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(Original Signature of Member)

110TH CONGRESS  
1ST SESSION

**H. R.**

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

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IN THE HOUSE OF REPRESENTATIVES

Mr. DINGELL (for himself, Mr. RANGEL, Mr. STARK, and Mr. PALLONE) introduced the following bill; which was referred to the Committee on

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**A BILL**

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

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

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

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

1 (b) TABLE OF CONTENTS.—The table of contents of  
2 this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—CHILDREN’S HEALTH INSURANCE PROGRAM

Sec. 100. Purpose.

Subtitle A—Funding

Sec. 101. Establishment of new base CHIP allotments.

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

Sec. 103. Redistribution of unused allotments to address State funding shortfalls.

Sec. 104. Extension of option for qualifying States.

Subtitle B—Improving Enrollment and Retention of Eligible Children

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

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

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

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

Subtitle C—Coverage

Sec. 121. Ensuring child-centered coverage.

Sec. 122. Improving benchmark coverage options.

Sec. 123. Premium grace period.

Subtitle D—Populations

Sec. 131. Optional coverage of older children under Medicaid and CHIP.

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

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

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

Subtitle E—Access

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

Sec. 142. Model of Interstate coordinated enrollment and coverage process.

Sec. 143. Medicaid citizenship documentation requirements.

Sec. 144. Access to dental care for children.

Sec. 145. Prohibiting initiation of new health opportunity account demonstration programs.

Subtitle F—Quality and Program Integrity

Sec. 151. Pediatric health quality measurement program.

Sec. 152. Application of certain managed care quality safeguards to CHIP.

Sec. 153. Updated Federal evaluation of CHIP.

- Sec. 154. Access to records for IG and GAO audits and evaluations.
- Sec. 155. References to title XXI.
- Sec. 156. Reliance on law; exception for State legislation.

## TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS

### Subtitle A—Improvements in Benefits

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

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

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

### Subtitle C—Part D Beneficiary Improvements

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

### Subtitle D—Reducing Health Disparities

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

Sec. 237. Definitions.

#### TITLE III—PHYSICIANS' SERVICE PAYMENT REFORM

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

#### TITLE IV—MEDICARE ADVANTAGE REFORMS

##### Subtitle A—Payment Reform

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

##### Subtitle B—Beneficiary Protections

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

##### Subtitle C—Quality and Other Provisions

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

##### Subtitle D—Extension of Authorities

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

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

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

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

## Subtitle A—Payment and Coverage Improvements

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

## Subtitle B—Extension of Medicare Rural Access Protections

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

## Subtitle C—End Stage Renal Disease Program

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

## Subtitle D—Miscellaneous

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

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

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

## TITLE VIII—MEDICAID

## Subtitle A—Protecting Existing Coverage

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

## Subtitle B—Payments

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

## Subtitle C—Miscellaneous

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

## TITLE IX—MISCELLANEOUS

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

## TITLE X—REVENUES

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

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

3     **SEC. 100. PURPOSE.**

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

9             **Subtitle A—Funding**

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

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

14             (1) in subsection (a)—

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

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

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

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

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

4           (3) by adding at the end the following new sub-  
5           section:

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

8           “(1) GENERAL ALLOTMENT COMPUTATION.—

9           Subject to the succeeding provisions of this sub-  
10          section, the Secretary shall compute a State allot-  
11          ment for each State for each fiscal year as follows:

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

15                         “(i) the State projection (in its sub-  
16                         mission on forms CMS—21B and CMS—  
17                         37 for May 2007) of Federal payments to  
18                         the State under this title for such fiscal  
19                         year, except that, in the case of a State  
20                         that has enacted legislation to modify its  
21                         State child health plan during 2007, the  
22                         State may substitute its projection in its  
23                         submission on forms CMS—21B and  
24                         CMS—37 for August 2007, instead of  
25                         such forms for May 2007; or



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

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

14                  “(C) REBASING IN FISCAL YEAR 2010 AND  
15                  EACH SECOND SUCCEEDING FISCAL YEAR.—For  
16                  fiscal year 2010 and each second succeeding fis-  
17                  cal year, the allotment of a State is equal to the  
18                  Federal payments to the State that are attrib-  
19                  utable to (and countable towards) the total  
20                  amount of allotments available under this sec-  
21                  tion to the State (including allotments made  
22                  available under paragraph (3) as well as  
23                  amounts redistributed to the State) in the pre-  
24                  vious fiscal year multiplied by the allotment in-

1           crease factor under paragraph (2) for the fiscal  
2           year involved.

3                   “(D) SPECIAL RULES FOR TERRITORIES.—  
4           Notwithstanding the previous subparagraphs,  
5           the allotment for a State that is not one of the  
6           50 States or the District of Columbia for fiscal  
7           year 2008 and for a succeeding fiscal year is  
8           equal to the Federal payments provided to the  
9           State under this title for the previous fiscal  
10          year multiplied by the allotment increase factor  
11          under paragraph (2) for the fiscal year involved  
12          (but determined by applying under paragraph  
13          (2)(B) as if the reference to ‘in the State’ were  
14          a reference to ‘in the United States’).

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

18                           “(A) PER CAPITA HEALTH CARE GROWTH  
19                   FACTOR.—1 plus the percentage increase in the  
20                   projected per capita amount of National Health  
21                   Expenditures from the calendar year in which  
22                   the previous fiscal year ends to the calendar  
23                   year in which the fiscal year involved ends, as  
24                   most recently published by the Secretary before  
25                   the beginning of the fiscal year.

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

10           “(3) PERFORMANCE-BASED SHORTFALL AD-  
11 JUSTMENT.—

12           “(A) IN GENERAL.—If a State’s expendi-  
13 tures under this title in a fiscal year (beginning  
14 with fiscal year 2008) exceed the total amount  
15 of allotments available under this section to the  
16 State in the fiscal year (determined without re-  
17 gard to any redistribution it receives under sub-  
18 section (f) that is available for expenditure dur-  
19 ing such fiscal year, but including any carryover  
20 from a previous fiscal year) and if the average  
21 monthly unduplicated number of children en-  
22 rolled under the State plan under this title (in-  
23 cluding children receiving health care coverage  
24 through funds under this title pursuant to a  
25 waiver under section 1115) during such fiscal

1           year exceeds its target average number of such  
2           enrollees (as determined under subparagraph  
3           (B)) for that fiscal year, the allotment under  
4           this section for the State for the subsequent fis-  
5           cal year (or, pursuant to subparagraph (F), for  
6           the fiscal year involved) shall be increased by  
7           the product of—

8                   “(i) the amount by which such aver-  
9                   age monthly caseload exceeds such target  
10                  number of enrollees; and

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

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

21                   “(i) for fiscal year 2008 is equal to  
22                   the monthly average unduplicated number  
23                   of children enrolled in the State child  
24                   health plan under this title (including such  
25                   children receiving health care coverage

1 through funds under this title pursuant to  
2 a waiver under section 1115) during fiscal  
3 year 2007 increased by the population  
4 growth for children in that State for the  
5 year ending on June 30, 2006 (as esti-  
6 mated by the Bureau of the Census) plus  
7 1 percentage point; or

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

17 “(C) PROJECTED PER CAPITA EXPENDI-  
18 TURES.—For purposes of subparagraph (A)(ii),  
19 the projected per capita expenditures under a  
20 State child health plan—

21 “(i) for fiscal year 2008 is equal to  
22 the average per capita expenditures (in-  
23 cluding both State and Federal financial  
24 participation) under such plan for the tar-  
25 geted low-income children counted in the

1 average monthly caseload for purposes of  
2 this paragraph during fiscal year 2007, in-  
3 creased by the annual percentage increase  
4 in the per capita amount of National  
5 Health Expenditures (as estimated by the  
6 Secretary) for 2008; or

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

16 “(D) AVAILABILITY.—Notwithstanding  
17 subsection (e), an increase in allotment under  
18 this paragraph shall only be available for ex-  
19 penditure during the fiscal year in which it is  
20 provided.

21 “(E) NO REDISTRIBUTION OF PERFORM-  
22 ANCE-BASED SHORTFALL ADJUSTMENT.—In no  
23 case shall any increase in allotment under this  
24 paragraph for a State be subject to redistribu-  
25 tion to other States.

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

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

19           “(4) CONTINUED REPORTING.—For purposes of  
20           paragraph (3) and subsection (f), the State shall  
21           submit to the Secretary the State’s projected Fed-  
22           eral expenditures, even if the amount of such ex-  
23           penditures exceeds the total amount of allotments  
24           available to the State in such fiscal year.”.

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

3 Section 2104(e) of the Social Security Act (42 U.S.C.  
4 1397dd(e)) is amended to read as follows:

5 “(e) AVAILABILITY OF AMOUNTS ALLOTTED.—

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

9 “(A) for each of fiscal years 1998 through  
10 2007, shall remain available for expenditure by  
11 the State through the end of the second suc-  
12 ceeding fiscal year; and

13 “(B) for fiscal year 2008 and each fiscal  
14 year thereafter, shall remain available for ex-  
15 penditure by the State through the end of the  
16 succeeding fiscal year.

17 “(2) AVAILABILITY OF AMOUNTS REDISTRIB-  
18 UTED.—Amounts redistributed to a State under sub-  
19 section (f) shall be available for expenditure by the  
20 State through the end of the fiscal year in which  
21 they are redistributed, except that funds so redis-  
22 tributed to a State that are not expended by the end  
23 of such fiscal year shall remain available after the  
24 end of such fiscal year and shall be available in the  
25 following fiscal year for subsequent redistribution  
26 under such subsection.”.



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

3 Section 2104(f) of the Social Security Act (42 U.S.C.  
4 1397dd(f)) is amended—

5 (1) by striking “The Secretary” and inserting  
6 the following:

7 “(1) IN GENERAL.—The Secretary”;

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

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

23 “(2) SHORTFALL STATES DESCRIBED.—

24 “(A) IN GENERAL.—For purposes of para-  
25 graph (1), with respect to a fiscal year, a short-  
26 fall State described in this subparagraph is a

1 State with a State child health plan approved  
2 under this title for which the Secretary esti-  
3 mates on the basis of the most recent data  
4 available to the Secretary, that the projected ex-  
5 penditures under such plan for the State for the  
6 fiscal year will exceed the sum of—

7 “(i) the amount of the State’s allot-  
8 ments for any preceding fiscal years that  
9 remains available for expenditure and that  
10 will not be expended by the end of the im-  
11 mediately preceding fiscal year;

12 “(ii) the amount (if any) of the per-  
13 formance based adjustment under sub-  
14 section (i)(3)(A); and

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

17 “(B) PRORATION RULE.—If the amounts  
18 available for redistribution under paragraph (1)  
19 for a fiscal year are less than the total amounts  
20 of the estimated shortfalls determined for the  
21 year under subparagraph (A), the amount to be  
22 redistributed under such paragraph for each  
23 shortfall State shall be reduced proportionally.

24 “(C) RETROSPECTIVE ADJUSTMENT.—The  
25 Secretary may adjust the estimates and deter-

1           minations made under paragraph (1) and this  
2           paragraph with respect to a fiscal year as nec-  
3           essary on the basis of the amounts reported by  
4           States not later than November 30 of the suc-  
5           ceeding fiscal year, as approved by the Sec-  
6           retary.”.

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

8           Section 2105(g)(1)(A) of the Social Security Act (42  
9 U.S.C. 1397ee(g)(1)(A)) is amended by inserting after “or  
10 2007” the following: “or 30 percent of any allotment  
11 under section 2104 for any subsequent fiscal year”.

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

14 **SEC. 111. CHIP PERFORMANCE BONUS PAYMENT TO OFF-**  
15 **SET ADDITIONAL ENROLLMENT COSTS RE-**  
16 **SULTING FROM ENROLLMENT AND RETEN-**  
17 **TION EFFORTS.**

18           Section 2105(a) of the Social Security Act (42 U.S.C.  
19 1397ee(a)) is amended by adding at the end the following  
20 new paragraphs:

21           “(3) PERFORMANCE BONUS PAYMENT TO OFF-  
22           SET ADDITIONAL MEDICAID AND CHIP CHILD EN-  
23           ROLLMENT COSTS RESULTING FROM ENROLLMENT  
24           AND RETENTION EFFORTS.—

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

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

15                 “(i) FOR ABOVE BASELINE MEDICAID  
16                 CHILD ENROLLMENT COSTS.—

17                         “(I) FIRST TIER ABOVE BASE-  
18                         LINE MEDICAID ENROLLEES.—An  
19                         amount equal to the number of first  
20                         tier above baseline child enrollees (as  
21                         determined under subparagraph  
22                         (C)(i)) under title XIX for the State  
23                         and fiscal year multiplied by 35 per-  
24                         cent of the projected per capita State  
25                         Medicaid expenditures (as determined

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

3 “(II) SECOND TIER ABOVE BASE-  
4 LINE MEDICAID ENROLLEES.—An  
5 amount equal to the number of second  
6 tier above baseline child enrollees (as  
7 determined under subparagraph  
8 (C)(ii) under title XIX for the State  
9 and fiscal year multiplied by 90 per-  
10 cent of the projected per capita State  
11 Medicaid expenditures (as determined  
12 under subparagraph (D)(i) for the  
13 State and fiscal year under title XIX.

14 “(ii) FOR ABOVE BASELINE CHIP EN-  
15 ROLLMENT COSTS.—

16 “(I) FIRST TIER ABOVE BASE-  
17 LINE CHIP ENROLLEES.—An amount  
18 equal to the number of first tier above  
19 baseline child enrollees under this title  
20 (as determined under subparagraph  
21 (C)(i) for the State and fiscal year  
22 multiplied by 5 percent of the pro-  
23 jected per capita State CHIP expendi-  
24 tures (as determined under subpara-

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

3 “(II) SECOND TIER ABOVE BASE-  
4 LINE CHIP ENROLLEES.—An amount  
5 equal to the number of second tier  
6 above baseline child enrollees under  
7 this title (as determined under sub-  
8 paragraph (C)(ii)) for the State and  
9 fiscal year multiplied by 75 percent of  
10 the projected per capita State CHIP  
11 expenditures (as determined under  
12 subparagraph (D)(ii)) for the State  
13 and fiscal year under this title.

14 “(C) NUMBER OF FIRST AND SECOND TIER  
15 ABOVE BASELINE CHILD ENROLLEES; BASELINE  
16 NUMBER OF CHILD ENROLLEES.—For purposes  
17 of this paragraph:

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

1                   “(I) the monthly average  
2                   unduplicated number of qualifying  
3                   children (as defined in subparagraph  
4                   (E)) enrolled during the fiscal year  
5                   under the State child health plan  
6                   under this title or under the State  
7                   plan under title XIX, respectively; ex-  
8                   ceeds

9                   “(II) the baseline number of en-  
10                  rollees described in clause (iii) for the  
11                  State and fiscal year under this title  
12                  or title XIX, respectively;

13                  but not to exceed 3 percent (in the case of  
14                  title XIX) or 7.5 percent (in the case of  
15                  this title) of the baseline number of enroll-  
16                  ees described in subclause (II).

