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110TH CONGRESS
2D SESSION

S. 3118

To amend titles XVIII and XIX of the Social Security Act to preserve beneficiary access to care by preventing a reduction in the Medicare physician fee schedule, to improve the quality of care by advancing value based purchasing, electronic health records, and electronic prescribing, and to maintain and improve access to care in rural areas, and for other purposes.

IN THE SENATE OF THE UNITED STATES

JUNE 11, 2008

Mr. GRASSLEY (for himself, Mr. McCONNELL, Mr. KYL, Mr. HATCH, Mr. SUNUNU, Mr. BUNNING, Mr. CRAPO, Mr. BURR, Mr. ENSIGN, Mr. ENZI, Mr. COLEMAN, Ms. MURKOWSKI, and Mr. STEVENS) introduced the following bill; which was read the first time

JUNE 12, 2008

Read the second time and placed on the calendar

A BILL

To amend titles XVIII and XIX of the Social Security Act to preserve beneficiary access to care by preventing a reduction in the Medicare physician fee schedule, to improve the quality of care by advancing value based purchasing, electronic health records, and electronic prescribing, and to maintain and improve access to care in rural areas, and for other purposes.

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

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

4 (a) **SHORT TITLE.**—This Act may be cited as the
 5 “Preserving Access to Medicare Act of 2008”.

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

Sec. 1. Short title; table of contents.

TITLE I—MEDICARE

Subtitle A—Rural Beneficiary Access Extensions and Improvements

- Sec. 100. Short title.
- Sec. 101. Temporary improvements to the Medicare inpatient hospital payment adjustment for low-volume hospitals.
- Sec. 102. Use of non-wage adjusted PPS rate under the Medicare-dependent hospital (MDH) program.
- Sec. 103. Ambulance services improvements.
- Sec. 104. Extension of authorization for FLEX grants.
- Sec. 105. Rebasing for sole community hospitals.
- Sec. 106. Extension and expansion of the Medicare hold harmless provision under the prospective payment system for hospital outpatient department (HOPD) services for certain hospitals.
- Sec. 107. Clarification of payment for clinical laboratory tests furnished by critical access hospitals.
- Sec. 108. Extension of floor on Medicare work geographic adjustment under the Medicare physician fee schedule.
- Sec. 109. Extension of treatment of certain physician pathology services under Medicare.
- Sec. 110. Adding hospital-based renal dialysis centers (including satellites) as originating sites for payment of telehealth services.
- Sec. 111. Adding skilled nursing facilities as originating sites for payment of telehealth services.
- Sec. 112. Applying rural home health add-on policy for 2009.

Subtitle B—Other Provisions Relating to Part A

- Sec. 121. Extension of the reclassification of certain hospitals under the Medicare program.
- Sec. 122. Institute of Medicine study and report on post-acute care.
- Sec. 123. Revocation of unique deeming authority of the Joint Commission.
- Sec. 124. MedPAC study and report on payments for hospice care.
- Sec. 125. Introducing the principals of value-based health care into the Medicare program.

Subtitle C—Other Provisions Relating to Part B

- Sec. 131. Physician payment, efficiency, and quality improvements.
- Sec. 132. Incentives for electronic prescribing.
- Sec. 133. Increasing the number of sites for the electronic health records demonstration.
- Sec. 134. Primary care improvements.
- Sec. 135. Medicare anesthesia teaching program improvements .
- Sec. 136. Medicare coordinated care practice research network demonstration.
- Sec. 137. Imaging provisions.
- Sec. 138. Accommodation of physicians ordered to active duty in the Armed Services.
- Sec. 139. Extension of exceptions process for Medicare therapy caps.
- Sec. 140. Speech-language pathology services.
- Sec. 141. Coverage of items and services under a cardiac rehabilitation program and a pulmonary rehabilitation program.
- Sec. 142. Repeal of transfer of ownership of oxygen equipment.
- Sec. 143. Extension of payment rule for brachytherapy and therapeutic radiopharmaceuticals.
- Sec. 144. Clinical laboratory tests.
- Sec. 145. Sense of the Senate on delayed implementation of competitive bidding for durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).

Subtitle D—End Stage Renal Disease Program Reforms

- Sec. 151. Kidney disease education and awareness provisions.
- Sec. 152. Renal dialysis provisions.

Subtitle E—Provisions Relating to Part C

- Sec. 161. Phase-out of indirect medical education (IME).
- Sec. 162. Revisions to quality improvement programs.
- Sec. 163. Revisions relating to specialized Medicare Advantage plans for special needs individuals.
- Sec. 164. Adjustment to the Medicare Advantage stabilization fund.
- Sec. 165. Access to Medicare reasonable cost contract plans.
- Sec. 166. MedPAC study and report on Medicare Advantage payments.
- Sec. 167. Marketing of Medicare Advantage plans and prescription drug plans.

Subtitle F—Other Provisions

- Sec. 171. Contract with a consensus-based entity regarding performance measurement.
- Sec. 172. Use of part D data.
- Sec. 173. Inclusion of Medicare providers and suppliers in Federal Payment Levy and Administrative Offset Program.

TITLE II—MEDICAID

- Sec. 201. Extension of transitional medical assistance (TMA) and abstinence education program through fiscal year 2009.
- Sec. 202. Extension of qualifying individual (QI) program through fiscal year 2009.
- Sec. 203. Medicaid DSH extension through December 31, 2009.
- Sec. 204. Asset verification through access to information held by financial institutions.

- Sec. 205. Application of Medicare payment adjustment for certain hospital-acquired conditions to payments for inpatient hospital services under Medicaid.
- Sec. 206. Reduction in payments for Medicaid administrative costs to prevent duplication of such payments under TANF.
- Sec. 207. Clarification treatment of regional medical center.
- Sec. 208. Grants to improve outreach and enrollment under Medicaid.

TITLE III—MISCELLANEOUS

- Sec. 301. Extension of TANF supplemental grants through fiscal year 2009.
- Sec. 302. Special Diabetes Programs for Type I Diabetes and Indians.
- Sec. 303. Additional Funding for State Health Insurance Assistance Programs, Area Agencies on Aging, and Aging and Disability Resource Centers.
- Sec. 304. Extension of Federal reimbursement of emergency health services furnished to undocumented aliens.

TITLE I—MEDICARE

Subtitle A—Rural Beneficiary Access Extensions and Improvements

SEC. 100. SHORT TITLE.

This subtitle may be cited as the “Craig Thomas Rural Hospital and Provider Equity Act of 2008”.

SEC. 101. TEMPORARY IMPROVEMENTS TO THE MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

Section 1886(d)(12) of the Social Security Act (42 U.S.C. 1395ww(d)(12)) is amended—

(1) in subparagraph (A), by inserting “or (D) (for discharges occurring in fiscal years 2009)” after “subparagraph (B)”;

(2) in subparagraph (B), by striking “The Secretary” and inserting “Except as provided in subparagraph (D), the Secretary”;

(3) in subparagraph (C)(i)—

(A) by inserting “(or, with respect to fiscal years 2009, 15 road miles)” after “25 road miles”; and

(B) by inserting “(or, with respect to fiscal years 2009, 1,500 discharges of individuals entitled to, or enrolled for, benefits under part A)” after “800 discharges”; and

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

“(D) TEMPORARY APPLICABLE PERCENTAGE INCREASE.—For discharges occurring in fiscal years 2009, the Secretary shall determine an applicable percentage increase for purposes of subparagraph (A) using a linear sliding scale ranging from 25 percent for low-volume hospitals with fewer than an appropriate number (as determined by the Secretary) of discharges of individuals entitled to, or enrolled for, benefits under part A in the fiscal year to 0 percent for low-volume hospitals with greater than

1 1,500 discharges of such individuals in the fis-
2 cal year.”.

3 **SEC. 102. USE OF NON-WAGE ADJUSTED PPS RATE UNDER**
4 **THE MEDICARE-DEPENDENT HOSPITAL**
5 **(MDH) PROGRAM.**

6 (a) USE OF NON-WAGE ADJUSTED PPS RATE
7 UNDER THE MEDICARE-DEPENDENT HOSPITAL (MDH)
8 PROGRAM.—Section 1886(d)(5)(G) of the Social Security
9 Act (42 U.S.C. 1395ww(d)(5)(G)) is amended by adding
10 at the end the following new clause:

11 “(v) In the case of discharges occurring on or after
12 October 1, 2008, and before October 1, 2009, in deter-
13 mining the amount under paragraph (1)(A)(iii) for pur-
14 poses of clauses (i) and (ii)(II), such amount shall, if it
15 results in greater payments to the hospital, be determined
16 without regard to any adjustment for different area wage
17 levels under paragraph (3)(E).”.

18 (b) TREATMENT OF CERTAIN HOSPITALS.—Notwith-
19 standing any other provision of law, effective for dis-
20 charges occurring on or after October 1, 2008, the provi-
21 sions of paragraph (5)(G) of section 1886(d) of the Social
22 Security Act (42 U.S.C. 1395ww(d)) shall apply for pur-
23 poses of making payments under such section to Wesley
24 Woods Geriatric Hospital (provider number 110203) in
25 the same manner as such provisions apply for purposes

1 of making payments under such section to a Medicare-
 2 dependent, small rural hospital (as defined in paragraph
 3 (5)(G)(iv) of such section).

4 **SEC. 103. AMBULANCE SERVICES IMPROVEMENTS.**

5 (a) EXTENSION OF INCREASED MEDICARE PAY-
 6 MENTS FOR GROUND AMBULANCE SERVICES.—Section
 7 1834(l)(13) of the Social Security Act (42 U.S.C.
 8 1395m(l)(13)) is amended—

9 (1) in subparagraph (A)—

10 (A) in the matter preceding clause (i), by
 11 inserting “and for such services furnished on or
 12 after July 1, 2008, and before January 1,
 13 2010” after “2007,”;

14 (B) in clause (i), by inserting “(or 3 per-
 15 cent if such service is furnished on or after July
 16 1, 2008, and before January 1, 2010)” after “2
 17 percent”; and

18 (C) in clause (ii), by inserting “(or 2 per-
 19 cent if such service is furnished on or after July
 20 1, 2008, and before January 1, 2010)” after “1
 21 percent”; and

22 (2) in subparagraph (B)—

23 (A) in the heading, by striking “2006” and
 24 inserting “APPLICABLE PERIOD”; and

1 (B) by inserting “applicable” before “pe-
 2 riod”.

3 (b) AIR AMBULANCE PAYMENT IMPROVEMENTS.—

4 (1) TREATMENT OF CERTAIN AREAS FOR PAY-
 5 MENT FOR AIR AMBULANCE SERVICES UNDER THE
 6 AMBULANCE FEE SCHEDULE.—Notwithstanding any
 7 other provision of law, for purposes of making pay-
 8 ments under section 1834(l) of the Social Security
 9 Act (42 U.S.C. 1395m(l)) for air ambulance services
 10 furnished during the period beginning on July 1,
 11 2008, and ending on December 31, 2009, any area
 12 that was designated as a rural area for purposes of
 13 making payments under such section for air ambu-
 14 lance services furnished on December 31, 2006, shall
 15 be treated as a rural area for purposes of making
 16 payments under such section for air ambulance serv-
 17 ices furnished during such period.

18 (2) CLARIFICATION REGARDING SATISFACTION
 19 OF REQUIREMENT OF MEDICALLY NECESSARY.—

20 (A) IN GENERAL.—Section
 21 1834(l)(14)(B)(i) of the Social Security Act (42
 22 U.S.C. 1395m(l)(14)(B)(i)) is amended by
 23 striking “reasonably determines or certifies”
 24 and inserting “certifies or reasonably deter-
 25 mines”.

1 (B) EFFECTIVE DATE.—The amendment
 2 made by subparagraph (A) shall apply to serv-
 3 ices furnished on or after the date of the enact-
 4 ment of this Act.

5 **SEC. 104. EXTENSION OF AUTHORIZATION FOR FLEX**
 6 **GRANTS.**

7 (a) IN GENERAL.—Section 1820(j) of the Social Se-
 8 curity Act (42 U.S.C. 1395i–4(j)) is amended—

9 (1) by striking “and for” and inserting “for”;
 10 and

11 (2) by inserting “, and for making grants to all
 12 States under paragraphs (1) and (2) of subsection
 13 (g), \$55,000,000 in each of fiscal years 2009 and
 14 2010” before the period at the end.

15 (b) MEDICARE RURAL HOSPITAL FLEXIBILITY PRO-
 16 GRAM.—Section 1820(g)(1) of the Social Security Act (42
 17 U.S.C. 1395i–4(g)(1)) is amended—

18 (1) in subparagraph (B), by striking “and” at
 19 the end;

20 (2) in subparagraph (C), by striking the period
 21 at the end and inserting “; and”; and

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

24 “(D) providing support for critical access
 25 hospitals for quality improvement, quality re-

1 porting, performance improvements, and
2 benchmarking.”.

3 **SEC. 105. REBASING FOR SOLE COMMUNITY HOSPITALS.**

4 (a) REBASING PERMITTED.—

5 (1) IN GENERAL.—Section 1886(b)(3) of the
6 Social Security Act (42 U.S.C. 1395ww(b)(3)) is
7 amended by adding at the end the following new
8 subparagraph:

9 “(L)(i) For cost reporting periods beginning on or
10 after January 1, 2009, in the case of a sole community
11 hospital there shall be substituted for the amount other-
12 wise determined under subsection (d)(5)(D)(i) of this sec-
13 tion, if such substitution results in a greater amount of
14 payment under this section for the hospital, the subpara-
15 graph (L) rebased target amount.

16 “(ii) For purposes of this subparagraph, the term
17 ‘subparagraph (L) rebased target amount’ has the mean-
18 ing given the term ‘target amount’ in subparagraph (C),
19 except that—

20 “(I) there shall be substituted for the base cost
21 reporting period the 12-month cost reporting period
22 beginning during fiscal year 2006;

23 “(II) any reference in subparagraph (C)(i) to
24 the ‘first cost reporting period’ described in such
25 subparagraph is deemed a reference to the first cost

1 reporting period beginning on or after January 1,
2 2009; and

3 “(III) the applicable percentage increase shall
4 only be applied under subparagraph (C)(iv) for dis-
5 charges occurring on or after January 1, 2009.”.

6 (2) CONFORMING AMENDMENTS.—Section
7 1886(b)(3) of the Social Security Act (42 U.S.C.
8 1395ww(b)(3)) is amended—

9 (A) in subparagraph (C), in the matter
10 preceding clause (i), by striking “subparagraph
11 (I)” and inserting “subparagraphs (I) and
12 (L)”; and

13 (B) in subparagraph (I)(i), in the matter
14 preceding subclause (I), by striking “For” and
15 inserting “Subject to subparagraph (L), for”.

16 (b) RURAL REFERRAL CENTER DESIGNATION.—Not-
17 withstanding any other provision of law, for purposes of
18 meeting the criteria for classification as a rural referral
19 center under section 1886(d)(5)(C) of the Social Security
20 Act (42 U.S.C. 1395ww(d)(5)(C)) with respect to cost re-
21 porting periods beginning on or after October 1, 2008, the
22 Halifax Regional Medical Center (provider number
23 340151) shall be deemed to satisfy the case mix require-
24 ment.

1 **SEC. 106. EXTENSION AND EXPANSION OF THE MEDICARE**
 2 **HOLD HARMLESS PROVISION UNDER THE**
 3 **PROSPECTIVE PAYMENT SYSTEM FOR HOS-**
 4 **PITAL OUTPATIENT DEPARTMENT (HOPD)**
 5 **SERVICES FOR CERTAIN HOSPITALS.**

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

8 (1) in subclause (II)—

9 (A) in the first sentence, by striking
 10 “2009” and inserting “2010”; and

11 (B) by striking the second sentence and in-
 12 serting the following new sentence: “For pur-
 13 poses of the preceding sentence, the applicable
 14 percentage shall be 95 percent with respect to
 15 covered OPD services furnished in 2006, 90
 16 percent with respect to such services furnished
 17 in 2007, and 85 percent with respect to such
 18 services furnished in 2008 or 2009.”; and

19 (2) by adding at the end the following new sub-
 20 clause:

21 “(III) In the case of a sole community
 22 hospital (as defined in section
 23 1886(d)(5)(D)(iii)) that has not more than
 24 100 beds, for covered OPD services fur-
 25 nished on or after January 1, 2009, and
 26 before January 1, 2010, for which the

1 PPS amount is less than the pre-BBA
 2 amount, the amount of payment under this
 3 subsection shall be increased by 85 percent
 4 of the amount of such difference.”.

5 **SEC. 107. CLARIFICATION OF PAYMENT FOR CLINICAL LAB-**
 6 **ORATORY TESTS FURNISHED BY CRITICAL**
 7 **ACCESS HOSPITALS.**

8 (a) CLARIFICATION OF PAYMENT FOR CLINICAL
 9 LABORATORY TESTS FURNISHED BY CRITICAL ACCESS
 10 HOSPITALS.—

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

14 (A) in the heading, by striking “NO BENE-
 15 FICIARY COST-SHARING FOR” and inserting
 16 “TREATMENT OF”; and

17 (B) by adding at the end the following new
 18 sentence: “For purposes of the preceding sen-
 19 tence and section 1861(mm)(3), clinical diag-
 20 nostic laboratory services furnished by a critical
 21 access hospital shall be treated as being fur-
 22 nished as part of outpatient critical access serv-
 23 ices without regard to whether the individual
 24 with respect to whom such services are fur-
 25 nished is physically present in the critical access

1 hospital at the time the specimen is collected as
 2 long as the individual is present within the
 3 same county as the hospital at the time the
 4 specimen is collected.”.

5 (2) EFFECTIVE DATE.—The amendments made
 6 by paragraph (1) shall apply to services furnished on
 7 or after July 1, 2009.

8 (b) MEDICARE CRITICAL ACCESS HOSPITAL DES-
 9 IGNATIONS.—Section 405(h) of the Medicare Prescription
 10 Drug, Improvement, and Modernization Act of 2003 (Pub-
 11 lic Law 108–173; 117 Stat. 2269) is amended by adding
 12 at the end the following new paragraph:

13 “(3) EXCEPTION.—

14 “(A) IN GENERAL.—The amendment made
 15 by paragraph (1) shall not apply to the certifi-
 16 cation by the State of Alabama on or after Jan-
 17 uary 1, 2006, under section
 18 1820(c)(2)(B)(i)(II) of the Social Security Act
 19 (42 U.S.C. 1395i–4(c)(2)(B)(i)(II)) of one hos-
 20 pital that meets the criteria described in sub-
 21 paragraph (B) as a necessary provider of health
 22 care services to residents in the area of the hos-
 23 pital.

1 “(B) CRITERIA DESCRIBED.—A hospital
 2 meets the criteria described in this subpara-
 3 graph if the hospital is located—

4 “(i) in the county seat of Butler, Ala-
 5 bama; and

6 “(ii) a 32-mile drive from a hospital,
 7 or another facility described in section
 8 1820(c) of the Social Security Act (42
 9 U.S.C. 1395i-4(c)).”.

10 **SEC. 108. EXTENSION OF FLOOR ON MEDICARE WORK GEO-**
 11 **GRAPHIC ADJUSTMENT UNDER THE MEDI-**
 12 **CARE PHYSICIAN FEE SCHEDULE.**

13 (a) IN GENERAL.—Section 1848(e)(1)(E) of the So-
 14 cial Security Act (42 U.S.C. 1395w-4(e)(1)(E)), as
 15 amended by section 103 of the Medicare, Medicaid, and
 16 SCHIP Extension Act of 2007 (Public Law 110-173), is
 17 amended by striking “before July 1, 2008” and inserting
 18 “before January 1, 2010”.

19 (b) TREATMENT OF PHYSICIANS’ SERVICES FUR-
 20 NISHED IN CERTAIN AREAS.—Section 1848(e)(1)(G) of
 21 the Social Security Act (42 U.S.C. 1395w-4(e)(1)(G)) is
 22 amended by adding at the end the following new sentence:
 23 “For purposes of payment for services furnished in the
 24 State described in the preceding sentence on or after Jan-
 25 uary 1, 2009, after calculating the work geographic index

1 in subparagraph (A)(iii), the Secretary shall increase the
 2 work geographic index to 1.5 if such index would otherwise
 3 be less than 1.5”.

4 (c) TECHNICAL CORRECTION.—Section 602(1) of the
 5 Medicare Prescription Drug, Improvement, and Mod-
 6 ernization Act of 2003 (Public Law 108–173; 117 Stat.
 7 2301) is amended to read as follows:

8 “(1) in subparagraph (A), by striking ‘subpara-
 9 graphs (B), (C), and (E)’ and inserting ‘subpara-
 10 graphs (B), (C), (E), and (G)’; and”.

11 **SEC. 109. EXTENSION OF TREATMENT OF CERTAIN PHYSI-**
 12 **CIAN PATHOLOGY SERVICES UNDER MEDI-**
 13 **CARE.**

14 Section 542(c) of the Medicare, Medicaid, and
 15 SCHIP Benefits Improvement and Protection Act of 2000
 16 (as enacted into law by section 1(a)(6) of Public Law 106–
 17 554), as amended by section 732 of the Medicare Prescrip-
 18 tion Drug, Improvement, and Modernization Act of 2003
 19 (42 U.S.C. 1395w–4 note), section 104 of division B of
 20 the Tax Relief and Health Care Act of 2006 (42 U.S.C.
 21 1395w–4 note), and section 104 of the Medicare, Med-
 22 icaid, and SCHIP Extension Act of 2007 (Public Law
 23 110–173), is amended by striking “2007, and the first 6
 24 months of 2008” and inserting “2007, 2008, and 2009”.

1 **SEC. 110. ADDING HOSPITAL-BASED RENAL DIALYSIS CEN-**
2 **TERS (INCLUDING SATELLITES) AS ORIGI-**
3 **NATING SITES FOR PAYMENT OF TELE-**
4 **HEALTH SERVICES.**

5 (a) IN GENERAL.—Section 1834(m)(4)(C)(ii) of the
6 Social Security Act (42 U.S.C. 1395m(m)(4)(C)(ii)) is
7 amended by adding at the end the following new sub-
8 clause:

9 “(VI) A hospital-based or critical
10 access hospital-based renal dialysis
11 center (including satellites).”.

12 (b) EFFECTIVE DATE.—The amendment made by
13 this section shall apply to services furnished on or after
14 January 1, 2009.

15 **SEC. 111. ADDING SKILLED NURSING FACILITIES AS ORIGI-**
16 **NATING SITES FOR PAYMENT OF TELE-**
17 **HEALTH SERVICES.**

18 (a) ADDITION.—

19 (1) IN GENERAL.—Section 1834(m)(4)(C)(ii) of
20 the Social Security Act (42 U.S.C.
21 1395m(m)(4)(C)(ii)), as amended by section 110, is
22 amended by adding at the end the following new
23 subclause:

24 “(VII) A skilled nursing facility
25 (as defined in section 1819(a)).”.

1 (2) CONFORMING AMENDMENT.—Section
 2 1888(e)(2)(A)(ii) of the Social Security Act (42
 3 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting
 4 “telehealth services furnished under section
 5 1834(m)(4)(C)(ii)(VII),” after “section
 6 1861(s)(2),”.

7 (b) EFFECTIVE DATE.—The amendments made by
 8 subsection (a) shall apply to telehealth services furnished
 9 on or after January 1, 2009.

10 **SEC. 112. APPLYING RURAL HOME HEALTH ADD-ON POLICY**
 11 **FOR 2009.**

12 Section 421(a) of the Medicare Prescription Drug,
 13 Improvement, and Modernization Act of 2003 (Public Law
 14 10–173; 117 Stat. 2283), as amended by section 5201(b)
 15 of the Deficit Reduction Act of 2005 (Public Law 109–
 16 171; 120 Stat. 46), is amended—

17 (1) by striking “, and episodes” and inserting
 18 “, episodes”; and

19 (2) by inserting “and episodes and visits ending
 20 on or after January 1, 2009, and before January 1,
 21 2010,” after “January 1, 2007,”.

Subtitle B—Other Provisions **Relating to Part A**

SEC. 121. EXTENSION OF THE RECLASSIFICATION OF CERTAIN HOSPITALS UNDER THE MEDICARE PROGRAM.

(a) EXTENSION.—

(1) IN GENERAL.—Subsection (a) of section 106 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395 note), as amended by section 117 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended by striking “September 30, 2008” and inserting “September 30, 2009”.

(2) SPECIAL EXCEPTION RECLASSIFICATIONS.—Section 117(a)(2) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) is amended by striking “September 30, 2008” and inserting “September 30, 2009”.

(b) FLOOR ON MEDICARE AREA WAGE INDEX.—

(1) IN GENERAL.—Notwithstanding any other provision of law, for purposes of section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)), the area wage index applicable under such section to any hospital located in a State with an area described in paragraph (2) shall not be

1 less than the area wage index applicable under such
2 section to such hospital during the period beginning
3 on or after October 1, 2006, and before October 1,
4 2007.

5 (2) AREA DESCRIBED.—An area described in
6 this paragraph is a rural area (as defined in para-
7 graph (2)(D) of section 1886(d) of the Social Secu-
8 rity Act (42 U.S.C. 1395ww(d))) where not less than
9 65 percent of the wages paid by all subsection (d)
10 hospitals (as defined in paragraph (1)(B) of such
11 section) that are located in such area on October 1,
12 2006, taking into account redesignations under sec-
13 tion 601(g) of the Social Security Amendments of
14 1983 (Public Law 98–21) and not taking into ac-
15 count reclassifications or redesignations under para-
16 graph (8) or (10) of such section 1886(d), are at-
17 tributable to wages paid by one hospital. For pur-
18 poses of making a determination under the pre-
19 ceding sentence, the wages to be used are the occu-
20 pational mix adjusted inflated wages used to develop
21 the wage index in effect during the period beginning
22 on October 1, 2006 and ending on September 30,
23 2007 (as published in the Federal Register on Octo-
24 ber 11, 2006 (71 Fed. Reg. 59,886)).

1 (3) IMPLEMENTATION.—The Secretary of
 2 Health and Human Services shall ensure that the
 3 aggregate payments made under section 1886(d) of
 4 the Social Security Act (42 U.S.C. 1395ww(d)) in a
 5 fiscal year for the operating costs of inpatient hos-
 6 pital services are not greater or less than those
 7 which would have been made in the year if this sub-
 8 section did not apply.

9 (4) EFFECTIVE DATE.—The provisions of this
 10 subsection shall apply to discharges occurring on or
 11 after October 1, 2008.

12 (c) MEDICARE HOSPITAL GEOGRAPHIC RECLASSI-
 13 FICATIONS.—

14 (1) RECLASSIFICATIONS.—Notwithstanding any
 15 other provision of law, effective for discharges occur-
 16 ring during fiscal years 2009, 2010, and 2011, for
 17 purposes of making payments under section 1886(d)
 18 of the Social Security Act (42 U.S.C. 1395ww(d)) to
 19 Ball Memorial Hospital (provider number 15–0089),
 20 such hospital is deemed to be located in the Indian-
 21 apolis-Carmel, IN Core Based Statistical Area.

22 (2) RULES.—

23 (A) IN GENERAL.—Except as provided in
 24 subparagraph (B), any reclassification made
 25 under paragraph (1) shall be treated as a deci-

sion of the Medicare Geographic Classification Review Board under section 1886(d)(10) of the Social Security Act (42 U.S.C. 1395ww(d)(10)).

