427(i) of such Code  
3 are each amended by inserting “(f),” after “(d),”.

4           (d) CONFORMING AMENDMENT.—Section 6427(d) of  
5 such Code is amended by striking “4041(l)” and inserting  
6 “4041(l)(1)”.

7           (e) EFFECTIVE DATE.—The amendments made by  
8 this section shall apply to fuel used in transportation pro-  
9 vided in quarters beginning after the date of the enact-  
10 ment of this Act.

          Passed the House of Representatives August 1,  
2007.

Attest:

*Clerk.*

110<sup>TH</sup> CONGRESS  
1<sup>ST</sup> SESSION

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**H. R. 3162**

**AN ACT**

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