17                  “(ii) SECOND TIER ABOVE BASELINE  
18                  CHILD ENROLLEES.—The number of sec-  
19                  ond tier above baseline child enrollees for  
20                  a State for a fiscal year under this title or  
21                  title XIX is equal to the number (if any,  
22                  as determined by the Secretary) by  
23                  which—

24                  “(I) the monthly average  
25                  unduplicated number of qualifying

1 children (as defined in subparagraph  
2 (E)) enrolled during the fiscal year  
3 under this title or under title XIX, re-  
4 spectively, as described in clause  
5 (i)(I); exceeds

6 “(II) the sum of the baseline  
7 number of child enrollees described in  
8 clause (iii) for the State and fiscal  
9 year under this title or title XIX, re-  
10 spectively, as described in clause  
11 (i)(II), and the maximum number of  
12 first tier above baseline child enrollees  
13 for the State and fiscal year under  
14 this title or title XIX, respectively, as  
15 determined under clause (i).

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

20 “(I) for fiscal year 2008 is equal  
21 to the monthly average unduplicated  
22 number of qualifying children enrolled  
23 in the State child health plan under  
24 this title or in the State plan under  
25 title XIX, respectively, during fiscal



1 year 2007 increased by the population  
2 growth for children in that State for  
3 the year ending on June 30, 2006 (as  
4 estimated by the Bureau of the Cen-  
5 sus) plus 1 percentage point; or

6 “(II) for a subsequent fiscal year  
7 is equal to the baseline number of  
8 child enrollees for the State for the  
9 previous fiscal year under this title or  
10 title XIX, respectively, increased by  
11 the population growth for children in  
12 that State for the year ending on  
13 June 30 before the beginning of the  
14 fiscal year (as estimated by the Bu-  
15 reau of the Census) plus 1 percentage  
16 point.

17 “(D) PROJECTED PER CAPITA STATE EX-  
18 PENDITURES.—For purposes of subparagraph  
19 (B)—

20 “(i) PROJECTED PER CAPITA STATE  
21 MEDICAID EXPENDITURES.—The projected  
22 per capita State Medicaid expenditures for  
23 a State and fiscal year under title XIX is  
24 equal to the average per capita expendi-  
25 tures (including both State and Federal fi-

1 nancial participation) for children under  
2 the State plan under such title, including  
3 under waivers but not including such chil-  
4 dren eligible for assistance by virtue of the  
5 receipt of benefits under title XVI, for the  
6 most recent fiscal year for which actual  
7 data are available (as determined by the  
8 Secretary), increased (for each subsequent  
9 fiscal year up to and including the fiscal  
10 year involved) by the annual percentage in-  
11 crease in per capita amount of National  
12 Health Expenditures (as estimated by the  
13 Secretary) for the calendar year in which  
14 the respective subsequent fiscal year ends  
15 and multiplied by a State matching per-  
16 centage equal to 100 percent minus the  
17 Federal medical assistance percentage (as  
18 defined in section 1905(b)) for the fiscal  
19 year involved.

20 “(ii) PROJECTED PER CAPITA STATE  
21 CHIP EXPENDITURES.—The projected per  
22 capita State CHIP expenditures for a  
23 State and fiscal year under this title is  
24 equal to the average per capita expendi-  
25 tures (including both State and Federal fi-

1           nancial participation) for children under  
2           the State child health plan under this title,  
3           including under waivers, for the most re-  
4           cent fiscal year for which actual data are  
5           available (as determined by the Secretary),  
6           increased (for each subsequent fiscal year  
7           up to and including the fiscal year in-  
8           volved) by the annual percentage increase  
9           in per capita amount of National Health  
10          Expenditures (as estimated by the Sec-  
11          retary) for the calendar year in which the  
12          respective subsequent fiscal year ends and  
13          multiplied by a State matching percentage  
14          equal to 100 percent minus the enhanced  
15          FMAP (as defined in section 2105(b)) for  
16          the fiscal year involved.

17           “(E) QUALIFYING CHILDREN DEFINED.—  
18          For purposes of this subsection, the term  
19          ‘qualifying children’ means, with respect to this  
20          title or title XIX, children who meet the eligi-  
21          bility criteria (including income, categorical eli-  
22          gibility, age, and immigration status criteria) in  
23          effect as of July 1, 2007, for enrollment under  
24          this title or title XIX, respectively, taking into  
25          account criteria applied as of such date under

1           this title or title XIX, respectively, pursuant to  
2           a waiver under section 1115.

3           “(4) ENROLLMENT AND RETENTION PROVI-  
4           SIONS FOR CHILDREN.— For purposes of paragraph  
5           (3)(A), a State meets the condition of this para-  
6           graph for a fiscal year if it is implementing at least  
7           4 of the following enrollment and retention provi-  
8           sions (treating each subparagraph as a separate en-  
9           rollment and retention provision) throughout the en-  
10          tire fiscal year:

11           “(A) CONTINUOUS ELIGIBILITY.—The  
12          State has elected the option of continuous eligi-  
13          bility for a full 12 months for all children de-  
14          scribed in section 1902(e)(12) under title XIX  
15          under 19 years of age, as well as applying such  
16          policy under its State child health plan under  
17          this title.

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

21           “(i) ELIMINATION OF ASSET TEST.—  
22          The State does not apply any asset or re-  
23          source test for eligibility for children under  
24          title XIX or this title.

1                   “(ii) ADMINISTRATIVE VERIFICATION  
2                   OF ASSETS.—The State—

3                   “(I) permits a parent or care-  
4                   taker relative who is applying on be-  
5                   half of a child for medical assistance  
6                   under title XIX or child health assist-  
7                   ance under this title to declare and  
8                   certify by signature under penalty of  
9                   perjury information relating to family  
10                  assets for purposes of determining  
11                  and redetermining financial eligibility;  
12                  and

13                  “(II) takes steps to verify assets  
14                  through means other than by requir-  
15                  ing documentation from parents and  
16                  applicants except in individual cases  
17                  of discrepancies or where otherwise  
18                  justified.

19                  “(C) ELIMINATION OF IN-PERSON INTER-  
20                  VIEW REQUIREMENT.—The State does not re-  
21                  quire an application of a child for medical as-  
22                  sistance under title XIX (or for child health as-  
23                  sistance under this title), including an applica-  
24                  tion for renewal of such assistance, to be made  
25                  in person nor does the State require a face-to-

1 face interview, unless there are discrepancies or  
2 individual circumstances justifying an in-person  
3 application or face-to-face interview.

4 “(D) USE OF JOINT APPLICATION FOR  
5 MEDICAID AND CHIP.—The application form  
6 and supplemental forms (if any) and informa-  
7 tion verification process is the same for pur-  
8 poses of establishing and renewing eligibility for  
9 children for medical assistance under title XIX  
10 and child health assistance under this title.

11 “(E) AUTOMATIC RENEWAL (USE OF AD-  
12 MINISTRATIVE RENEWAL).—

13 “(i) IN GENERAL.—The State pro-  
14 vides, in the case of renewal of a child’s  
15 eligibility for medical assistance under title  
16 XIX or child health assistance under this  
17 title, a pre-printed form completed by the  
18 State based on the information available to  
19 the State and notice to the parent or care-  
20 taker relative of the child that eligibility of  
21 the child will be renewed and continued  
22 based on such information unless the State  
23 is provided other information. Nothing in  
24 this clause shall be construed as preventing  
25 a State from verifying, through electronic

1 and other means, the information so pro-  
2 vided.

3 “(ii) SATISFACTION THROUGH DEM-  
4 ONSTRATED USE OF EX PARTE PROCESS.—  
5 A State shall be treated as satisfying the  
6 requirement of clause (i) if renewal of eli-  
7 gibility of children under title XIX or this  
8 title is determined without any require-  
9 ment for an in-person interview, unless  
10 sufficient information is not in the State’s  
11 possession and cannot be acquired from  
12 other sources (including other State agen-  
13 cies) without the participation of the appli-  
14 cant or the applicant’s parent or caretaker  
15 relative.

16 “(F) PRESUMPTIVE ELIGIBILITY FOR  
17 CHILDREN.—The State is implementing section  
18 1920A under title XIX as well as, pursuant to  
19 section 2107(e)(1), under this title .

20 “(G) EXPRESS LANE.—The State is imple-  
21 menting the option described in section  
22 1902(e)(13) under title XIX as well as, pursu-  
23 ant to section 2107(e)(1), under this title.”.

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

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

7 “(13) EXPRESS LANE OPTION.—

8 “(A) IN GENERAL.—

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



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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

12 “(D) OPTION FOR AUTOMATIC ENROLLMENT.—

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

8 (b) CHIP.—Section 2107(e)(1) of such Act (42  
9 U.S.C. 1397gg(e)(1)) is amended by redesignating sub-  
10 paragraph (B) and succeeding subparagraphs as subpara-  
11 graph (C) and succeeding subparagraphs and by inserting  
12 after subparagraph (A) the following new subparagraph:

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

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

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

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

9 (d) AUTHORIZATION OF INFORMATION DISCLOSURE.—  
10 SURE.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

## 14 **Subtitle C—Coverage**

15 **SEC. 121. ENSURING CHILD-CENTERED COVERAGE.**

16 (a) ADDITIONAL REQUIRED SERVICES.—

17 (1) CHILD-CENTERED COVERAGE.—Section  
18 2103 of the Social Security Act (42 U.S.C. 1397cc)  
19 is amended—

20 (A) in subsection (a)—

21 (i) in the matter before paragraph  
22 (1), by striking “subsection (c)(5)” and in-  
23 serting “paragraphs (5) and (6) of sub-  
24 section (c)”; and



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

3 (B) in subsection (c)—

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

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

8 “(5) DENTAL, FQHC, AND RHC SERVICES.—The  
9 child health assistance provided to a targeted low-in-  
10 come child (whether through benchmark coverage or  
11 benchmark-equivalent coverage or otherwise) shall  
12 include coverage of the following:

13 “(A) Dental services necessary to prevent  
14 disease and promote oral health, restore oral  
15 structures to health and function, and treat  
16 emergency conditions.

17 “(B) Federally-qualified health center serv-  
18 ices (as defined in section 1905(l)(2)) and rural  
19 health clinic services (as defined in section  
20 1905(l)(1)).

21 Nothing in this section shall be construed as pre-  
22 venting a State child health plan from providing  
23 such services as part of benchmark coverage or in  
24 addition to the benefits provided through benchmark  
25 coverage.”.

1           (2) REQUIRED PAYMENT FOR FQHC AND RHC  
2 SERVICES.—Section 2107(e)(1) of such Act (42  
3 U.S.C. 1397gg(e)(1)), as amended by sections  
4 112(b) and 112(d)(2), is amended by inserting after  
5 subparagraph (B) the following new subparagraph  
6 (and redesignating the succeeding subparagraphs ac-  
7 cordingly):

8           “(C) Section 1902(bb) (relating to pay-  
9 ment for services provided by Federally-quali-  
10 fied health centers and rural health clinics).”.

11           (3) MENTAL HEALTH PARITY.—Section  
12 2103(a)(2)(C) of such Act (42 U.S.C.  
13 1397aa(a)(2)(C)) is amended by inserting “(or 100  
14 percent in the case of the category of services de-  
15 scribed in subparagraph (B) of such subsection)”  
16 after “75 percent”.

17           (4) EFFECTIVE DATE.—The amendments made  
18 by this subsection and subsection (d) shall apply to  
19 health benefits coverage provided on or after October  
20 1, 2008.

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

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

4           (A) in subparagraph (A)—

5               (i) in the matter before clause (i), by  
6       striking “Notwithstanding any other provi-  
7       sion of this title” and inserting “Subject to  
8       subparagraph (E)”; and

9               (ii) by striking “enrollment in cov-  
10       erage that provides” and all that follows  
11       and inserting “benchmark coverage de-  
12       scribed in subsection (b)(1) or benchmark  
13       equivalent coverage described in subsection  
14       (b)(2).”;

15           (B) by striking subparagraph (C) and in-  
16       serting the following new subparagraph:

17               “(C) STATE OPTION TO PROVIDE ADDI-  
18       TIONAL BENEFITS.—A State, at its option, may  
19       provide such additional benefits to benchmark  
20       coverage described in subsection (b)(1) or  
21       benchmark equivalent coverage described in  
22       subsection (b)(2) as the State may specify.”;  
23       and

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

1           “(E) REQUIRING COVERAGE OF EPSDT  
2 SERVICES.—Nothing in this paragraph shall be  
3 construed as affecting a child’s entitlement to  
4 care and services described in subsections  
5 (a)(4)(B) and (r) of section 1905 and provided  
6 in accordance with section 1902(a)(43) whether  
7 provided through benchmark coverage, bench-  
8 mark equivalent coverage, or otherwise.”.

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

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

16           (1) IN GENERAL.—Section 2110(a)(5) of such  
17 Act (42 U.S.C. 1397jj(a)(5)) is amended by insert-  
18 ing after “health center services” the following: “and  
19 school-based health center serviceservices for which  
20 coverage is otherwise provided under this title when  
21 furnished by a school-based health center that is au-  
22 thorized to furnish such services under State law”.

23           (2) EFFECTIVE DATE.—The amendment made  
24 by paragraph (1) shall apply to child health assist-

1           ance furnished on or after the date of the enactment  
2           of this Act.

3           (d) ASSURING ACCESS TO CARE.—

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

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

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

13          (a) LIMITATION ON SECRETARY-APPROVED COV-  
14          ERAGE.—

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

21                 (2) UNDER MEDICAID.—Section 1937(b)(1)(D)  
22          of the Social Security Act (42 U.S.C. 1396u-  
23          7(b)(1)(D)) is amended by inserting before the pe-  
24          riod at the end the following: “if the health benefits  
25          coverage is at least equivalent to the benefits cov-

1 erage in benchmark coverage described in subpara-  
2 graph (A), (B), or (C)’’.

3 (b) REQUIREMENT FOR MOST POPULAR FAMILY  
4 COVERAGE FOR STATE EMPLOYEE COVERAGE BENCH-  
5 MARK.—

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

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

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

21 **SEC. 123. PREMIUM GRACE PERIOD.**

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

1                   “(C) PREMIUM GRACE PERIOD.—The State  
2 child health plan—

3                   “(i) shall afford individuals enrolled  
4 under the plan a grace period of at least  
5 30 days from the beginning of a new cov-  
6 erage period to make premium payments  
7 before the individual’s coverage under the  
8 plan may be terminated; and

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

12                   “(I) that failure to make a pre-  
13 mium payment within the grace pe-  
14 riod will result in termination of cov-  
15 erage under the State child health  
16 plan; and

17                   “(II) of the individual’s right to  
18 challenge the proposed termination  
19 pursuant to the applicable Federal  
20 regulations.

21                   For purposes of clause (i), the term ‘new cov-  
22 erage period’ means the month immediately fol-  
23 lowing the last month for which the premium  
24 has been paid.”.

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

## 4 **Subtitle D—Populations**

### 5 **SEC. 131. OPTIONAL COVERAGE OF OLDER CHILDREN** 6 **UNDER MEDICAID AND CHIP.**

7 (a) MEDICAID.—

8 (1) IN GENERAL.—Section 1902(l)(1)(D) of the  
9 Social Security Act (42 U.S.C. 1396a(l)(1)(D)) is  
10 amended by striking “but have not attained 19 years  
11 of age” and inserting “but is under 19 years of age  
12 (or, at the option of a State and subject to section  
13 131(d) of the Children’s Health and Medicare Pro-  
14 tection Act of 2007, under such higher age, not to  
15 exceed 25 years of age, as the State may elect)”.

16 (2) CONFORMING AMENDMENTS.—

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

23 (B) Section 1902(e)(12) of such Act (42  
24 U.S.C. 1396a(e)(12)) is amended by inserting  
25 “or such higher age as the State has elected



1 under subsection (l)(1)(D)” after “19 years of  
2 age”.