(B) NON-APPLICATION OF DUPLICATIVE 3-YEAR APPLICATION PROVISION.—Section 1886(d)(10)(D)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(10)(D)(v)), as it relates to a reclassification being effective for 3 fiscal years, shall not apply with respect to any reclassification made under paragraph (1).

SEC. 122. INSTITUTE OF MEDICINE STUDY AND REPORT ON POST-ACUTE CARE.

(a) IN GENERAL.—

(1) STUDY.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall enter into a contract with the Institute of Medicine of the National Academies (in this section referred to as the “Institute”) under which the Institute shall conduct a study on short- and long-term steps that can be taken under the Medicare program to reform the currently fragmented post-acute care payment and delivery system. Such study shall include an assessment of—

1 (A) potential elements of an integrated
2 continuum of care, such as—

3 (i) a uniform assessment tool for post-
4 acute care patients;

5 (ii) evidence-based admission criteria
6 for each post-acute care setting;

7 (iii) an integrated site-neutral pay-
8 ment methodology; and

9 (iv) an integrated quality assessment
10 system; and

11 (B) actions necessary to establish the inte-
12 grated continuum of care.

13 (2) CONSULTATION.—In conducting the study
14 under paragraph (1), the Institute shall consult with
15 the Administrator of the Centers for Medicare &
16 Medicaid Services regarding the status of efforts by
17 the Administrator to develop a common assessment
18 instrument for post-acute care patients under the
19 Medicare program.

20 (3) REPORT.—Not later than 2 years after the
21 effective date of the contract under paragraph (1),
22 the Institute shall submit a report to the Secretary
23 of Health and Human Services containing the re-
24 sults of the study conducted under paragraph (1),
25 together with recommendations for such legislation

1 and administrative action as the Institute deter-
 2 mines appropriate.

3 (b) FUNDING.—The Secretary of Health and Human
 4 Services shall provide for the transfer, from the Federal
 5 Hospital Insurance Trust Fund established under section
 6 1817 of the Social Security Act (42 U.S.C. 1395i), of
 7 \$2,700,000 for the purpose of carrying out this section.

8 **SEC. 123. REVOCATION OF UNIQUE DEEMING AUTHORITY**
 9 **OF THE JOINT COMMISSION.**

10 (a) REVOCATION.—Section 1865 of the Social Secu-
 11 rity Act (42 U.S.C. 1395bb) is amended—

12 (1) by striking subsection (a); and

13 (2) by redesignating subsections (b), (c), (d),
 14 and (e) as subsections (a), (b), (c), and (d), respec-
 15 tively.

16 (b) CONFORMING AMENDMENTS.—(1) Section 1865
 17 of the Social Security Act (42 U.S.C. 1395bb) is amend-
 18 ed—

19 (A) in subsection (a)(1), as redesignated by
 20 subsection (a)(2), by striking “In addition, if” and
 21 inserting “If”;

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

23 (i) by striking “released to him by the
 24 Joint Commission on Accreditation of Hos-

1 pitals,” and inserting “released to the Secretary
2 by”; and

3 (ii) by striking the comma after “Associa-
4 tion”;

5 (C) in subsection (c), as so redesignated, by
6 striking “pursuant to subsection (a) or (b)(1)” and
7 inserting “pursuant to subsection (a)(1)”; and

8 (D) in subsection (d), as so redesignated, by
9 striking “pursuant to subsection (a) or (b)(1)” and
10 inserting “pursuant to subsection (a)(1)”.

11 (2) Section 1861(e) of the Social Security Act (42
12 U.S.C. 1395x(e)) is amended in the fourth sentence by
13 striking “and (ii) is accredited by the Joint Commission
14 on Accreditation of Hospitals, or is accredited by or ap-
15 proved by a program of the country in which such institu-
16 tion is located if the Secretary finds the accreditation or
17 comparable approval standards of such program to be es-
18 sentially equivalent to those of the Joint Commission on
19 Accreditation of Hospitals” and inserting “and (ii) is ac-
20 credited by a national accreditation body recognized by the
21 Secretary under section 1865(a), or is accredited by or
22 approved by a program of the country in which such insti-
23 tution is located if the Secretary finds the accreditation
24 or comparable approval standards of such program to be

1 essentially equivalent to those of such a national accredita-
 2 tion body.”.

3 (3) Section 1864(c) of the Social Security Act (42
 4 U.S.C. 1395aa(c)) is amended by striking “pursuant to
 5 subsection (a) or (b)(1) of section 1865” and inserting
 6 “pursuant to section 1865(a)(1)”.

7 (4) Section 1875(b) of the Social Security Act (42
 8 U.S.C. 1395ll(b)) is amended by striking “the Joint Com-
 9 mission on Accreditation of Hospitals,” and inserting “na-
 10 tional accreditation bodies under section 1865(a)”.

11 (5) Section 1834(a)(20)(B) of the Social Security Act
 12 (42 U.S.C. 1395m(a)(20)(B)) is amended by striking
 13 “section 1865(b)” and inserting “section 1865(a)”.

14 (6) Section 1852(e)(4)(C) of the Social Security Act
 15 (42 U.S.C. 1395w–22(e)(4)(C)) is amended by striking
 16 “section 1865(b)(2)” and inserting “section 1865(a)(2)”.

17 (c) **AUTHORITY TO RECOGNIZE THE JOINT COMMIS-**
 18 **SION AS A NATIONAL ACCREDITATION BODY.**—The Sec-
 19 retary of Health and Human Services may recognize the
 20 Joint Commission as a national accreditation body under
 21 section 1865 of the Social Security Act (42 U.S.C.
 22 1395bb), as amended by this section, upon such terms and
 23 conditions, and upon submission of such information, as
 24 the Secretary may require.

1 (d) EFFECTIVE DATE; TRANSITION RULE.—(1) Sub-
 2 ject to paragraph (2), the amendments made by this sec-
 3 tion shall apply with respect to accreditations of hospitals
 4 granted on or after the date that is 24 months after the
 5 date of enactment of this Act.

6 (2) For purposes of title XVIII of the Social Security
 7 Act (42 U.S.C. 1395 et seq.), the amendments made by
 8 this section shall not effect the accreditation of a hospital
 9 by the Joint Commission, or under accreditation or com-
 10 parable approval standards found to be essentially equiva-
 11 lent to accreditation or approval standards of the Joint
 12 Commission, for the period of time applicable under such
 13 accreditation.

14 **SEC. 124. MEDPAC STUDY AND REPORT ON PAYMENTS FOR**
 15 **HOSPICE CARE.**

16 (a) STUDY.—The Medicare Payment Advisory Com-
 17 mission shall conduct a study on payments for hospice
 18 care under the Medicare program under title XVIII of the
 19 Social Security Act. Such study shall include an analysis
 20 of potential changes in payment methodologies for hospice
 21 care under the Medicare program, including revisions to
 22 the cap amount under section 1814(i)(2) of the Social Se-
 23 curity Act (42 U.S.C. 1395f(i)(2)), that may reflect—

24 (1) hospice patient characteristics;

- 1 (2) variation in hospice care utilization by pa-
- 2 tient characteristics;
- 3 (3) average lengths of stay in hospice care;
- 4 (4) disease category;
- 5 (5) geographic differences;
- 6 (6) specific types of hospice care services pro-
- 7 vided; and
- 8 (7) site of service.

9 (b) REPORT.—Not later than June 15, 2009, the
 10 Medicare Payment Advisory Commission shall submit a
 11 report to Congress on the study conducted under sub-
 12 section (a). Such report shall include recommendations for
 13 such legislation and administrative action as the Medicare
 14 Payment Advisory Commission determines appropriate.

15 (c) HOSPICE CARE DEFINED.—In this section, the
 16 term “hospice care” has the meaning given such term in
 17 section 1861(dd) of the Social Security Act (42 U.S.C.
 18 1395x(dd)).

19 **SEC. 125. INTRODUCING THE PRINCIPALS OF VALUE-BASED**
 20 **HEALTH CARE INTO THE MEDICARE PRO-**
 21 **GRAM.**

22 (a) INCENTIVES FOR PROVIDERS AND SUPPLIERS.—
 23 (1) IN GENERAL.—The Secretary of Health and
 24 Human Services (in this section referred to as the
 25 “Secretary”) shall design and implement a budget-

1 neutral system for use in the Medicare program
2 under title XVIII of the Social Security Act under
3 which a portion of the payments that would other-
4 wise be made under such program to some or all
5 classes of individuals and entities furnishing items
6 or services to beneficiaries of such program would be
7 based on the quality of their performance.

8 (2) IMPLEMENTATION.—The Secretary shall
9 first implement such system in hospitals. The initial
10 focus of such efforts shall be on quality. The system
11 shall also include incentives for reducing unwar-
12 ranted geographic variations in quality.

13 (3) AUTHORITY.—The Secretary may imple-
14 ment the system described in this subsection without
15 regard to any provision of title XVIII of the Social
16 Security Act that would, in the absence of para-
17 graphs (1) and (2), apply with respect to payment
18 to an individual or entity furnishing items or serv-
19 ices for which payment may be made under the
20 Medicare program.

21 (b) DEFINITION OF INFORMATION ON QUALITY OF
22 CARE.—In this section, the term “information on quality
23 of care” means measures of—

24 (1) the use of clinical processes and structures
25 known to improve care;

- 1 (2) health outcomes; and
 2 (3) patient perceptions of their care.

3 **Subtitle C—Other Provisions**
 4 **Relating to Part B**

5 **SEC. 131. PHYSICIAN PAYMENT, EFFICIENCY, AND QUALITY**
 6 **IMPROVEMENTS.**

7 (a) IN GENERAL.—

8 (1) INCREASE IN UPDATE FOR THE SECOND
 9 HALF OF 2008 AND FOR 2009.—

10 (A) FOR THE SECOND HALF OF 2008.—

11 Section 1848(d)(8) of the Social Security Act
 12 (42 U.S.C. 1395w–4(d)(8)), as added by section
 13 101 of the Medicare, Medicaid, and SCHIP Ex-
 14 tension Act of 2007 (Public Law 110–173), is
 15 amended—

16 (i) in the heading, by striking “A POR-
 17 TION OF”;

18 (ii) in subparagraph (A), by striking
 19 “for the period beginning on January 1,
 20 2008, and ending on June 30, 2008,”; and

21 (iii) in subparagraph (B)—

22 (I) in the heading, by striking
 23 “THE REMAINING PORTION OF 2008
 24 AND”; and

1 (II) by striking “for the period
2 beginning on July 1, 2008, and end-
3 ing on December 31, 2008, and”.

4 (B) FOR 2009.—Section 1848(d) of the So-
5 cial Security Act (42 U.S.C. 1395w-4(d)), as
6 amended by section 101 of the Medicare, Med-
7 icaid, and SCHIP Extension Act of 2007 (Pub-
8 lic Law 110-173), is amended by adding at the
9 end the following new paragraph:

10 “(9) UPDATE FOR 2009.—

11 “(A) IN GENERAL.—Subject to paragraphs
12 (7)(B) and (8)(B), in lieu of the update to the
13 single conversion factor established in para-
14 graph (1)(C) that would otherwise apply for
15 2009, the update to the single conversion factor
16 shall be 1.1 percent.

17 “(B) NO EFFECT ON COMPUTATION OF
18 CONVERSION FACTOR FOR 2010 AND SUBSE-
19 QUENT YEARS.—The conversion factor under
20 this subsection shall be computed under para-
21 graph (1)(A) for 2010 and subsequent years as
22 if subparagraph (A) had never applied.”.

23 (2) REVISION OF THE PHYSICIAN ASSISTANCE
24 AND QUALITY INITIATIVE FUND.—Section 1848(l)(2)
25 of the Social Security Act (42 U.S.C. 1395w-

1 4(l)(2)), as amended by section 101(a)(2) of the
 2 Medicare, Medicaid, and SCHIP Extension Act of
 3 2007 (Public Law 110–173), is amended—

4 (A) in subparagraph (A)—

5 (i) in clause (i)—

6 (I) in subclause (III), by striking

7 “\$4,960,000,000” and inserting

8 “\$4,090,000,000”;

9 (II) by adding at the end the fol-

10 lowing new clause:

11 “(IV) For expenditures during

12 2014 through 2017, an amount equal

13 to \$30,660,000,000.”; and

14 (ii) in clause (ii), by adding at the end

15 the following new subclause:

16 “(III) 2014 THROUGH 2017.—

17 The amount available for expenditures

18 during 2014 through 2017 shall only

19 be available for an adjustment to the

20 update of the conversion factor under

21 subsection (d) for that year.”; and

22 (B) in subparagraph (B)—

23 (i) in clause (ii), by striking “and” at

24 the end;

1 (ii) in clause (iii), by striking the pe-
 2 riod at the end and inserting “; and”; and
 3 (iii) by adding at the end the fol-
 4 lowing new clause:
 5 “(iv) 2014 through 2017 for payment
 6 with respect to physicians’ services fur-
 7 nished during 2014 through 2017.”.

8 (b) EXTENSION AND IMPROVEMENT OF THE QUAL-
 9 ITY REPORTING SYSTEM.—

10 (1) SYSTEM.—Section 1848(k)(2) of the Social
 11 Security Act (42 U.S.C. 1395w–4(k)(2)), as amend-
 12 ed by section 101(b)(1) of the Medicare, Medicaid,
 13 and SCHIP Extension Act of 2007 (Public Law
 14 110–173), is amended by adding at the end the fol-
 15 lowing new subparagraphs:

16 “(C) FOR 2010 AND SUBSEQUENT
 17 YEARS.—

18 “(i) IN GENERAL.—Subject to clause
 19 (ii), for purposes of reporting data on qual-
 20 ity measures for covered professional serv-
 21 ices furnished during 2010 and each subse-
 22 quent year, subject to subsection
 23 (m)(3)(C), the quality measures (including
 24 electronic prescribing quality measures)
 25 specified under this paragraph shall be

1 such measures selected by the Secretary
2 from measures that have been endorsed by
3 the entity with a contract with the Sec-
4 retary under section 1890(a).

5 “(ii) EXCEPTION.—In the case of a
6 specified area determined appropriate by
7 the Secretary for which no measure has
8 been endorsed by the entity with a contract
9 under section 1890(a), the Secretary may
10 specify a measure that is not so endorsed
11 as long as due consideration is given to
12 measures that have been endorsed or
13 adopted by a consensus-based organization
14 identified by the Secretary, such as the
15 AQA alliance.

16 “(D) OPPORTUNITY TO PROVIDE INPUT ON
17 MEASURES FOR 2009 AND SUBSEQUENT
18 YEARS.—For each quality measure (including
19 an electronic prescribing quality measure)
20 adopted by the Secretary under subparagraph
21 (B) (with respect to 2009) or subparagraph
22 (C), the Secretary shall ensure that eligible pro-
23 fessionals have the opportunity to provide input
24 during the development, endorsement, or selec-

1 tion of measures applicable to services they fur-
 2 nish.”.

3 (2) REDESIGNATION OF REPORTING SYSTEM.—
 4 Subsection (c) of section 101 of division B of the
 5 Tax Relief and Health Care Act of 2006 (42 U.S.C.
 6 1395w–4 note), as amended by section 101(b)(2) of
 7 the Medicare, Medicaid, and SCHIP Extension Act
 8 of 2007 (Public Law 110–173), is redesignated as
 9 subsection (m) of section 1848 of the Social Security
 10 Act.

11 (3) INCENTIVE PAYMENTS UNDER REPORTING
 12 SYSTEM.—Section 1848(m) of the Social Security
 13 Act, as redesignated by paragraph (2), is amended—

14 (A) by amending the heading to read as
 15 follows: “INCENTIVE PAYMENTS FOR QUALITY
 16 REPORTING”;

17 (B) by striking paragraph (1) and insert-
 18 ing the following:

19 “(1) INCENTIVE PAYMENTS.—

20 “(A) IN GENERAL.—For 2007 through
 21 2010, with respect to covered professional serv-
 22 ices furnished during a reporting period by an
 23 eligible professional, if—

24 “(i) there are any quality measures
 25 that have been established under the physi-

1 cian reporting system that are applicable
2 to any such services furnished by such pro-
3 fessional for such reporting period; and

4 “(ii) the eligible professional satisfac-
5 torily submits (as determined under this
6 subsection) to the Secretary data on such
7 quality measures in accordance with such
8 reporting system for such reporting period,
9 in addition to the amount otherwise paid under
10 this part, there also shall be paid to the eligible
11 professional (or to an employer or facility in the
12 cases described in clause (A) of section
13 1842(b)(6)) or, in the case of a group practice
14 under paragraph (3)(C), to the group practice,
15 from the Federal Supplementary Medical Insur-
16 ance Trust Fund established under section
17 1841 an amount equal to the applicable quality
18 percent of the Secretary’s estimate (based on
19 claims submitted not later than 2 months after
20 the end of the reporting period) of the allowed
21 charges under this part for all such covered
22 professional services furnished by the eligible
23 professional (or, in the case of a group practice
24 under paragraph (3)(C), by the group practice)
25 during the reporting period.

1 “(B) APPLICABLE QUALITY PERCENT.—

2 For purposes of subparagraph (A), the term

3 ‘applicable quality percent’ means—

4 “(i) for 2007 and 2008, 1.5 percent;

5 and

6 “(ii) for 2009 and 2010, 2.0 per-

7 cent.”;

8 (C) by striking paragraph (3) and redesign-

9 nating paragraph (2) as paragraph (3);

10 (D) in paragraph (3), as so redesignated—

11 (i) in the matter preceding subpara-

12 graph (A), by striking “For purposes” and

13 inserting the following:

14 “(A) IN GENERAL.—For purposes”;

15 (ii) by redesignating subparagraphs

16 (A) and (B) as clauses (i) and (ii), respec-

17 tively, and moving the indentation of such

18 clauses 2 ems to the right;

19 (iii) in subparagraph (A), as added by

20 clause (i), by adding at the end the fol-

21 lowing flush sentence:

22 “For years after 2008, quality measures for

23 purposes of this subparagraph shall not include

24 electronic prescribing quality measures.”; and

1 (iv) by adding at the end the following
 2 new subparagraphs:

3 “(C) SATISFACTORY REPORTING MEAS-
 4 URES FOR GROUP PRACTICES.—

5 “(i) IN GENERAL.—By January 1,
 6 2010, the Secretary shall establish and
 7 have in place a process under which eligi-
 8 ble professionals in a group practice (as
 9 defined by the Secretary) shall be treated
 10 as satisfactorily submitting data on quality
 11 measures under subparagraph (A) and as
 12 meeting the requirement described in sub-
 13 paragraph (B)(ii)) for covered professional
 14 services for a reporting period (or, for pur-
 15 poses of subsection (a)(5), for a reporting
 16 period for a year) if, in lieu of reporting
 17 measures under subsection (k)(2)(C), the
 18 group practice reports measures deter-
 19 mined appropriate by the Secretary, such
 20 as measures that target high-cost chronic
 21 conditions and preventive care, in a form
 22 and manner, and at a time, specified by
 23 the Secretary.

24 “(ii) STATISTICAL SAMPLING
 25 MODEL.—The process under clause (i)

1 shall provide for the use of a statistical
2 sampling model to submit data on meas-
3 ures, such as the model used under the
4 Physician Group Practice demonstration
5 project under section 1866A.

6 “(iii) NO DOUBLE PAYMENTS.—Pay-
7 ments to a group practice under this sub-
8 section by reason of the process under
9 clause (i) shall be in lieu of the payments
10 that would otherwise be made under this
11 subsection to eligible professionals in the
12 group practice for satisfactorily submitting
13 data on quality measures.

14 “(D) AUTHORITY TO REVISE SATISFAC-
15 TORILY REPORTING DATA.—For years after
16 2009, the Secretary, in consultation with stake-
17 holders and experts, may revise the criteria
18 under this subsection for satisfactorily submit-
19 ting data on quality measures under subpara-
20 graph (A) and the criteria for submitting data
21 on electronic prescribing quality measures
22 under subparagraph (B)(ii).”;

23 (E) in paragraph (5)—

1 (i) in subparagraph (C), by inserting
2 “for 2007, 2008, and 2009,” after “provi-
3 sion of law,”;

4 (ii) in subparagraph (D)—

5 (I) in clause (i)—

6 (aa) by inserting “for 2007
7 and 2008” after “under this sub-
8 section”; and

9 (bb) by striking “paragraph
10 (2)” and inserting “this sub-
11 section”;

12 (II) in clause (ii), by striking
13 “shall” and inserting “may establish
14 procedures to”; and

15 (III) in clause (iii)—

16 (aa) by inserting “(or, in the
17 case of a group practice under
18 paragraph (3)(C), the group
19 practice)” after “an eligible pro-
20 fessional”;

21 (bb) by striking “bonus in-
22 centive payment” and inserting
23 “incentive payment under this
24 subsection”; and

- 1 (cc) by adding at the end
- 2 the following new sentence: “If
- 3 such payments for such period
- 4 have already been made, the Sec-
- 5 retary shall recoup such pay-
- 6 ments from the eligible profes-
- 7 sional (or the group practice).”;
- 8 (iii) in subparagraph (E)(i)—
- 9 (I) in subclause (II), by striking
- 10 “paragraph (2)” and inserting “this
- 11 subsection”; and
- 12 (II) in subclause (IV)—
- 13 (aa) by striking “the bonus”
- 14 and inserting “any”; and
- 15 (bb) by inserting “and the
- 16 payment adjustment under sub-
- 17 section (a)(5)(A)” before the pe-
- 18 riod at the end;
- 19 (iv) in subparagraph (F)—
- 20 (I) by striking “2009, paragraph
- 21 (3) shall not apply, and” and insert-
- 22 ing “subsequent years,”; and
- 23 (II) by striking “paragraph (2)”
- 24 and inserting “this subsection”; and

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

3 “(G) POSTING ON WEBSITE.—The Sec-
 4 retary shall post on the Internet website of the
 5 Centers for Medicare & Medicaid Services, in an
 6 easily understandable format, a list of the
 7 names of the following:

8 “(i) The eligible professionals (or, in
 9 the case of reporting under paragraph
 10 (3)(C), the group practices) who satisfac-
 11 torily submitted data on quality measures
 12 under this subsection.

13 “(ii) The eligible professionals (or, in
 14 the case of reporting under paragraph
 15 (3)(C), the group practices) who are suc-
 16 cessful electronic prescribers.”; and

17 (F) in paragraph (6), by striking subpara-
 18 graph (C) and inserting the following:

19 “(C) REPORTING PERIOD.—

20 “(i) IN GENERAL.—Subject to clauses
 21 (ii) and (iii), the term ‘reporting period’
 22 means—

23 “(I) for 2007, the period begin-
 24 ning on July 1, 2007, and ending on
 25 December 31, 2007; and

1 “(II) for 2008, 2009, 2010, and
2 2011, the entire year.

3 “(ii) AUTHORITY TO REVISE REPORT-
4 ING PERIOD.—For years after 2009, the
5 Secretary may revise the reporting period
6 under clause (i) if the Secretary deter-
7 mines such revision is appropriate, pro-
8 duces valid results on measures reported,
9 and is consistent with the goals of maxi-
10 mizing scientific validity and reducing ad-
11 ministrative burden. If the Secretary re-
12 vises such period pursuant to the preceding
13 sentence, the term ‘reporting period’ shall
14 mean such revised period.

15 “(iii) REFERENCE.—Any reference in
16 this subsection to a reporting period with
17 respect to the application of subsection
18 (a)(5) shall be deemed a reference to the
19 reporting period under subparagraph
20 (D)(iii) of such subsection.”.

21 (4) INCLUSION OF QUALIFIED AUDIOLOGISTS
22 AS ELIGIBLE PROFESSIONALS.—

23 (A) IN GENERAL.—Section 1848(k)(3)(B)
24 of the Social Security Act (42 U.S.C. 1395w–

1 4(k)(3)(B)), is amended by adding at the end
2 the following new clause:

3 “(iv) Beginning with 2009, a qualified
4 audiologist (as defined in section
5 1861(l)(3)(B)).”.

6 (B) NO CHANGE IN BILLING.—Nothing in
7 the amendment made by subparagraph (A)
8 shall be construed to change the way in which
9 billing for audiology services (as defined in sec-
10 tion 1861(l)(2) of the Social Security Act (42
11 U.S.C. 1395x(l)(2))) occurs under title XVIII
12 of such Act as of July 1, 2008.

13 (5) CONFORMING AMENDMENTS.—Section
14 1848(m) of the Social Security Act, as added and
15 amended by paragraphs (2) and (3), is amended—

16 (A) in paragraph (5)—

17 (i) in subparagraph (A)—

18 (I) by striking “section 1848(k)
19 of the Social Security Act, as added
20 by subsection (b),” and inserting
21 “subsection (k)”; and

22 (II) by striking “such section”
23 and inserting “such subsection”;

1 (ii) in subparagraph (B), by striking
 2 “of the Social Security Act (42 U.S.C.
 3 1395l)”;

4 (iii) in subparagraph (E)—

5 (I) in clause (i), in the matter
 6 preceding subclause (I), by striking
 7 “1869 or 1878 of the Social Security
 8 Act or otherwise” and inserting
 9 “1869, section 1878, or otherwise”;
 10 and

11 (II) in clause (ii), by striking “of
 12 the Social Security Act”; and

13 (iv) in subparagraph (F)—

14 (I) by striking “paragraph (2)(B)
 15 of section 1848(k) of the Social Secu-
 16 rity Act (42 U.S.C. 1395w-4(k))” and
 17 inserting “subsection (k)(2)(B)”; and

18 (II) by striking “paragraph (4)
 19 of such section” and inserting “sub-
 20 section (k)(4)”;

21 (B) in paragraph (6)—

22 (i) in subparagraph (A), by striking
 23 “section 1848(k)(3) of the Social Security
 24 Act, as added by subsection (b)” and in-
 25 serting “subsection (k)(3)”; and

1 (ii) in subparagraph (B), by striking
 2 “section 1848(k) of the Social Security
 3 Act, as added by subsection (b)” and in-
 4 serting “subsection (k)”; and
 5 (C) by striking paragraph (6)(D).

6 (6) NO AFFECT ON INCENTIVE PAYMENTS FOR
 7 2007 OR 2008.—Nothing in the amendments made by
 8 this subsection or section 132 shall affect the oper-
 9 ation of the provisions of section 1848(m) of the So-
 10 cial Security Act, as redesignated and amended by
 11 such subsection and section, with respect to 2007 or
 12 2008.

13 (c) PHYSICIAN FEEDBACK PROGRAM TO IMPROVE
 14 EFFICIENCY AND CONTROL COSTS.—

15 (1) IN GENERAL.—Section 1848 of the Social
 16 Security Act (42 U.S.C. 1395w-4), as amended by
 17 subsection (b), is amended by adding at the end the
 18 following new subsection:

19 “(n) PHYSICIAN FEEDBACK PROGRAM.—

20 “(1) ESTABLISHMENT.—

21 “(A) IN GENERAL.—The Secretary shall
 22 establish a Physician Feedback Program (in
 23 this subsection referred to as the ‘Program’)
 24 under which the Secretary shall use claims data
 25 under this title (and may use other data) to

1 provide confidential reports to physicians (and,
 2 as determined appropriate by the Secretary, to
 3 groups of physicians) that measure the re-
 4 sources involved in furnishing care to individ-
 5 uals under this title. If determined appropriate
 6 by the Secretary, the Secretary may include in-
 7 formation on the quality of care furnished to in-
 8 dividuals under this title by the physician (or
 9 group of physicians) in such reports.

10 “(B) RESOURCE USE.—The resources de-
 11 scribed in subparagraph (A) may be meas-
 12 ured—

13 “(i) on an episode basis;

14 “(ii) on a per capita basis; or

15 “(iii) on both an episode and a per
 16 capita basis.