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

8 (D) Section 1920A(b)(1) of such Act (42  
9 U.S.C. 1396r-1a(b)(1)) is amended by insert-  
10 ing “or under such higher age as the State has  
11 elected under section 1902(l)(1)(D)” after “19  
12 years of age”.

13 (E) Section 1928(h)(1) of such Act (42  
14 U.S.C. 1396s(h)(1)) is amended by striking “18  
15 years of age or younger” and inserting “under  
16 19 years of age or under such higher age as the  
17 State has elected under section 1902(l)(1)(D)”.

18 (F) Section 1932(a)(2)(A) of such Act (42  
19 U.S.C. 1396u-2(a)(2)(A)) is amended by in-  
20 sserting “(or under such higher age as the State  
21 has elected under section 1902(l)(1)(D))” after  
22 “19 years of age”.

23 (b) TITLE XXI.—Section 2110(c)(1) of such Act (42  
24 U.S.C. 1397jj(c)(1)) is amended by inserting “(or, at the  
25 option of the State and subject to section 131(d) of the

1 Children's Health and Medicare Protection Act of 2007,  
2 under such higher age as the State has elected under sec-  
3 tion 1902(l)(1)(D))”.

4 (c) EFFECTIVE DATE.—Subject to subsection (d),  
5 the amendments made by this section take effect on Janu-  
6 ary 1, 2010.

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

9 (1) for 2010, a State election under section  
10 1902(l)(1)(D) shall only apply with respect to title  
11 XXI of such Act and the age elected may not exceed  
12 21 years of age;

13 (2) for 2011, a State election under section  
14 1902(l)(1)(D) may apply under titles XIX and XXI  
15 of such Act and the age elected may not exceed 23  
16 years of age;

17 (3) for 2012, a State election under section  
18 1902(l)(1)(D) may apply under titles XIX and XXI  
19 of such Act and the age elected may not exceed 24  
20 years of age; and

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

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

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

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

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

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

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

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

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

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

6 (b) CHIP.—Section 2107(e)(1) of such Act (42  
7 U.S.C. 1397gg(e)(1)), as amended by section 112(b),  
8 112(d)(2),and 121(a)(2), is amended by redesignating  
9 subparagraphs (E) through (G) as subparagraphs (G)  
10 through (I), respectively, and by inserting after subpara-  
11 graph (D) the following new subparagraphs:

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

21 “(F) Section 1903(v)(4)(A) (relating to op-  
22 tional coverage of categories of lawfully residing  
23 immigrants), insofar as it relates to the cat-  
24 egory of children described in clause (ii) of such  
25 section, but only if the State has elected to

1           apply such section with respect to such children  
2           under title XIX.”.

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

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

9           (a) CHIP.—

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

13 **“SEC. 2111. OPTIONAL COVERAGE OF TARGETED LOW-IN-**  
14                   **COME PREGNANT WOMEN.**

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

21           “(1) the State has established an income eligi-  
22 bility level—

23           “(A) for pregnant women, under any of  
24 clauses (i)(III), (i)(IV), or (ii)(IX) of section  
25 1902(a)(10)(A), that is at least 185 percent (or

1           such higher percent as the State has in effect  
2           for pregnant women under this title) of the pov-  
3           erty line applicable to a family of the size in-  
4           volved, but in no case a percent lower than the  
5           percent in effect under any such clause as of  
6           July 1, 2007; and

7           “(B) for children under 19 years of age  
8           under this title (or title XIX) that is at least  
9           200 percent of the poverty line applicable to a  
10          family of the size involved; and

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

3 “(7) In applying section 2104(i)—

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

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

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

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

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

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

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

3 (2) ADDITIONAL AMENDMENT.—Section  
4 2107(e)(1)(H) of such Act (42 U.S.C.  
5 1397gg(e)(1)(H)), as redesignated by section  
6 133(b), is amended to read as follows:

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

10 (b) AMENDMENTS TO MEDICAID.—

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

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

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

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

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

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

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

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

1                                   **Subtitle E—Access**

2   **SEC. 141. CHILDREN’S ACCESS, PAYMENT, AND EQUALITY**

3                                   **COMMISSION.**

4           Title XIX of the Social Security Act is amended by

5 inserting before section 1901 the following new section:

6           “CHILDREN’S ACCESS, PAYMENT, AND EQUALITY

7                                   COMMISSION

8           “SEC. 1900. (a) ESTABLISHMENT.—There is hereby

9 established as an agency of Congress the Children’s Ac-

10 cess, Payment, and Equality Commission (in this section

11 referred to as the ‘Commission’).

12           “(b) DUTIES.—

13                   “(1) REVIEW OF PAYMENT POLICIES AND AN-

14 NUAL REPORTS.—The Commission shall—

15                           “(A) review Federal and State payment

16 policies of the Medicaid program established

17 under this title (in this section referred to as

18 ‘Medicaid’) and the State Children’s Health In-

19 surance Program established under title XXI

20 (in this section referred to as ‘CHIP’), includ-

21 ing topics described in paragraph (2);

22                           “(B) review access to, and affordability of,

23 coverage and services for enrollees under Med-

24 icaid and CHIP;

1           “(C) make recommendations to Congress  
2           concerning such policies;

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

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

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

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

21                 “(B) The impact of Federal and State  
22                 Medicaid and CHIP payment policies on access  
23                 to services (including dental services) for chil-  
24                 dren (including children with disabilities) and  
25                 other Medicaid and CHIP populations.

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

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

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

23           “(F) The affordability, cost effectiveness,  
24 and accessibility of services needed by special

1 populations under Medicaid and CHIP as com-  
2 pared with private-sector coverage.

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

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

20 “(3) COMMENTS ON CERTAIN SECRETARIAL RE-  
21 PORTS.—If the Secretary submits to Congress (or a  
22 committee of Congress) a report that is required by  
23 law and that relates to payment policies under Med-  
24 icaid or CHIP, the Secretary shall transmit a copy  
25 of the report to the Commission. The Commission



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

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

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

23 “(6) APPROPRIATE COMMITTEE OF CON-  
24 GRESS.—For purposes of this section, the term ‘ap-  
25 propriate committees of Congress’ means the Com-

1       mittees on Energy and Commerce of the House of  
2       Representatives and the Committee on Finance of  
3       the Senate.

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

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

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

21           “(1) Subsection (c) (relating to membership),  
22      except that the membership of the Commission shall  
23      also include representatives of children, pregnant  
24      women, individuals with disabilities, seniors, low-in-

1       come families, and other groups of CHIP and Med-  
2       icaid beneficiaries.

3               “(2) Subsection (d) (relating to staff and con-  
4       sultants).

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

6       “(d) AUTHORIZATION OF APPROPRIATIONS.—

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

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

17   **SEC. 142. MODEL OF INTERSTATE COORDINATED ENROLL-**  
18                           **MENT AND COVERAGE PROCESS.**

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

1 beneficiaries, shall develop a model process for the coordi-  
2 nation of the enrollment, retention, and coverage under  
3 such programs of children who, because of migration of  
4 families, emergency evacuations, educational needs, or  
5 otherwise, frequently change their State of residency or  
6 otherwise are temporarily located outside of the State of  
7 their residency.

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

14 **SEC. 143. MEDICAID CITIZENSHIP DOCUMENTATION RE-**  
15 **QUIREMENTS.**

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

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

23 (A) in subsection (a)(46)—

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

25 and

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

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

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

20 (C) in subsection (b)(3), by inserting “or  
21 any citizenship documentation requirement for  
22 a child under 21 years of age that is more re-  
23 strictive than what a State may provide under  
24 section 1903(x)” before the period at the end.

1           (2) AUDITING REQUIREMENT.—Section 1903(x)  
2           of such Act (as amended by section 405(e)(1)(A) of  
3           division B of the Tax Relief and Health Care Act of  
4           2006 (Public Law 109–432)) is amended by adding  
5           at the end the following new paragraph:

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

21          “(B) In conducting audits under subparagraph (A),  
22          payments for non-emergency benefits shall be treated as  
23          erroneous if the audit could not confirm the citizenship  
24          of the individual based either on documentation in the case

1 file or on documentation obtained independently during  
2 the audit.

3 “(C) If the erroneous error rate described in subpara-  
4 graph (A)—

5 “(i) exceeds 3 percent, the State shall—

6 “(I) remit to the Secretary the Federal  
7 share of improper expenditures in excess of the  
8 3 percent level described in such subparagraph;

9 “(II) shall develop a corrective action plan;  
10 and

11 “(III) shall conduct another audit the fol-  
12 lowing fiscal year, after the corrective action  
13 plan is implemented; or

14 “(ii) does not exceed 3 percent, the State is not  
15 required to conduct another audit under subpara-  
16 graph (A) until the third fiscal year succeeding the  
17 fiscal year for which the audit was conducted.”;

18 (3) ELIMINATION OF DENIAL OF PAYMENTS  
19 FOR CHILDREN.—Section 1903(i)(22) of such Act  
20 (42 U.S.C. 1396b(i)(22)) is amended by inserting  
21 “(other than a child under the age of 21)” after “for  
22 an individual”.

23 (b) CLARIFICATION OF RULES FOR CHILDREN BORN  
24 IN THE UNITED STATES TO MOTHERS ELIGIBLE FOR

1 MEDICAID.—Section 1903(x)(2) of such Act (42 U.S.C.  
2 1396b(x)(2)) is amended—

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

5 (2) by redesignating subparagraph (D) as sub-  
6 paragraph (E); and

7 (3) by inserting after subparagraph (C) the fol-  
8 lowing new subparagraph:

9 “(D) pursuant to the application of section  
10 1902(e)(4) (and, in the case of an individual who is  
11 eligible for medical assistance on such basis, the in-  
12 dividual shall be deemed to have provided satisfac-  
13 tory documentary evidence of citizenship or nation-  
14 ality and shall not be required to provide further  
15 documentary evidence on any date that occurs dur-  
16 ing or after the period in which the individual is eli-  
17 gible for medical assistance on such basis; or”.

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

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

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

24 “(v) For an individual who is a member of,  
25 or enrolled in or affiliated with, a federally-rec-



1           ognized Indian tribe, a document issued by such  
2           tribe evidencing such membership, enrollment,  
3           or affiliation with the tribe (such as a tribal en-  
4           rollment card or certificate of degree of Indian  
5           blood), and, only with respect to those federally-  
6           recognized Indian tribes located within States  
7           having an international border whose member-  
8           ship includes individuals who are not citizens of  
9           the United States, such other forms of docu-  
10          mentation (including tribal documentation, if  
11          appropriate) as the Secretary, after consulting  
12          with such tribes, determines to be satisfactory  
13          documentary evidence of citizenship or nation-  
14          ality for purposes of satisfying the requirement  
15          of this subparagraph.”.

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

20                 “(5) In the case of an individual declaring to be a  
21          citizen or national of the United States with respect to  
22          whom a State requires the presentation of satisfactory  
23          documentary evidence of citizenship or nationality under  
24          section 1902(a)(46)(B), the individual shall be provided  
25          at least the reasonable opportunity to present satisfactory

1 documentary evidence of citizenship or nationality under  
2 this subsection as is provided under clauses (i) and (ii)  
3 of section 1137(d)(4)(A) to an individual for the submittal  
4 to the State of evidence indicating a satisfactory immigra-  
5 tion status and shall not be denied medical assistance on  
6 the basis of failure to provide such documentation until  
7 the individual has had such an opportunity.”.

8 (e) EFFECTIVE DATE.—

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

13 (2) RESTORATION OF ELIGIBILITY.—In the  
14 case of an individual who, during the period that  
15 began on July 1, 2006, and ends on the date of the  
16 enactment of this Act, was determined to be ineli-  
17 gible for medical assistance under a State Medicaid  
18 program solely as a result of the application of sub-  
19 sections (i)(22) and (x) of section 1903 of the Social  
20 Security Act (as in effect during such period), but  
21 who would have been determined eligible for such as-  
22 sistance if such subsections, as amended by this sec-  
23 tion, had applied to the individual, a State may  
24 deem the individual to be eligible for such assistance  
25 as of the date that the individual was determined to

1 be ineligible for such medical assistance on such  
2 basis.

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

4 (a) DENTAL EDUCATION FOR PARENTS OF  
5 NEWBORNS.—The Secretary of Health and Human Serv-  
6 ices shall develop and implement, through entities that  
7 fund or provide perinatal care services to targeted low-  
8 income children under a State child health plan under title  
9 XXI of the Social Security Act, a program to deliver oral  
10 health educational materials that inform new parents  
11 about risks for, and prevention of, early childhood caries  
12 and the need for a dental visit within their newborn’s first  
13 year of life.

14 (b) PROVISION OF DENTAL SERVICES THROUGH  
15 FQHCs.—

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

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

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

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

24 “(71) provide that the State will not prevent a  
25 Federally-qualified health center from entering into

1 contractual relationships with private practice dental  
2 providers in the provision of Federally-qualified  
3 health center services.”.

4 (2) CHIP.—Section 2107(e)(1) of such Act is  
5 amended—

6 (A) by redesignating subparagraphs (B)  
7 through (D) as subparagraphs (C) through (E);  
8 and

9 (B) by inserting after subparagraph (A)  
10 the following new subparagraph:

11 “(B) Section 1902(a)(71) (relating to lim-  
12 iting FQHC contracting for provision of dental  
13 services).”.

14 (3) EFFECTIVE DATE.—The amendments made  
15 by this subsection shall take effect on January 1,  
16 2008.

17 (c) REPORTING INFORMATION ON DENTAL  
18 HEALTH.—

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

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

4           “(e) INFORMATION ON DENTAL CARE FOR CHIL-  
5           DREN.—

6           “(1) IN GENERAL.—Each annual report under  
7           subsection (a) shall include the following information  
8           with respect to care and services described in section  
9           1905(r)(3) provided to targeted low-income children  
10          enrolled in the State child health plan under this  
11          title at any time during the year involved:

12                 “(A) The number of enrolled children by  
13                 age grouping used for reporting purposes under  
14                 section 1902(a)(43).

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

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

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

8           (3) EFFECTIVE DATE.—The amendments made  
9           by this subsection shall be effective for annual re-  
10          ports submitted for years beginning after date of en-  
11          actment.

12          (d) GAO STUDY AND REPORT.—

13                 (1) STUDY.—The Comptroller General of the  
14                 United States shall provide for a study that exam-  
15                 ines—

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

18                         (B) the feasibility and appropriateness of  
19                         using qualified mid-level dental health pro-  
20                         viders, in coordination with dentists, to improve  
21                         access for children to oral health services and  
22                         public health overall.

23                 (2) REPORT.—Not later than 1 year after the  
24                 date of the enactment of this Act, the Comptroller

1 General shall submit to Congress a report on the  
2 study conducted under paragraph (1).

3 **SEC. 145. PROHIBITING INITIATION OF NEW HEALTH OP-**  
4 **PORTUNITY ACCOUNT DEMONSTRATION PRO-**  
5 **GRAMS.**

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

10 **Subtitle F—Quality and Program**  
11 **Integrity**

12 **SEC. 151. PEDIATRIC HEALTH QUALITY MEASUREMENT**  
13 **PROGRAM.**

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

16 (1) ESTABLISHMENT OF PROGRAM TO DEVELOP  
17 QUALITY MEASURES FOR CHILDREN'S HEALTH.—

18 The Secretary of Health and Human Services (in  
19 this section referred to as the “Secretary”) shall es-  
20 tablish a child health care quality measurement pro-  
21 gram (in this subsection referred to as the “chil-  
22 dren’s health quality measurement program”) to de-  
23 velop and implement—

24 (A) pediatric quality measures on chil-  
25 dren’s health care that may be used by public

1 and private health care purchasers (and a sys-  
2 tem for reporting such measures); and

3 (B) measures of overall program perform-  
4 ance that may be used by public and private  
5 health care purchasers.

6 The Secretary shall publish, not later than Sep-  
7 tember 30, 2009, the recommended measures under  
8 the program for application under the amendments  
9 made by subsection (b) for years beginning with  
10 2010.

11 (2) MEASURES.—

12 (A) SCOPE.—The measures developed  
13 under the children’s health quality measure-  
14 ment program shall—

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

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

24 (iii) be designed to ensure that the  
25 data required for such measures is col-



1 lected and reported in a standard format  
2 that permits comparison at a State, plan,  
3 and provider level, and between insured  
4 and uninsured children;

5 (iv) take into account existing meas-  
6 ures of child health quality and be periodi-  
7 cally updated;

8 (v) include measures of clinical health  
9 care quality which meet the requirements  
10 for pediatric quality measures in para-  
11 graph (1);

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

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

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

23 (i) The proportion of insured (and un-  
24 insured) children who receive age-appro-  
25 priate preventive health and dental care

1 (including age appropriate immunizations)  
2 at each stage of child health development.

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

8 (iii) The effectiveness of early health  
9 care interventions for children whose as-  
10 sssments indicate the presence or risk of  
11 physical or mental conditions that could  
12 adversely affect growth and development.

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

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

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

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

1 (C) REPORTING METHODOLOGY FOR ANAL-  
2 YSIS BY PEDIATRIC CHARACTERISTICS.—The  
3 children’s health quality measurement program  
4 shall describe with specificity such measures  
5 and the process by which such measures will be  
6 reported in a manner that permits analysis  
7 based on each of the following pediatric charac-  
8 teristics:

- 9 (i) Age.  
10 (ii) Gender.  
11 (iii) Race.  
12 (iv) Ethnicity.  
13 (v) Primary language of the child’s  
14 parents (or caretaker relative).  
15 (vi) Disability or chronic condition  
16 (including cystic fibrosis).  
17 (vii) Geographic location.  
18 (viii) Coverage status under public  
19 and private health insurance programs.

20 (D) PEDIATRIC QUALITY MEASURE.—In  
21 this subsection, the term “pediatric quality  
22 measure” means a measurement of clinical care  
23 that assesses one or more aspects of pediatric  
24 health care quality (in various settings) includ-  
25 ing the structure of the clinical care system, the

1 process and outcome of care, or patient experi-  
2 ence in such care.

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

8 (A) States;

9 (B) pediatric hospitals, pediatricians, and  
10 other primary and specialized pediatric health  
11 care professionals (including members of the al-  
12 lied health professions) who specialize in the  
13 care and treatment of children, particularly  
14 children with special physical, mental, and de-  
15 velopmental health care needs;

16 (C) dental professionals;

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

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

1 (F) national organizations and individuals  
2 with expertise in pediatric health quality per-  
3 formance measurement; and

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

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

13 (5) TECHNICAL ASSISTANCE.—The Secretary  
14 shall provide technical assistance to States to estab-  
15 lish for the reporting of quality measures under ti-  
16 tles XIX and XXI of the Social Security Act in ac-  
17 cordance with the children’s health quality measure-  
18 ment program.

19 (b) DISSEMINATION OF INFORMATION ON THE QUAL-  
20 ITY OF PROGRAM PERFORMANCE.—Not later than Janu-  
21 ary 1, 2009, and annually thereafter, the Secretary shall  
22 collect, analyze, and make publicly available on a public  
23 website of the Department of Health and Human Services  
24 in an online format—

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

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

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

16           (1) the quality of health care for children en-  
17 rolled under title XIX and XXI of the Social Secu-  
18 rity Act under the children’s health quality measure-  
19 ment program; and

20           (2) patterns of health care utilization with re-  
21 spect to the measures specified in subsection  
22 (a)(2)(B) among children by the pediatric character-  
23 istics listed in subsection (a)(2)(C).

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

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

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

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

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

20 Section 2108(c) of the Social Security Act (42 U.S.C.  
21 1397hh(c)) is amended by striking paragraph (5) and in-  
22 serting the following:

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

25 “(A) IN GENERAL.—The Secretary, di-  
26 rectly or through contracts or interagency

1 agreements, shall conduct an independent sub-  
2 sequent evaluation of 10 States with approved  
3 child health plans.

4 “(B) SELECTION OF STATES AND MAT-  
5 TERS INCLUDED.—Paragraphs (2) and (3) shall  
6 apply to such subsequent evaluation in the  
7 same manner as such provisions apply to the  
8 evaluation conducted under paragraph (1).

9 “(C) SUBMISSION TO CONGRESS.—Not  
10 later than December 31, 2010, the Secretary  
11 shall submit to Congress the results of the eval-  
12 uation conducted under this paragraph.

13 “(D) FUNDING.—Out of any money in the  
14 Treasury of the United States not otherwise ap-  
15 propriated, there are appropriated \$10,000,000  
16 for fiscal year 2009 for the purpose of con-  
17 ducting the evaluation authorized under this  
18 paragraph. Amounts appropriated under this  
19 subparagraph shall remain available for expend-  
20 iture through fiscal year 2011.” .

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

23 Section 2108(d) of the Social Security Act (42 U.S.C.  
24 1397hh(d)) is amended to read as follows:



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

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

13           Section 704 of the Medicare, Medicaid, and SCHIP  
14 Balanced Budget Refinement Act of 1999 (Appendix F,  
15 113 Stat. 1501A–321), as enacted into law by section  
16 1000(a)(6) of Public Law 106–113) is repealed.

17 **SEC. 156. RELIANCE ON LAW; EXCEPTION FOR STATE LEG-**  
18 **ISLATION.**

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

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

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

12          (b) EXCEPTION FOR STATE LEGISLATION.—In the  
13          case of a State plan under title XIX or State child health  
14          plan under XXI of the Social Security Act, which the Sec-  
15          retary of Health and Human Services determines requires  
16          State legislation in order for respective plan to meet one  
17          or more additional requirements imposed by amendments  
18          made by this title or title VIII, the respective State plan  
19          shall not be regarded as failing to comply with the require-  
20          ments of such title solely on the basis of its failure to meet  
21          such an additional requirement before the first day of the  
22          first calendar quarter beginning after the close of the first  
23          regular session of the State legislature that begins after  
24          the date of enactment of this Act. For purposes of the  
25          previous sentence, in the case of a State that has a 2-

1 year legislative session, each year of the session shall be  
2 considered to be a separate regular session of the State  
3 legislature.

4 **TITLE II—MEDICARE**  
5 **BENEFICIARY IMPROVEMENTS**  
6 **Subtitle A—Improvements in**  
7 **Benefits**

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

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

13 (1) in subsection (s)(2)—

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

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

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

20 “(BB) additional pre-  
21 ventive services (described in  
22 subsection (ccc)(1)(M));”;  
23 and

24 (2) by adding at the end the following new sub-  
25 section:

1 “Preventive Services

2 “(ccc)(1) The term ‘preventive services’ means the  
3 following:

4 “(A) Prostate cancer screening tests (as  
5 defined in subsection (oo)).

6 “(B) Colorectal cancer screening tests (as  
7 defined in subsection (pp)).

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

10 “(D) Screening for glaucoma for certain  
11 individuals (as described in subsection  
12 (s)(2)(U)).

13 “(E) Medical nutrition therapy services for  
14 certain individuals (as described in subsection  
15 (s)(2)(V)).

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

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

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

22 “(I) Ultrasound screening for abdominal  
23 aortic aneurysm for certain individuals (as de-  
24 scribed in described in subsection (s)(2)(AA)).

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

4           “(K) Hepatitis B vaccine and its adminis-  
5           tration for certain individuals (as described in  
6           subsection (s)(10)(B)).

7           “(L) Screening mammography (as defined  
8           in subsection (jj)).

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

11          “(N) Bone mass measurement (as defined  
12          in subsection (rr)).

13          “(O) Additional preventive services (as de-  
14          termined under paragraph (2)).

15          “(2)(A) The term ‘additional preventive serv-  
16          ices’ means items and services, including mental  
17          health services, not described in subparagraphs (A)  
18          through (N) of paragraph (1) that the Secretary de-  
19          termines to be reasonable and necessary for the pre-  
20          vention or early detection of an illness or disability.

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

23                 “(C) take into account evidence-based rec-  
24                 ommendations by the United States Preventive

1 Services Task Force and other appropriate or-  
2 ganizations; and

3 “(D) use the process for making national  
4 coverage determinations (as defined in section  
5 1869(f)(1)(B)) under this title.”.

6 (b) PAYMENT AND ELIMINATION OF COST-SHAR-  
7 ING.—

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

11 (A) in clause (T), by striking “80 percent”  
12 and inserting “100 percent”; and

13 (B) by striking “and” before “(V)”; and

14 (C) by inserting before the semicolon at  
15 the end the following: “, and (W) with respect  
16 to additional preventive services (as defined in  
17 section 1861(ccc)(2)) and other preventive serv-  
18 ices for which a payment rate is not otherwise  
19 established under this section, the amount paid  
20 shall be 100 percent of the lesser of the actual  
21 charge for the services or the amount deter-  
22 mined under a fee schedule established by the  
23 Secretary for purposes of this clause”.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

22 (a) IN GENERAL.—Section 1833(b)(8) of the Social  
23 Security Act (42 U.S.C. 1395l(b)(8)) is amended by in-  
24 serting “, regardless of the code applied, of the establish-  
25 ment of a diagnosis as a result of the test, or of the re-



1 moval of tissue or other matter or other procedure that  
2 is performed in connection with and as a result of the  
3 screening test” after “1861(pp)(1))”.

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

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

8 Section 1833(c) of the Social Security Act (42 U.S.C.  
9 1395l(c)) is amended—

10 (1) in the first sentence, by striking “62–1/2  
11 percent” and inserting “the incurred expense per-  
12 centage (as specified in the last sentence)”; and

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

1 **Subtitle B—Improving, Clarifying,**  
2 **and Simplifying Financial As-**  
3 **sistance for Low Income Medi-**  
4 **care Beneficiaries**

5 **SEC. 211. IMPROVING ASSETS TESTS FOR MEDICARE SAV-**  
6 **INGS PROGRAM AND LOW-INCOME SUBSIDY**  
7 **PROGRAM.**

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

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

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

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

19 (2) ANNUAL INCREASE IN LIS RESOURCE  
20 TEST.—Section 1860D–14(a)(3)(E)(i) of such Act  
21 (42 U.S.C. 1395w-114(a)(3)(E)(i)) is amended—

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

24 (B) in subclause (II), by inserting “(before  
25 2009)” after “subsequent year”;

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

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

5 “(III) for 2009, \$17,000 (or  
6 \$34,000 in the case of the combined  
7 value of the individual’s assets or re-  
8 sources and the assets or resources of  
9 the individual’s spouse); and

10 “(IV) for a subsequent year, the  
11 dollar amounts specified in this sub-  
12 clause (or subclause (III)) for the pre-  
13 vious year increased by \$1,000 (or  
14 \$2,000 in the case of the combined  
15 value referred to in subclause (III)).”.

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

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

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

7 (a) MAKING PROGRAM PERMANENT.—

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

11 (A) by striking “sections 1933 and” and  
12 by inserting “section”; and

13 (B) by striking “(but only with” and all  
14 that follows through “September 2007”.

15 (2) ELIMINATION OF FUNDING LIMITATION.—

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

18 (i) in subsection (a), by striking “who  
19 are selected to receive such assistance  
20 under subsection (b)”

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

23 (iii) in subsection (d), by striking  
24 “furnished in a State” and all that follows  
25 and inserting “the Federal medical assist-

1           ance percentage shall be equal to 100 per-  
2           cent.”; and

3                   (iv) by redesignating subsections (d)  
4           and (f) as subsections (b) and (c), respec-  
5           tively.

6           (B) CONFORMING AMENDMENT.—Section  
7           1905(b) of such Act (42 U.S.C. 1396d(b)) is  
8           amended by striking “1933(d)” and inserting  
9           “1933(b)”.

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

13           (b) INCREASE IN ELIGIBILITY TO 150 PERCENT OF  
14           THE FEDERAL POVERTY LEVEL.—Section  
15           1902(a)(10)(E)(iv) of such Act is further amended by in-  
16           serting “(or, effective January 1, 2008, 150 percent)”  
17           after “135 percent”.

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

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

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

1           this section, an individual shall be permitted to  
2           qualify on the basis of self-certification of in-  
3           come and resources without the need to provide  
4           additional documentation.”.

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

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

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

5 “(7) The Secretary shall take all reasonable  
6 steps to encourage States to provide for administra-  
7 tive verification of income and automatic reenroll-  
8 ment (as provided under clauses (iii) and (iv) of sec-  
9 tion 1860D–14(a)(3)(C) in the case of the low-in-  
10 come subsidy program).”.

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

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

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

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

1 and the medicare savings program under title  
2 XIX.

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

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

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

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



1           “(3) TRANSMITTAL OF COMPLETED APPLICA-  
2           TION.—If such an employee assists in completing  
3           such an application, the employee, with the consent  
4           of the applicant, shall transmit the completed appli-  
5           cation to the appropriate State medicaid agency for  
6           processing.

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

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

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

23          (f) TRANSLATION OF MODEL FORM.—Section  
24          1905(p)(5)(A) of the Social Security Act (42 U.S.C.  
25          1396d(p)(5)(A)) is amended by adding at the end the fol-

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

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

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

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

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

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

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

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

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

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

19 “(v) the applicable year.

20 “(B) APPLICABLE YEAR.—

21 “(i) IN GENERAL.—For the purposes  
22 of this paragraph, the term ‘applicable  
23 year’ means the most recent taxable year  
24 for which information is available in the  
25 Internal Revenue Service’s taxpayer data

1 information systems, or, if there is no re-  
2 turn filed for the individual for such year,  
3 the prior taxable year.

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

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

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

23 (2) PROCEDURES AND RECORDKEEPING RE-  
24 LATED TO DISCLOSURES.—Paragraph (4) of section  
25 6103(p) of such Code is amended by striking “or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

9 “(iv) OVERALL LIMITATION ON COST-  
10 SHARING.—In the case of all such individ-  
11 uals, a limitation on aggregate cost-sharing  
12 under this part for a year not to exceed  
13 2.5 percent of income.”; and

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

16 “(F) OVERALL LIMITATION ON COST-SHAR-  
17 ING.—A limitation on aggregate cost-sharing  
18 under this part for a year not to exceed 2.5 per-  
19 cent of income.”.

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

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

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

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

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

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

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

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

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

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

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

5 “(iii) QUALITY.—

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

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

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

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

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

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

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

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

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

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

19 (2) in clause (ii)—

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

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

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

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

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

12 “(I) under section 1860D–14;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

24                                   “(I) Anticonvulsants.

25                                   “(II) Antineoplastics.



1 “(III) Antiretrovirals.

2 “(IV) Antidepressants.

3 “(V) Antipsychotics.