17 “(2) IMPLEMENTATION.—The Secretary shall
 18 implement the Program by not later than January
 19 1, 2009.

20 “(3) DATA FOR REPORTS.—To the extent prac-
 21 ticable, reports under the Program shall be based on
 22 the most recent data available.

23 “(4) AUTHORITY TO FOCUS APPLICATION.—The
 24 Secretary may focus the application of the Program
 25 as appropriate, such as focusing the Program on—

1 “(A) physician specialties that account for
2 a certain percentage of all spending for physi-
3 cians’ services under this title;

4 “(B) physicians who treat conditions that
5 have a high cost or a high volume, or both,
6 under this title;

7 “(C) physicians who use a high amount of
8 resources compared to other physicians;

9 “(D) physicians practicing in certain geo-
10 graphic areas; or

11 “(E) physicians who treat a minimum
12 number of individuals under this title.

13 “(5) AUTHORITY TO EXCLUDE CERTAIN INFOR-
14 MATION IF INSUFFICIENT INFORMATION.—The Sec-
15 retary may exclude certain information regarding a
16 service from a report under the Program with re-
17 spect to a physician (or group of physicians) if the
18 Secretary determines that there is insufficient infor-
19 mation relating to that service to provide a valid re-
20 port on that service.

21 “(6) ADJUSTMENT OF DATA.—To the extent
22 practicable, the Secretary shall make appropriate ad-
23 justments to the data used in preparing reports
24 under the Program, such as adjustments to take

1 into account variations in health status and other
 2 patient characteristics.

3 “(7) EDUCATION AND OUTREACH.—The Sec-
 4 retary shall provide for education and outreach ac-
 5 tivities to physicians on the operation of, and meth-
 6 odologies employed under, the Program.

7 “(8) DISCLOSURE EXEMPTION.—Reports under
 8 the Program shall be exempt from disclosure under
 9 section 552 of title 5, United States Code.”.

10 (2) GAO STUDY AND REPORT ON THE PHYSI-
 11 CIAN FEEDBACK PROGRAM.—

12 (A) STUDY.—The Comptroller General of
 13 the United States shall conduct a study of the
 14 Physician Feedback Program conducted under
 15 section 1848(n) of the Social Security Act, as
 16 added by paragraph (1), including the imple-
 17 mentation of the Program.

18 (B) REPORT.—Not later than March 1,
 19 2011, the Comptroller General of the United
 20 States shall submit a report to Congress con-
 21 taining the results of the study conducted under
 22 subparagraph (A), together with recommenda-
 23 tions for such legislation and administrative ac-
 24 tion as the Comptroller General determines ap-
 25 propriate.

1 (d) PLAN FOR TRANSITION TO VALUE-BASED PUR-
2 CHASING PROGRAM FOR PHYSICIANS AND OTHER PRACTI-
3 TIONERS.—

4 (1) IN GENERAL.—The Secretary of Health and
5 Human Services shall develop a plan to transition to
6 a value-based purchasing program for payment
7 under the Medicare program for covered professional
8 services (as defined in section 1848(k)(3)(A) of the
9 Social Security Act (42 U.S.C. 1395w–4(k)(3)(A))).

10 (2) REPORT.—Not later than May 1, 2010, the
11 Secretary of Health and Human Services shall sub-
12 mit a report to Congress containing the plan devel-
13 oped under paragraph (1), together with rec-
14 ommendations for such legislation and administra-
15 tive action as the Secretary determines appropriate.

16 (e) IMPLEMENTATION.—For purposes of carrying out
17 the provisions of, and amendments made by, this title, in
18 addition to any amounts otherwise provided in such provi-
19 sions and amendments, there are appropriated to the Cen-
20 ters for Medicare & Medicaid Services Program Manage-
21 ment Account, out of any money in the Treasury not oth-
22 erwise appropriated, \$140,000,000 for the period of fiscal
23 years 2009 through 2013.

1 **SEC. 132. INCENTIVES FOR ELECTRONIC PRESCRIBING.**

2 (a) INCENTIVE PAYMENTS.—Section 1848(m) of the
3 Social Security Act, as added and amended by section
4 131(b), is amended—

5 (1) by inserting after paragraph (1), the fol-
6 lowing new paragraph:

7 “(2) INCENTIVE PAYMENTS FOR ELECTRONIC
8 PRESCRIBING.—

9 “(A) IN GENERAL.—For 2009 through
10 2013, with respect to covered professional serv-
11 ices furnished during a reporting period by an
12 eligible professional, if the eligible professional
13 is a successful electronic prescriber for such re-
14 porting period, in addition to the amount other-
15 wise paid under this part, there also shall be
16 paid to the eligible professional (or to an em-
17 ployer or facility in the cases described in
18 clause (A) of section 1842(b)(6)) or, in the case
19 of a group practice under paragraph (3)(C), to
20 the group practice, from the Federal Supple-
21 mentary Medical Insurance Trust Fund estab-
22 lished under section 1841 an amount equal to
23 the applicable electronic prescribing percent of
24 the Secretary’s estimate (based on claims sub-
25 mitted not later than 2 months after the end of
26 the reporting period) of the allowed charges

1 under this part for all such covered professional
2 services furnished by the eligible professional
3 (or, in the case of a group practice under para-
4 graph (3)(C), by the group practice) during the
5 reporting period.

6 “(B) LIMITATION WITH RESPECT TO ELEC-
7 TRONIC PRESCRIBING QUALITY MEASURES.—
8 The provisions of this paragraph and subsection
9 (a)(5) shall not apply to an eligible professional
10 (or, in the case of a group practice under para-
11 graph (3)(C), to the group practice) if, for the
12 reporting period (or, for purposes of subsection
13 (a)(5), for the reporting period for a year)—

14 “(i) the allowed charges under this
15 part for all covered professional services
16 furnished by the eligible professional (or
17 group, as applicable) for the codes to
18 which the electronic prescribing quality
19 measure applies (as identified by the Sec-
20 retary and published on the Internet
21 website of the Centers for Medicare &
22 Medicaid Services as of January 1, 2008,
23 and as subsequently modified by the Sec-
24 retary) are less than 10 percent of the
25 total of the allowed charges under this part

for all such covered professional services
furnished by the eligible professional (or
the group, as applicable); or

“(ii) if determined appropriate by the
Secretary, the eligible professional does not
submit (including both electronically and
nonelectronically) a sufficient number (as
determined by the Secretary) of prescrip-
tions under part D.

If the Secretary makes the determination to
apply clause (ii) for a period, then clause (i)
shall not apply for such period.

“(C) APPLICABLE ELECTRONIC PRE-
SCRIBING PERCENT.—For purposes of subpara-
graph (A), the term ‘applicable electronic pre-
scribing percent’ means—

“(i) for 2009 and 2010, 2.0 percent;

“(ii) for 2011 and 2012, 1.0 percent;

and

“(iii) for 2013, 0.5 percent.”;

(2) in paragraph (3), as redesignated by section
131(b)—

(A) in the heading, by inserting “AND SUC-
CESSFUL ELECTRONIC PRESCRIBER” after “RE-
PORTING”; and

1 (B) by inserting after subparagraph (A)
2 the following new subparagraph:

3 “(B) SUCCESSFUL ELECTRONIC PRE-
4 SCRIBER.—

5 “(i) IN GENERAL.—For purposes of
6 paragraph (2) and subsection (a)(5), an el-
7 igible professional shall be treated as a
8 successful electronic prescriber for a re-
9 porting period (or, for purposes of sub-
10 section (a)(5), for the reporting period for
11 a year) if the eligible professional meets
12 the requirement described in clause (ii), or,
13 if the Secretary determines appropriate,
14 the requirement described in clause (iii). If
15 the Secretary makes the determination
16 under the preceding sentence to apply the
17 requirement described in clause (ii) for a
18 period, then the requirement described in
19 clause (i) shall not apply for such period.

20 “(ii) REQUIREMENT FOR SUBMITTING
21 DATA ON ELECTRONIC PRESCRIBING QUAL-
22 ITY MEASURES.—The requirement de-
23 scribed in this clause is that, with respect
24 to covered professional services furnished
25 by an eligible professional during a report-

1 ing period (or, for purposes of subsection
2 (a)(5), for the reporting period for a year),
3 if there are any electronic prescribing qual-
4 ity measures that have been established
5 under the physician reporting system and
6 are applicable to any such services fur-
7 nished by such professional for the period,
8 such professional reported each such meas-
9 ure under such system in at least 50 per-
10 cent of the cases in which such measure is
11 reportable by such professional under such
12 system.

13 “(iii) REQUIREMENT FOR ELECTRONI-
14 CALLY PRESCRIBING UNDER PART D.—The
15 requirement described in this clause is that
16 the eligible professional electronically sub-
17 mitted a sufficient number (as determined
18 by the Secretary) of prescriptions under
19 part D during the reporting period (or, for
20 purposes of subsection (a)(5), for the re-
21 porting period for a year).

22 “(iv) USE OF PART D DATA.—Not-
23 withstanding sections 1858(c)(3)(B),
24 1860D–15(d)(2)(B), and 1860D–15(f)(2),
25 the Secretary may use data submitted for

purposes of part D for purposes of clause (iii) and paragraph (2)(B)(ii). Such data shall only be used for such purposes.

“(v) STANDARDS FOR ELECTRONIC PRESCRIBING.—To the extent practicable, in determining whether eligible professionals meet the requirements under clauses (ii) and (iii) for purposes of clause (i), the Secretary shall ensure that eligible professionals utilize electronic prescribing systems in compliance with standards established for such systems pursuant to the Part D Electronic Prescribing Program under section 1860D–4(e).”; and

(3) in paragraph (5)(E)—

(A) in clause (i), by striking subclause (III) and inserting the following new subclause:

“(III) the determination of a successful electronic prescriber under paragraph (3), the limitation under paragraph (2)(B), and the exception under subsection (a)(5)(B); and”; and

(B) in clause (ii), by inserting “or subsection (a)(5)” after “this subsection”.

1 (b) INCENTIVE PAYMENT ADJUSTMENT.—Section
 2 1848(a) of the Social Security Act (42 U.S.C. 1395w–
 3 4(a)) is amended by adding at the end the following new
 4 paragraph:

5 “(5) INCENTIVES FOR ELECTRONIC PRE-
 6 SCRIBING.—

7 “(A) ADJUSTMENT.—

8 “(i) IN GENERAL.—Subject to sub-
 9 paragraph (B) and subsection (m)(2)(B),
 10 with respect to covered professional serv-
 11 ices furnished by an eligible professional
 12 during 2011 or any subsequent year, if the
 13 eligible professional is not a successful
 14 electronic prescriber for the reporting pe-
 15 riod for the year (as determined under
 16 subsection (m)(3)(B)), the fee schedule
 17 amount for such services furnished by such
 18 professional during the year (including the
 19 fee schedule amount for purposes of deter-
 20 mining a payment based on such amount)
 21 shall be equal to the applicable percent of
 22 the fee schedule amount that would other-
 23 wise apply to such services under this sub-
 24 section (determined after application of

1 paragraph (3) but without regard to this
2 paragraph).

3 “(ii) APPLICABLE PERCENT.—For
4 purposes of clause (i), the term ‘applicable
5 percent’ means—

6 “(I) for 2011, 99 percent;

7 “(II) for 2012, 98.5 percent; and

8 “(III) for 2013 and each subse-
9 quent year, 98 percent.

10 “(B) SIGNIFICANT HARDSHIP EXCEP-
11 TION.—The Secretary may exempt an eligible
12 professional from the application of the pay-
13 ment adjustment under subparagraph (A) if the
14 Secretary determines that compliance with the
15 requirement for being a successful electronic
16 prescriber would be a significant hardship, such
17 as an eligible professional who practices in a
18 rural area without sufficient Internet access
19 and an eligible professional who frequently
20 sends prescriptions to pharmacies that are not
21 capable of receiving prescriptions electronically.

22 “(C) APPLICATION.—

23 “(i) PHYSICIAN REPORTING SYSTEM
24 RULES.—Paragraphs (5), (6), and (8) of
25 subsection (k) shall apply for purposes of

1 this paragraph in the same manner as they
2 apply for purposes of such subsection.

3 “(ii) INCENTIVE PAYMENT VALIDA-
4 TION RULES.—Clauses (ii) and (iii) of sub-
5 section (m)(5)(D) shall apply for purposes
6 of this paragraph in a similar manner as
7 they apply for purposes of such subsection.

8 “(D) DEFINITIONS.—For purposes of this
9 paragraph:

10 “(i) ELIGIBLE PROFESSIONAL; COV-
11 ERED PROFESSIONAL SERVICES.—The
12 terms ‘eligible professional’ and ‘covered
13 professional services’ have the meanings
14 given such terms in subsection (k)(3).

15 “(ii) PHYSICIAN REPORTING SYS-
16 TEM.—The term ‘physician reporting sys-
17 tem’ means the system established under
18 subsection (k).

19 “(iii) REPORTING PERIOD.—The term
20 ‘reporting period’ means, with respect to a
21 year, a period specified by the Secretary.”.

1 **SEC. 133. INCREASING THE NUMBER OF SITES FOR THE**
2 **ELECTRONIC HEALTH RECORDS DEM-**
3 **ONSTRATION.**

4 Out of funds in the Treasury not otherwise appro-
5 priated, there are appropriated for the period of fiscal
6 years 2009 through 2014, \$45,000,000 to the Centers for
7 Medicare & Medicaid Services Program Management Ac-
8 count for administrative costs to increase the number of
9 sites, up to 40, in which the Electronic Health Records
10 Demonstration is being conducted.

11 **SEC. 134. PRIMARY CARE IMPROVEMENTS.**

12 (a) INCENTIVE PAYMENT PROGRAM FOR PRIMARY
13 CARE SERVICES FURNISHED IN PHYSICIAN SCARCITY
14 AREAS.—

15 (1) IN GENERAL.—Section 1833 of the Social
16 Security Act (42 U.S.C. 1395l) is amended by add-
17 ing at the end the following new subsection:

18 “(v) INCENTIVE PAYMENTS FOR PRIMARY CARE
19 SERVICES FURNISHED IN PHYSICIAN SCARCITY AREAS.—

20 “(1) IN GENERAL.—In the case of primary care
21 services furnished on or after January 1, 2011, by
22 a primary care physician in a primary care scarcity
23 county, in addition to the amount of payment that
24 would otherwise be made for such services under this
25 part, there also shall be paid (on a monthly or quar-

1 terly basis) an amount equal to 5 percent of the pay-
2 ment amount for the service under this part.

3 “(2) DEFINITIONS.—In this subsection:

4 “(A) PRIMARY CARE PHYSICIAN.—The
5 term ‘primary care physician’ means a physi-
6 cian (as described in section 1861(r)(1)) for
7 whom primary care services accounted for at
8 least a specified percent (as determined by the
9 Secretary) of the allowed charges under this
10 part for such physician in a prior period as de-
11 termined appropriate by the Secretary.

12 “(B) PRIMARY CARE SCARCITY COUNTY.—
13 The term ‘primary care scarcity county’ means
14 the primary care scarcity counties that the Sec-
15 retary was using under subsection (u) with re-
16 spect to physicians’ services furnished on De-
17 cember 31, 2007.

18 “(C) PRIMARY CARE SERVICES.—The term
19 ‘primary care services’ means procedure codes
20 for services in the category of the Healthcare
21 Common Procedure Coding System, as estab-
22 lished by the Secretary under section
23 1848(c)(5) (as of December 31, 2008 and as
24 subsequently modified by the Secretary) con-
25 sisting of evaluation and management services,

1 but limited to such procedure codes in the cat-
 2 egory of office or other outpatient services, and
 3 consisting of subcategories of such procedure
 4 codes for services for both new and established
 5 patients.

6 “(3) JUDICIAL REVIEW.—There shall be no ad-
 7 ministrative or judicial review under section 1869,
 8 1878, or otherwise, respecting the identification of
 9 primary care physicians, primary care specialty
 10 areas, or primary care services under this sub-
 11 section.”.

12 (2) CONFORMING AMENDMENT.—Section
 13 1834(g)(2)(B) of the Social Security Act (42 U.S.C.
 14 1395m(g)(2)(B)) is amended by adding at the end
 15 the following sentence: “Section 1833(v) shall not be
 16 taken into account in determining the amounts that
 17 would otherwise be paid pursuant to the preceding
 18 sentence.”.

19 (b) REVISIONS TO THE MEDICARE MEDICAL HOME
 20 DEMONSTRATION PROJECT.—

21 (1) AUTHORITY TO EXPAND.—Section 204(b)
 22 of division B of the Tax Relief and Health Care Act
 23 of 2006 (42 U.S.C. 1395b–1 note) is amended—

1 (A) in paragraph (1), by striking “The
2 project” and inserting “Subject to paragraph
3 (3), the project”; and

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

6 “(3) EXPANSION.—The Secretary may expand
7 the duration and the scope of the project under
8 paragraph (1), to an extent determined appropriate
9 by the Secretary, if the Secretary determines that
10 such expansion will result in any of the following
11 conditions being met:

12 “(A) The expansion of the project is ex-
13 pected to improve the quality of patient care
14 without increasing spending under the Medicare
15 program (not taking into account amounts
16 available under subsection (g)).

17 “(B) The expansion of the project is ex-
18 pected to reduce spending under the Medicare
19 program (not taking into account amounts
20 available under subsection (g)) without reducing
21 the quality of patient care.”.

22 (2) FUNDING AND APPLICATION.—Section 204
23 of division B of the Tax Relief and Health Care Act
24 of 2006 (42 U.S.C. 1395b–1 note) is amended by
25 adding at the end the following new subsections:

1 “(g) FUNDING FROM SMI TRUST FUND.—There
 2 shall be available, from the Federal Supplementary Med-
 3 ical Insurance Trust Fund (under section 1841 of the So-
 4 cial Security Act (42 U.S.C. 1395t)), the amount of
 5 \$100,000,000 to carry out the project.

6 “(h) APPLICATION.—Chapter 35 of title 44, United
 7 States Code, shall not apply to the conduct of the
 8 project.”.

9 (c) APPLICATION OF BUDGET-NEUTRALITY ADJUS-
 10 TOR TO CONVERSION FACTOR.—Section 1848(c)(2)(B) of
 11 the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)) is
 12 amended by adding at the end the following new clause:

13 “(vi) ALTERNATIVE APPLICATION OF
 14 BUDGET-NEUTRALITY ADJUSTMENT.—Not-
 15 withstanding subsection (d)(9)(A), effective
 16 for fee schedules established beginning
 17 with 2009, with respect to the 5-year re-
 18 view of work relative value units used in
 19 fee schedules for 2007 and 2008, in lieu of
 20 continuing to apply budget-neutrality ad-
 21 justments required under clause (ii) for
 22 2007 and 2008 to work relative value
 23 units, the Secretary shall apply such budg-
 24 et-neutrality adjustments to the conversion

1 factor otherwise determined for years be-
2 ginning with 2009.”.

3 **SEC. 135. MEDICARE ANESTHESIA TEACHING PROGRAM IM-**
4 **PROVEMENTS.**

5 (a) SPECIAL PAYMENT RULE FOR TEACHING ANES-
6 THESIOLOGISTS.—Section 1848(a) of the Social Security
7 Act (42 U.S.C. 1395w-4(a)), as amended by section
8 132(b), is amended—

9 (1) in paragraph (4)(A), by inserting “except as
10 provided in paragraph (5),” after “anesthesia
11 cases,”; and

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

14 “(6) SPECIAL RULE FOR TEACHING ANESTHE-
15 SIOLOGISTS.—With respect to physicians’ services
16 furnished on or after January 1, 2010, in the case
17 of teaching anesthesiologists involved in the training
18 of physician residents in a single anesthesia case or
19 two concurrent anesthesia cases, the fee schedule
20 amount to be applied shall be 100 percent of the fee
21 schedule amount otherwise applicable under this sec-
22 tion if the anesthesia services were personally per-
23 formed by the teaching anesthesiologist alone and
24 paragraph (4) shall not apply if—

1 “(A) the teaching anesthesiologist is
 2 present during all critical or key portions of the
 3 anesthesia service or procedure involved; and

4 “(B) the teaching anesthesiologist (or an-
 5 other anesthesiologist with whom the teaching
 6 anesthesiologist has entered into an arrange-
 7 ment) is immediately available to furnish anes-
 8 thesia services during the entire procedure.”.

9 (b) TREATMENT OF CERTIFIED REGISTERED NURSE
 10 ANESTHETISTS.—With respect to items and services fur-
 11 nished on or after January 1, 2010, the Secretary of
 12 Health and Human Services shall make appropriate ad-
 13 justments to payments under the Medicare program under
 14 title XVIII of the Social Security Act for teaching certified
 15 registered nurse anesthetists to implement a policy with
 16 respect to teaching certified registered nurse anesthetists
 17 that—

18 (1) is consistent with the adjustments made by
 19 the special rule for teaching anesthesiologists under
 20 section 1848(a)(6) of the Social Security Act, as
 21 added by subsection (a); and

22 (2) maintains the existing payment differences
 23 between teaching anesthesiologists and teaching cer-
 24 tified registered nurse anesthetists.

1 **SEC. 136. MEDICARE COORDINATED CARE PRACTICE RE-**
2 **SEARCH NETWORK DEMONSTRATION.**

3 (a) DEMONSTRATION PROGRAM.—

4 (1) IN GENERAL.—Not later than October 1,
5 2009, the Secretary shall establish a demonstration
6 program to test best practices and new and innova-
7 tive coordinated care projects for Medicare bene-
8 ficiaries with multiple chronic conditions.

9 (2) DEMONSTRATION PROGRAM DESIGN.—

10 (A) INITIAL SITES.—The Secretary shall
11 select not less than 8 organizations to partici-
12 pate in the demonstration program under this
13 section initially. The organizations selected
14 under this subparagraph shall meet the fol-
15 lowing requirements:

16 (i) The organizations are highly quali-
17 fied direct providers of coordinated care to
18 Medicare beneficiaries with multiple chron-
19 ic conditions.

20 (ii) The organizations were partici-
21 pants in the Medicare Coordinated Care
22 Demonstration under section 4016 of the
23 Balanced Budget Act of 1997 (42 U.S.C.
24 1395b–1 note) as of October 1, 2007.

25 (B) ADDITIONAL SITES.—The Secretary
26 may select organizations to participate in the

demonstration program under this section in addition to those initially selected under subparagraph (A). The organizations selected under this subparagraph shall meet the following requirements:

(i) The organizations are highly qualified direct providers of coordinated care to Medicare beneficiaries with multiple chronic conditions.

(ii) The organizations meet such other criteria as the Secretary determines appropriate.

(3) DURATION.—

(A) IN GENERAL.—Subject to subparagraph (B), the demonstration program under this section shall be conducted for a 5-year period.

(B) EXPANSION OF DEMONSTRATION PROGRAM; IMPLEMENTATION OF DEMONSTRATION PROGRAM RESULTS.—

(i) EXPANSION OF DEMONSTRATION PROGRAM.—If the report under paragraph (5) contains an evaluation that the demonstration program under this section—

1 (I) reduces expenditures under
2 the Medicare program; or

3 (II) does not increase expendi-
4 tures under the Medicare program
5 and increases the quality of health
6 care services provided to Medicare
7 beneficiaries with multiple chronic
8 conditions and satisfaction of bene-
9 ficiaries and health care providers;
10 the Secretary shall continue the existing
11 demonstration program and may expand
12 the demonstration program.

13 (ii) IMPLEMENTATION OF DEM-
14 ONSTRATION PROGRAM RESULTS.—If the
15 report under paragraph (5) contains an
16 evaluation described in clause (i), the Sec-
17 retary may issue regulations to implement,
18 on a permanent basis, the components of
19 the demonstration program that are bene-
20 ficial to the Medicare program.

21 (4) USE OF CONTRACTOR TO FACILITATE COM-
22 MUNICATION AND INFORMATION SHARING.—

23 (A) IN GENERAL.—Under the demonstra-
24 tion program under this section, the Secretary
25 shall enter into a contract with a contractor to

1 facilitate communications and data analysis
2 among sites participating in the demonstration
3 program and to share information on best prac-
4 tices with such sites.

5 (B) DUTIES.—The contractor shall have
6 such duties and responsibilities as are specified
7 by the Secretary, including ensuring, to the ex-
8 tent feasible, that each site participating in the
9 demonstration program under this section re-
10 ceives timely and regular access to data from
11 the other sites participating in the demonstra-
12 tion program to enable each site to modify, re-
13 fine, and evaluate current and proposed chronic
14 care interventions and new models of care.

15 (b) EVALUATION AND REPORT.—Not later than 4
16 years after the establishment of the demonstration pro-
17 gram under this section, the Secretary shall submit a re-
18 port to Congress on the Medicare chronic care practice
19 research network based on an evaluation of the dem-
20 onstration program. Such report shall include an evalua-
21 tion of the effectiveness of each site participating in the
22 demonstration program, including the following:

23 (1) An analysis of progress made under the
24 demonstration program toward developing an effi-
25 cient and effective research infrastructure capable of

1 robustly testing new interventions and models of
2 care for Medicare beneficiaries with multiple chronic
3 conditions in a timely manner.

4 (2) An evaluation of the impacts of the care co-
5 ordination models used by each site participating in
6 the demonstration program, including the overall
7 quality of care provided, patient satisfaction, and
8 cost-effectiveness of the interventions tested under
9 the demonstration program at each site.

10 (3) An evaluation of the capability of the dem-
11 onstration program to define and test specifications
12 needed to deploy successful interventions on a large
13 geographic or nationwide scale without loss of effec-
14 tiveness.

15 (4) A description of any benefits to the Medi-
16 care program under title XVIII of the Social Secu-
17 rity Act resulting from increased collaboration and
18 partnership between participating sites under the
19 demonstration program.

20 (5) Any other information regarding the dem-
21 onstration program that the Secretary determines
22 appropriate.

23 (6) Recommendations for practices and guide-
24 lines for chronic care, including a summary of the
25 care models found to be most effective in managing

1 Medicare beneficiaries with multiple chronic condi-
2 tions under the demonstration program under this
3 subsection.

4 (7) Recommendations for such legislation and
5 administrative action as the Secretary determines
6 appropriate.

7 (c) FUNDING.—

8 (1) IMPLEMENTATION FUNDING.—The Sec-
9 retary shall provide for the transfer from the Fed-
10 eral Hospital Insurance Trust Fund under section
11 1817 of the Social Security Act (42 U.S.C. 1395i)
12 and the Federal Supplementary Medical Insurance
13 Trust Fund under section 1841 of such Act (42
14 U.S.C. 1395t), in such proportion as the Secretary
15 determines to be appropriate, of \$15,000,000 to the
16 Centers for Medicare & Medicaid Services Program
17 Management Account to implement the demonstra-
18 tion program under this section.

19 (2) ADDITIONAL FUNDING.—

20 (A) IN GENERAL.—In addition to the im-
21 plementation funding under paragraph (1), the
22 Secretary shall provide for the transfer from
23 the Federal Hospital Insurance Trust Fund
24 under section 1817 of the Social Security Act
25 (42 U.S.C. 1395i) and the Federal Supple-

mentary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines to be appropriate, of such funds as are necessary to the Centers for Medicare & Medicaid Services Program Management Account to carry out the demonstration program under this section.

(B) LIMITATION.—Except with respect to the implementation funding under paragraph (1), in conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary estimates would have been paid if the demonstration program under this section were not implemented.

(d) WAIVER.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to carry out this section.