4 “(VI) Immunosuppressants.

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

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

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

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

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

3 “(ii) 100 percent of any late enrollment penalties im-  
4 posed under section 1860D–13(b) for such individual.”.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

10 (a) REQUIREMENTS.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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



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

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

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

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

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

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

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

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

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

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

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

21 (B) improve methods for health data col-  
22 lection and analysis including additional popu-  
23 lation groups beyond the Office of Management  
24 and Budget categories if such groups can be

1 aggregated into the minimum race and ethnicity  
2 categories;

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

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

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

16 (1) identify appropriate quality assurance mech-  
17 anisms to monitor for health disparities under the  
18 Medicare program;

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

21 (3) develop new quality measures relating to ra-  
22 cial and ethnic disparities in health and health care;

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



1 for language services using the results of the dem-  
2 onstration program conducted under section 233.

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

5 (A) How to develop and structure appro-  
6 priate payment systems for language services  
7 for all Medicare service providers.

8 (B) The feasibility of adopting a payment  
9 methodology for on-site interpreters, including  
10 interpreters who work as independent contrac-  
11 tors and interpreters who work for agencies  
12 that provide on-site interpretation, pursuant to  
13 which such interpreters could directly bill Medi-  
14 care for services provided in support of physi-  
15 cian office services for an LEP Medicare pa-  
16 tient.

17 (C) The feasibility of Medicare contracting  
18 directly with agencies that provide off-site inter-  
19 pretation including telephonic and video inter-  
20 pretation pursuant to which such contractors  
21 could directly bill Medicare for the services pro-  
22 vided in support of physician office services for  
23 an LEP Medicare patient.

24 (D) The feasibility of modifying the exist-  
25 ing Medicare resource-based relative value scale

1 (RBRVS) by using adjustments (such as multi-  
2 pliers or add-ons) when a patient is LEP.

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

8 (3) VARIATION IN PAYMENT SYSTEM DE-  
9 SCRIBED.—The payment systems described in sub-  
10 section (b) may allow variations based upon types of  
11 service providers, available delivery methods, and  
12 costs for providing language services including such  
13 factors as—

14 (A) the type of language services provided  
15 (such as provision of health care or health care  
16 related services directly in a non-English lan-  
17 guage by a bilingual provider or use of an inter-  
18 preter);

19 (B) type of interpretation services provided  
20 (such as in-person, telephonic, video interpreta-  
21 tion);

22 (C) the methods and costs of providing  
23 language services (including the costs of pro-  
24 viding language services with internal staff or

1 through contract with external independent con-  
2 tractors and/or agencies);

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

6 (E) providing services in rural areas.

7 (4) REPORT.—The Secretary shall submit a re-  
8 port on the study conducted under subsection (a) to  
9 appropriate committees of Congress not later than 1  
10 year after the expiration of the demonstration pro-  
11 gram conducted under section 3.

12 (b) HEALTH PLANS.—Section 1857(g)(1) of the So-  
13 cial Security Act (42 U.S.C. 1395w-27(g)(1)) is amend-  
14 ed—

15 (1) by striking “or” at the end of subparagraph  
16 (F);

17 (2) by adding “and” at the end of subpara-  
18 graph (G); and

19 (3) by inserting after subparagraph (G) the fol-  
20 lowing new subparagraph:

21 “(H) fails substantially to provide lan-  
22 guage services to limited English proficient  
23 beneficiaries enrolled in the plan that are re-  
24 quired under law;”.

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

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

15 (b) ELIGIBILITY; PRIORITY.—

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

18 (A) be—

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

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

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



1 (iv) a PDP sponsor of a prescription  
2 drug plan under part D of such title; and  
3 (B) prepare and submit to the Secretary  
4 an application, at such time, in such manner,  
5 and accompanied by such additional informa-  
6 tion as the Secretary may require.

7 (2) PRIORITY.—

8 (A) DISTRIBUTION.—To the extent fea-  
9 sible, in awarding grants under this section, the  
10 Secretary shall award—

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

13 (ii) 6 grants to service providers de-  
14 scribed in paragraph (1)(A)(ii);

15 (iii) 6 grants to organizations de-  
16 scribed in paragraph (1)(A)(iii); and

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

19 (B) FOR COMMUNITY ORGANIZATIONS.—  
20 The Secretary shall give priority to applicants  
21 that have developed partnerships with commu-  
22 nity organizations or with agencies with experi-  
23 ence in language access.

24 (C) VARIATION IN GRANTEES.—The Sec-  
25 retary shall also ensure that the grantees under

1           this section represent, among other factors,  
2           variations in—

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

6                   (ii) languages needed and their fre-  
7                   quency of use;

8                   (iii) urban and rural settings;

9                   (iv) at least two geographic regions;

10                  and

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

13           (c) USE OF FUNDS.—

14                   (1) IN GENERAL.—A grantee shall use grant  
15                  funds received under this section to pay for the pro-  
16                  vision of competent language services to Medicare  
17                  beneficiaries who are limited English proficient.  
18                  Competent interpreter services may be provided  
19                  through on-site interpretation, telephonic interpreta-  
20                  tion, or video interpretation or direct provision of  
21                  health care or health care related services by a bilin-  
22                  gual health care provider. A grantee may use bilin-  
23                  gual providers, staff, or contract interpreters. A  
24                  grantee may use grant funds to pay for competent  
25                  translation services. A grantee may use up to 10

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

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

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

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

1 (B) the grantee's own data if the grantee  
2 routinely collects data on Medicare bene-  
3 ficiaries' primary language in a manner deter-  
4 mined by the Secretary to yield accurate data  
5 and such data shows greater numbers of LEP  
6 individuals than the data listed in subparagraph  
7 (A).

8 (4) LIMITATIONS.—

9 (A) REPORTING.—Payments shall only be  
10 provided under this section to grantees that re-  
11 port their costs of providing language services  
12 as required under subsection (e). If a grantee  
13 fails to provide the reports under such section  
14 for the first year of a grant, the Secretary may  
15 terminate the grant and solicit applications  
16 from new grantees to participate in the subse-  
17 quent two years of the demonstration program.

18 (B) TYPE OF SERVICES.—

19 (i) IN GENERAL.—Subject to clause  
20 (ii), payments shall be provided under this  
21 section only to grantees that utilize com-  
22 petent bilingual staff or competent inter-  
23 preter or translation services which—

24 (I) if the grantee operates in a  
25 State that has statewide health care

1 interpreter standards, meet the State  
2 standards currently in effect; or

3 (II) if the grantee operates in a  
4 State that does not have statewide  
5 health care interpreter standards, uti-  
6 lizes competent interpreters who fol-  
7 low the National Council on Inter-  
8 preting in Health Care's Code of Eth-  
9 ics and Standards of Practice.

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

12 (I) in the case of a Medicare ben-  
13 efiary who is limited English pro-  
14 ficient (who has been informed in the  
15 beneficiary's primary language of the  
16 availability of free interpreter and  
17 translation services) and who requests  
18 the use of family, friends, or other  
19 persons untrained in interpretation or  
20 translation and the grantee documents  
21 the request in the beneficiary's record;  
22 and

23 (II) in the case of a medical  
24 emergency where the delay directly as-  
25 sociated with obtaining a competent

1 interpreter or translation services  
2 would jeopardize the health of the pa-  
3 tient.

4 Nothing in clause (ii)(II) shall be con-  
5 strued to exempt an emergency rooms or  
6 similar entities that regularly provide  
7 health care services in medical emergencies  
8 from having in place systems to provide  
9 competent interpreter and translation serv-  
10 ices without undue delay.

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

13 (1) ensure that appropriate clinical and support  
14 staff receive ongoing education and training in lin-  
15 guistically appropriate service delivery; ensure the  
16 linguistic competence of bilingual providers;

17 (2) offer and provide appropriate language serv-  
18 ices at no additional charge to each patient with lim-  
19 ited English proficiency at all points of contact, in  
20 a timely manner during all hours of operation;

21 (3) notify Medicare beneficiaries of their right  
22 to receive language services in their primary lan-  
23 guage;

1 (4) post signage in the languages of the com-  
2 monly encountered group or groups present in the  
3 service area of the organization; and

4 (5) ensure that—

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

7 (B) consistent with the privacy protections  
8 provided under the regulations promulgated  
9 pursuant to section 264(e) of the Health Insur-  
10 ance Portability and Accountability Act of 1996  
11 (42 U.S.C. 1320d–2 note), if the recipient of  
12 language services is a minor or is incapacitated,  
13 the primary language of the parent or legal  
14 guardian is collected and utilized.

15 (e) REPORTING REQUIREMENTS.—Grantees under  
16 this section shall provide the Secretary with reports at the  
17 conclusion of the each year of a grant under this section.  
18 each report shall include at least the following informa-  
19 tion:

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

22 (2) The languages of those Medicare bene-  
23 ficiaries.

24 (3) The types of language services provided  
25 (such as provision of services directly in non-English

1 language by a bilingual health care provider or use  
2 of an interpreter).

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

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

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

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

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

16 (g) EVALUATION AND REPORT.—The Secretary shall  
17 conduct an evaluation of the demonstration program  
18 under this section and shall submit to the appropriate  
19 committees of Congress a report not later than 1 year  
20 after the completion of the program. The report shall in-  
21 clude the following:

22 (1) An analysis of the patient outcomes and  
23 costs of furnishing care to the LEP Medicare bene-  
24 ficiaries participating in the project as compared to



1 such outcomes and costs for limited English pro-  
2 ficient Medicare beneficiaries not participating.

3 (2) The effect of delivering culturally and lin-  
4 guistically appropriate services on beneficiary access  
5 to care, utilization of services, efficiency and cost-ef-  
6 fectiveness of health care delivery, patient satisfac-  
7 tion, and select health outcomes.

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

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

15 (i) AUTHORIZATION OF APPROPRIATIONS.—There  
16 are authorized to be appropriated to carry out this section  
17 \$10,000,000 for each fiscal year of the demonstration.

18 **SEC. 234. DEMONSTRATION TO IMPROVE CARE TO PRE-**  
19 **VIOUSLY UNINSURED.**

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

1 (b) SCOPE.—The demonstration shall be in no fewer  
2 than 10 sites, and shall include state health insurance as-  
3 sistance programs, community health centers, community-  
4 based organizations, community health workers, and other  
5 service providers under parts A, B, and C of title XVIII  
6 of the Social Security Act. Grantees that are plans oper-  
7 ating under part C shall document that enrollees who were  
8 previously uninsured receive the “Welcome to Medicare”  
9 physical exam.

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

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

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

23 (2) The effect of such outreach on beneficiary  
24 access to care, utilization of services, efficiency and

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

3 **SEC. 235. OFFICE OF THE INSPECTOR GENERAL REPORT**  
4 **ON COMPLIANCE WITH AND ENFORCEMENT**  
5 **OF NATIONAL STANDARDS ON CULTURALLY**  
6 **AND LINGUISTICALLY APPROPRIATE SERV-**  
7 **ICES (CLAS) IN MEDICARE.**

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

12 (1) the extent to which Medicare providers and  
13 plans are complying with the Office for Civil Rights’  
14 Guidance to Federal Financial Assistance Recipients  
15 Regarding Title VI Prohibition Against National Or-  
16 igin Discrimination Affecting Limited English Pro-  
17 ficient Persons and the Office of Minority Health’s  
18 Culturally and Linguistically Appropriate Services  
19 Standards in health care; and

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

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

1 (b) IMPLEMENTATION.—Not later than one year  
2 after the date of publication of the report under subsection  
3 (a), the Department of Health and Human Services shall  
4 implement changes responsive to any deficiencies identi-  
5 fied in the report.

6 **SEC. 236. IOM REPORT ON IMPACT OF LANGUAGE ACCESS**  
7 **SERVICES.**

8 (a) IN GENERAL.—The Secretary of Health and  
9 Human Services shall seek to enter into an arrangement  
10 with the Institute of under which the Institute will prepare  
11 and publish, not later than 3 years after the date of the  
12 enactment of this Act, a report on the impact of language  
13 access services on the health and health care of limited  
14 English proficient populations.

15 (b) CONTENTS.—Such report shall include—

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

20 (2) a description of the effect of providing lan-  
21 guage access services on quality of health care and  
22 access to care and reduced medical error; and

23 (3) a description of the costs associated with or  
24 savings related to provision of language access serv-  
25 ices.

1 **SEC. 237. DEFINITIONS.**

2 In this subtitle:

3 (1) BILINGUAL.—The term “bilingual” with re-  
4 spect to an individual means a person who has suffi-  
5 cient degree of proficiency in two languages and can  
6 ensure effective communication can occur in both  
7 languages.

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

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

1 health-related terminology and provides accurate  
2 translations by choosing equivalent expressions that  
3 convey the best matching and meaning to the source  
4 language and captures, to the greatest possible ex-  
5 tent, all nuances intended in the source document.

6 (4) EFFECTIVE COMMUNICATION.—The term  
7 “effective communication” means an exchange of in-  
8 formation between the provider of health care or  
9 health care-related services and the limited English  
10 proficient recipient of such services that enables lim-  
11 ited English proficient individuals to access, under-  
12 stand, and benefit from health care or health care-  
13 related services.

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

18 (6) HEALTH CARE SERVICES.—The term  
19 “health care services” means services that address  
20 physical as well as mental health conditions in all  
21 care settings.

22 (7) HEALTH CARE-RELATED SERVICES.—The  
23 term “health care-related services” means human or  
24 social services programs or activities that provide ac-  
25 cess, referrals or links to health care.

1           (8) LANGUAGE ACCESS.—The term “language  
2           access” means the provision of language services to  
3           an LEP individual designed to enhance that individ-  
4           ual’s access to, understanding of or benefit from  
5           health care or health care-related services.

6           (9) LANGUAGE SERVICES.—The term “lan-  
7           guage services” means provision of health care serv-  
8           ices directly in a non-English language, interpreta-  
9           tion, translation, and non-English signage.

10          (10) LIMITED ENGLISH PROFICIENT.—The  
11          term “limited English proficient” or “LEP” with re-  
12          spect to an individual means an individual who  
13          speaks a primary language other than English and  
14          who cannot speak, read, write or understand the  
15          English language at a level that permits the indi-  
16          vidual to effectively communicate with clinical or  
17          nonclinical staff at an entity providing health care or  
18          health care related services.

19          (11) MEDICARE PROGRAM.—The term “Medi-  
20          care program” means the programs under parts A  
21          through D of title XVIII of the Social Security Act.

22          (12) SERVICE PROVIDER.—The term “service  
23          provider” includes all suppliers, providers of services,  
24          or entities under contract to provide coverage, items

1 or services under any part of title XVIII of the So-  
2 cial Security Act.

3 **TITLE III—PHYSICIANS’ SERVICE**  
4 **PAYMENT REFORM**

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

7 (a) ESTABLISHMENT OF SERVICE CATEGORIES.—  
8 Subsection (j) of section 1848 of the Social Security Act  
9 (42 U.S.C. 1395w-4) is amended by adding at the end  
10 the following new paragraph:

11 “(5) SERVICE CATEGORIES.—For services fur-  
12 nished on or after January 1, 2008, each of the fol-  
13 lowing categories of physicians’ services shall be  
14 treated as a separate ‘service category’:

15 “(A) Evaluation and management services  
16 for primary care (including new and established  
17 patient office visits delivered by physicians who  
18 the Secretary determines provide accessible,  
19 continuous, coordinated, and comprehensive  
20 care for Medicare beneficiaries, emergency de-  
21 partment visits, and home visits), and for pre-  
22 ventive services (including screening mammog-  
23 raphy, colorectal cancer screening, and other  
24 services as defined by the Secretary, limited to



1 the recommendations of the United States Pre-  
2 ventive Services Task Force).

3 “(B) Evaluation and management services  
4 not described in subparagraph (A).

5 “(C) Imaging services (as defined in sub-  
6 section (b)(4)(B)) and diagnostic tests (other  
7 than clinical diagnostic laboratory tests) not de-  
8 scribed in subparagraph (A).

9 “(D) Procedures that are subject (under  
10 regulations promulgated to carry out this sec-  
11 tion) to a 10-day or 90-day global period (in  
12 this paragraph referred to as ‘major proce-  
13 dures’), except that the Secretary may reclas-  
14 sify as minor procedures under subparagraph  
15 (F) any procedures that would otherwise be in-  
16 cluded in this category if the Secretary deter-  
17 mines that such procedures are not major pro-  
18 cedures.

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

23 “(F) Minor procedures and any other phy-  
24 sicians’ services that are not described in a pre-  
25 ceding subparagraph.”.

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

5 (1) in subparagraph (A)—

6 (A) by designating the sentence beginning  
7 “The conversion factor” as clause (i) with the  
8 heading “APPLICATION OF SINGLE CONVERSION  
9 FACTOR” and with appropriate indentation;

10 (B) by striking “The conversion factor”  
11 and inserting “Subject to clause (ii), the con-  
12 version factor”; and

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

15 “(ii) APPLICATION OF MULTIPLE CON-  
16 VERSION FACTORS BEGINNING WITH  
17 2008.—

18 “(I) IN GENERAL.—In applying  
19 clause (i) for years beginning with  
20 2008, separate conversion factors  
21 shall be established for each service  
22 category of physicians’ services (as de-  
23 fined in subsection (j)(5)) and any  
24 reference in this section to a conver-  
25 sion factor for such years shall be

1 deemed to be a reference to the con-  
2 version factor for each of such cat-  
3 egories.

4 “(II) INITIAL CONVERSION FAC-  
5 TORS; SPECIAL RULE FOR ANES-  
6 THESIA SERVICES.— Such factors for  
7 2008 shall be based upon the single  
8 conversion factor for 2007 multiplied  
9 by the update established under para-  
10 graph (8) for such category for 2008.  
11 In the case of the service category de-  
12 scribed in subsection (j)(5)(F) (relat-  
13 ing to anesthesia services), the conver-  
14 sion factor for 2008 shall be based on  
15 the separate conversion factor speci-  
16 fied in subparagraph (D) for 2007  
17 multiplied by the update established  
18 under paragraph (8) for such category  
19 for 2008.

20 “(III) UPDATING OF CONVER-  
21 SION FACTORS.— Such factor for a  
22 service category for a subsequent year  
23 shall be based upon the conversion  
24 factor for such category for the pre-  
25 vious year and adjusted by the update

1 established for such category under  
2 paragraph (8) for the year involved.”;  
3 and

4 (2) in subparagraph (D), by inserting “(before  
5 2008)” after “for a year”.

6 (c) ESTABLISHING UPDATES FOR CONVERSION FAC-  
7 TORS FOR SERVICE CATEGORIES.—Section 1848(d) of the  
8 Social Security Act (42 U.S.C. 1395w-4(d)) is amended—

9 (1) in paragraph (4)(B), by striking “and (6)”  
10 and inserting “, (6), and (8)”;

11 (2) in paragraph (4)(C)(iii), by striking “The  
12 allowed” and inserting “Subject to paragraph  
13 (8)(B), the allowed”;

14 (3) in paragraph (4)(D), by striking “The up-  
15 date” and inserting “Subject to paragraph (8)(E),  
16 the update”; and

17 (4) by adding at the end the following new  
18 paragraphs:

19 “(8) UPDATES FOR SERVICE CATEGORIES BE-  
20 GINNING WITH 2008.—

21 “(A) IN GENERAL.—In applying paragraph  
22 (4) for a year beginning with 2008, the fol-  
23 lowing rules apply:

24 “(i) APPLICATION OF SEPARATE UP-  
25 DATE ADJUSTMENTS FOR EACH SERVICE

1           CATEGORY.—Pursuant to paragraph  
2           (1)(A)(ii)(I), the update shall be made to  
3           the conversion factor for each service cat-  
4           egory (as defined in subsection (j)(5))  
5           based upon an update adjustment factor  
6           for the respective category and year and  
7           the update adjustment factor shall be com-  
8           puted, for a year, separately for each serv-  
9           ice category.

10           “(ii) COMPUTATION OF ALLOWED AND  
11           ACTUAL EXPENDITURES BASED ON SERV-  
12           ICE CATEGORIES.—In computing the prior  
13           year adjustment component and the cumu-  
14           lative adjustment component under clauses  
15           (i) and (ii) of paragraph (4)(B), the fol-  
16           lowing rules apply:

17           “(I) APPLICATION BASED ON  
18           SERVICE CATEGORIES.—The allowed  
19           expenditures and actual expenditures  
20           shall be the allowed and actual ex-  
21           penditures for the service category, as  
22           determined under subparagraph (B).

23           “(II) LIMITATION TO PHYSICIAN  
24           FEE-SCHEDULE SERVICES.—Actual  
25           expenditures shall only take into ac-

1 count expenditures for services fur-  
2 nished under the physician fee sched-  
3 ule.

4 “(III) APPLICATION OF CAT-  
5 EGORY SPECIFIC TARGET GROWTH  
6 RATE.—The growth rate applied  
7 under clause (ii)(II) of such para-  
8 graph shall be the target growth rate  
9 for the service category involved under  
10 subsection (f)(5).

11 “(IV) ALLOCATION OF CUMU-  
12 LATIVE OVERHANG.—There shall be  
13 substituted for the difference de-  
14 scribed in subparagraph (B)(ii)(I) of  
15 such paragraph the amount described  
16 in subparagraph (C)(i) for the service  
17 category involved.

18 “(B) DETERMINATION OF ALLOWED EX-  
19 PENDITURES.—In applying paragraph (4) for a  
20 year beginning with 2008, notwithstanding sub-  
21 paragraph (C)(iii) of such paragraph, the al-  
22 lowed expenditures for a service category for a  
23 year is an amount computed by the Secretary  
24 as follows:

25 “(i) FOR 2008.—For 2008:

1                   “(I) TOTAL 2007 ALLOWED EX-  
2                   PENDITURES.—Compute the total al-  
3                   lowed expenditures for services fur-  
4                   nished under the physician fee sched-  
5                   ule under such paragraph for 2007.

6                   “(II) INCREASE BY GROWTH  
7                   RATE.—Increase the total under sub-  
8                   clause (I) by the target growth rate  
9                   for such category under subsection (f)  
10                  for 2008.

11                  “(III) ALLOCATION TO SERVICE  
12                  CATEGORY.—Multiply the increased  
13                  total under subclause (II) by the over-  
14                  hang allocation factor for the service  
15                  category (as defined in subparagraph  
16                  (C)(iii)).

17                  “(ii) FOR SUBSEQUENT YEARS.—For  
18                  a subsequent year, take the amount of al-  
19                  lowed expenditures for such category for  
20                  the preceding year (under clause (i) or this  
21                  clause) and increase it by the target  
22                  growth rate determined under subsection  
23                  (f) for such category and year.

1                   “(C) COMPUTATION AND APPLICATION OF  
2 CUMULATIVE OVERHANG AMONG CAT-  
3 EGORIES.—

4                   “(i) IN GENERAL.—For purposes of  
5 applying paragraph (4)(B)(ii)(II) under  
6 clause (ii)(IV), the amount described in  
7 this clause for a year (beginning with  
8 2008) is the sum of the following:

9                   “(I) PRE-2008 CUMULATIVE  
10 OVERHANG.—The amount of the pre-  
11 2008 cumulative excess spending (as  
12 defined in clause (ii)) multiplied by  
13 the overhang allocation factor for the  
14 service category (under clause (iii)).

15                   “(II) POST-2007 CUMULATIVE  
16 AMOUNTS.—For a year beginning  
17 with 2009, the difference (which may  
18 be positive or negative) between the  
19 amount of the allowed expenditures  
20 for physicians’ services (as determined  
21 under paragraph (4)(C)) in the serv-  
22 ice category from January 1, 2008,  
23 through the end of the prior year and  
24 the amount of the actual expenditures



1 for such services in such category dur-  
2 ing that period.

3 “(ii) PRE-2008 CUMULATIVE EXCESS  
4 SPENDING DEFINED.—For purposes of  
5 clause (i)(I), the term ‘pre-2008 cumu-  
6 lative excess spending’ means the dif-  
7 ference described in paragraph  
8 (4)(B)(ii)(I) as determined for the year  
9 2008, taking into account expenditures  
10 through December 31, 2007. Such dif-  
11 ference takes into account expenditures in-  
12 cluded in subsection (f)(4)(A).

13 “(iii) OVERHANG ALLOCATION FAC-  
14 TOR.—For purposes of this paragraph, the  
15 term ‘overhang allocation factor’ means,  
16 for a service category, the proportion, as  
17 determined by the Secretary of total actual  
18 expenditures under this part for items and  
19 services in such category during 2007 to  
20 the total of such actual expenditures for all  
21 the service categories. In calculating such  
22 proportion, the Secretary shall only take  
23 into account services furnished under the  
24 physician fee schedule.

1           “(D) FLOOR FOR UPDATES FOR 2008 AND  
2           2009.—The update to the conversion factors for  
3           each service category for each of 2008 and  
4           2009 shall be not less than 0.5 percent.

5           “(E) CHANGE IN RESTRICTION ON UPDATE  
6           ADJUSTMENT FACTOR FOR 2010 AND 2011.—The  
7           update adjustment factor determined under  
8           subparagraph (4)(B), as modified by this para-  
9           graph, for a service category for a year (begin-  
10          ning with 2010 and ending with 2011) may be  
11          less than -0.07, but may not be less than  
12          -0.14.”.

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

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

18               “(5) APPLICATION OF SEPARATE TARGET  
19          GROWTH RATES FOR EACH SERVICE CATEGORY BE-  
20          GINNING WITH 2008.—The target growth rate for a  
21          year beginning with 2008 shall be computed and ap-  
22          plied separately under this subsection for each serv-  
23          ice category (as defined in subsection (j)(5)) and  
24          shall be computed using the same method for com-

1       puting the sustainable growth rate except for the fol-  
2       lowing:

3               “(A) The reference in paragraphs (2)(A)  
4               and (2)(D) to ‘all physicians’ services’ is  
5               deemed a reference to the physicians’ services  
6               included in such category but shall not take  
7               into account items and services included in phy-  
8               sicians’ services through the operation of para-  
9               graph (4)(A).

10              “(B) The factor described in paragraph  
11              (2)(C) for the service category described in sub-  
12              section (j)(5)(A) shall be increased by 0.03.

13              “(C) A national coverage determination (as  
14              defined in section 1869(f)(1)(B)) shall be treat-  
15              ed as a change in regulation described in para-  
16              graph (2)(D).”.

17              (2) USE OF TARGET GROWTH RATES.—Section  
18       1848 of such Act is further amended—

19              (A) in subsection (d)—

20                      (i) in paragraph (1)(E)(ii), by insert-  
21                      ing “or target” after “sustainable”; and

22                      (ii) in paragraph (4)(B)(ii)(II), by in-  
23                      serting “or target” after “sustainable”;

24              and

25              (B) in subsection (f)—

1 (i) in the heading by inserting “; TAR-  
2 GET GROWTH RATE” after “SUSTAINABLE  
3 GROWTH RATE”

4 (ii) in paragraph (1)—

5 (I) by striking “and” at the end  
6 of subparagraph (A);

7 (II) in subparagraph (B), by in-  
8 serting “before 2008” after “each  
9 succeeding year” and by striking the  
10 period at the end and inserting “;  
11 and”; and

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

14 “(C) November 1 of each succeeding year  
15 the target growth rate for such succeeding year  
16 and each of the 2 preceding years.”; and

17 (iii) in paragraph (2), in the matter  
18 before subparagraph (A), by inserting after  
19 “beginning with 2000” the following: “and  
20 ending with 2007” .

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

24 (1) REPORTING REQUIREMENT.—The Secretary  
25 of Health and Human Services shall include infor-

1       mation in the annual physician fee schedule pro-  
2       posed rule on the change in the annual rate of  
3       growth of actual expenditures for clinical diagnostic  
4       laboratory tests or drugs, biologicals, and radio-  
5       pharmaceuticals for which payment is made under  
6       part B of title XVIII of the Social Security Act.

7               (2) RECOMMENDATIONS.—The report sub-  
8       mitted under paragraph (1) shall include an analysis  
9       of the reasons for such excess expenditures and rec-  
10      ommendations for addressing them in the future.

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

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

18               “(7) USE OF EXPERT PANEL TO IDENTIFY  
19      MISVALUED PHYSICIANS' SERVICES.—

20                       “(A) IN GENERAL.—The Secretary shall  
21      establish an expert panel (in this paragraph re-  
22      ferred to as the ‘expert panel’)—

23                               “(i) to identify, through data analysis,  
24      physicians' services for which the relative  
25      value under this subsection is potentially

1 misvalued, particularly those services for  
2 which such relative value may be over-  
3 valued;

4 “(ii) to assess whether those  
5 misvalued services warrant review using  
6 existing processes (referred to in para-  
7 graph (2)(J)(ii)) for the consideration of  
8 coding changes; and

9 “(iii) to advise the Secretary con-  
10 cerning the exercise of authority under  
11 clauses (ii)(III) and (vi) of paragraph  
12 (2)(B).

13 “(B) COMPOSITION OF PANEL.—The ex-  
14 pert panel shall be appointed by the Secretary  
15 and composed of—

16 “(i) members with expertise in med-  
17 ical economics and technology diffusion;

18 “(ii) members with clinical expertise;

19 “(iii) physicians, particularly physi-  
20 cians (such as a physician employed by the  
21 Veterans Administration or a physician  
22 who has a full time faculty appointment at  
23 a medical school) who are not directly af-  
24 fected by changes in the physician fee  
25 schedule under this section;

1 “(iv) carrier medical directors; and

2 “(v) representatives of private payor  
3 health plans.

4 “(C) APPOINTMENT CONSIDERATIONS.—In  
5 appointing members to the expert panel, the  
6 Secretary shall assure racial and ethnic diver-  
7 sity on the panel and may consider appointing  
8 a liaison from organizations with experience in  
9 the consideration of coding changes to the  
10 panel.”.

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

14 “(8) EXAMINATION OF SERVICES WITH SUB-  
15 STANTIAL CHANGES.—The Secretary, in consultation  
16 with the expert panel under paragraph (7), shall—

17 “(A) conduct a five-year review of physi-  
18 cians’ services in conjunction with the RUC 5-  
19 year review, particularly for services that have  
20 experienced substantial changes in length of  
21 stay, site of service, volume, practice expense,  
22 or other factors that may indicate changes in  
23 physician work;

24 “(B) identify new services to determine if  
25 they are likely to experience a reduction in rel-

1           ative value over time and forward a list of the  
2           services so identified for such five-year review;  
3           and

4                   “(C) for physicians’ services that are oth-  
5           erwise unreviewed under the process the Sec-  
6           retary has established, periodically review a  
7           sample of relative value units within different  
8           types of services to assess the accuracy of the  
9           relative values contained in the Medicare physi-  
10          cian fee schedule.”.