SEC. 137. IMAGING PROVISIONS.

(a) ACCREDITATION REQUIREMENT.—

(1) ACCREDITATION REQUIREMENT.—Section 1834 of the Social Security Act (42 U.S.C. 1395m)

1 is amended by inserting after subsection (d) the fol-
2 lowing new subsection:

3 “(e) ACCREDITATION REQUIREMENT FOR ADVANCED
4 DIAGNOSTIC IMAGING SERVICES.—

5 “(1) IN GENERAL.—

6 “(A) IN GENERAL.—Beginning with Janu-
7 ary 1, 2012, with respect to the technical com-
8 ponent of advanced diagnostic imaging services
9 for which payment is made under the fee sched-
10 ule established under section 1848(b) and that
11 are furnished by a supplier, payment may only
12 be made if such supplier is accredited by an ac-
13 creditation organization designated by the Sec-
14 retary under paragraph (2)(B)(i).

15 “(B) ADVANCED DIAGNOSTIC IMAGING
16 SERVICES DEFINED.—In this subsection, the
17 term ‘advanced diagnostic imaging services’ in-
18 cludes diagnostic magnetic resonance imaging,
19 computed tomography, nuclear medicine (in-
20 cluding positron emission tomography), and
21 such other diagnostic imaging services described
22 in section 1848(b)(4)(B) (excluding X-ray,
23 ultrasound, and fluoroscopy) as specified by the
24 Secretary, in consultation with physician spe-
25 cialty organizations and other stakeholders.

1 “(C) SUPPLIER DEFINED.—In this sub-
2 section, the term ‘supplier’ has the meaning
3 given such term in section 1861(d).

4 “(2) ACCREDITATION ORGANIZATIONS.—

5 “(A) FACTORS FOR DESIGNATION OF AC-
6 CREDITATION ORGANIZATIONS.—The Secretary
7 shall consider the following factors in desig-
8 nating accreditation organizations under sub-
9 paragraph (B)(i) and in reviewing and modi-
10 fying the list of accreditation organizations des-
11 ignated pursuant to subparagraph (C):

12 “(i) The ability of the organization to
13 conduct timely reviews of accreditation ap-
14 plications.

15 “(ii) Whether the organization has es-
16 tablished a process for the timely integra-
17 tion of new advanced diagnostic imaging
18 services into the organization’s accredita-
19 tion program.

20 “(iii) Whether the organization uses
21 random site visits, site audits, or other
22 strategies for ensuring accredited suppliers
23 maintain adherence to the criteria de-
24 scribed in paragraph (3).

1 “(iv) The ability of the organization
2 to take into account the capacities of sup-
3 pliers located in a rural area (as defined in
4 section 1886(d)(2)(D)).

5 “(v) Whether the organization has es-
6 tablished reasonable fees to be charged to
7 suppliers applying for accreditation.

8 “(vi) Such other factors as the Sec-
9 retary determines appropriate.

10 “(B) DESIGNATION.—Not later than Janu-
11 ary 1, 2010, the Secretary shall designate orga-
12 nizations to accredit suppliers furnishing the
13 technical component of advanced diagnostic im-
14 aging services. The list of accreditation organi-
15 zations so designated may be modified pursuant
16 to subparagraph (C).

17 “(C) REVIEW AND MODIFICATION OF LIST
18 OF ACCREDITATION ORGANIZATIONS.—

19 “(i) IN GENERAL.—The Secretary
20 shall review the list of accreditation organi-
21 zations designated under subparagraph (B)
22 taking into account the factors under sub-
23 paragraph (A). Taking into account the re-
24 sults of such review, the Secretary may, by
25 regulation, modify the list of accreditation

1 organizations designated under subpara-
2 graph (B).

3 “(ii) SPECIAL RULE FOR ACCREDITA-
4 TIONS DONE PRIOR TO REMOVAL FROM
5 LIST OF DESIGNATED ACCREDITATION OR-
6 GANIZATIONS.—In the case where the Sec-
7 retary removes an organization from the
8 list of accreditation organizations des-
9 ignated under subparagraph (B), any sup-
10 plier that is accredited by the organization
11 during the period beginning on the date on
12 which the organization is designated as an
13 accreditation organization under subpara-
14 graph (B) and ending on the date on
15 which the organization is removed from
16 such list shall be considered to have been
17 accredited by an organization designated
18 by the Secretary under subparagraph (B)
19 for the remaining period such accreditation
20 is in effect.

21 “(3) CRITERIA FOR ACCREDITATION.—The Sec-
22 retary shall establish procedures to ensure that the
23 criteria used by an accreditation organization des-
24 ignated under paragraph (2)(B) to evaluate a sup-
25 plier that furnishes the technical component of ad-

1 vanced diagnostic imaging services for the purpose
2 of accreditation of such supplier is specific to each
3 imaging modality. Such criteria shall include—

4 “(A) standards for qualifications of med-
5 ical personnel who are not physicians and who
6 furnish the technical component of advanced di-
7 agnostic imaging services;

8 “(B) standards for qualifications and re-
9 sponsibilities of medical directors and super-
10 vising physicians, including standards that rec-
11 ognize the considerations described in para-
12 graph (4);

13 “(C) procedures to ensure that equipment
14 used in furnishing the technical component of
15 advanced diagnostic imaging services meets per-
16 formance specifications;

17 “(D) standards that require the supplier
18 have procedures in place to ensure the safety of
19 persons who furnish the technical component of
20 advanced diagnostic imaging services and indi-
21 viduals to whom such services are furnished;

22 “(E) standards that require the establish-
23 ment and maintenance of a quality assurance
24 and quality control program by the supplier
25 that is adequate and appropriate to ensure the

1 reliability, clarity, and accuracy of the technical
 2 quality of diagnostic images produced by such
 3 supplier; and

4 “(F) any other standards or procedures
 5 the Secretary determines appropriate.

6 “(4) RECOGNITION IN STANDARDS FOR THE
 7 EVALUATION OF MEDICAL DIRECTORS AND SUPER-
 8 VISING PHYSICIANS.—The standards described in
 9 paragraph (3)(B) shall recognize whether a medical
 10 director or supervising physician—

11 “(A) in a particular specialty receives
 12 training in advanced diagnostic imaging serv-
 13 ices in a residency program;

14 “(B) has attained, through experience, the
 15 necessary expertise to be a medical director or
 16 a supervising physician;

17 “(C) has completed any continuing medical
 18 education courses relating to such services; or

19 “(D) has met such other standards as the
 20 Secretary determines appropriate.

21 “(5) RULE FOR ACCREDITATIONS MADE PRIOR
 22 TO DESIGNATION.—In the case of a supplier that is
 23 accredited before January 1, 2010, by an accredita-
 24 tion organization designated by the Secretary under
 25 paragraph (2)(B) as of January 1, 2010, such sup-

plier shall be considered to have been accredited by an organization designated by the Secretary under such paragraph as of January 1, 2012, for the remaining period such accreditation is in effect.”.

(2) CONFORMING AMENDMENTS.—

(A) IN GENERAL.—Section 1862(a) of the Social Security Act (42 U.S.C. 1395y(a)) is amended—

(i) in paragraph (21), by striking “or” at the end;

(ii) in paragraph (22), by striking the period at the end and inserting “; or”; and

(iii) by inserting after paragraph (22) the following new paragraph:

“(23) which are the technical component of advanced diagnostic imaging services described in section 1834(e)(1)(B) for which payment is made under the fee schedule established under section 1848(b) and that are furnished by a supplier (as defined in section 1861(d)), if such supplier is not accredited by an accreditation organization designated by the Secretary under section 1834(e)(2)(B).”.

(B) EFFECTIVE DATE.—The amendments made by this paragraph shall apply to advanced

1 diagnostic imaging services furnished on or
2 after January 1, 2012.

3 (b) DEMONSTRATION PROJECT TO ASSESS THE AP-
4 PROPRIATE USE OF IMAGING SERVICES.—

5 (1) CONDUCT OF DEMONSTRATION PROJECT.—

6 (A) IN GENERAL.—The Secretary of
7 Health and Human Services (in this section re-
8 ferred to as the “Secretary”) shall conduct a
9 demonstration project using the models de-
10 scribed in paragraph (2)(E) to collect data re-
11 garding physician compliance with appropriate-
12 ness criteria selected under paragraph (2)(D) in
13 order to determine the appropriateness of ad-
14 vanced diagnostic imaging services furnished to
15 Medicare beneficiaries.

16 (B) ADVANCED DIAGNOSTIC IMAGING
17 SERVICES.—In this subsection, the term “ad-
18 vanced diagnostic imaging services” has the
19 meaning given such term in section
20 1834(e)(1)(B) of the Social Security Act, as
21 added by subsection (a).

22 (C) AUTHORITY TO FOCUS DEMONSTRA-
23 TION PROJECT.—The Secretary may focus the
24 demonstration project with respect to certain
25 advanced diagnostic imaging services, such as

1 services that account for a large amount of ex-
2 penditures under the Medicare program, serv-
3 ices that have recently experienced a high rate
4 of growth, or services for which appropriateness
5 criteria exists.

6 (2) IMPLEMENTATION AND DESIGN OF DEM-
7 ONSTRATION PROJECT.—

8 (A) IMPLEMENTATION AND DURATION.—

9 (i) IMPLEMENTATION.—The Secretary
10 shall implement the demonstration project
11 under this subsection not later than Janu-
12 ary 1, 2010.

13 (ii) DURATION.—The Secretary shall
14 conduct the demonstration project under
15 this subsection for a 2-year period.

16 (B) APPLICATION AND SELECTION OF PAR-
17 TICIPATING PHYSICIANS.—

18 (i) APPLICATION.—Each physician
19 that desires to participate in the dem-
20 onstration project under this subsection
21 shall submit an application to the Sec-
22 retary at such time, in such manner, and
23 containing such information as the Sec-
24 retary may require.

1 (ii) SELECTION.—The Secretary shall
2 select physicians to participate in the dem-
3 onstration project under this subsection
4 from among physicians submitting applica-
5 tions under clause (i). The Secretary shall
6 ensure that the physicians selected—

7 (I) represent a wide range of geo-
8 graphic areas, demographic character-
9 istics (such as urban, rural, and sub-
10 urban), and practice settings (such as
11 private and academic practices); and

12 (II) have the capability to submit
13 data to the Secretary (or an entity
14 under a subcontract with the Sec-
15 retary) in an electronic format in ac-
16 cordance with standards established
17 by the Secretary.

18 (C) ADMINISTRATIVE COSTS AND INCEN-
19 TIVES.—The Secretary shall—

20 (i) reimburse physicians for reason-
21 able administrative costs incurred in par-
22 ticipating in the demonstration project
23 under this subsection; and

24 (ii) provide reasonable incentives to
25 physicians to encourage participation in

1 the demonstration project under this sub-
2 section.

3 (D) USE OF APPROPRIATENESS CRI-
4 TERIA.—

5 (i) IN GENERAL.—The Secretary, in
6 consultation with medical specialty soci-
7 eties and other stakeholders, shall select
8 criteria with respect to the clinical appro-
9 priateness of advanced diagnostic imaging
10 services for use in the demonstration
11 project under this subsection.

12 (ii) CRITERIA SELECTED.—Any cri-
13 teria selected under clause (i) shall—

14 (I) be developed or endorsed by a
15 medical specialty society; and

16 (II) be developed in adherence to
17 appropriateness principles developed
18 by a consensus organization, such as
19 the AQA alliance.

20 (E) MODELS FOR COLLECTING DATA RE-
21 GARDING PHYSICIAN COMPLIANCE WITH SE-
22 LECTED CRITERIA.—Subject to subparagraph
23 (H), in carrying out the demonstration project
24 under this subsection, the Secretary shall use
25 each of the following models for collecting data

1 regarding physician compliance with appro-
2 priateness criteria selected under subparagraph
3 (D):

4 (i) A model described in subparagraph
5 (F).

6 (ii) A model described in subpara-
7 graph (G).

8 (iii) Any other model that the Sec-
9 retary determines to be useful in evalu-
10 ating the use of appropriateness criteria
11 for advanced diagnostic imaging services.

12 (F) POINT OF SERVICE MODEL DE-
13 SCRIBED.—A model described in this subpara-
14 graph is a model that—

15 (i) uses an electronic or paper intake
16 form that—

17 (I) contains a certification by the
18 physician furnishing the imaging serv-
19 ice that the data on the intake form
20 was confirmed with the Medicare ben-
21 eficiary before the service was fur-
22 nished;

23 (II) contains standardized data
24 elements for diagnosis, service or-
25 dered, service furnished, and such

1 other information determined by the
2 Secretary, in consultation with med-
3 ical specialty societies and other
4 stakeholders, to be germane to evalu-
5 ating the effectiveness of the use of
6 appropriateness criteria selected under
7 subparagraph (D); and

8 (III) is accessible to physicians
9 participating in the demonstration
10 project under this subsection in a for-
11 mat that allows for the electronic sub-
12 mission of such form; and

13 (ii) provides for feedback reports in
14 accordance with paragraph (3)(B).

15 (G) POINT OF ORDER MODEL DE-
16 SCRIBED.—A model described in this subpara-
17 graph is a model that—

18 (i) uses a computerized order-entry
19 system that requires the transmittal of rel-
20 evant supporting information at the time
21 of referral for advanced diagnostic imaging
22 services and provides automated decision-
23 support feedback to the referring physician
24 regarding the appropriateness of fur-
25 nishing such imaging services; and

1 (ii) provides for feedback reports in
2 accordance with paragraph (3)(B).

3 (H) LIMITATION.—In no case may the
4 Secretary use prior authorization—

5 (i) as a model for collecting data re-
6 garding physician compliance with appro-
7 priateness criteria selected under subpara-
8 graph (D) under the demonstration project
9 under this subsection; or

10 (ii) under any model used for col-
11 lecting such data under the demonstration
12 project.

13 (I) REQUIRED CONTRACTS AND PERFORM-
14 ANCE STANDARDS FOR CERTAIN ENTITIES.—

15 (i) IN GENERAL.—The Secretary shall
16 enter into contracts with entities to carry
17 out the model described in subparagraph
18 (G).

19 (ii) PERFORMANCE STANDARDS.—The
20 Secretary shall establish and enforce per-
21 formance standards for such entities under
22 the contracts entered into under clause (i),
23 including performance standards with re-
24 spect to—

1 (I) the satisfaction of Medicare
2 beneficiaries who are furnished ad-
3 vanced diagnostic imaging services by
4 a physician participating in the dem-
5 onstration project;

6 (II) the satisfaction of physicians
7 participating in the demonstration
8 project;

9 (III) if applicable, timelines for
10 the provision of feedback reports
11 under paragraph (3)(B); and

12 (IV) any other areas determined
13 appropriate by the Secretary.

14 (3) COMPARISON OF UTILIZATION OF AD-
15 VANCED DIAGNOSTIC IMAGING SERVICES AND FEED-
16 BACK REPORTS.—

17 (A) COMPARISON OF UTILIZATION OF AD-
18 VANCED DIAGNOSTIC IMAGING SERVICES.—The
19 Secretary shall consult with medical specialty
20 societies and other stakeholders to develop
21 mechanisms for comparing the utilization of ad-
22 vanced diagnostic imaging services by physi-
23 cians participating in the demonstration project
24 under this subsection against—

1 (i) the appropriateness criteria se-
2 lected under paragraph (2)(D); and

3 (ii) to the extent feasible, the utiliza-
4 tion of such services by physicians not par-
5 ticipating in the demonstration project.

6 (B) FEEDBACK REPORTS.—The Secretary
7 shall, in consultation with medical specialty so-
8 cieties and other stakeholders, develop mecha-
9 nisms to provide feedback reports to physicians
10 participating in the demonstration project
11 under this subsection. Such feedback reports
12 shall include—

13 (i) a profile of the rate of compliance
14 by the physician with appropriateness cri-
15 teria selected under paragraph (2)(D), in-
16 cluding a comparison of—

17 (I) the rate of compliance by the
18 physician with such criteria; and

19 (II) the rate of compliance by the
20 physician's peers (as defined by the
21 Secretary) with such criteria; and

22 (ii) to the extent feasible, a compari-
23 son of—

1 (I) the rate of utilization of ad-
2 vanced diagnostic imaging services by
3 the physician; and

4 (II) the rate of utilization of such
5 services by the physician's peers (as
6 defined by the Secretary) who are not
7 participating in the demonstration
8 project.

9 (4) CONDUCT OF DEMONSTRATION PROJECT
10 AND WAIVER.—

11 (A) CONDUCT OF DEMONSTRATION
12 PROJECT.—Chapter 35 of title 44, United
13 States Code, shall not apply to the conduct of
14 the demonstration project under this sub-
15 section.

16 (B) WAIVER.—The Secretary may waive
17 such provisions of titles XI and XVIII of the
18 Social Security Act (42 U.S.C. 1301 et seq.;
19 1395 et seq.) as may be necessary to carry out
20 the demonstration project under this sub-
21 section.

22 (5) EVALUATION AND REPORT.—

23 (A) EVALUATION.—The Secretary shall
24 evaluate the demonstration project under this
25 subsection to—

1 (i) assess the timeliness and efficacy
2 of the demonstration project;

3 (ii) assess the performance of entities
4 under a contract entered into under para-
5 graph (2)(I)(i);

6 (iii) analyze data—

7 (I) on the rates of appropriate,
8 uncertain, and inappropriate advanced
9 diagnostic imaging services furnished
10 by physicians participating in the
11 demonstration project;

12 (II) on patterns and trends in
13 the appropriateness and inappropri-
14 ateness of such services furnished by
15 such physicians;

16 (III) on patterns and trends in
17 national and regional variations of
18 care with respect to the furnishing of
19 such services; and

20 (IV) on the correlation between
21 the appropriateness of the services
22 furnished and image results; and

23 (iv) address—

24 (I) the thresholds used under the
25 demonstration project to identify ac-

1 ceptable and outlier levels of perform-
2 ance with respect to the appropriate-
3 ness of advanced diagnostic imaging
4 services furnished;

5 (II) whether prospective use of
6 appropriateness criteria could have an
7 effect on the volume of such services
8 furnished;

9 (III) whether expansion of the
10 use of appropriateness criteria with
11 respect to such services to a broader
12 population of Medicare beneficiaries
13 would be advisable;

14 (IV) whether, under such an ex-
15 pansion, physicians who demonstrate
16 consistent compliance with such ap-
17 propriateness criteria should be ex-
18 empted from certain requirements;

19 (V) the use of incident-specific
20 versus practice-specific outlier infor-
21 mation in formulating future rec-
22 ommendations with respect to the use
23 of appropriateness criteria for such
24 services under the Medicare program;
25 and

1 (VI) the potential for using
2 methods (including financial incen-
3 tives), in addition to those used under
4 the models under the demonstration
5 project, to ensure compliance with
6 such criteria.

7 (B) REPORT.—Not later than 1 year after
8 the completion of the demonstration project
9 under this subsection, the Secretary shall sub-
10 mit to Congress a report containing the results
11 of the evaluation of the demonstration project
12 conducted under subparagraph (A), together
13 with recommendations for such legislation and
14 administrative action as the Secretary deter-
15 mines appropriate.

16 (6) FUNDING.—The Secretary shall provide for
17 the transfer from the Federal Supplementary Med-
18 ical Insurance Trust Fund established under section
19 1841 of the Social Security Act (42 U.S.C. 1395t)
20 of \$10,000,000, for carrying out the demonstration
21 project under this subsection (including costs associ-
22 ated with administering the demonstration project,
23 reimbursing physicians for administrative costs and
24 providing incentives to encourage participation under
25 paragraph (2)(C), entering into contracts under

1 paragraph (2)(I), and evaluating the demonstration
 2 project under paragraph (5)).

3 (c) DISCLOSURE REQUIREMENT FOR PHYSICIANS
 4 REFERRING FOR IMAGING SERVICES.—

5 (1) IN GENERAL.—Section 1877(b)(2) of the
 6 Social Security Act (42 U.S.C. 1395nn(b)(2)) is
 7 amended by adding at the end the following new
 8 sentence: “Such requirements shall, with respect to
 9 magnetic resonance imaging, computed tomography,
 10 positron emission tomography, and any other des-
 11 ignated health services specified under subsection
 12 (h)(6)(D) that the Secretary determines appropriate,
 13 include a requirement that the referring physician
 14 inform the individual in writing at the time of the
 15 referral that the individual may obtain the services
 16 for which the individual is being referred from a per-
 17 son other than a person described in subparagraph
 18 (A)(i) and provide such individual with a written list
 19 of suppliers (as defined in section 1861(d)) who fur-
 20 nish such services in the area in which such indi-
 21 vidual resides.”.

22 (2) EFFECTIVE DATE.—The amendment made
 23 by this subsection shall apply to services furnished
 24 on or after January 1, 2010.

1 (d) GAO STUDY AND REPORTS ON ACCREDITATION
2 REQUIREMENT FOR ADVANCED DIAGNOSTIC IMAGING
3 SERVICES.—

4 (1) STUDY.—

5 (A) IN GENERAL.—The Comptroller Gen-
6 eral of the United States (in this subsection re-
7 ferred to as the “Comptroller General”) shall
8 conduct a study, by imaging modality, on—

9 (i) the effect of the accreditation re-
10 quirement under section 1834(e) of the So-
11 cial Security Act, as added by subsection
12 (a); and

13 (ii) any other relevant questions in-
14 volving access to, and the value of, ad-
15 vanced diagnostic imaging services for
16 Medicare beneficiaries.

17 (B) ISSUES.—The study conducted under
18 subparagraph (A) shall examine the following:

19 (i) The impact of such accreditation
20 requirement on the number, type, and
21 quality of imaging services furnished to
22 Medicare beneficiaries.

23 (ii) The cost of such accreditation re-
24 quirement, including costs to facilities of
25 compliance with such requirement and

costs to the Secretary of administering such requirement.

(iii) Access to imaging services by Medicare beneficiaries, especially in rural areas, before and after implementation of such accreditation requirement.

(iv) Such other issues as the Secretary determines appropriate.

(2) REPORTS.—

(A) PRELIMINARY REPORT.—Not later than March 1, 2013, the Comptroller General shall submit a preliminary report to Congress on the study conducted under paragraph (1).

(B) FINAL REPORT.—Not later than March 1, 2014, the Comptroller General shall submit a final report to Congress on the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

**SEC. 138. ACCOMMODATION OF PHYSICIANS ORDERED TO
ACTIVE DUTY IN THE ARMED SERVICES.**

Section 1842(b)(6)(D)(iii) of the Social Security Act (42 U.S.C. 1395u(b)(6)(D)(iii)), as amended by section 116 of the Medicare, Medicaid, and SCHIP Extension Act

1 of 2007 (Public Law 110–173), is amended by striking
 2 “(before July 1, 2008)”.

3 **SEC. 139. EXTENSION OF EXCEPTIONS PROCESS FOR MEDI-**
 4 **CARE THERAPY CAPS.**

5 Section 1833(g)(5) of the Social Security Act (42
 6 U.S.C. 1395l(g)(5)), as amended by section 105 of the
 7 Medicare, Medicaid, and SCHIP Extension Act of 2007
 8 (Public Law 110–173), is amended by striking “June 30,
 9 2008” and inserting “December 31, 2009”.

10 **SEC. 140. SPEECH-LANGUAGE PATHOLOGY SERVICES.**

11 (a) IN GENERAL.—Section 1861(ll) of the Social Se-
 12 curity Act (42 U.S.C. 1395x(ll)) is amended—

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

15 (2) by inserting after paragraph (1) the fol-
 16 lowing new paragraph:

17 “(2) The term ‘outpatient speech-language pathology
 18 services’ has the meaning given the term ‘outpatient phys-
 19 ical therapy services’ in subsection (p), except that in ap-
 20 plying such subsection—

21 “(A) ‘speech-language pathology’ shall be sub-
 22 stituted for ‘physical therapy’ each place it appears;
 23 and

1 “(B) ‘speech-language pathologist’ shall be sub-
 2 stituted for ‘physical therapist’ each place it ap-
 3 pears.”.

4 (b) CONFORMING AMENDMENTS.—

5 (1) Section 1832(a)(2)(C) of the Social Security
 6 Act (42 U.S.C. 1395k(a)(2)(C)) is amended—

7 (A) by striking “and outpatient” and in-
 8 serting “, outpatient”; and

9 (B) by inserting before the semicolon at
 10 the end the following: “, and outpatient speech-
 11 language pathology services (other than services
 12 to which the second sentence of section 1861(p)
 13 applies through the application of section
 14 1861(l)(2))”.

15 (2) Subparagraphs (A) and (B) of section
 16 1833(a)(8) of such Act (42 U.S.C. 1395l(a)(8)) are
 17 each amended by striking “(which includes out-
 18 patient speech-language pathology services)” and in-
 19 serting “, outpatient speech-language pathology
 20 services,”.

21 (3) Section 1833(g)(1) of such Act (42 U.S.C.
 22 1395l(g)(1)) is amended—

23 (A) by inserting “and speech-language pa-
 24 thology services of the type described in such

1 section through the application of section
2 1861(ll)(2)” after “1861(p)”;

3 (B) by inserting “and speech-language pa-
4 thology services” after “and physical therapy
5 services”.

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

8 (A) by striking “section 1861(g)” and in-
9 serting “subsection (g) or (ll)(2) of section
10 1861” each place it appears; and

11 (B) by inserting “or outpatient speech-lan-
12 guage pathology services, respectively” after
13 “occupational therapy services”.

14 (5) Section 1861(p) of such Act (42 U.S.C.
15 1395x(p)) is amended by striking the fourth sen-
16 tence.

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

21 (7) Section 1862(a)(20) of such Act (42 U.S.C.
22 1395y(a)(20)) is amended—

23 (A) by striking “outpatient occupational
24 therapy services or outpatient physical therapy
25 services” and inserting “outpatient physical

1 therapy services, outpatient speech-language pa-
2 thology services, or outpatient occupational
3 therapy services”; and

4 (B) by striking “section 1861(g)” and in-
5 serting “subsection (g) or (ll)(2) of section
6 1861”.

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

9 (A) by striking “section 1861(g)” and in-
10 serting “subsection (g) or (ll)(2) of section
11 1861” the first two places it appears;

12 (B) by striking “defined) or” and inserting
13 “defined),”; and

14 (C) by inserting before the semicolon at
15 the end the following: “, or (through the oper-
16 ation of section 1861(ll)(2)) with respect to the
17 furnishing of outpatient speech-language pa-
18 thology”.

19 (9) Section 1877(h)(6) of such Act (42 U.S.C.
20 1395nn(h)(6)) is amended by adding at the end the
21 following new subparagraph:

22 “(L) Outpatient speech-language pathology
23 services.”.

1 (c) EFFECTIVE DATE.—The amendments made by
 2 this section shall apply to services furnished on or after
 3 January 1, 2009.

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. 141. COVERAGE OF ITEMS AND SERVICES UNDER A**
 11 **CARDIAC REHABILITATION PROGRAM AND A**
 12 **PULMONARY REHABILITATION PROGRAM.**

13 (a) IN GENERAL.—Section 1861 of the Social Secu-
 14 rity Act (42 U.S.C. 1395x), as amended by section 114
 15 of the Medicare, Medicaid, and SCHIP Extension Act of
 16 2007 (Public Law 110–171), is amended—

17 (1) in subsection (s)(2)—

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

20 (B) in subparagraph (AA), by striking the
 21 period at the end and inserting “; and”; and

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

24 “(BB) items and services furnished under
 25 a cardiac rehabilitation program (as defined in

1 subsection (ddd)) or under a pulmonary reha-
 2 bilitation program (as defined in subsection
 3 (eee)).”; and

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

6 “Cardiac Rehabilitation Program

7 “(ddd)(1) The term ‘cardiac rehabilitation program’
 8 means a physician-supervised program (as described in
 9 paragraph (2)) that furnishes the items and services de-
 10 scribed in paragraph (3).