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

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

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

17                           “(III) **REDUCTIONS IN WORK**  
18                           **VALUE UNITS FOR SERVICES WITH AC-**  
19                           **CELERATED VOLUME GROWTH.—**Eff-  
20                           fective January 1, 2009, reduced ex-  
21                           penditures attributable to clause  
22                           (vi).”; and

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



1                   “(vi) AUTHORIZING REDUCTION IN  
2                   WORK VALUE UNITS FOR SERVICES WITH  
3                   ACCELERATED VOLUME GROWTH.—The  
4                   Secretary may provide (without using ex-  
5                   isting processes the Secretary has estab-  
6                   lished for review of relative value) for a re-  
7                   duction in the work value units for a par-  
8                   ticular physician’s service if the annual  
9                   rate of growth in the expenditures for such  
10                  service for which payment is made under  
11                  this part for individuals for 2006 or a sub-  
12                  sequent year exceeds the average annual  
13                  rate of growth in expenditures of all physi-  
14                  cians’ services for which payment is made  
15                  under this part by more than 10 percent-  
16                  age points for such year.

17                  “(vii) CONSULTATION WITH EXPERT  
18                  PANEL AND BASED ON CLINICAL EVI-  
19                  DENCE.—The Secretary shall exercise au-  
20                  thority under clauses (ii)(III) and (vi) in  
21                  consultation with the expert panel estab-  
22                  lished under paragraph (7) and shall take  
23                  into account clinical evidence supporting or  
24                  refuting the merits of such accelerated  
25                  growth”.

1           (2) EFFECTIVE DATE.—The amendments made  
2           by paragraph (1) shall apply with respect to pay-  
3           ment for services furnished on or after January 1,  
4           2009.

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

9   “(III) ADJUSTMENT AUTHORITY  
10    FOR EFFICIENCY GAINS FOR NEW  
11    PROCEDURES.—In carrying out sub-  
12    clauses (I) and (II), the Secretary  
13    may apply a methodology, based on  
14    supporting evidence, under which  
15    there is imposed a reduction over a  
16    period of years in specified relative  
17    value units in the case of a new (or  
18    newer) procedure to take into account  
19    inherent efficiencies that are typically  
20    or likely to be gained during the pe-  
21    riod of initial increased application of  
22    the procedure.”.

1 **SEC. 303. PHYSICIAN FEEDBACK MECHANISM ON PRACTICE**  
2 **PATTERNS.**

3 By not later than July 1, 2008, the Secretary of  
4 Health and Human Services shall develop and implement  
5 a mechanism to measure resource use on a per capita and  
6 an episode basis in order to provide confidential feedback  
7 to physicians in the Medicare program on how their prac-  
8 tice patterns compare to physicians generally, both in the  
9 same locality as well as nationally. Such feedback shall  
10 not be subject to disclosure under section 552 of title 5,  
11 United States Code).

12 **SEC. 304. PAYMENTS FOR EFFICIENT PHYSICIANS.**

13 Section 1833 of the Social Security Act (42 U.S.C.  
14 1395l) is amended by adding at the end the following new  
15 subsection:

16 “(v) INCENTIVE PAYMENTS FOR EFFICIENT PHYSI-  
17 CIANS.—

18 “(1) IN GENERAL.—In the case of physicians’  
19 services furnished on or after January 1, 2009, and  
20 before January 1, 2011, by a participating physician  
21 in an efficient area (as identified under paragraph  
22 (2)), in addition to the amount of payment that  
23 would otherwise be made for such services under this  
24 part, there also shall be paid an amount equal to 5  
25 percent of the payment amount for the services  
26 under this part.

1           “(2) IDENTIFICATION OF EFFICIENT AREAS.—

2                   “(A) IN GENERAL.—Based upon available  
3 data, the Secretary shall identify those counties  
4 or equivalent areas in the United States in the  
5 lowest fifth percentile of utilization based on  
6 per capita spending for services provided in  
7 2007 under this part and part A.

8                   “(B) IDENTIFICATION OF COUNTIES  
9 WHERE SERVICE IS FURNISHED.—For pur-  
10 poses of paying the additional amount specified  
11 in paragraph (1), if the Secretary uses the 5-  
12 digit postal ZIP Code where the service is fur-  
13 nished, the dominant county of the postal ZIP  
14 Code (as determined by the United States Post-  
15 al Service, or otherwise) shall be used to deter-  
16 mine whether the postal ZIP Code is in a coun-  
17 ty described in subparagraph (A).

18                   “(C) JUDICIAL REVIEW.— There shall be  
19 no administrative or judicial review under sec-  
20 tion 1869, 1878, or otherwise, respecting—

21                           “(i) the identification of a county or  
22 other area under subparagraph (A); or

23                           “(ii) the assignment of a postal ZIP  
24 Code to a county or other area under sub-  
25 paragraph (B).

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

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

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

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

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

1 (b) RECOMMENDATIONS ON INCREASED USE OF  
2 BUNDLED PAYMENTS.—Not later than December 31,  
3 2008, the Comptroller General of the United States  
4 shall—

5 (1) complete an analysis of those procedures  
6 under the Medicare physician fee schedule for which  
7 no global payment methodology is applied but for  
8 which a “bundled” payment methodology would be  
9 appropriate; and

10 (2) submit to Congress a report on such anal-  
11 ysis and include in the report recommendations on  
12 increasing the use of “bundled” payment method-  
13 ology under such schedule.

14 (c) MEDICARE PHYSICIAN FEE SCHEDULE.—In this  
15 section, the term “Medicare physician fee schedule” means  
16 the fee schedule established under section 1848 of the So-  
17 cial Security Act (42 U.S.C. 1395w-4).

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

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

1 sedes the project that was initiated under section 204 of  
2 the Medicare Improvement and Extension Act of 2006 (di-  
3 vision B of Public Law 109–432). The purpose of the ex-  
4 panded project is—

5 (1) to guide the redesign of the health care de-  
6 livery system to provide accessible, continuous, com-  
7 prehensive, and coordinated, care to Medicare bene-  
8 ficiaries; and

9 (2) to provide care management fees to per-  
10 sonal physicians delivering continuous and com-  
11 prehensive care in qualified medical homes.

12 (b) NATURE AND SCOPE OF PROJECT.—

13 (1) DURATION; SCOPE.—The expanded project  
14 shall operate during a period of three years, begin-  
15 ning not later than October 1, 2009, and shall in-  
16 clude a nationally representative sample of physi-  
17 cians serving urban, rural, and underserved areas  
18 throughout the United States.

19 (2) ENCOURAGING PARTICIPATION OF SMALL  
20 PHYSICIAN PRACTICES.—

21 (A) IN GENERAL.—The expanded project  
22 shall be designed to include the participation of  
23 physicians in practices with fewer than four  
24 full-time equivalent physicians, as well as physi-

1           cians in larger practices particularly in rural  
2           and underserved areas.

3                   (B) TECHNICAL ASSISTANCE.— In order to  
4           facilitate the participation under the expanded  
5           project of physicians in such practices, the Sec-  
6           retary shall make available additional technical  
7           assistance to such practices during the first  
8           year of the expanded project.

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

13                   (A) the selection of up to 100 HIT-en-  
14          hanced medical homes; and

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

18                   (4) BENEFICIARY PARTICIPATION.—The Sec-  
19          retary shall establish a process for any Medicare  
20          beneficiary who is served by a medical home partici-  
21          pating in the expanded project to elect to participate  
22          in the project. Each beneficiary who elects to so par-  
23          ticipate shall be eligible—



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

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

8 The Secretary shall develop standard recruitment  
9 materials and election processes for Medicare bene-  
10 ficiaries who are electing to participate in the ex-  
11 panded project.

12 (c) STANDARDS FOR MEDICAL HOMES, HIT-EN-  
13 HANCED MEDICAL HOMES.—

14 (1) STANDARD SETTING AND CERTIFICATION  
15 PROCESS.—The Secretary shall establish a process  
16 for selection of a qualified standard setting and cer-  
17 tification organization—

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

22 (B) to provide for the review and certifi-  
23 cation of medical practices as meeting such  
24 standards.

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

6                   (A) ACCESS AND COMMUNICATION WITH  
7                   PATIENTS.—The practice applies standards for  
8                   access to care and communication with partici-  
9                   pating beneficiaries.

10                   (B) MANAGING PATIENT INFORMATION  
11                   AND USING INFORMATION IN MANAGEMENT TO  
12                   SUPPORT PATIENT CARE.—The practice has  
13                   readily accessible, clinically useful information  
14                   on participating beneficiaries that enables the  
15                   practice to treat such beneficiaries comprehen-  
16                   sively and systematically.

17                   (C) MANAGING AND COORDINATING CARE  
18                   ACCORDING TO INDIVIDUAL NEEDS.—The prac-  
19                   tice maintains continuous relationships with  
20                   participating beneficiaries by implementing evi-  
21                   dence-based guidelines and applying them to  
22                   the identified needs of individual beneficiaries  
23                   over time and with the intensity needed by such  
24                   beneficiaries.

1 (D) PROVIDING ONGOING ASSISTANCE AND  
2 ENCOURAGEMENT IN PATIENT SELF-MANAGE-  
3 MENT.—The practice—

4 (i) collaborates with participating  
5 beneficiaries to pursue their goals for opti-  
6 mal achievable health; and

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

10 (E) RESOURCES TO MANAGE CARE.—The  
11 practice has in place the resources and proc-  
12 esses necessary to achieve improvements in the  
13 management and coordination of care for par-  
14 ticipating beneficiaries.

15 (F) MONITORING PERFORMANCE.—The  
16 practice monitors its clinical process and per-  
17 formance (including outcome measures) in  
18 meeting the applicable standards under this  
19 subsection and provides information in a form  
20 and manner specified by the Secretary with re-  
21 spect to such process and performance.

22 (3) ADDITIONAL STANDARDS FOR HIT-EN-  
23 HANCED MEDICAL HOME.—For purposes of this sub-  
24 section, the term “HIT-enhanced medical home”  
25 means a medical home that has been certified, under

1 paragraph (1), as using a health information tech-  
2 nology system that includes at least the following  
3 elements:

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

8 (i) IN GENERAL.—The record—

9 (I) has the capability of inter-  
10 operability with secure data acquisi-  
11 tion from health information tech-  
12 nology systems of other health care  
13 providers in the area served by the  
14 home; or

15 (II) the capability to securely ac-  
16 quire clinical data delivered by such  
17 other health care providers to a secure  
18 common data source.

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

21 (iii) The record has the capability to  
22 acquire, manage, and display all the types  
23 of clinical information commonly relevant  
24 to services furnished by the home, such as  
25 complete medical records, radiographic

1 image retrieval, and clinical laboratory in-  
2 formation.

3 (iv) The record is integrated with de-  
4 cision support capacities that facilitate the  
5 use of evidence-based medicine and clinical  
6 decision support tools to guide decision-  
7 making at the point-of-care based on pa-  
8 tient-specific factors.

9 (B) E-PRESCRIBING.—The system sup-  
10 ports e-prescribing and computerized physician  
11 order entry.

12 (C) OUTCOME MEASUREMENT.—The sys-  
13 tem supports the secure, confidential provision  
14 of clinical process and outcome measures ap-  
15 proved by the National Quality Forum to the  
16 Secretary for use in confidential manner for  
17 provider feedback and peer review and for out-  
18 comes and clinical effectiveness research.

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

24 (E) SUPPORT OF BASIC STANDARDS.—  
25 The elements of such system, such as the elec-

1           tronic health record, email communications, pa-  
2           tient registries, and clinical-decision support  
3           tools, are integrated in a manner to better  
4           achieve the basic standards specified in para-  
5           graph (2) for a medical home.

6           (4) USE OF DATA.—The Secretary shall use the  
7           data submitted under paragraph (1)(F) in a con-  
8           fidential manner for feedback and peer review for  
9           medical homes and for outcomes and clinical effec-  
10          tiveness research. After the first two years of the ex-  
11          panded project, these data may be used for adjust-  
12          ment in the monthly medical home care management  
13          fee under subsection (d)(2)(E).

14          (d) MONTHLY MEDICAL HOME CARE MANAGEMENT  
15          FEE.—

16                (1) IN GENERAL.—Under the expanded project,  
17                the Secretary shall provide for payment to the per-  
18                sonal physician of each participating beneficiary of a  
19                monthly medical home care management fee.

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

23                    (A) OPERATING EXPENSES.—The addi-  
24                    tional practice expenses for the delivery of serv-  
25                    ices through a medical home, taking into ac-

1 count the additional expenses for an HIT-en-  
2 hanced medical home. Such expenses include  
3 costs associated with—

4 (i) structural expenses, such as equip-  
5 ment, maintenance, and training costs;

6 (ii) enhanced access and communica-  
7 tion functions;

8 (iii) population management and reg-  
9 istry functions;

10 (iv) patient medical data and referral  
11 tracking functions;

12 (v) provision of evidence-based care;

13 (vi) implementation and maintenance  
14 of health information technology;

15 (vii) reporting on performance and  
16 improvement conditions; and

17 (viii) patient education and patient  
18 decision support, including print and elec-  
19 tronic patient education materials.

20 (B) ADDED VALUE SERVICES.—The value  
21 of additional physician work, such as aug-  
22 mented care plan oversight, expanded e-mail  
23 and telephonic consultations, extended patient  
24 medical data review (including data stored and  
25 transmitted electronically), and physician super-

1 vision of enhanced self management education,  
2 and expanded follow-up accomplished by non-  
3 physician personnel, in a medical home that is  
4 not adequately taken into account in the estab-  
5 lishment of the physician fee schedule under  
6 section 1848 of the Social Security Act.

7 (C) RISK ADJUSTMENT.—The development  
8 of an appropriate risk adjustment mechanism  
9 to account for the varying costs of medical  
10 homes based upon characteristics of partici-  
11 pating beneficiaries.

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

16 (E) PERFORMANCE-BASED.—After the  
17 first two years of the expanded project, an ad-  
18 justment of the fee based on performance of the  
19 home in achieving quality or outcomes stand-  
20 ards.

21 (3) PERSONAL PHYSICIAN DEFINED.—For pur-  
22 poses of this subsection, the term “personal physi-  
23 cian” means, with respect to a participating Medi-  
24 care beneficiary, a physician (as defined in section  
25 1861(r)(1) of the Social Security Act (42 U.S.C.



1 1395x(r)(1)) who provides accessible, continuous, co-  
2 ordinated, and comprehensive care for the bene-  
3 ficiary as part of a medical practice that is a quali-  
4 fied medical home. Such a physician may be a spe-  
5 cialist for a beneficiary requiring ongoing care for a  
6 chronic condition or multiple chronic conditions  
7 (such as severe asthma, complex diabetes, cardio-  
8 vascular disease, rheumatologic disorder) or for a  
9 beneficiary with a prolonged illness.