11 “(2) A program described in this paragraph is a pro-
 12 gram under which—

13 “(A) items and services under the program are
 14 delivered—

15 “(i) in a physician’s office;

16 “(ii) in a physician-directed clinic; or

17 “(iii) in a hospital on an outpatient basis;

18 “(B) a physician is immediately available and
 19 accessible for medical consultation and medical
 20 emergencies at all times items and services are being
 21 furnished under the program, except that, in the
 22 case of items and services furnished under such a
 23 program in a hospital, such availability shall be pre-
 24 sumed; and

1 “(C) individualized treatment is furnished
2 under a written plan established, reviewed, and
3 signed by a physician every 30 days that describes—

4 “(i) the individual’s diagnosis;

5 “(ii) the type, amount, frequency, and du-
6 ration of the items and services furnished under
7 the plan; and

8 “(iii) the goals set for the individual under
9 the plan.

10 “(3) The items and services described in this para-
11 graph are—

12 “(A) physician-prescribed exercise;

13 “(B) cardiac risk factor modification, including
14 education, counseling, and behavioral intervention
15 (to the extent such education, counseling, and behav-
16 ioral intervention is closely related to the individual’s
17 care and treatment and is tailored to the individual’s
18 needs);

19 “(C) psychosocial assessment;

20 “(D) outcomes assessment; and

21 “(E) such other items and services as the Sec-
22 retary may determine, but only if such items and
23 services are—

1 “(i) reasonable and necessary for the diag-
 2 nosis or active treatment of the individual’s
 3 condition;

4 “(ii) reasonably expected to improve or
 5 maintain the individual’s condition and func-
 6 tional level; and

7 “(iii) furnished under such guidelines re-
 8 lating to the frequency and duration of such
 9 items and services as the Secretary shall estab-
 10 lish, taking into account accepted norms of
 11 medical practice and the reasonable expectation
 12 of improvement of the individual.

13 “(4) The Secretary shall establish standards to en-
 14 sure that a physician with expertise in the management
 15 of individuals with cardiac pathophysiology who is licensed
 16 to practice medicine in the State in which a cardiac reha-
 17 bilitation program is offered—

18 “(A) is responsible for such program; and

19 “(B) in consultation with appropriate staff, is
 20 involved substantially in directing the progress of in-
 21 dividual patients in the program.

22 “Pulmonary Rehabilitation Program

23 “(eee)(1) The term ‘pulmonary rehabilitation pro-
 24 gram’ means a physician-supervised program (as de-
 25 scribed in subsection (ddd)(2) with respect to a program

1 under this subsection) that furnishes the items and serv-
2 ices described in paragraph (2).

3 “(2) The items and services described in this para-
4 graph are—

5 “(A) physician-prescribed exercise;

6 “(B) education or training (to the extent the
7 education or training is closely and clearly related to
8 the individual’s care and treatment and is tailored to
9 such individual’s needs);

10 “(C) psychosocial assessment;

11 “(D) outcomes assessment; and

12 “(E) such other items and services as the Sec-
13 retary may determine, but only if such items and
14 services are—

15 “(i) reasonable and necessary for the diag-
16 nosis or active treatment of the individual’s
17 condition;

18 “(ii) reasonably expected to improve or
19 maintain the individual’s condition and func-
20 tional level; and

21 “(iii) furnished under such guidelines re-
22 lating to the frequency and duration of such
23 items and services as the Secretary shall estab-
24 lish, taking into account accepted norms of

1 medical practice and the reasonable expectation
2 of improvement of the individual.

3 “(3) The Secretary shall establish standards to en-
4 sure that a physician with expertise in the management
5 of patients with respiratory pathophysiology who is li-
6 censed to practice medicine in the State in which a pul-
7 monary rehabilitation program is offered—

8 “(A) is responsible for such program; and

9 “(B) in consultation with appropriate staff, is
10 involved substantially in directing the progress of in-
11 dividual patients in the program.”.

12 (b) EFFECTIVE DATE.—The amendments made by
13 this section shall apply to items and services furnished on
14 or after January 1, 2009.

15 **SEC. 142. REPEAL OF TRANSFER OF OWNERSHIP OF OXY-**
16 **GEN EQUIPMENT.**

17 (a) IN GENERAL.—Section 1834(a)(5)(F) of the So-
18 cial Security Act (42 U.S.C. 1395m(a)(5)(F)) is amend-
19 ed—

20 (1) in the heading, by striking “OWNERSHIP OF
21 EQUIPMENT” and inserting “RENTAL CAP”; and

22 (2) by striking clause (ii) and inserting the fol-
23 lowing:

24 “(ii) PAYMENTS AND RULES AFTER
25 RENTAL CAP.—After the 36th continuous

1 month during which payment is made for
2 the equipment under this paragraph—

3 “(I) the supplier furnishing such
4 equipment under this subsection shall
5 continue to furnish the equipment
6 during any period of medical need for
7 the remainder of the reasonable useful
8 lifetime of the equipment, as deter-
9 mined by the Secretary;

10 “(II) payments for oxygen shall
11 continue to be made in the amount
12 recognized for oxygen under para-
13 graph (9) for the period of medical
14 need; and

15 “(III) maintenance and servicing
16 payments shall, if the Secretary deter-
17 mines such payments are reasonable
18 and necessary, be made (for parts and
19 labor not covered by the supplier’s or
20 manufacturer’s warranty, as deter-
21 mined by the Secretary to be appro-
22 priate for the equipment), and such
23 payments shall be in an amount deter-
24 mined to be appropriate by the Sec-
25 retary.”.

1 (b) EFFECTIVE DATE.—The amendments made by
 2 subsection (a) shall take effect on January 1, 2009.

3 **SEC. 143. EXTENSION OF PAYMENT RULE FOR**
 4 **BRACHYTHERAPY AND THERAPEUTIC RADIO-**
 5 **PHARMACEUTICALS.**

6 Section 1833(t)(16)(C) of the Social Security Act (42
 7 U.S.C. 1395l(t)(16)(C)), as amended by section 106 of the
 8 Medicare, Medicaid, and SCHIP Extension Act of 2007
 9 (Public Law 110–173), is amended by striking “July 1,
 10 2008” each place it appears and inserting “January 1,
 11 2010”.

12 **SEC. 144. CLINICAL LABORATORY TESTS.**

13 (a) REPEAL OF MEDICARE COMPETITIVE BIDDING
 14 DEMONSTRATION PROJECT FOR CLINICAL LABORATORY
 15 SERVICES.—

16 (1) IN GENERAL.—Section 1847 of the Social
 17 Security Act (42 U.S.C. 1395w–3) is amended by
 18 striking subsection (e).

19 (2) CONFORMING AMENDMENTS.—Section
 20 1833(a)(1)(D) of the Social Security Act (42 U.S.C.
 21 1395l(a)(1)(D)) is amended—

22 (A) by inserting “or” before “(ii)”; and

23 (B) by striking “or (iii) on the basis” and
 24 all that follows before the comma at the end.

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

4 (b) CLINICAL LABORATORY TEST FEE SCHEDULE
5 UPDATE ADJUSTMENT.—Section 1833(h)(2)(A)(i) of the
6 Social Security Act (42 U.S.C. 1395l(h)(2)(A)(ii)) is
7 amended by inserting “minus, for each of the years 2009
8 through 2013, 0.5 percentage points” after “city aver-
9 age)”.

10 **SEC. 145. SENSE OF THE SENATE ON DELAYED IMPLEMEN-**
11 **TATION OF COMPETITIVE BIDDING FOR DU-**
12 **RABLE MEDICAL EQUIPMENT, PROSTHETICS,**
13 **ORTHOTICS, AND SUPPLIES (DMEPOS).**

14 It is the Sense of the Senate that—

15 (1) the implementation of the durable medical
16 equipment, prosthetics, orthotics, and supplies
17 (DMEPOS) competitive bidding program under sec-
18 tion 1847 of the Social Security Act (42 U.S.C.
19 1395w–3) should be delayed by 18 months in order
20 to review and address ongoing concerns about the
21 bidding process and to ensure continued access to
22 quality medical equipment and supplies for all Medi-
23 care beneficiaries; and

24 (2) such delay should be offset by a reduction
25 in current payment rates for durable medical equip-

1 ment, prosthetics, orthotics, and supplies under the
 2 Medicare program.

3 **Subtitle D—End Stage Renal**
 4 **Disease Program Reforms**

5 **SEC. 151. KIDNEY DISEASE EDUCATION AND AWARENESS**
 6 **PROVISIONS.**

7 (a) CHRONIC KIDNEY DISEASE INITIATIVES.—Part
 8 P of title III of the Public Health Service Act (42 U.S.C.
 9 280g et seq.) is amended by adding at the end the fol-
 10 lowing new section:

11 **“SEC. 399R. CHRONIC KIDNEY DISEASE INITIATIVES.**

12 “(a) IN GENERAL.—The Secretary may establish
 13 pilot projects to—

14 “(1) increase awareness regarding chronic kid-
 15 ney disease, focusing on prevention;

16 “(2) increase screening for chronic kidney dis-
 17 ease, focusing on Medicare beneficiaries at risk of
 18 chronic kidney disease; and

19 “(3) enhance surveillance systems to better as-
 20 sess the prevalence and incidence of chronic kidney
 21 disease.

22 “(b) SCOPE AND DURATION.—

23 “(1) SCOPE.—The Secretary shall select at
 24 least 3 States in which to conduct pilot projects
 25 under this section.

1 “(2) DURATION.—The pilot projects under this
 2 section shall be conducted for a period that is not
 3 longer than 5 years and shall begin on January 1,
 4 2009.

5 “(c) EVALUATION AND REPORT.—The Comptroller
 6 General of the United States shall conduct an evaluation
 7 of the pilot projects conducted under this section. Not
 8 later than 12 months after the date on which the pilot
 9 projects are completed, the Comptroller General shall sub-
 10 mit to Congress a report on the evaluation.”.

11 (b) MEDICARE COVERAGE OF KIDNEY DISEASE PA-
 12 TIENT EDUCATION SERVICES.—

13 (1) COVERAGE OF KIDNEY DISEASE EDUCATION
 14 SERVICES.—

15 (A) COVERAGE.—Section 1861(s)(2) of the
 16 Social Security Act (42 U.S.C. 1395x(s)(2)), as
 17 amended by section 141(a)(1), is amended—

18 (i) in subparagraph (AA), by striking

19 “and” after the semicolon at the end;

20 (ii) in subparagraph (BB), by adding

21 “and” after the semicolon at the end; and

22 (iii) by adding at the end the fol-
 23 lowing new subparagraph:

24 “(CC) kidney disease education services (as de-
 25 fined in subsection (fff));”.

1 (B) SERVICES DESCRIBED.—Section 1861
2 of the Social Security Act (42 U.S.C. 1395x),
3 as amended by section 141(a)(2), is amended
4 by adding at the end the following new sub-
5 section:

6 “Kidney Disease Education Services

7 “(fff)(1) The term ‘kidney disease education services’
8 means educational services that are—

9 “(A) furnished to an individual with stage IV
10 chronic kidney disease who, according to accepted
11 clinical guidelines identified by the Secretary, will re-
12 quire dialysis or a kidney transplant;

13 “(B) furnished, upon the referral of the physi-
14 cian managing the individual’s kidney condition, by
15 a qualified person (as defined in paragraph (2)); and

16 “(C) designed—

17 “(i) to provide comprehensive information
18 (consistent with the standards set under para-
19 graph (3)) regarding—

20 “(I) the management of comorbidities,
21 including for purposes of delaying the need
22 for dialysis;

23 “(II) the prevention of uremic com-
24 plications; and

1 “(III) each option for renal replace-
2 ment therapy (including hemodialysis and
3 peritoneal dialysis at home and in-center
4 as well as vascular access options and
5 transplantation);

6 “(ii) to ensure that the individual has the
7 opportunity to actively participate in the choice
8 of therapy; and

9 “(iii) to be tailored to meet the needs of
10 the individual involved.

11 “(2) The term ‘qualified person’ means—

12 “(A) a physician (as defined in section
13 1861(r)(1)) or a physician assistant, nurse practi-
14 tioner, or clinical nurse specialist (as defined in sec-
15 tion 1861(aa)(5)), who furnishes services for which
16 payment may be made under the fee schedule estab-
17 lished under section 1848; and

18 “(B) a renal dialysis facility subject to the re-
19 quirements of section 1881(b)(1) with personnel
20 who—

21 “(i) provide the services described in para-
22 graph (1); and

23 “(ii) meet the requirements of subpara-
24 graph (A).

1 “(3) The Secretary shall set standards for the con-
 2 tent of such information to be provided under paragraph
 3 (1)(C)(i) after consulting with physicians, other health
 4 professionals, health educators, professional organizations,
 5 accrediting organizations, kidney patient organizations, di-
 6 alysis facilities, transplant centers, network organizations
 7 described in section 1881(c)(2), and other knowledgeable
 8 persons. To the extent possible the Secretary shall consult
 9 with persons or entities described in the previous sentence,
 10 other than a dialysis facility, that has not received indus-
 11 try funding from a drug or biological manufacturer or di-
 12 alysis facility.

13 “(4) No individual shall be furnished more than 6
 14 sessions of kidney disease education services under this
 15 title.”.

16 (C) PAYMENT UNDER THE PHYSICIAN FEE
 17 SCHEDULE.—Section 1848(j)(3) of the Social
 18 Security Act (42 U.S.C. 1395w-4(j)(3)) is
 19 amended by inserting “(2)(CC),” after
 20 “(2)(AA),”.

21 (D) LIMITATION ON NUMBER OF SES-
 22 SIONS.—Section 1862(a)(1) of the Social Secu-
 23 rity Act (42 U.S.C. 1395y(a)(1)) is amended—
 24 (i) in subparagraph (M), by striking
 25 “and” at the end;

1 (ii) in subparagraph (N), by striking
 2 the semicolon at the end and inserting “,
 3 and”; and

4 (iii) by adding at the end the fol-
 5 lowing new subparagraph:

6 “(O) in the case of kidney disease education
 7 services (as defined in paragraph (1) of section
 8 1861(fff)), which are furnished in excess of the
 9 number of sessions covered under paragraph (4) of
 10 such section;”.

11 (2) EFFECTIVE DATE.—The amendments made
 12 by this subsection shall apply to services furnished
 13 on or after January 1, 2010.

14 **SEC. 152. RENAL DIALYSIS PROVISIONS.**

15 (a) COMPOSITE RATE.—

16 (1) UPDATE.—Section 1881(b)(12)(G) of the
 17 Social Security Act (42 U.S.C. 1395rr(b)(12)(G)) is
 18 amended—

19 (A) in clause (i), by striking “and” at the
 20 end;

21 (B) in clause (ii)—

22 (i) by inserting “and before January
 23 1, 2009,” after “April 1, 2007,”; and

24 (ii) by striking the period at the end
 25 and inserting “; and”; and

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

3 “(iii) furnished on or after January 1, 2009,
 4 and before January 1, 2010, by 1.0 percent above
 5 the amount of such composite rate component for
 6 such services furnished on December 31, 2008; and
 7 “(iv) furnished on or after January 1, 2010, by
 8 1.0 percent above the amount of such composite rate
 9 component for such services furnished on December
 10 31, 2009.”.

11 (2) SITE NEUTRAL COMPOSITE RATE.—Section
 12 1881(b)(12)(A) of the Social Security Act (42
 13 U.S.C. 1395rr(b)(12)(A)) is amended by adding at
 14 the end the following new sentence: “Under such
 15 system, the payment rate for dialysis services fur-
 16 nished on or after January 1, 2009, by providers of
 17 services shall be the same as the payment rate (com-
 18 puted without regard to this sentence) for such serv-
 19 ices furnished by renal dialysis facilities, and in ap-
 20 plying the geographic index under subparagraph (D)
 21 to providers of services, the labor share shall be
 22 based on the labor share otherwise applied for renal
 23 dialysis facilities.”.

24 (b) DEVELOPMENT OF ESRD BUNDLED PAYMENT
 25 SYSTEM.—

1 (1) IN GENERAL.—Section 1881(b) of the So-
2 cial Security Act (42 U.S.C. 1395rr(b)) is amended
3 by adding at the end the following new paragraph:

4 “(14)(A)(i) Subject to subparagraph (E), for services
5 furnished on or after January 1, 2011, the Secretary shall
6 implement a payment system under which a single pay-
7 ment is made under this title to a provider of services or
8 a renal dialysis facility for renal dialysis services (as de-
9 fined in subparagraph (B)) in lieu of any other payment
10 (including a payment adjustment under paragraph
11 (12)(B)(ii)) and for such services and items furnished pur-
12 suant to paragraph (4).

13 “(ii) In implementing the system under this para-
14 graph the Secretary shall ensure that the estimated total
15 amount of payments under this title for 2011 for renal
16 dialysis services shall equal 98 percent of the estimated
17 total amount of payments for renal dialysis services, in-
18 cluding payments under paragraph (12)(B)(ii), that would
19 have been made under this title with respect to services
20 furnished in 2011 if such system had not been imple-
21 mented. In making such estimation, the Secretary shall
22 use per patient utilization data from 2007, 2008, or 2009,
23 whichever has the lowest per patient utilization.

24 “(B) For purposes of this paragraph, the term ‘renal
25 dialysis services’ includes—

1 “(i) items and services included in the com-
2 posite rate for renal dialysis services as of December
3 31, 2010;

4 “(ii) erythropoiesis stimulating agents and any
5 oral form of such agents that are furnished to indi-
6 viduals for the treatment of end stage renal disease;

7 “(iii) other drugs and biologicals that are fur-
8 nished to individuals for the treatment of end stage
9 renal disease and for which payment was (before the
10 application of this paragraph) made separately
11 under this title, and any oral equivalent form of
12 such drug or biological; and

13 “(iv) diagnostic laboratory tests and other items
14 and services not described in clause (i) that are fur-
15 nished to individuals for the treatment of end stage
16 renal disease.

17 Such term does not include vaccines.

18 “(C) The system under this paragraph may provide
19 for payment on the basis of services furnished during a
20 week or month or such other appropriate unit of payment
21 as the Secretary specifies.

22 “(D) Such system—

23 “(i) shall include a payment adjustment based
24 on case mix that may take into account patient

1 weight, body mass index, comorbidities, length of
2 time on dialysis, age, and other appropriate factors;

3 “(ii) shall include a payment adjustment for
4 high cost outliers due to unusual variations in the
5 type or amount of medically necessary care, includ-
6 ing variations in the amount of erythropoiesis stimu-
7 lating agents necessary for anemia management;

8 “(iii) shall include a payment adjustment that
9 reflects the extent to which costs incurred by rural,
10 low-volume providers and facilities (as defined by the
11 Secretary) in furnishing renal dialysis services ex-
12 ceed the costs incurred by other providers and facili-
13 ties in furnishing such services, and for payment for
14 renal dialysis services furnished on or after January
15 1, 2011, and before January 1, 2014, such payment
16 adjustment shall not be less than 10 percent; and

17 “(iv) may include such other payment adjust-
18 ments as the Secretary determines appropriate, such
19 as a payment adjustment—

20 “(I) for pediatric providers of services and
21 renal dialysis facilities; and

22 “(II) for providers of services or renal di-
23 alysis facilities located in rural areas.

1 The Secretary shall take into consideration the unique
2 treatment needs of children and young adults in estab-
3 lishing such system.

4 “(E)(i) The Secretary shall provide for a four-year
5 phase-in (in equal increments) of the payment amount
6 under the payment system under this paragraph, with
7 such payment amount being fully implemented for renal
8 dialysis services furnished on or after January 1, 2014.

9 “(ii) A provider of services or renal dialysis facility
10 may make a one-time election to be excluded from the
11 phase-in under clause (i) and be paid entirely based on
12 the payment amount under the payment system under this
13 paragraph. Such an election shall be made prior to Janu-
14 ary 1, 2011, in a form and manner specified by the Sec-
15 retary, and is final and may not be rescinded.

16 “(iii) The Secretary shall make an adjustment to the
17 payments under this paragraph for years during which the
18 phase-in under clause (i) is applicable so that the esti-
19 mated total amount of payments under this paragraph,
20 including payments under this subparagraph, shall equal
21 the estimated total amount of payments that would other-
22 wise occur under this paragraph without such phase-in.

23 “(F)(i) Subject to clause (ii), beginning in 2012, the
24 Secretary shall annually increase payment amounts estab-
25 lished under this paragraph by an ESRD market basket

1 percentage increase factor for a bundled payment system
2 for renal dialysis services that reflects changes over time
3 in the prices of an appropriate mix of goods and services
4 included in renal dialysis services minus 1.0 percentage
5 point.

6 “(ii) For years during which a phase-in of the pay-
7 ment system pursuant to subparagraph (E) is applicable,
8 the following rules shall apply to the portion of the pay-
9 ment under the system that is based on the payment of
10 the composite rate that would otherwise apply if the sys-
11 tem under this paragraph had not been enacted:

12 “(I) The update under clause (i) shall not
13 apply.

14 “(II) The Secretary shall annually increase
15 such composite rate by the ESRD market basket
16 percentage increase factor described in clause (i)
17 minus 1.0 percentage point.

18 “(G) There shall be no administrative or judicial re-
19 view under section 1869, section 1878, or otherwise of the
20 determination of payment amounts under subparagraph
21 (A), the establishment of an appropriate unit of payment
22 under subparagraph (C), the identification of renal dialy-
23 sis services included in the bundled payment, the adjust-
24 ments under subparagraph (D), the application of the

1 phase-in under subparagraph (E), and the establishment
 2 of the updates under subparagraph (F).

3 “(H) Erythropoiesis stimulating agents and other
 4 drugs and biologicals shall be treated as prescribed and
 5 dispensed or administered and available only under part
 6 B if they are—

7 “(i) furnished to an individual for the treatment
 8 of end stage renal disease; and

9 “(ii) included in subparagraph (B) for purposes
 10 of payment under this paragraph.”.

11 (2) PROHIBITION OF UNBUNDLING.—Section
 12 1862(a) of the Social Security Act (42 U.S.C.
 13 1395y(a)), as amended by section 137(a)(2), is
 14 amended—

15 (A) in paragraph (22), by striking “or” at
 16 the end;

17 (B) in paragraph (23), by striking the pe-
 18 riod at the end and inserting “; or”; and

19 (C) by inserting after paragraph (23) the
 20 following new paragraph:

21 “(24) where such expenses are for renal dialysis
 22 services (as defined in subparagraph (B) of section
 23 1881(b)(14)) for which payment is made under such
 24 section unless such payment is made under such sec-

1 tion to a provider of services or a renal dialysis facil-
 2 ity for such services.”.

3 (3) CONFORMING AMENDMENTS.—(A) Section
 4 1881(b) of the Social Security Act (42 U.S.C.
 5 1395rr(b)) is amended—

6 (i) in paragraph (12)(A), by striking “In
 7 lieu of payment” and inserting “Subject to
 8 paragraph (14), in lieu of payment”;

9 (ii) in the second sentence of paragraph
 10 (12)(F)—

11 (I) by inserting “or paragraph (14)”
 12 after “this paragraph”; and

13 (II) by inserting “or under the system
 14 under paragraph (14)” after “subpara-
 15 graph (B)”; and

16 (iii) in paragraph (13)—

17 (I) in subparagraph (A), in the matter
 18 preceding clause (i), by striking “The pay-
 19 ment amounts” and inserting “Subject to
 20 paragraph (14), the payment amounts”;
 21 and

22 (II) in subparagraph (B)—

23 (aa) in clause (i), by striking
 24 “(i)” after “(B)” and by inserting “,

1 subject to paragraph (14)” before the
2 period at the end; and

3 (bb) by striking clause (ii).

4 (B) Section 1861(s)(2)(F) of the Social Secu-
5 rity Act (42 U.S.C. 1395x(s)(2)(F)) is amended by
6 inserting “, and, for items and services furnished on
7 or after January 1, 2011, renal dialysis services (as
8 defined in section 1881(b)(14)(B))” before the semi-
9 colon at the end.

10 (C) Section 623(e) of the Medicare Prescription
11 Drug, Improvement, and Modernization Act of 2003
12 (42 U.S.C. 1395rr note) is repealed.

13 (4) RULE OF CONSTRUCTION.—Nothing in this
14 subsection or the amendments made by this sub-
15 section shall be construed as authorizing or requir-
16 ing the Secretary of Health and Human Services to
17 make payments under the payment system imple-
18 mented under paragraph (14)(A)(i) of section
19 1881(b) of the Social Security Act (42 U.S.C.
20 1395rr(b)), as added by paragraph (1), for any un-
21 recovered amount for any bad debt attributable to
22 deductible and coinsurance on items and services not
23 included in the basic case-mix adjusted composite
24 rate under paragraph (12) of such section as in ef-
25 fect before the date of the enactment of this Act.

1 (c) QUALITY INCENTIVES IN THE END-STAGE RENAL
 2 DISEASE PROGRAM.—Section 1881 of the Social Security
 3 Act (42 U.S.C. 1395rr) is amended by adding at the end
 4 the following new subsection:

5 “(h) QUALITY INCENTIVES IN THE END-STAGE
 6 RENAL DISEASE PROGRAM.—

7 “(1) QUALITY INCENTIVES.—

8 “(A) IN GENERAL.—With respect to renal
 9 dialysis services (as defined in subsection
 10 (b)(14)(B)) furnished on or after January 1,
 11 2012, in the case of a provider of services or a
 12 renal dialysis facility that does not meet the re-
 13 quirement described in subparagraph (B) with
 14 respect to the year, payments otherwise made
 15 to such provider or facility under the system
 16 under subsection (b)(14) for such services shall
 17 be reduced by up to 2.0 percent, as determined
 18 appropriate by the Secretary.

19 “(B) REQUIREMENT.—The requirement
 20 described in this subparagraph is that the pro-
 21 vider or facility meets (or exceeds) the total
 22 performance score under paragraph (3) with re-
 23 spect to performance standards established by
 24 the Secretary with respect to measures specified
 25 in paragraph (2).

1 “(C) NO EFFECT IN SUBSEQUENT
2 YEARS.—The reduction under subparagraph
3 (A) shall apply only with respect to the year in-
4 volved, and the Secretary shall not take into ac-
5 count such reduction in computing the single
6 payment amount under the system under para-
7 graph (14) in a subsequent year.

8 “(2) MEASURES.—

9 “(A) IN GENERAL.—The measures speci-
10 fied under this paragraph with respect to the
11 year involved shall include—

12 “(i) measures on anemia management
13 that reflect the labeling approved by the
14 Food and Drug Administration for such
15 management and measures on dialysis ade-
16 quacy;

17 “(ii) to the extent feasible, such meas-
18 ure (or measures) of patient satisfaction as
19 the Secretary shall specify; and

20 “(iii) such other measures as the Sec-
21 retary specifies, including, to the extent
22 feasible, measures on—

23 “(I) iron management; and

1 “(II) vascular access, including
2 for maximizing the placement of arte-
3 rial venous fistula.

4 “(B) USE OF ENDORSED MEASURES.—

5 “(i) IN GENERAL.—Subject to clause
6 (ii), any measure specified by the Secretary
7 under subparagraph (A)(iii) must have
8 been endorsed by the entity with a contract
9 under section 1890(a).

10 “(ii) EXCEPTION.—In the case of a
11 specified area or medical topic determined
12 appropriate by the Secretary for which a
13 feasible and practical measure has not
14 been endorsed by the entity with a contract
15 under section 1890(a), the Secretary may
16 specify a measure that is not so endorsed
17 as long as due consideration is given to
18 measures that have been endorsed or
19 adopted by a consensus organization iden-
20 tified by the Secretary.

21 “(C) UPDATING MEASURES.—The Sec-
22 retary shall establish a process for updating the
23 measures specified under subparagraph (A) in
24 consultation with interested parties.

1 “(D) CONSIDERATION.—In specifying
 2 measures under subparagraph (A), the Sec-
 3 retary shall consider the availability of meas-
 4 ures that address the unique treatment needs of
 5 children and young adults with kidney failure.

6 “(3) PERFORMANCE SCORES.—

7 “(A) TOTAL PERFORMANCE SCORE.—

8 “(i) IN GENERAL.—Subject to clause
 9 (ii), the Secretary shall develop a method-
 10 ology for assessing the total performance
 11 of each provider of services and renal di-
 12 alysis facility based on performance stand-
 13 ards with respect to the measures selected
 14 under paragraph (2) for a performance pe-
 15 riod established under paragraph (4)(D)
 16 (in this subsection referred to as the ‘total
 17 performance score’).

18 “(ii) APPLICATION.—For providers of
 19 services and renal dialysis facilities that do
 20 not meet (or exceed) the total performance
 21 score established by the Secretary, the Sec-
 22 retary shall ensure that the application of
 23 the methodology developed under clause (i)
 24 results in an appropriate distribution of re-
 25 ductions in payment under paragraph (1)

1 among providers and facilities achieving
 2 different levels of total performance scores,
 3 with providers and facilities achieving the
 4 lowest total performance scores receiving
 5 the largest reduction in payment under
 6 paragraph (1)(A).

7 “(B) PERFORMANCE SCORE WITH RE-
 8 SPECT TO INDIVIDUAL MEASURES.—The Sec-
 9 retary shall also calculate separate performance
 10 scores for each measure, including for dialysis
 11 adequacy and anemia management.

12 “(4) PERFORMANCE STANDARDS.—

13 “(A) ESTABLISHMENT.—Subject to sub-
 14 paragraph (E), the Secretary shall establish
 15 performance standards with respect to meas-
 16 ures selected under paragraph (2) for a per-
 17 formance period with respect to a year (as es-
 18 tablished under subparagraph (D)).

19 “(B) ACHIEVEMENT AND IMPROVE-
 20 MENT.—The performance standards established
 21 under subparagraph (A) shall include levels of
 22 achievement and improvement, as determined
 23 appropriate by the Secretary.

24 “(C) TIMING.—The Secretary shall estab-
 25 lish the performance standards under subpara-

1 graph (A) prior to the beginning of the per-
2 formance period for the year involved.

3 “(D) PERFORMANCE PERIOD.—The Sec-
4 retary shall establish the performance period
5 with respect to a year. Such performance period
6 shall occur prior to the beginning of such year.

7 “(5) LIMITATION ON REVIEW.—There shall be
8 no administrative or judicial review under section
9 1869, section 1878, or otherwise of the following:

10 “(A) The determination of the amount of
11 the payment reduction under paragraph (1).

12 “(B) The establishment of the performance
13 standards and the performance period under
14 paragraph (4).

15 “(C) The specification of measures under
16 paragraph (2).

17 “(D) The methodology developed under
18 paragraph (3) that is used to calculate total
19 performance scores and performance scores for
20 individual measures.

21 “(6) PUBLIC REPORTING.—

22 “(A) IN GENERAL.—The Secretary shall
23 establish procedures for making information re-
24 garding performance under this subsection
25 available to the public, including—

1 “(i) the total performance score
2 achieved by the provider of services or
3 renal dialysis facility under paragraph (3)
4 and appropriate comparisons of providers
5 of services and renal dialysis facilities to
6 the national average with respect to such
7 scores; and

8 “(ii) the performance score achieved
9 by the provider or facility with respect to
10 individual measures.

11 “(B) OPPORTUNITY TO REVIEW.—The pro-
12 cedures established under subparagraph (A)
13 shall ensure that a provider of services and a
14 renal dialysis facility has the opportunity to re-
15 view the information that is to be made public
16 with respect to the provider or facility prior to
17 such data being made public.

18 “(C) CERTIFICATES.—

19 “(i) IN GENERAL.—The Secretary
20 shall provide certificates to providers of
21 services and renal dialysis facilities who
22 furnish renal dialysis services under this
23 section to display in patient areas. The
24 certificate shall indicate the total perform-

1 ance score achieved by the provider or fa-
2 cility under paragraph (3).

3 “(ii) DISPLAY.—Each facility or pro-
4 vider receiving a certificate under clause (i)
5 shall prominently display the certificate at
6 the provider or facility.

7 “(D) WEB-BASED LIST.—The Secretary
8 shall establish a list of providers of services and
9 renal dialysis facilities who furnish renal dialy-
10 sis services under this section that indicates the
11 total performance score and the performance
12 score for individual measures achieved by the
13 provider and facility under paragraph (3). Such
14 information shall be posted on the Internet
15 website of the Centers for Medicare & Medicaid
16 Services in an easily understandable format.”.

17 (d) GAO REPORT ON ESRD BUNDLING SYSTEM AND
18 QUALITY INITIATIVE.—Not later than April 1, 2012, the
19 Comptroller General of the United States shall submit to
20 Congress a report on the implementation of the payment
21 system under subsection (b)(14) of section 1881 of the
22 Social Security Act (as added by subsection (b)) for renal
23 dialysis services and related services (defined in subpara-
24 graph (B) of such subsection (b)(14)) and the quality ini-
25 tiative under subsection (h) of such section 1881 (as

1 added by subsection (b)). Such report shall include the fol-
2 lowing information:

3 (1) The changes in utilization rates for
4 erythropoiesis stimulating agents.

5 (2) The mode of administering such agents, in-
6 cluding information on the proportion of individuals
7 receiving such agents intravenously as compared to
8 subcutaneously.

9 (3) An analysis of the payment adjustment
10 under subparagraph (D)(iii) of such subsection
11 (b)(14), including an examination of the extent to
12 which costs incurred by rural, low-volume providers
13 and facilities (as defined by the Secretary) in fur-
14 nishing renal dialysis services exceed the costs in-
15 curred by other providers and facilities in furnishing
16 such services, and a recommendation regarding the
17 appropriateness of such adjustment.

18 (4) Any other information or recommendations
19 for legislative and administrative actions determined
20 appropriate by the Comptroller General.

1 **Subtitle E—Provisions Relating to**
2 **Part C**

3 **SEC. 161. PHASE-OUT OF INDIRECT MEDICAL EDUCATION**
4 **(IME).**

5 (a) IN GENERAL.—Section 1853(k) of the Social Se-
6 curity Act (42 U.S.C. 1395w–23(k)) is amended—

7 (1) in paragraph (1), in the matter preceding
8 subparagraph (A), by striking “paragraph (2)” and
9 inserting “paragraphs (2) and (4)”; and

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

12 “(4) PHASE-OUT OF THE INDIRECT COSTS OF
13 MEDICAL EDUCATION FROM CAPITATION RATES.—

14 “(A) IN GENERAL.—After determining the
15 applicable amount for an area for a year under
16 paragraph (1) (beginning with 2010), the Sec-
17 retary shall adjust such applicable amount to
18 exclude from such applicable amount the phase-
19 in percentage (as defined in subparagraph
20 (B)(i)) for the year of the Secretary’s estimate
21 of the standardized costs for payments under
22 section 1886(d)(5)(B) in the area for the year.
23 Any adjustment under the preceding sentence
24 shall be made prior to the application of para-
25 graph (2).

1 “(B) PERCENTAGES DEFINED.—For pur-
2 poses of this paragraph:

3 “(i) PHASE-IN PERCENTAGE.—The
4 term ‘phase-in percentage’ means, for an
5 area for a year, the ratio (expressed as a
6 percentage, but in no case greater than
7 100 percent) of—

8 “(I) the maximum cumulative ad-
9 justment percentage for the year (as
10 defined in clause (ii)); to

11 “(II) the standardized IME cost
12 percentage (as defined in clause (iii))
13 for the area and year.

14 “(ii) MAXIMUM CUMULATIVE ADJUST-
15 MENT PERCENTAGE.—The term ‘maximum
16 cumulative adjustment percentage’ means,
17 for—

18 “(I) 2010, 0.6 percent; and

19 “(II) a subsequent year, the max-
20 imum cumulative adjustment percent-
21 age for the previous year increased by
22 0.6 percentage points.

23 “(iii) STANDARDIZED IME COST PER-
24 CENTAGE.—The term ‘standardized IME
25 cost percentage’ means, for an area for a

1 year, the per capita costs for payments
 2 under section 1886(d)(5)(B) (expressed as
 3 a percentage of the fee-for-service amount
 4 specified in subparagraph (C)) for the area
 5 and the year.

6 “(C) FEE-FOR-SERVICE AMOUNT.—The
 7 fee-for-service amount specified in this subpara-
 8 graph for an area for a year is the amount
 9 specified under subsection (c)(1)(D) for the
 10 area and the year.”.

11 (b) EXCLUDING ADJUSTMENT FROM THE UP-
 12 DATE.—Section 1853(k)(1)(B)(i) of the Social Security
 13 Act (42 U.S.C. 1395w–23(k)(1)(B)(i)) is amended by
 14 striking “paragraph (2)” and inserting “paragraphs (2)
 15 and (4)”.

16 (c) HOLD HARMLESS FOR PACE PROGRAM PAY-
 17 MENTS.—Section 1894(d) of the Social Security Act (42
 18 U.S.C. 1395eee(d)) is amended by adding at the end the
 19 following new paragraph:

20 “(3) CAPITATION RATES DETERMINED WITH-
 21 OUT REGARD TO THE PHASE-OUT OF THE INDIRECT
 22 COSTS OF MEDICAL EDUCATION FROM THE ANNUAL
 23 MEDICARE ADVANTAGE CAPITATION RATE.—Capita-
 24 tion amounts under this subsection shall be deter-

1 mined without regard to the application of section
2 1853(k)(4).”.

3 **SEC. 162. REVISIONS TO QUALITY IMPROVEMENT PRO-**
4 **GRAMS.**

5 (a) REQUIREMENT FOR MA PRIVATE FEE-FOR-
6 SERVICE AND MSA PLANS TO HAVE A QUALITY IM-
7 PROVEMENT PROGRAM.—Section 1852(e)(1) of the Social
8 Security Act (42 U.S.C. 1395w–22(e)(1)) is amended by
9 striking “(other than an MA private fee-for-service plan
10 or an MSA plan)”.

11 (b) DATA COLLECTION REQUIREMENTS FOR MA RE-
12 GIONAL PLANS, MA PRIVATE FEE-FOR-SERVICE PLANS,
13 AND MSA PLANS.—

14 (1) IN GENERAL.—Section 1852(e)(3)(A) of the
15 Social Security Act (42 U.S.C. 1395w–22(e)(3)(A))
16 is amended—

17 (A) in clause (i)—

18 (i) by striking “clauses (ii) and (iii)”
19 and inserting “clause (ii)”; and

20 (ii) by adding at the end the following
21 new sentence: “With respect to MA private
22 fee-for-service plans and MSA plans, the
23 requirements under the preceding sentence
24 may not exceed the requirements under
25 this subparagraph with respect to MA local

1 plans that are preferred provider organiza-
 2 tion plans, except that the limitation under
 3 clause (ii) shall not apply and such re-
 4 quirements shall apply regardless of wheth-
 5 er or not the services are furnished by pro-
 6 viders of services, physicians, or other
 7 health care practitioners and suppliers that
 8 have contracts with the organization offer-
 9 ing the MA private fee-for-service plan or
 10 the MSA plan.”

11 (B) by striking clause (ii);

12 (C) by redesignating clauses (iii) and (iv)
 13 as clauses (ii) and (iii), respectively; and

14 (D) in clause (ii), as redesignated by sub-
 15 paragraph (C)—

16 (i) in the heading—

17 (I) by inserting “LOCAL” after
 18 “TO”; and

19 (II) by inserting “AND MA RE-
 20 GIONAL PLANS” after “ORGANIZA-
 21 TIONS”; and

22 (ii) by inserting “and to MA regional
 23 plans” after “organization plans”.

1 (2) LIMITATION.—Section 1852(e)(3)(B) of the
2 Social Security Act (42 U.S.C. 1395w–22(e)(3)(B))
3 is amended—

4 (A) in clause (ii), by striking “subclause
5 (iii)” and inserting “clauses (iii) and (iv)”; and

6 (B) by adding at the end the following new
7 clause:

8 “(iv) LIMITATION.—Notwithstanding
9 clause (ii), with respect to MA private fee-
10 for-service plans and MSA plans, to the ex-
11 tent that services are not services fur-
12 nished by providers of services, physicians,
13 or other health care practitioners and sup-
14 pliers that have contracts with the organi-
15 zation offering the plan, the data required
16 to be collected, analyzed, and reported
17 under subparagraph (A)(i) shall only in-
18 clude administrative and beneficiary survey
19 data.”.

20 (c) EFFECTIVE DATE.—The amendments made by
21 this subsection shall apply to plan years beginning on or
22 after January 1, 2010.

1 **SEC. 163. REVISIONS RELATING TO SPECIALIZED MEDI-**
2 **CARE ADVANTAGE PLANS FOR SPECIAL**
3 **NEEDS INDIVIDUALS.**

4 (a) **EXTENSION OF AUTHORITY TO RESTRICT EN-**
5 **ROLLMENT.**—Section 1859(f) of the Social Security Act
6 (42 U.S.C. 1395w–28(f)), as amended by section 108(a)
7 of the Medicare, Medicaid, and SCHIP Extension Act of
8 2007 (Public Law 110–173), is amended by striking
9 “2010” and inserting “2011”.

10 (b) **MORATORIUM ON AUTHORITY TO DESIGNATE**
11 **OTHER PLANS AS SPECIALIZED MA PLANS.**—During the
12 period beginning on January 1, 2010, and ending on De-
13 cember 31, 2010, the Secretary of Health and Human
14 Services may not exercise the authority provided under
15 section 231(d) of the Medicare Prescription Drug, Im-
16 provement, and Modernization Act of 2003 (42 U.S.C.
17 1395w–21 note) to designate other plans as specialized
18 MA plans for special needs individuals.

19 (c) **REQUIREMENTS FOR ENROLLMENT.**—

20 (1) **IN GENERAL.**—Section 1859 of the Social
21 Security Act (42 U.S.C. 1395w–28) is amended—

22 (A) in subsection (b)(6)(A), by inserting
23 “and that meets the applicable requirements of
24 paragraph (2), (3), or (4) of subsection (f), as
25 the case may be” before the period at the end;
26 and

1 (B) in subsection (f)—

2 (i) by amending the heading to read
3 as follows: “PROVISIONS REGARDING SPE-
4 CIALIZED MA PLANS FOR SPECIAL NEEDS
5 INDIVIDUALS”;

6 (ii) by designating the sentence begin-
7 ning “In the case of” as paragraph (1)
8 with the heading “RESTRICTIONS ON EN-
9 ROLLMENT.—” and with appropriate in-
10 dentation; and

11 (iii) by adding at the end the fol-
12 lowing new paragraphs:

13 “(2) ADDITIONAL REQUIREMENTS FOR INSTI-
14 TUTIONAL SNPS.—In the case of a specialized MA
15 plan for special needs individuals described in sub-
16 section (b)(6)(B)(i), the applicable requirements de-
17 scribed in this paragraph are as follows:

18 “(A) Enrollment under the plan is re-
19 stricted so, of the individuals who are enrolling
20 in the plan on or after January 1, 2009, at
21 least 90 percent of such individuals are individ-
22 uals who are special needs individuals described
23 in subsection (b)(6)(B)(i). In applying this sub-
24 paragraph, in order for an individual residing in
25 a community setting but requiring an institu-

1 tional level of care to be treated as an indi-
2 vidual described in such subsection, the indi-
3 vidual must be assessed and certified, using a
4 State assessment tool of the State in which the
5 individual resides, as requiring an institutional
6 level of care.

7 “(B) Effective for plan years beginning on
8 or after January 1, 2010, the plan has in place
9 a model of care plan described in paragraph
10 (5).

11 “(3) ADDITIONAL REQUIREMENTS FOR DUAL
12 SNPS.—In the case of a specialized MA plan for spe-
13 cial needs individuals described in subsection
14 (b)(6)(B)(ii), the applicable requirements described
15 in this paragraph are as follows:

16 “(A) Enrollment under the plan is re-
17 stricted so, of the individuals who are enrolling
18 in the plan on or after January 1, 2009, at
19 least 90 percent of such individuals are individ-
20 uals who are special needs individuals described
21 in subsection (b)(6)(B)(ii).

22 “(B) Effective for plan years beginning on
23 or after January 1, 2010, the plan has in place
24 a model of care plan described in paragraph
25 (5).

1 “(C) Effective for plan years beginning on
2 or after January 1, 2012, the plan has docu-
3 mented arrangements with the State Medicaid
4 agency that address cooperation on coordination
5 of the operation of the plan and the State Med-
6 icaid plan under title XIX for such special
7 needs individuals and that include at least the
8 following:

9 “(i) A means for the agency to verify
10 an enrollee’s eligibility for medical assist-
11 ance under such title.

12 “(ii) A means to identify and share
13 information on provider participation
14 under such title.

15 “(iii) A means to supply the special-
16 ized MA plan with information on the ben-
17 efits to which an individual enrolled under
18 the State Medicaid plan and eligible for
19 medical assistance under title XIX is enti-
20 tled.

21 “(D) Effective for plan years beginning on
22 or after January 1, 2010, the plan has nec-
23 essary arrangements, including arrangements
24 with providers, in order to assure that enrollees
25 who are special needs individuals described in

1 subsection (b)(6)(B)(ii) are not charged or lia-
2 ble for cost-sharing for items and services fur-
3 nished through the plan and for which they are
4 entitled to benefits under title XIX in excess of
5 the cost-sharing that the individuals would be
6 charged if the individuals were enrolled under
7 the original Medicare fee-for-service program
8 and not under the plan.

9 “(E) Effective for enrollments made dur-
10 ing or after the annual open enrollment period
11 for the plan year beginning on the earlier of
12 January 1, 2012 or the first plan year for
13 which the plan reaches an agreement with the
14 state, the plan provides each prospective en-
15 rollee described in subsection (b)(6)(B)(ii),
16 prior to enrollment, with an accurate and easily
17 understandable summary comparison (using a
18 standardized format established by the Sec-
19 retary) that compares—

20 “(i) the benefits and cost-sharing that
21 apply to individuals entitled to benefits
22 under a State Medicaid program under
23 title XIX if such individuals enroll in the
24 original Medicare fee-for-service program
25 under Parts A and B; and

1 “(ii) the benefits and cost-sharing
2 that apply to individuals entitled to bene-
3 fits under a State Medicaid program under
4 title XIX if such individuals enroll in the
5 plan.

6 Such summary comparison shall be included
7 with any description of benefits offered by the
8 plan.

9 “(4) ADDITIONAL REQUIREMENTS FOR SEVERE
10 OR DISABLING CHRONIC CONDITION SNPS.—In the
11 case of a specialized MA plan for special needs indi-
12 viduals described in subsection (b)(6)(B)(iii), the ap-
13 plicable requirements described in this paragraph
14 are as follows:

15 “(A) Enrollment under the plan is re-
16 stricted so, of the individuals who are enrolling
17 in the plan on or after January 1, 2009, at
18 least 90 percent of such individuals are individ-
19 uals who are special needs individuals described
20 in subsection (b)(6)(B)(iii).

21 “(B) Effective for plan years beginning on
22 or after January 1, 2010, the plan has in place
23 a model of care plan described in paragraph
24 (5).”.

1 (2) RESOURCES FOR STATE MEDICAID AGEN-
 2 CIES.—The Secretary of Health and Human Serv-
 3 ices shall provide for the designation of appropriate
 4 staff and resources that can address State inquiries
 5 with respect to the coordination of State and Fed-
 6 eral policies for specialized MA plans for special
 7 needs individuals described in subsection
 8 (b)(6)(B)(ii) of section 1859 of the Social Security
 9 Act (42 U.S.C. 1395w–28) as described in sub-
 10 section (f)(3) of such section, as added by this sub-
 11 section.

12 (3) RULE OF CONSTRUCTION.—Nothing in the
 13 provisions of, or amendments made by, this sub-
 14 section shall be construed to require a State to enter
 15 into a contract or agreement with a Medicare Ad-
 16 vantage organization with respect to such plans.

17 (d) MODEL OF CARE PLAN REQUIREMENT FOR ALL
 18 SNPs.—

19 (1) IN GENERAL.—Section 1859(f) of the Social
 20 Security Act (42 U.S.C. 1395w–28(f)), as amended
 21 by subsection (c)(1), is amended by adding at the
 22 end the following new paragraph:

23 “(5) MODEL OF CARE PLAN REQUIREMENT FOR
 24 ALL SNPs.—A model of care plan described in this
 25 paragraph for a specialized MA plan is a model of

1 care plan that specifies how the plan will coordinate
2 and deliver care designed for the plan’s enrollees.
3 Such model shall include at least the following:

4 “(A) Targeting a population of special
5 needs enrollees for whom the plan is designed.

6 “(B) Coordination of care for enrollees.

7 “(C) Inclusion of a network of providers
8 and services with clinical expertise relevant to
9 the targeted enrollee population.

10 “(D) Delivery of care based on appropriate
11 protocols for the targeted enrollee population.

12 “(E) Application of performance measures
13 to evaluate processes and outcomes of the
14 model.

15 “(F) At least annually, or more often as
16 each enrollee’s situation may require, contacting
17 each enrollee (or the enrollee’s representative)
18 and evaluating the enrollee in order to ensure
19 that the model of care is being appropriately
20 applied to such enrollee.”.

21 (2) REVIEW TO ENSURE COMPLIANCE WITH
22 MODEL OF CARE PLAN REQUIREMENTS.—Section
23 1857(d) of the Social Security Act (42 U.S.C.
24 1395w–27(d)) is amended by adding at the end the
25 following new paragraph:

“(6) REVIEW TO ENSURE COMPLIANCE WITH
MODEL OF CARE PLAN REQUIREMENTS FOR SPE-
CIALIZED MEDICARE ADVANTAGE PLANS FOR SPE-
CIAL NEEDS INDIVIDUALS.—In conjunction with a
general compliance audit of a specialized Medicare
Advantage plan for special needs individuals under
paragraph (2), the Secretary shall conduct a review
to ensure that such plan is in compliance with the
model of care plan requirements under section
1859(f)(5).”.

(e) 1-YEAR EXTENSION OF MORATORIUM FOR CHRONIC CARE SNPs.—Section 108(b)(2) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) is amended by inserting after “December 31, 2009” the following: “(or December 31, 2010, in the case of a specialized MA plan for special needs individuals described in section 1859(b)(6)(B)(iii) of the Social Security Act)”.

19 SEC. 164. ADJUSTMENT TO THE MEDICARE ADVANTAGE
20 STABILIZATION FUND.

Section 1858(e)(2)(A)(i) of the Social Security Act (42 U.S.C. 1395w-27a(e)(2)(A)(i)), as amended by section 110 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110-173), is amended—

1 (1) by striking “2013” and inserting “2014”;

2 and

3 (2) by striking “\$1,790,000,000” and inserting

4 “\$1”.

5 **SEC. 165. ACCESS TO MEDICARE REASONABLE COST CON-**
 6 **TRACT PLANS.**

7 (a) EXTENSION OF REASONABLE COST CON-
 8 TRACTS.—Section 1876(h)(5)(C)(ii) of the Social Security
 9 Act (42 U.S.C. 1395mm(h)(5)(C)(ii)), as amended by sec-
 10 tion 109 of the Medicare, Medicaid, and SCHIP Extension
 11 Act of 2007 (Public Law 110–173), is amended by strik-
 12 ing “January 1, 2009” and inserting “January 1, 2010”
 13 in the matter preceding subclause (I).

14 (b) REVISIONS TO LIMITATION ON EXTENSION OR
 15 RENEWAL.—

16 (1) CLARIFICATION REGARDING USE OF COUN-
 17 TIES RATHER THAN SERVICE AREAS IN APPLICATION
 18 OF PROHIBITION.—Section 1876(h)(5)(C)(ii) of the
 19 Social Security Act (42 U.S.C.
 20 1395mm(h)(5)(C)(ii)), in the matter preceding sub-
 21 clause (I), is amended by striking “for a service
 22 area” and all that follows through “previous year
 23 was” and inserting “for a county in the service area
 24 of such contract insofar as such county during the
 25 entire previous year was entirely”.

1 (2) REQUIREMENT FOR AT LEAST TWO MEDI-
 2 CARE ADVANTAGE ORGANIZATIONS TO BE OFFERING
 3 A PLAN IN AN AREA FOR THE PROHIBITION TO BE
 4 APPLICABLE.—Subclauses (I) and (II) of section
 5 1876(h)(5)(C)(ii) of the Social Security Act (42
 6 U.S.C. 1395mm(h)(5)(C)(ii)) are each amended by
 7 inserting “, provided that all such plans are not of-
 8 fered by the same Medicare Advantage organization”
 9 after “clause (iii)”.

10 (c) REVISION OF REQUIREMENTS FOR PLANS THAT
 11 ARE USED TO DETERMINE IF PROHIBITION IS APPLICA-
 12 BLE.—Section 1876(h)(5)(C)(iii) of the Social Security
 13 Act (42 U.S.C. 1395mm(h)(5)(C)(iii)) is amended—

14 (1) in the matter preceding subclause (I)—

15 (A) by inserting “portion of the plan’s”
 16 after “if the”; and

17 (B) by inserting “that is within the service
 18 area of a reasonable cost reimbursement con-
 19 tract” after “for the year”; and

20 (2) in subclause (I)—

21 (A) by inserting “that are not in another
 22 Metropolitan Statistical Area with a population
 23 of more than 250,000” after “such Metropoli-
 24 tan Statistical Area”; and

1 (B) by adding at the end the following new
2 sentence: “If the service area includes a portion
3 in more than 1 Metropolitan Statistical Area
4 with a population of more than 250,000, the
5 minimum enrollment determination under the
6 preceding sentence shall be made with respect
7 to each such Metropolitan Statistical Area (and
8 such applicable contiguous counties to such
9 Metropolitan Statistical Area).”.

10 (d) GAO STUDY AND REPORT.—

11 (1) STUDY.—The Comptroller General of the
12 United States shall conduct a study of the reasons
13 (if any) why reasonable cost contracts under section
14 1876(h) of the Social Security Act (42 U.S.C.
15 1395mm(h)) are unable to become Medicare Advan-
16 tage plans under part C of title XVIII of such Act.

17 (2) REPORT.—Not later than July 1, 2009, the
18 Comptroller General of the United States shall sub-
19 mit a report to Congress containing the results of
20 the study conducted under paragraph (1), together
21 with recommendations for such legislation and ad-
22 ministrative action as the Comptroller General deter-
23 mines appropriate.

1 **SEC. 166. MEDPAC STUDY AND REPORT ON MEDICARE AD-**
2 **VANTAGE PAYMENTS.**

3 (a) STUDY.—The Medicare Payment Advisory Com-
4 mission (in this section referred to as the “Commission”)
5 shall conduct a study of the following:

6 (1) The correlation between—

7 (A) the costs that Medicare Advantage or-
8 ganizations with respect to Medicare Advantage
9 plans incur in providing coverage under the
10 plan for items and services covered under the
11 original Medicare fee-for-service program under
12 parts A and B of title XVIII of the Social Secu-
13 rity Act, as reflected in plan bids; and

14 (B) county-level spending under such origi-
15 nal Medicare fee-for-service program on a per
16 capita basis, as calculated by the Chief Actuary
17 of the Centers for Medicare & Medicaid Serv-
18 ices.

19 The study with respect to the issue described in the
20 preceding sentence shall include differences in cor-
21 relation statistics by plan type and geographic area.

22 (2) Based on these results of the study with re-
23 spect to the issue described in paragraph (1), and
24 other data the Commission determines appro-
25 priate—

1 (A) alternate approaches to achieving pay-
2 ment neutrality under the Medicare program
3 with respect to a Medicare beneficiary enrolled
4 in a Medicare Advantage plan and a Medicare
5 beneficiary enrolled in such original Medicare
6 fee-for-service program other than through
7 county-level payment area equivalents, such
8 as—

9 (i) blends of national average per cap-
10 ita spending under such original Medicare
11 fee-for-service program and local spending
12 under such original Medicare fee-for-serv-
13 ice program;

14 (ii) price adjusting national average
15 per capita spending under such original
16 Medicare fee-for-service program by geog-
17 raphy and excluding utilization factors;
18 and

19 (iii) blends of national average per
20 capita spending under such original Medi-
21 care fee-for-service program with Medicare
22 Advantage plan bids; and

23 (B) the accuracy and completeness of
24 county-level estimates of per capita spending
25 under such original Medicare fee-for-service

program (including counties in Puerto Rico), as used to determine the annual Medicare Advantage capitation rate under section 1853 of the Social Security Act (42 U.S.C. 1395w–23), and whether such estimates include—

(i) expenditures with respect to Medicare beneficiaries at facilities of the Department of Veterans Affairs; and

(ii) all appropriate administrative expenses, including claims processing.

(3) Ways to improve the accuracy and completeness of county-level estimates of per capita spending described in paragraph (2)(B).

(b) REPORT.—Not later than December 1, 2009, the Commission shall submit a report to Congress containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Commission determines appropriate.

**SEC. 167. MARKETING OF MEDICARE ADVANTAGE PLANS
AND PRESCRIPTION DRUG PLANS.**

(a) PROHIBITIONS.—

(1) MEDICARE ADVANTAGE PROGRAM.—

(A) IN GENERAL.—Section 1851(h)(4) of the Social Security Act (42 U.S.C. 1395w–

21(h)(4) is amended by striking subparagraph
(A) and inserting the following:

“(A) shall not permit a Medicare Advantage organization (or the marketing representatives of such an organization) to—

“(i) provide cash or other remuneration as an inducement for enrollment or otherwise;

“(ii) offer gifts, except for gifts of nominal value (as determined by the Secretary), to potential enrollees;

“(iii) provide meals, regardless of value, to potential enrollees;

“(iv) solicit door-to-door or through other unsolicited means of direct contact, including the telephone and personally approaching the beneficiary, unless the beneficiary initiates the contact;

“(v) engage in activities that mislead beneficiaries about or misrepresent the Medicare Advantage organization or the Medicare Advantage plan offered by the organization, including any activities prohibited under cobranding standards estab-

lished by the Secretary to prevent beneficiaries from being misled;

“(vi) market non-health care related products to potential enrollees during any Medicare Advantage sales activity or presentation;

“(vii) conduct a marketing appointment with a beneficiary unless the organization has a documented agreement with the beneficiary in advance of the appointment as to what health care related products will be discussed;

“(viii) conduct sales presentations or distribute and accept Medicare Advantage plan enrollment forms in health care provider offices or, under rules provided by the Secretary, other places where health care is delivered; or

“(ix) engage in any other marketing activity prohibited by the Secretary; and”.

(2) MEDICARE PRESCRIPTION DRUG PROGRAM.—Section 1860D–4 of the Social Security Act (42 U.S.C. 1395w–104) is amended by adding at the end the following new subsection:

1 “(l) REQUIREMENTS WITH RESPECT TO MAR-
 2 KETING.—The following provisions shall apply to a PDP
 3 sponsor in the same manner as such provisions apply to
 4 a Medicare Advantage organization:

5 “(1) The prohibitions on the conduct of certain
 6 activities under section 1851(h)(4)(A).”.

7 (b) ADDITIONAL MARKETING PROTECTIONS.—

8 (1) MEDICARE ADVANTAGE PROGRAM.—Section
 9 1851(h) of the Social Security Act (42 U.S.C.
 10 1395w–21(h)) is amended by adding at the end the
 11 following new paragraph:

12 “(6) ADDITIONAL MARKETING PROTECTIONS.—

13 “(A) CONFIRMATION OF MARKETING RE-
 14 SOURCES.—Each Medicare Advantage organiza-
 15 tion shall establish and maintain a system for
 16 confirming that individuals who are enrolled in
 17 a Medicare Advantage plan offered by the orga-
 18 nization—

19 “(i) have in fact enrolled in such plan;

20 and

21 “(ii) understand the rules applicable
 22 under such plan.

23 “(B) LICENSING OF MARKETING REP-
 24 RESENTATIVES.—

1 “(i) IN GENERAL.—Each Medicare
2 Advantage organization shall—

3 “(I) only conduct marketing ac-
4 tivities (as defined by the Secretary)
5 in a State through marketing rep-
6 resentatives who are licensed by the
7 State; and

8 “(II) inform the State that it has
9 appointed those individuals as mar-
10 keting representatives of the organiza-
11 tion, consistent with the State’s ap-
12 pointment laws, except that no ap-
13 pointment fees shall apply to such ap-
14 pointment.

15 “(ii) MARKETING REPRESENTATIVE
16 DEFINED.—In this subsection, the term
17 ‘marketing representative’ means an em-
18 ployee, agent, broker, or other third party
19 who conducts marketing activities (as so
20 defined) for a Medicare Advantage organi-
21 zation.

22 “(C) COMPLIANCE WITH STATE REQUESTS
23 FOR INFORMATION.—Each Medicare Advantage
24 organization shall comply with State requests
25 for information about the performance of a li-

1 censed agent or broker as part of a State inves-
2 tigation into the individual’s conduct.”.

3 (2) MEDICARE PRESCRIPTION DRUG PRO-
4 GRAM.—Section 1860D–4(l) of the Social Security
5 Act, as added by subsection (a)(2), is amended by
6 adding at the end the following new paragraph:

7 “(2) The additional marketing protections
8 under section 1851(h)(6).”.

9 (c) COMMISSIONS AND TRAINING FOR MARKETING
10 REPRESENTATIVES.—

11 (1) MEDICARE ADVANTAGE PROGRAM.—Section
12 1851(h) of the Social Security Act (42 U.S.C.
13 1395w–21(h)), as amended by subsection (b)(1), is
14 amended by adding at the end the following new
15 paragraph:

16 “(7) COMMISSIONS AND TRAINING FOR MAR-
17 KETING REPRESENTATIVES.—

18 “(A) COMMISSIONS.—Not later than Janu-
19 ary 1, 2009, the Secretary shall issue rules gov-
20 erning commissions and, as determined appro-
21 priate by the Secretary, other compensation of-
22 fered by Medicare Advantage organizations.
23 Such rules—

24 “(i) shall be intended to provide mar-
25 keting representatives with incentives to

1 recommend appropriate plan options for
 2 individual beneficiaries; and

3 “(ii) shall take effect on a date speci-
 4 fied by the Secretary.

5 “(B) TRAINING.—Each Medicare Advan-
 6 tage organization shall ensure that marketing
 7 representatives who sell Medicare products are
 8 trained and tested on—

9 “(i) rules and regulations under the
 10 program under this title; and

11 “(ii) other information specific to the
 12 Medicare Advantage plan products the or-
 13 ganization intends to sell.”.

14 (2) MEDICARE PRESCRIPTION DRUG PRO-
 15 GRAM.—Section 1860D–4(l) of the Social Security
 16 Act, as added by subsection (a)(2) and amended by
 17 subsection (b)(2), is amended by adding at the end
 18 the following new paragraph:

19 “(3) The requirements with respect to commis-
 20 sions and training for marketing representatives
 21 under section 1851(h)(7).”.

22 (d) EFFECTIVE DATE.—Except as provided in sec-
 23 tion 1851(h)(7)(A) of the Social Security Act, as added
 24 by subsection (c)(1), the amendments made by this section

1 shall apply with respect to marketing for plan years begin-
 2 ning on or after January 1, 2009.

3 **Subtitle F—Other Provisions**

4 **SEC. 171. CONTRACT WITH A CONSENSUS-BASED ENTITY** 5 **REGARDING PERFORMANCE MEASUREMENT.**

6 (a) CONTRACT.—

7 (1) IN GENERAL.—Part E of title XVIII of the
 8 Social Security Act (42 U.S.C. 1395x et seq.) is
 9 amended by inserting after section 1889 the fol-
 10 lowing new section:

11 “CONTRACT WITH A CONSENSUS-BASED ENTITY
 12 REGARDING PERFORMANCE MEASUREMENT

13 “SEC. 1890. (a) CONTRACT.—

14 “(1) IN GENERAL.—For purposes of activities
 15 conducted under this Act, the Secretary shall iden-
 16 tify and have in effect a contract with a consensus-
 17 based entity, such as the National Quality Forum,
 18 that meets the requirements described in subsection
 19 (c). Such contract shall provide that the entity will
 20 perform the duties described in subsection (b).

21 “(2) TIMING FOR FIRST CONTRACT.—As soon
 22 as practicable after the date of the enactment of this
 23 subsection, the Secretary shall enter into the first
 24 contract under paragraph (1).

25 “(3) PERIOD OF CONTRACT.—A contract under
 26 paragraph (1) shall be for a period of 4 years (ex-

1 cept as may be renewed after a subsequent bidding
2 process).

3 “(4) COMPETITIVE PROCEDURES.—Competitive
4 procedures (as defined in section 4(5) of the Office
5 of Federal Procurement Policy Act (41 U.S.C.
6 403(5))) shall be used to enter into a contract under
7 paragraph (1).

8 “(b) DUTIES.—The duties described in this sub-
9 section are the following:

10 “(1) PRIORITY SETTING PROCESS.—The entity
11 shall synthesize evidence and convene key stake-
12 holders to make recommendations, with respect to
13 activities conducted under this Act, on an integrated
14 national strategy and priorities for health care per-
15 formance measurement in all applicable settings. In
16 making such recommendations, the entity shall—

17 “(A) ensure that priority is given to meas-
18 ures—

19 “(i) that address the health care pro-
20 vided to patients with prevalent, high-cost
21 chronic diseases;

22 “(ii) with the greatest potential for
23 improving the quality, efficiency, and pa-
24 tient-centeredness of health care; and

1 “(iii) that may be implemented rap-
 2 idly due to existing evidence, standards of
 3 care, or other reasons; and

4 “(B) take into account measures that—

5 “(i) may assist consumers and pa-
 6 tients in making informed health care deci-
 7 sions;

8 “(ii) address health disparities across
 9 groups and areas; and

10 “(iii) address the continuum of care a
 11 patient receives, including services fur-
 12 nished by multiple health care providers or
 13 practitioners and across multiple settings.

14 “(2) ENDORSEMENT OF MEASURES.—The enti-
 15 ty shall provide for the endorsement of standardized
 16 health care performance measures. The endorsement
 17 process under the preceding sentence shall consider
 18 whether a measure—

19 “(A) is evidence-based, reliable, valid,
 20 verifiable, relevant to enhanced health out-
 21 comes, actionable at the caregiver level, feasible
 22 to collect and report, and responsive to vari-
 23 ations in patient characteristics, such as health
 24 status, language capabilities, race or ethnicity,
 25 and income level; and

1 “(B) is consistent across types of health
2 care providers, including hospitals and physi-
3 cians.

4 “(3) MAINTENANCE OF MEASURES.—The entity
5 shall establish and implement a process to ensure
6 that measures endorsed under paragraph (2) are up-
7 dated (or retired if obsolete) as new evidence is de-
8 veloped.

9 “(4) PROMOTION OF THE DEVELOPMENT OF
10 ELECTRONIC HEALTH RECORDS.—The entity shall
11 promote the development and use of electronic
12 health records that contain the functionality for
13 automated collection, aggregation, and transmission
14 of performance measurement information.

15 “(5) ANNUAL REPORT TO CONGRESS AND THE
16 SECRETARY; SECRETARIAL PUBLICATION AND COM-
17 MENT.—

18 “(A) ANNUAL REPORT.—By not later than
19 March 1 of each year (beginning with 2009),
20 the entity shall submit to Congress and the Sec-
21 retary a report containing a description of—

22 “(i) the implementation of quality
23 measurement initiatives under this Act and
24 the coordination of such initiatives with

1 quality initiatives implemented by other
2 payers;

3 “(ii) the recommendations made
4 under paragraph (1); and

5 “(iii) the performance by the entity of
6 the duties required under the contract en-
7 tered into with the Secretary under sub-
8 section (a).

9 “(B) SECRETARIAL REVIEW AND PUBLICA-
10 TION OF ANNUAL REPORT.—Not later than 6
11 months after receiving a report under subpara-
12 graph (A) for a year, the Secretary shall—

13 “(i) review such report; and

14 “(ii) publish such report in the Fed-
15 eral Register, together with any comments
16 of the Secretary on such report.

17 “(c) REQUIREMENTS DESCRIBED.—The require-
18 ments described in this subsection are the following:

19 “(1) PRIVATE NONPROFIT.—The entity is a pri-
20 vate nonprofit entity governed by a board.

21 “(2) BOARD MEMBERSHIP.—The members of
22 the board of the entity include—

23 “(A) representatives of health plans and
24 health care providers and practitioners or rep-
25 resentatives of groups representing such health

1 plans and health care providers and practi-
2 tioners;

3 “(B) health care consumers or representa-
4 tives of groups representing health care con-
5 sumers; and

6 “(C) representatives of purchasers and em-
7 ployers or representatives of groups rep-
8 resenting purchasers or employers.

9 “(3) ENTITY MEMBERSHIP.—The membership
10 of the entity includes persons who have experience
11 with—

12 “(A) urban health care issues;

13 “(B) safety net health care issues;

14 “(C) rural and frontier health care issues;

15 and

16 “(D) health care quality and safety issues.

17 “(4) OPEN AND TRANSPARENT.—With respect
18 to matters related to the contract with the Secretary
19 under subsection (a), the entity conducts its business
20 in an open and transparent manner and provides the
21 opportunity for public comment on its activities.

22 “(5) VOLUNTARY CONSENSUS STANDARDS SET-
23 TING ORGANIZATION.—The entity operates as a vol-
24 untary consensus standards setting organization as
25 defined for purposes of section 12(d) of the National

1 Technology Transfer and Advancement Act of 1995
2 (Public Law 104–113) and Office of Management
3 and Budget Revised Circular A–119 (published in
4 the Federal Register on February 10, 1998).

5 “(6) EXPERIENCE.—The entity has at least 4
6 years of experience in establishing national con-
7 sensus standards.

8 “(7) MEMBERSHIP FEES.—If the entity re-
9 quires a membership fee for participation in the
10 functions of the entity, such fees shall be reasonable
11 and adjusted based on the capacity of the potential
12 member to pay the fee. In no case shall membership
13 fees pose a barrier to the participation of individuals
14 or groups with low or nominal resources to partici-
15 pate in the functions of the entity.

16 “(d) FUNDING.—For purposes of carrying out this
17 subsection, the Secretary shall provide for the transfer,
18 from the Federal Hospital Insurance Trust Fund under
19 section 1817 and the Federal Supplementary Medical In-
20 surance Trust Fund under section 1841 (in such propor-
21 tion as the Secretary determines appropriate), of up to
22 \$40,000,000 to the Centers for Medicare & Medicaid Serv-
23 ices Program Management Account for the period of fiscal
24 years 2009 through 2012.”.

1 (2) SENSE OF THE SENATE.—It is the Sense of
 2 the Senate that the selection by the Secretary of
 3 Health and Human Services of an entity to contract
 4 with under section 1890(a) of the Social Security
 5 Act, as added by subsection (a), should not be con-
 6 strued as diminishing the significant contributions of
 7 the Boards of Medicine, the quality alliances, and
 8 other clinical and technical experts to efforts to
 9 measure and improve the quality of health care serv-
 10 ices.

11 (b) GAO STUDY AND REPORTS ON THE PERFORM-
 12 ANCE AND COSTS OF THE CONSENSUS-BASED ENTITY
 13 UNDER THE CONTRACT.—

14 (1) IN GENERAL.—The Comptroller General of
 15 the United States shall conduct a study on—

16 (A) the performance of the entity with a
 17 contract with the Secretary of Health and
 18 Human Services under section 1890(a) of the
 19 Social Security Act, as added by subsection (a),
 20 of its duties under such contract; and

21 (B) the costs incurred by such entity in
 22 performing such duties.

23 (2) REPORTS.—Not later than 18 months and
 24 36 months after the effective date of the first con-
 25 tract entered into under such section 1890(a), the

1 Comptroller General of the United States shall sub-
2 mit a report to Congress containing the results of
3 the study conducted under paragraph (1), together
4 with recommendations for such legislation and ad-
5 ministrative action as the Comptroller General deter-
6 mines appropriate.

7 **SEC. 172. USE OF PART D DATA.**

8 Section 1860D–12(b)(3)(D) of the Social Security
9 Act (42 U.S.C. 1395w–112(b)(3)(D)) is amended by add-
10 ing at the end the following sentence: “Notwithstanding
11 any other provision of law, information provided to the
12 Secretary under the application of section 1857(e)(1) to
13 contracts under this section under the preceding sentence
14 may be used for the purposes of carrying out this part,
15 improving public health through research on the utiliza-
16 tion, safety, effectiveness, quality, and efficiency of health
17 care services (as the Secretary determines appropriate),
18 and conducting Congressional oversight, monitoring, and
19 analysis of the program under this title.”.

20 **SEC. 173. INCLUSION OF MEDICARE PROVIDERS AND SUP-**
21 **PLIERS IN FEDERAL PAYMENT LEVY AND AD-**
22 **MINISTRATIVE OFFSET PROGRAM.**

23 (a) IN GENERAL.—Section 1874 of the Social Secu-
24 rity Act (42 U.S.C. 1395kk) is amended by adding at the
25 end the following new subsection:

1 “(d) INCLUSION OF MEDICARE PROVIDER AND SUP-
2 PLIER PAYMENTS IN FEDERAL PAYMENT LEVY PRO-
3 GRAM.—

4 “(1) IN GENERAL.—The Centers for Medicare
5 & Medicaid Services shall take all necessary steps to
6 participate in the Federal Payment Levy Program
7 under section 6331(h) of the Internal Revenue Code
8 of 1986 as soon as possible and shall ensure that—

9 “(A) at least 50 percent of all payments
10 under parts A and B are processed through
11 such program beginning within 1 year after the
12 date of the enactment of this section;

13 “(B) at least 75 percent of all payments
14 under parts A and B are processed through
15 such program beginning within 2 years after
16 such date; and

17 “(C) all payments under parts A and B
18 are processed through such program beginning
19 not later than September 30, 2011.

20 “(2) ASSISTANCE.—The Financial Management
21 Service and the Internal Revenue Service shall pro-
22 vide assistance to the Centers for Medicare & Med-
23 icaid Services to ensure that all payments described
24 in paragraph (1) are included in the Federal Pay-

1 ment Levy Program by the deadlines specified in
2 that subsection.”.

3 (b) APPLICATION OF ADMINISTRATIVE OFFSET PRO-
4 VISIONS TO MEDICARE PROVIDER OR SUPPLIER PAY-
5 MENTS.—Section 3716 of title 31, United States Code, is
6 amended—

7 (1) by inserting “the Department of Health and
8 Human Services,” after “United States Postal Serv-
9 ice,” in subsection (c)(1)(A); and

10 (2) by adding at the end of subsection (c)(3)
11 the following new subparagraph:

12 “(D) This section shall apply to payments
13 made after the date which is 90 days after the
14 enactment of this subparagraph (or such earlier
15 date as designated by the Secretary of Health
16 and Human Services) with respect to claims or
17 debts, and to amounts payable, under title
18 XVIII of the Social Security Act.”.

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

TITLE II—MEDICAID

SEC. 201. EXTENSION OF TRANSITIONAL MEDICAL ASSIST- ANCE (TMA) AND ABSTINENCE EDUCATION PROGRAM THROUGH FISCAL YEAR 2009.

Section 401 of division B of the Tax Relief and Health Care Act of 2006 (Public Law 109–432, 120 Stat. 2994), as amended by section 1 of Public Law 110–48 (121 Stat. 244), section 2 of the TMA, Abstinence, Education, and QI Programs Extension Act of 2007 (Public Law 110–90, 121 Stat. 984), and section 202 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) is amended—

(1) by striking “June 30, 2008” and inserting “September 30, 2009”;

(2) by striking “the third quarter of fiscal year 2008” and inserting “the fourth quarter of fiscal year 2009”; and

(3) by striking “the third quarter of fiscal year 2007” and inserting “the fourth quarter of fiscal year 2007”.

SEC. 202. EXTENSION OF QUALIFYING INDIVIDUAL (QI) PROGRAM THROUGH FISCAL YEAR 2009.

(a) EXTENSION.—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is

1 amended by striking “June 2008” and inserting “Sep-
2 tember 2009”.

3 (b) EXTENDING TOTAL AMOUNT AVAILABLE FOR
4 ALLOCATION.—Section 1933(g) of such Act (42 U.S.C.
5 1396u-3(g)) is amended—

6 (1) in paragraph (2)—

7 (A) by striking “and” at the end of sub-
8 paragraph (H);

9 (B) in subparagraph (I)—

10 (i) by striking “June 30” and insert-
11 ing “September 30”;

12 (ii) by striking “\$200,000,000” and
13 inserting “\$375,000,000”; and

14 (iii) by striking the period at the end
15 and inserting a semicolon; and

16 (C) by adding at the end the following new
17 subparagraphs:

18 “(J) for the period that begins on October
19 1, 2008, and ends on December 31, 2008, the
20 total allocation amount is \$150,000,000; and

21 “(K) for the period that begins on January
22 1, 2009, and ends on September 30, 2009, the
23 total allocation amount is \$350,000,000.”; and

1 (2) in paragraph (3), in the matter preceding
 2 subparagraph (A), by striking “or (H)” and insert-
 3 ing “(H), or (J)”.

4 **SEC. 203. MEDICAID DSH EXTENSION THROUGH DECEMBER**
 5 **31, 2009.**

6 Section 1923(f)(6) of the Social Security Act (42
 7 U.S.C. 1396r-4(f)(6)) is amended—

8 (1) in the heading, by striking “FOR FISCAL
 9 YEAR 2007 AND PORTIONS OF FISCAL YEAR 2008”;

10 (2) in subparagraph (A)—

11 (A) in clause (i)—

12 (i) in the second sentence—

13 (I) by striking “fiscal year 2008
 14 for the period ending on June 30,
 15 2008” and inserting “fiscal years
 16 2008 and 2009”; and

17 (II) by striking “ $\frac{3}{4}$ of”; and

18 (ii) by adding at the end the following
 19 new sentences: “Only with respect to fiscal
 20 year 2010 for the period ending on Decem-
 21 ber 31, 2009, the DSH allotment for Ten-
 22 nessee for such portion of the fiscal year,
 23 notwithstanding such table or terms, shall
 24 be $\frac{1}{4}$ of the amount specified in the first
 25 sentence for fiscal year 2007.”;

(B) in clause (ii), by striking “or for a period in fiscal year 2008” and inserting “, 2008, 2009, or for a period in fiscal year 2010”; and

(C) in clause (iv)—

(i) in the heading, by striking “FISCAL YEAR 2007 AND FISCAL YEAR 2008” and inserting “FISCAL YEARS 2007 THROUGH 2009 AND THE FIRST CALENDAR QUARTER OF FISCAL YEAR 2010”;

(ii) in subclause (I), by striking “or for a period in fiscal year 2008” and inserting “, 2008, 2009, or for a period in fiscal year 2010”; and

(iii) in subclause (II), by striking “or for a period in fiscal year 2008” and inserting “, 2008, 2009, or for a period in fiscal year 2010”; and

(3) in subparagraph (B)(i)—

(A) in the first sentence, by striking “fiscal year 2007” and inserting “each of fiscal years 2007 through 2009”; and

(B) by striking the second sentence and inserting the following: “Only with respect to fiscal year 2010 for the period ending on December 31, 2009, the DSH allotment for Hawaii

1 for such portion of the fiscal year, notwith-
 2 standing the table set forth in paragraph (2),
 3 shall be \$2,500,000.”.

4 **SEC. 204. ASSET VERIFICATION THROUGH ACCESS TO IN-**
 5 **FORMATION HELD BY FINANCIAL INSTITU-**
 6 **TIONS.**

7 (a) ADDITION OF AUTHORITY.—Title XIX of the So-
 8 cial Security Act is amended by inserting after section
 9 1939 the following new section:

10 “ASSET VERIFICATION THROUGH ACCESS TO
 11 INFORMATION HELD BY FINANCIAL INSTITUTIONS

12 “SEC. 1940. (a) IMPLEMENTATION.—

13 “(1) IN GENERAL.—Subject to the provisions of
 14 this section, each State shall implement an asset
 15 verification program described in subsection (b), for
 16 purposes of determining or redetermining the eligi-
 17 bility of an individual for medical assistance under
 18 the State plan under this title.

19 “(2) PLAN SUBMITTAL.—In order to meet the
 20 requirement of paragraph (1), each State shall—

21 “(A) submit not later than a deadline spec-
 22 ified by the Secretary consistent with paragraph
 23 (3), a State plan amendment under this title
 24 that describes how the State intends to imple-
 25 ment the asset verification program; and

1 “(B) provide for implementation of such
2 program for eligibility determinations and rede-
3 terminations made on or after 6 months after
4 the deadline established for submittal of such
5 plan amendment.

6 “(3) PHASE-IN.—

7 “(A) IN GENERAL.—

8 “(i) IMPLEMENTATION IN CURRENT
9 ASSET VERIFICATION DEMO STATES.—The
10 Secretary shall require those States speci-
11 fied in subparagraph (C) (to which an
12 asset verification program has been applied
13 before the date of the enactment of this
14 section) to implement an asset verification
15 program under this subsection by the end
16 of fiscal year 2009.

17 “(ii) IMPLEMENTATION IN OTHER
18 STATES.—The Secretary shall require
19 other States to submit and implement an
20 asset verification program under this sub-
21 section in such manner as is designed to
22 result in the application of such programs,
23 in the aggregate for all such other States,
24 to enrollment of approximately, but not
25 less than, the following percentage of en-

rollees, in the aggregate for all such other States, by the end of the fiscal year involved:

“(I) 12.5 percent by the end of fiscal year 2009.

“(II) 25 percent by the end of fiscal year 2010.

“(III) 50 percent by the end of fiscal year 2011.

“(IV) 75 percent by the end of fiscal year 2012.

“(V) 100 percent by the end of fiscal year 2013.

“(B) CONSIDERATION.—In selecting States under subparagraph (A)(ii), the Secretary shall consult with the States involved and take into account the feasibility of implementing asset verification programs in each such State.

“(C) STATES SPECIFIED.—The States specified in this subparagraph are California, New York, and New Jersey.

“(D) CONSTRUCTION.—Nothing in subparagraph (A)(ii) shall be construed as preventing a State from requesting, and the Secretary approving, the implementation of an

1 asset verification program in advance of the
 2 deadline otherwise established under such sub-
 3 paragraph.

4 “(4) EXEMPTION OF TERRITORIES.—This sec-
 5 tion shall only apply to the 50 States and the Dis-
 6 trict of Columbia.

7 “(b) ASSET VERIFICATION PROGRAM.—

8 “(1) IN GENERAL.—For purposes of this sec-
 9 tion, an asset verification program means a program
 10 described in paragraph (2) under which a State—

11 “(A) requires each applicant for, or recipi-
 12 ent of, medical assistance under the State plan
 13 under this title on the basis of being aged,
 14 blind, or disabled to provide authorization by
 15 such applicant or recipient (and any other per-
 16 son whose resources are material to the deter-
 17 mination of the eligibility of the applicant or re-
 18 cipient for such assistance) for the State to ob-
 19 tain (subject to the cost reimbursement require-
 20 ments of section 1115(a) of the Right to Finan-
 21 cial Privacy Act but at no cost to the applicant
 22 or recipient) from any financial institution
 23 (within the meaning of section 1101(1) of such
 24 Act) any financial record (within the meaning
 25 of section 1101(2) of such Act) held by the in-

stitution with respect to the applicant or recipient (and such other person, as applicable), whenever the State determines the record is needed in connection with a determination with respect to such eligibility for (or the amount or extent of) such medical assistance; and

“(B) uses the authorization provided under subparagraph (A) to verify the financial resources of such applicant or recipient (and such other person, as applicable), in order to determine or redetermine the eligibility of such applicant or recipient for medical assistance under the State plan.

“(2) PROGRAM DESCRIBED.—A program described in this paragraph is a program for verifying individual assets in a manner consistent with the approach used by the Commissioner of Social Security under section 1631(e)(1)(B)(ii).

“(c) DURATION OF AUTHORIZATION.—Notwithstanding section 1104(a)(1) of the Right to Financial Privacy Act, an authorization provided to a State under subsection (b)(1) shall remain effective until the earliest of—

“(1) the rendering of a final adverse decision on the applicant’s application for medical assistance under the State’s plan under this title;

1 “(2) the cessation of the recipient’s eligibility
2 for such medical assistance; or

3 “(3) the express revocation by the applicant or
4 recipient (or such other person described in sub-
5 section (b)(1), as applicable) of the authorization, in
6 a written notification to the State.

7 “(d) TREATMENT OF RIGHT TO FINANCIAL PRIVACY
8 ACT REQUIREMENTS.—

9 “(1) An authorization obtained by the State
10 under subsection (b)(1) shall be considered to meet
11 the requirements of the Right to Financial Privacy
12 Act for purposes of section 1103(a) of such Act, and
13 need not be furnished to the financial institution,
14 notwithstanding section 1104(a) of such Act.

15 “(2) The certification requirements of section
16 1103(b) of the Right to Financial Privacy Act shall
17 not apply to requests by the State pursuant to an
18 authorization provided under subsection (b)(1).

19 “(3) A request by the State pursuant to an au-
20 thorization provided under subsection (b)(1) is
21 deemed to meet the requirements of section
22 1104(a)(3) of the Right to Financial Privacy Act
23 and of section 1102 of such Act, relating to a rea-
24 sonable description of financial records.

1 “(e) REQUIRED DISCLOSURE.—The State shall in-
 2 form any person who provides authorization pursuant to
 3 subsection (b)(1)(A) of the duration and scope of the au-
 4 thorization.

5 “(f) REFUSAL OR REVOCATION OF AUTHORIZA-
 6 TION.—If an applicant for, or recipient of, medical assist-
 7 ance under the State plan under this title (or such other
 8 person described in subsection (b)(1), as applicable) re-
 9 fuses to provide, or revokes, any authorization made by
 10 the applicant or recipient (or such other person, as appli-
 11 cable) under subsection (b)(1)(A) for the State to obtain
 12 from any financial institution any financial record, the
 13 State may, on that basis, determine that the applicant or
 14 recipient is ineligible for medical assistance.

15 “(g) USE OF CONTRACTOR.—For purposes of imple-
 16 menting an asset verification program under this section,
 17 a State may select and enter into a contract with a public
 18 or private entity meeting such criteria and qualifications
 19 as the State determines appropriate, consistent with re-
 20 quirements in regulations relating to general contracting
 21 provisions and with section 1903(i)(2). In carrying out ac-
 22 tivities under such contract, such an entity shall be subject
 23 to the same requirements and limitations on use and dis-
 24 closure of information as would apply if the State were
 25 to carry out such activities directly.

1 “(h) TECHNICAL ASSISTANCE.—The Secretary shall
 2 provide States with technical assistance to aid in imple-
 3 mentation of an asset verification program under this sec-
 4 tion.

5 “(i) REPORTS.—A State implementing an asset
 6 verification program under this section shall furnish to the
 7 Secretary such reports concerning the program, at such
 8 times, in such format, and containing such information
 9 as the Secretary determines appropriate.

10 “(j) TREATMENT OF PROGRAM EXPENSES.—Not-
 11 withstanding any other provision of law, reasonable ex-
 12 penses of States in carrying out the program under this
 13 section shall be treated, for purposes of section 1903(a),
 14 in the same manner as State expenditures specified in
 15 paragraph (7) of such section.”.

16 (b) STATE PLAN REQUIREMENTS.—Section 1902(a)
 17 of such Act (42 U.S.C. 1396a(a)) is amended—

18 (1) in paragraph (69) by striking “and” at the
 19 end;

20 (2) in paragraph (70) by striking the period at
 21 the end and inserting “; and”; and

22 (3) by inserting after paragraph (70), as so
 23 amended, the following new paragraph:

1 “(71) provide that the State will implement an
2 asset verification program as required under section
3 1940.”.

4 (c) WITHHOLDING OF FEDERAL MATCHING PAY-
5 MENTS FOR NONCOMPLIANT STATES.—Section 1903(i) of
6 such Act (42 U.S.C. 1396b(i)) is amended—

7 (1) in paragraph (22) by striking “or” at the
8 end;

9 (2) in paragraph (23) by striking the period at
10 the end and inserting “; or”; and

11 (3) by adding after paragraph (23) the fol-
12 lowing new paragraph:

13 “(24) if a State is required to implement an
14 asset verification program under section 1940 and
15 fails to implement such program in accordance with
16 such section, with respect to amounts expended by
17 such State for medical assistance for individuals
18 subject to asset verification under such section, un-
19 less—

20 “(A) the State demonstrates to the Sec-
21 retary’s satisfaction that the State made a good
22 faith effort to comply;

23 “(B) not later than 60 days after the date
24 of a finding that the State is in noncompliance,
25 the State submits to the Secretary (and the

1 Secretary approves) a corrective action plan to
 2 remedy such noncompliance; and

3 “(C) not later than 12 months after the
 4 date of such submission (and approval), the
 5 State fulfills the terms of such corrective action
 6 plan.”.

7 (d) REPEAL.—Section 4 of Public Law 110–90 is re-
 8 pealed.

9 **SEC. 205. APPLICATION OF MEDICARE PAYMENT ADJUST-**
 10 **MENT FOR CERTAIN HOSPITAL-ACQUIRED**
 11 **CONDITIONS TO PAYMENTS FOR INPATIENT**
 12 **HOSPITAL SERVICES UNDER MEDICAID.**

13 (a) STATE PLAN REQUIREMENT.—Section
 14 1902(a)(13)(A)(iv) of the Social Security Act (42 U.S.C.
 15 1396a(a)(13)(A)(iv)) is amended—

16 (1) by striking “rates take” and inserting
 17 “rates—

18 “(I) take”;

19 (2) by striking the semicolon and inserting a
 20 comma; and

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

22 “(II) ensure that higher pay-
 23 ments are not made for services re-
 24 lated to the presence of a condition
 25 that could be identified by a sec-

1 ondary diagnostic code described in
2 section 1886(d)(4)(D);”.

3 (b) EFFECTIVE DATE.—

4 (1) IN GENERAL.—Except as provided in para-
5 graph (2), the amendments made by subsection (a)
6 take effect on October 1, 2008.

7 (2) EXTENSION OF EFFECTIVE DATE FOR
8 STATE LAW AMENDMENT.—In the case of a State
9 plan under title XIX of the Social Security Act (42
10 U.S.C. 1396 et seq.) which the Secretary of Health
11 and Human Services determines requires State legis-
12 lation in order for the plan to meet the additional
13 requirements imposed by the amendments made by
14 this section, the State plan shall not be regarded as
15 failing to comply with the requirements of such title
16 solely on the basis of its failure to meet these addi-
17 tional requirements before the first day of the first
18 calendar quarter beginning after the close of the
19 first regular session of the State legislature that be-
20 gins after the date of enactment of this Act. For
21 purposes of the previous sentence, in the case of a
22 State that has a 2-year legislative session, each year
23 of the session is considered to be a separate regular
24 session of the State legislature.

1 **SEC. 206. REDUCTION IN PAYMENTS FOR MEDICAID ADMIN-**
 2 **ISTRATIVE COSTS TO PREVENT DUPLICATION**
 3 **OF SUCH PAYMENTS UNDER TANF.**

4 Section 1903 of the Social Security Act (42 U.S.C.
 5 1396b) is amended—

6 (1) in subsection (a)(7), by striking “section
 7 1919(g)(3)(B)” and inserting “subsection (h)”;

8 (2) in subsection (a)(2)(D) by inserting “, sub-
 9 ject to subsection (g)(3)(C) of such section” after
 10 “as are attributable to State activities under section
 11 1919(g)”;

12 (3) by adding after subsection (g) the following
 13 new subsection:

14 “(h) REDUCTION IN PAYMENTS FOR ADMINISTRA-
 15 TIVE COSTS TO PREVENT DUPLICATION OF PAYMENTS
 16 UNDER TITLE IV.—Beginning with the calendar quarter
 17 commencing October 1, 2008, the Secretary shall reduce
 18 the amount paid to each State under subsection (a)(7) for
 19 each quarter by an amount equal to $\frac{1}{4}$ of the annualized
 20 amount determined for the Medicaid program under sec-
 21 tion 16(k)(2)(B) of the Food Stamp Act of 1977 (7 U.S.C.
 22 2025(k)(2)(B)).”.

23 **SEC. 207. CLARIFICATION TREATMENT OF REGIONAL MED-**
 24 **ICAL CENTER.**

25 (a) IN GENERAL.—Nothing in section 1903(w) of the
 26 Social Security Act (42 U.S.C. 1396b(w)) shall be con-

1 strued by the Secretary of Health and Human Services
2 as prohibiting a State's use of funds as the non-Federal
3 share of expenditures under title XIX of such Act where
4 such funds are transferred from or certified by a publicly-
5 owned regional medical center located in another State
6 and described in subsection (b), so long as the Secretary
7 determines that such use of funds is proper and in the
8 interest of the program under title XIX.

9 (b) CENTER DESCRIBED.—A center described in this
10 subsection is a publicly-owned regional medical center
11 that—

12 (1) provides level 1 trauma and burn care serv-
13 ices;

14 (2) provides level 3 neonatal care services;

15 (3) is obligated to serve all patients, regardless
16 of ability to pay;

17 (4) is located within a Standard Metropolitan
18 Statistical Area (SMSA) that includes at least 3
19 States;

20 (5) provides services as a tertiary care provider
21 for patients residing within a 125-mile radius; and

22 (6) meets the criteria for a disproportionate
23 share hospital under section 1923 of such Act (42
24 U.S.C. 1396r-4) in at least one State other than the
25 State in which the center is located.

1 **SEC. 208. GRANTS TO IMPROVE OUTREACH AND ENROLL-**
 2 **MENT UNDER MEDICAID.**

3 (a) **AUTHORITY TO AWARD GRANTS.**—From the
 4 amounts appropriated for a fiscal year under subsection
 5 (g), the Secretary shall award grants to eligible entities
 6 to conduct outreach and enrollment efforts that are de-
 7 signed to increase the enrollment and participation of eli-
 8 gible individuals under Medicaid.

9 (b) **PRIORITY FOR AWARD OF GRANTS.**—

10 (1) **IN GENERAL.**—In awarding grants under
 11 subsection (a), the Secretary shall give priority to el-
 12 igible entities that—

13 (A) propose to target geographic areas
 14 with high rates of—

15 (i) individuals who are eligible for, but
 16 unenrolled in, Medicaid, including such in-
 17 dividuals who reside in rural areas; or

18 (ii) racial and ethnic minorities and
 19 health disparity populations, including
 20 those proposals that address cultural and
 21 linguistic barriers to enrollment; and

22 (B) submit the most demonstrable evidence
 23 required under paragraphs (1) and (2) of sub-
 24 section (c).

25 (2) **10 PERCENT SET ASIDE FOR OUTREACH TO**
 26 **INDIANS.**—An amount equal to 10 percent of the

1 funds appropriated under subsection (g) for a fiscal
2 year shall be used by the Secretary to award grants
3 to Indian Health Service providers and urban Indian
4 organizations receiving funds under title V of the In-
5 dian Health Care Improvement Act (25 U.S.C. 1651
6 et seq.) for outreach to, and enrollment of, individ-
7 uals who are Indians.

8 (c) APPLICATION.—An eligible entity that desires to
9 receive a grant under subsection (a) shall submit an appli-
10 cation to the Secretary in such form and manner, and con-
11 taining such information, as the Secretary may decide.
12 Such application shall include—

13 (1) evidence demonstrating that the entity in-
14 cludes members who have access to, and credibility
15 with, ethnic or low-income populations in the com-
16 munities in which activities funded under the grant
17 are to be conducted;

18 (2) evidence demonstrating that the entity has
19 the ability to address barriers to enrollment, such as
20 lack of awareness of eligibility, stigma concerns and
21 punitive fears associated with receipt of benefits,
22 and other cultural barriers to applying for and re-
23 ceiving medical assistance;

1 (3) specific quality or outcomes performance
 2 measures to evaluate the effectiveness of activities
 3 funded by a grant awarded under this section; and

4 (4) an assurance that the eligible entity shall—

5 (A) conduct an assessment of the effective-
 6 ness of such activities against the performance
 7 measures;

8 (B) cooperate with the collection and re-
 9 porting of enrollment data and other informa-
 10 tion in order for the Secretary to conduct such
 11 assessments; and

12 (C) in the case of an eligible entity that is
 13 not a State, provide each State in which the eli-
 14 gible entity conducts outreach activities with
 15 grant funds with enrollment data and other in-
 16 formation as necessary for each such State to
 17 administer its State Medicaid program.

18 (d) DISSEMINATION OF ENROLLMENT DATA AND IN-
 19 FORMATION DETERMINED FROM EFFECTIVENESS AS-
 20 SESSMENTS; ANNUAL REPORT.—The Secretary shall—

21 (1) make publicly available the enrollment data
 22 and information collected and reported in accordance
 23 with subsection (c)(4)(B); and

24 (2) not later than December 31, 2009, submit
 25 a report to Congress on the outreach and enrollment

1 activities conducted with funds appropriated under
2 this section.

3 (e) SUPPLEMENT, NOT SUPPLANT.—Federal funds
4 awarded under this section shall be used to supplement,
5 not supplant, non-Federal funds that are otherwise avail-
6 able for activities funded under this section.

7 (f) DEFINITIONS.—In this section:

8 (1) ELIGIBLE ENTITY.—The term “eligible enti-
9 ty” means any of the following:

10 (A) A State.

11 (B) A local government.

12 (C) An Indian tribe or tribal consortium, a
13 tribal organization, an urban Indian organiza-
14 tion receiving funds under title V of the Indian
15 Health Care Improvement Act (25 U.S.C. 1651
16 et seq.), or an Indian Health Service provider.

17 (D) A Federal health safety net organiza-
18 tion.

19 (E) A State, national, local, or community-
20 based public or nonprofit private organization.

21 (F) A faith-based organization or con-
22 sortia, to the extent that a grant awarded to
23 such an entity is consistent with the require-
24 ments of section 1955 of the Public Health

1 Service Act (42 U.S.C. 300x–65) relating to a
2 grant award to non-governmental entities.

3 (G) An elementary or secondary school.

4 (2) FEDERAL HEALTH SAFETY NET ORGANIZA-
5 TION.—The term “Federal health safety net organi-
6 zation” means—

7 (A) a federally-qualified health center (as
8 defined in section 1905(l)(2)(B) of the Social
9 Security Act (42 U.S.C. 1396d(l)(2)(B));

10 (B) a hospital defined as a dispro-
11 portionate share hospital for purposes of section
12 1923 of such Act (42 U.S.C. 1396r–4);

13 (C) a covered entity described in section
14 340B(a)(4) of the Public Health Service Act
15 (42 U.S.C. 256b(a)(4)); and

16 (D) any other entity or consortium that
17 serves children under a federally-funded pro-
18 gram, including the special supplemental nutri-
19 tion program for women, infants, and children
20 (WIC) established under section 17 of the Child
21 Nutrition Act of 1966 (42 U.S.C. 1786), the
22 head start and early head start programs under
23 the Head Start Act (42 U.S.C. 9801 et seq.),
24 the school lunch program established under the

1 Richard B. Russell National School Lunch Act,
2 and an elementary or secondary school.

3 (3) INDIANS; INDIAN TRIBE; TRIBAL ORGANIZA-
4 TION; URBAN INDIAN ORGANIZATION.—The terms
5 “Indian”, “Indian tribe”, “tribal organization”, and
6 “urban Indian organization” have the meanings
7 given such terms in section 4 of the Indian Health
8 Care Improvement Act (25 U.S.C. 1603).

9 (4) MEDICAID.—The term “Medicaid” means
10 the program of medical assistance established under
11 title XIX of the Social Security Act (42 U.S.C. 1396
12 et seq.).

13 (g) APPROPRIATION.—There is appropriated, out of
14 any money in the Treasury not otherwise appropriated,
15 for the purpose of awarding grants under this section,
16 \$25,000,000 for fiscal year 2009, to remain available until
17 expended. Amounts appropriated and paid under the au-
18 thority of this section to an eligible entity that is a State
19 shall be in addition to amounts paid to the State under
20 section 1903(a) of the Social Security Act (42 U.S.C.
21 1396b(a)).

1 **TITLE III—MISCELLANEOUS**

2 **SEC. 301. EXTENSION OF TANF SUPPLEMENTAL GRANTS**
 3 **THROUGH FISCAL YEAR 2009.**

4 (a) EXTENSION.—Section 7101(a) of the Deficit Re-
 5 duction Act of 2005 (Public Law 109–171; 120 Stat. 135)
 6 is amended by striking “fiscal year 2008” and inserting
 7 “fiscal year 2009”.

8 (b) CONFORMING AMENDMENT.—Section
 9 403(a)(3)(H)(ii) of the Social Security Act (42 U.S.C.
 10 603(a)(3)(H)(ii)) is amended to read as follows:

11 “(ii) subparagraph (G) shall be ap-
 12 plied as if ‘fiscal year 2009’ were sub-
 13 stituted for ‘fiscal year 2001’; and”.

14 **SEC. 302. SPECIAL DIABETES PROGRAMS FOR TYPE I DIA-**
 15 **BETES AND INDIANS.**

16 (a) SPECIAL DIABETES PROGRAMS FOR TYPE I DIA-
 17 BETES.—Section 330B(b)(2)(C) of the Public Health
 18 Service Act (42 U.S.C. 254c–2(b)(2)(C)) is amended by
 19 striking “2009” and inserting “2011”.

20 (b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—
 21 Section 330C(c)(2)(C) of the Public Health Service Act
 22 (42 U.S.C. 254c–3(c)(2)(C)) is amended by striking
 23 “2009” and inserting “2011”.

24 (c) REPORT ON GRANT PROGRAMS.—Section 4923(b)
 25 of the Balanced Budget Act of 1997 (42 U.S.C. 1254c–

1 2 note), as amended by section 931(c) of the Medicare,
 2 Medicaid, and SCHIP Benefits Improvement and Protec-
 3 tion Act of 2000, as enacted into law by section 1(a)(6)
 4 of Public Law 106–554, and section 1(c) of Public Law
 5 107–360, is amended—

6 (1) in paragraph (1), by striking “and” at the
 7 end;

8 (2) in paragraph (2)—

9 (A) by striking “a final report” and insert-
 10 ing “a second interim report”; and

11 (B) by striking the period at the end and
 12 inserting “; and”; and

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

15 “(3) a final report on such evaluation not later
 16 than January 1, 2011.”.

17 **SEC. 303. ADDITIONAL FUNDING FOR STATE HEALTH IN-**
 18 **SURANCE ASSISTANCE PROGRAMS, AREA**
 19 **AGENCIES ON AGING, AND AGING AND DIS-**
 20 **ABILITY RESOURCE CENTERS.**

21 (a) STATE HEATH INSURANCE PROGRAMS.—

22 (1) IN GENERAL.—Paragraph (2) of section
 23 118(a) of the Medicare, Medicaid, and SCHIP Ex-
 24 tension Act of 2007 (Public Law 110–173) is
 25 amended by inserting “and of \$19,000,000 to such

1 account for fiscal year 2009” before the period at
2 the end.

3 (2) AMOUNT OF GRANTS.—The amount of a
4 grant to a State under such section 118(a) from the
5 total amount made available under that section for
6 fiscal year 2009 shall be equal to the sum of the
7 amount allocated to the State under paragraph
8 (3)(A) and the amount allocated to the State under
9 subparagraph (3)(B).

10 (3) ALLOCATION TO STATES.—

11 (A) ALLOCATION BASED ON PERCENTAGE
12 OF LOW-INCOME BENEFICIARIES.—The amount
13 allocated to a State under this subparagraph
14 from $\frac{2}{3}$ of the total amount made available
15 under section 118(a) of such Act for fiscal year
16 2009 shall be based on the number of individ-
17 uals who meet the requirement under sub-
18 section (a)(3)(A)(ii) of section 1860D–14 of the
19 Social Security Act (42 U.S.C. 1395w–114) but
20 who have not enrolled to receive a subsidy
21 under such section 1860D–14 relative to the
22 total number of individuals who meet the re-
23 quirement under such subsection (a)(3)(A)(ii)
24 in each State, as estimated by the Secretary.

1 (B) ALLOCATION BASED ON PERCENTAGE
 2 OF RURAL BENEFICIARIES.—The amount allo-
 3 cated to a State under this subparagraph from
 4 $\frac{1}{3}$ of the total amount made available under
 5 section 118(a) of such Act for fiscal year 2009
 6 shall be based on the number of part D eligible
 7 individuals (as defined in section 1860D–
 8 1(a)(3)(A) of such Act (42 U.S.C. 1395w–
 9 101(a)(3)(A))) residing in a rural area relative
 10 to the total number of such individuals in each
 11 State, as estimated by the Secretary.

12 (4) PORTION OF GRANT BASED ON PERCENT-
 13 AGE OF LOW-INCOME BENEFICIARIES TO BE USED
 14 TO PROVIDE OUTREACH TO INDIVIDUALS WHO MAY
 15 BE SUBSIDY ELIGIBLE INDIVIDUALS OR ELIGIBLE
 16 FOR THE MEDICARE SAVINGS PROGRAM.—Each
 17 grant awarded under section 118(a) of such Act
 18 with respect to amounts allocated under paragraph
 19 (3)(A) shall be used to provide outreach to individ-
 20 uals who may be subsidy eligible individuals (as de-
 21 fined in section 1860D–14(a)(3)(A) of the Social Se-
 22 curity Act (42 U.S.C. 1395w–114(a)(3)(A)) or eligi-
 23 ble for the Medicare Savings Program (as defined in
 24 subsection (c)).

1 (b) AREA AGENCIES ON AGING AND DISABILITY RE-
2 SOURCE CENTERS.—

3 (1) IN GENERAL.—Paragraph (2) of section
4 118(b) of the Medicare, Medicaid, and SCHIP Ex-
5 tension Act of 2007 (Public Law 110–173) is
6 amended by striking “for the period of fiscal years
7 2008 through 2009” and inserting “for fiscal year
8 2008 and of \$6,000,000 to such account for fiscal
9 year 2009”.

10 (2) AMOUNT OF GRANT.—The amount of a
11 grant to a State under such section 118(b) from the
12 total amount made available under that section for
13 fiscal year 2009 shall be determined in the same
14 manner as the amount of a grant to a State under
15 section 118(a) of the Medicare, Medicaid, and
16 SCHIP Extension Act of 2007 (Public Law 110–
17 173) is determined for fiscal year 2009.

18 (3) ALLOCATION AND USE OF PORTION OF
19 GRANT FUNDS TO PROVIDE OUTREACH TO INDIVID-
20 UALS WHO MAY BE SUBSIDY ELIGIBLE INDIVIDUALS
21 OR ELIGIBLE FOR THE MEDICARE SAVINGS PRO-
22 GRAM.—

23 (A) ALLOCATION.—The total amount
24 available under section 118(b) of the Medicare,
25 Medicaid, and SCHIP Extension Act of 2007

1 (Public Law 110–173) for fiscal year 2009
2 shall be allocated to States in the same manner
3 as the amount made available for such fiscal
4 year under section 118(a) of such Act is allo-
5 cated to States under subparagraphs (A) and
6 (B) of subsection (a)(3) of this Act.

7 (B) USE OF PORTION OF GRANT FUNDS TO
8 PROVIDE OUTREACH TO INDIVIDUALS WHO MAY
9 BE SUBSIDY ELIGIBLE INDIVIDUALS OR ELIGI-
10 BLE FOR THE MEDICARE SAVINGS PROGRAM.—
11 Paragraph (4) of subsection (a) of this Act
12 shall apply to the amounts allocated under this
13 paragraph in the same manner such paragraph
14 applies to the amounts allocated under sub-
15 section (a)(3) of this Act.

16 (c) MEDICARE SAVINGS PROGRAM DEFINED.—For
17 purposes of this section, the term “Medicare Savings Pro-
18 gram” means the program of medical assistance for pay-
19 ment of the cost of Medicare cost-sharing under the Med-
20 icaid program pursuant to sections 1902(a)(10)(E) and
21 1933 of the Social Security Act (42 U.S.C.
22 1396a(a)(10)(E), 1396u–3).

1 **SEC. 304. EXTENSION OF FEDERAL REIMBURSEMENT OF**
2 **EMERGENCY HEALTH SERVICES FURNISHED**
3 **TO UNDOCUMENTED ALIENS.**

4 Section 1011(a) of the Medicare Prescription Drug,
5 Improvement, and Modernization Act of 2003 (42 U.S.C.
6 13955dd note) is amended—

7 (1) in paragraph (1), by inserting “and
8 \$200,000,000 for each of fiscal years 2009 and
9 2010,” after “2008”;

10 (2) by redesignating paragraph (2) as para-
11 graph (3); and

12 (3) by inserting after paragraph (1) the fol-
13 lowing new paragraph:

14 “(2) ADMINISTRATIVE COSTS.—From the funds
15 made available under paragraph (1) for fiscal year
16 2009, the Secretary may use not more than
17 \$8,000,000 of such funds for the administration of
18 this section.”.

Calendar No. 776

110TH CONGRESS
2D Session

S. 3118

A BILL

To amend titles XVIII and XIX of the Social Security Act to preserve beneficiary access to care by preventing a reduction in the Medicare physician fee schedule, to improve the quality of care by advancing value based purchasing, electronic health records, and electronic prescribing, and to maintain and improve access to care in rural areas, and for other purposes.

JUNE 12, 2008

Read the second time and placed on the calendar