10 (e) FUNDING.—

11 (1) USE OF CURRENT PROJECT FUNDING.—

12 Funds otherwise applied to the demonstration under  
13 section 204 of the Medicare Improvement and Ex-  
14 tension Act of 2006 (division B of Public Law 109–  
15 432) shall be available to carry out the expanded  
16 project

17 (2) ADDITIONAL FUNDING FROM SMI TRUST  
18 FUND.—

19 (A) IN GENERAL.—In addition to the  
20 funds provided under paragraph (1), there shall  
21 be available, from the Federal Supplementary  
22 Medical Insurance Trust Fund (under section  
23 1841 of the Social Security Act), the amount of  
24 \$500,000,000 to carry out the expanded  
25 project, including payments to of monthly med-

1           ical home care management fees under sub-  
2           section (d), reductions in coinsurance for par-  
3           ticipating beneficiaries under subsection  
4           (b)(4)(B), and funds for the design, implemen-  
5           tation, and evaluation of the expanded project.

6                   (B) MONITORING EXPENDITURES; EARLY  
7           TERMINATION.—The Secretary shall monitor  
8           the expenditures under the expanded project  
9           and may terminate the project early in order  
10          that expenditures not exceed the amount of  
11          funding provided for the project under subpara-  
12          graph (A).

13          (f) EVALUATIONS AND REPORTS.—

14                   (1) ANNUAL INTERIM EVALUATIONS AND RE-  
15          PORTS.—For each year of the expanded project, the  
16          Secretary shall provide for an evaluation of the  
17          project and shall submit to Congress, by a date spec-  
18          ified by the Secretary, a report on the project and  
19          on the evaluation of the project for each such year.

20                   (2) FINAL EVALUATION AND REPORT.—The  
21          Secretary shall provide for an evaluation of the ex-  
22          panded project and shall submit to Congress, not  
23          later than 18 months after the date of completion of  
24          the project, a report on the project and on the eval-  
25          uation of the project.

1 **SEC. 307. REPEAL OF PHYSICIAN ASSISTANCE AND QUAL-**  
2 **ITY INITIATIVE FUND.**

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

5 **SEC. 308. ADJUSTMENT TO MEDICARE PAYMENT LOCAL-**  
6 **ITIES.**

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

10 “(6) FEE SCHEDULE GEOGRAPHIC AREAS.—

11 “(A) IN GENERAL.—

12 “(i) REVISION.—Subject to clause (ii),  
13 for services furnished on or after January  
14 1, 2009, the Secretary shall revise the fee  
15 schedule areas used for payment under  
16 this section applicable to the State of Cali-  
17 fornia using the county-based geographic  
18 adjustment factor as specified in option 3  
19 (table 9) in the proposed rule for the 2008  
20 physician fee schedule published at 72  
21 Fed. Reg. 38,122 (July 12, 2007).

22 “(ii) TRANSITION.—For services fur-  
23 nished during the period beginning Janu-  
24 ary 1, 2009, and ending December 31,  
25 2010, after calculating the work, practice  
26 expense, and malpractice geographic indi-

1 ces described in clauses (i), (ii), and (iii) of  
2 paragraph (1)(A) that would otherwise  
3 apply, the Secretary shall increase any  
4 such geographic index for any county in  
5 California that is lower than the geo-  
6 graphic index used for payment for serv-  
7 ices under this section as of December 31,  
8 2008, in such county to such geographic  
9 index level.

10 “(iii) NON-APPLICATION OF PERIODIC  
11 REVISION.—If a periodic review of geo-  
12 graphic indices, as required under para-  
13 graph (1)(B), results in a reduction in a  
14 work, practice expense and malpractice ge-  
15 ographic index for any county in California  
16 that is below the geographic index level es-  
17 tablished pursuant to clause (ii) during a  
18 portion of the period described in such  
19 clause, the work, practice expense, or mal-  
20 practice index established in such clause  
21 shall be applied to payment for services  
22 furnished in such county during such por-  
23 tion of such period.

24 “(B) SUBSEQUENT REVISIONS.—

1                   “(i) TIMING.—Not later than January  
2                   1, 2014, the Secretary shall review and  
3                   make revisions to fee schedule areas in all  
4                   States for which more than one fee sched-  
5                   ule area is used for payment of services  
6                   under this section. The Secretary may re-  
7                   vise fee schedule areas in States in which  
8                   a single fee schedule area is used for pay-  
9                   ment for services under this section using  
10                  the same methodology applied in the pre-  
11                  vious sentence.

12                  “(ii) LINK WITH GEOGRAPHIC INDEX  
13                  DATA REVISION.—The revision described in  
14                  clause (i) shall be made effective concur-  
15                  rently with the application of the periodic  
16                  review of geographic adjustment factors re-  
17                  quired under paragraph (1)(C) for 2014.”.

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

19                  (a) PAYMENT UNDER PART B OF THE MEDICARE  
20 PROGRAM FOR DIAGNOSTIC IMAGING SERVICES FUR-  
21 NISHED IN FACILITIES CONDITIONED ON ACCREDITATION  
22 OF FACILITIES.—

23                   (1) SPECIAL PAYMENT RULE.—

1 (A) IN GENERAL.—Section 1848(b)(4) of  
2 the Social Security Act (42 U.S.C. 1395w-  
3 4(b)(4)) is amended—

4 (i) in the heading, by striking “RULE”  
5 and inserting “RULES”;

6 (ii) in subparagraph (A), by striking  
7 “IN GENERAL” and inserting “LIMITA-  
8 TION”; and

9 (iii) by adding at the end the fol-  
10 lowing new subparagraph:

11 “(C) PAYMENT ONLY FOR SERVICES PRO-  
12 VIDED IN ACCREDITED FACILITIES.—

13 “(i) IN GENERAL.—In the case of im-  
14 aging services that are diagnostic imaging  
15 services described in clause (ii), the pay-  
16 ment amount for the technical component  
17 and the professional component of the  
18 services established for a year under the  
19 fee schedule described in paragraph (1)  
20 shall each be zero, unless the services are  
21 furnished at a diagnostic imaging services  
22 facility that meets the certificate require-  
23 ment described in section 354(b)(1) of the  
24 Public Health Service Act, as applied  
25 under subsection (m). The previous sen-

1 tence shall not apply with respect to the  
2 professional component of a diagnostic im-  
3 aging service that is furnished by a physi-  
4 cian or that is an ultrasound furnished by  
5 nurse practitioner or or nurse-midwife.

6 “(ii) DIAGNOSTIC IMAGING SERV-  
7 ICES.—For purposes of clause (i) and sub-  
8 section (m), the term ‘diagnostic imaging  
9 services’ means all imaging modalities, in-  
10 cluding diagnostic magnetic resonance im-  
11 aging (‘MRI’), computed tomography  
12 (‘CT’), positron emission tomography  
13 (‘PET’), nuclear medicine procedures, x-  
14 rays, sonograms, ultrasounds, echocardi-  
15 ograms, and such emerging diagnostic im-  
16 aging technologies as specified by the Sec-  
17 retary. Such term does not include image  
18 guided procedures.”.

19 (B) EFFECTIVE DATE.—

20 (i) IN GENERAL.—Subject to clause  
21 (ii), the amendments made by subpara-  
22 graph (A) shall apply to diagnostic imag-  
23 ing services furnished on or after January  
24 1, 2010.

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

6 (2) CERTIFICATION OF FACILITIES THAT FUR-  
7 NISH DIAGNOSTIC IMAGING SERVICES.—Section  
8 1848 of the Social Security Act (42 U.S.C. 1395w-  
9 4) is amended by adding at the end the following  
10 new subsection:

11 “(m) CERTIFICATION OF FACILITIES THAT FURNISH  
12 DIAGNOSTIC IMAGING SERVICES.—

13 “(1) IN GENERAL.—For purposes of subsection  
14 (b)(4)(C)(i), except as provided under paragraphs  
15 (2) through (8), the provisions of section 354 of the  
16 Public Health Service Act (as in effect as of June  
17 1, 2007), relating to the certification of mammo-  
18 graphy facilities, shall apply, with respect to the pro-  
19 vision of diagnostic imaging services (as defined in  
20 subsection (b)(4)(C)(ii)) and to a diagnostic imaging  
21 services facility defined in paragraph (8) (and to the  
22 process of accrediting such facilities) in the same  
23 manner that such provisions apply, with respect to  
24 the provision of mammograms and to a facility de-



1       fined in subsection (a)(3) of such section (and to the  
2       process of accrediting such mammography facilities).

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

6           “(A) any reference to ‘mammography’, or  
7       ‘breast imaging’ is deemed a reference to ‘diag-  
8       nostic imaging services (as defined in section  
9       1848(b)(4)(C)(ii) of the Social Security Act)’;

10          “(B) any reference to a mammogram or  
11       film is deemed a reference to an image, as de-  
12       fined in paragraph (8);

13          “(C) any reference to ‘mammography facil-  
14       ity’ or to a ‘facility’ under such section 354 is  
15       deemed a reference to a diagnostic imaging  
16       services facility, as defined in paragraph (8);

17          “(D) any reference to radiological equip-  
18       ment used to image the breast is deemed a ref-  
19       erence to medical imaging equipment used to  
20       provide diagnostic imaging services;

21          “(E) any reference to radiological proce-  
22       dures or radiological is deemed a reference to  
23       medical imaging services, as defined in para-  
24       graph (8) or medical imaging, respectively;

1           “(F) any reference to an inspection (as de-  
2           fined in subsection (a)(4) of such section) or in-  
3           specter is deemed a reference to an audit (as  
4           defined in paragraph (8)) or auditor, respec-  
5           tively;

6           “(G) any reference to a medical physicist  
7           (as described in subsection (f)(1)(E) of such  
8           section) is deemed to include a reference to a  
9           magnetic resonance scientist or the appropriate  
10          qualified expert as determined by the accred-  
11          iting body;

12          “(H) in applying subsection (d)(1)(A)(i) of  
13          such section, the reference to ‘type of each x-  
14          ray machine, image receptor, and processor’ is  
15          deemed a reference to ‘type of imaging equip-  
16          ment’;

17          “(I) in applying subsection (d)(1)(B) of  
18          such section, the reference that ‘the person or  
19          agent submits to the Secretary’ is deemed a ref-  
20          erence that ‘the person or agent submits to the  
21          Secretary, through the appropriate accredita-  
22          tion body’;

23          “(J) in applying subsection (d)(1)(B)(i) of  
24          such section, the reference to standards estab-  
25          lished by the Secretary is deemed a reference to

1 standards established by an accreditation body  
2 and approved by the Secretary;

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

5 “(i) in paragraph (1)(A), the ref-  
6 erence to ‘may’ is deemed a reference to  
7 ‘shall’;

8 “(ii) in paragraph (1)(B)(i)(II), the  
9 reference to ‘a random sample of clinical  
10 images from such facilities’ is deemed a  
11 reference to ‘a statistically significant ran-  
12 dom sample of clinical images from a sta-  
13 tistically significant random sample of fa-  
14 cilities’;

15 “(iii) in paragraph (3)(A) of such sec-  
16 tion—

17 “(I) the reference to ‘paragraph  
18 (1)(B)’ in such subsection is deemed  
19 to be a reference to ‘paragraph (1)(B)  
20 and subsection (f)’; and

21 “(II) the reference to the ‘Sec-  
22 retary’ is deemed a reference to ‘an  
23 accreditation body, with the approval  
24 of the Secretary’; and

1           “(iv) in paragraph (6)(B), the ref-  
2           erence to the Committee on Labor and  
3           Human Resources of the Senate is deemed  
4           to be the Committee on Finance of the  
5           Senate and the reference to the Committee  
6           on Energy and Commerce of the House of  
7           Representatives is deemed to include a ref-  
8           erence to the Committee on Ways and  
9           Means of the House of Representatives;

10           “(L) in applying subsection (f), relating to  
11           quality standards—

12           “(i) each reference to standards estab-  
13           lished by the Secretary is deemed a ref-  
14           erence to standards established by an ac-  
15           creditation body involved and approved by  
16           the Secretary under subsection (d)(1)(B)(i)  
17           of such section

18           “(ii) in paragraph (1)(A), the ref-  
19           erence to ‘radiation dose’ is deemed a ref-  
20           erence to ‘radiation dose, as appropriate’;

21           “(iii) in paragraph (1)(B), the ref-  
22           erence to ‘radiological standards’ is deemed  
23           a reference to ‘medical imaging standards,  
24           as appropriate’;

1           “(iv) in paragraphs (1)(D)(ii) and  
2           (1)(E)(iii), the reference to ‘the Secretary’  
3           is deemed a reference to ‘an accreditation  
4           body with the approval of the Secretary’;

5           “(v) in each of subclauses (III) and  
6           (IV) of paragraph (1)(G)(ii), each ref-  
7           erence to ‘patient’ is deemed a reference to  
8           ‘patient, if requested by the patient’; and

9           “(M) in applying subsection (g), relating to  
10          inspections—

11           “(i) each reference to the ‘Secretary  
12           or State or local agency acting on behalf of  
13           the Secretary’ is deemed to include a ref-  
14           erence to an accreditation body involved;

15           “(ii) in the first sentence of para-  
16           graph (1)(F), the reference to ‘annual in-  
17           spections required under this paragraph’ is  
18           deemed a reference to ‘the audits carried  
19           out in facilities at least every three years  
20           from the date of initial accreditation under  
21           this paragraph’; and

22           “(iii) in the second sentence of para-  
23           graph (1)(F), the reference to ‘inspections  
24           carried out under this paragraph’ is  
25           deemed a reference to ‘audits conducted

1 under this paragraph during the previous  
2 year’.

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

6 “(A) IN GENERAL.—Except as provided in  
7 subparagraph (B)—

8 “(i) any reference to ‘October 1,  
9 1994’ shall be deemed a reference to ‘Jan-  
10 uary 1, 2010’;

11 “(ii) the reference to ‘the date of the  
12 enactment of this section’ in each of sub-  
13 sections (e)(1)(D) and (f)(1)(E)(iii) is  
14 deemed to be a reference to ‘the date of  
15 the enactment of the Children’s Health  
16 and Medicare Protection Act of 2007’;

17 “(iii) the reference to ‘annually’ in  
18 subsection (g)(1)(E) is deemed a reference  
19 to ‘every three years’;

20 “(iv) the reference to ‘October 1,  
21 1996’ in subsection (l) is deemed to be a  
22 reference to ‘January 1, 2011’;

23 “(v) the reference to ‘October 1,  
24 1999’ in subsection (n)(3)(H) is deemed to  
25 be a reference to ‘January 1, 2012’; and

1                   “(vi) the reference to ‘October 1,  
2                   1993’ in the matter following paragraph  
3                   (3)(J) of subsection (n) is deemed to be a  
4                   reference ‘January 1, 2010’.

5                   “(B) ULTRASOUND SERVICES.—With re-  
6                   spect to diagnostic imaging services that are  
7                   ultrasounds—

8                   “(i) any reference to ‘October 1,  
9                   1994’ shall be deemed a reference to ‘Jan-  
10                  uary 1, 2012’;

11                  “(ii) the reference to ‘the date of the  
12                  enactment of this section’ in subsection  
13                  (f)(1)(E)(iii) is deemed to be a reference to  
14                  ‘7 years after the date of the enactment of  
15                  the Children’s Health and Medicare Pro-  
16                  tection Act of 2007’;

17                  “(iii) the reference to ‘October 1,  
18                  1996’ in subsection (l) is deemed to be a  
19                  reference to ‘January 1, 2013’;

20                  “(4) PROVISIONS NOT APPLICABLE.—For pur-  
21                  poses of paragraph (1), in applying section 354 of  
22                  the Public Health Service Act, the following provi-  
23                  sion shall not apply:

24                  “(A) Subsections (e) and (f) of such sec-  
25                  tion, in so far as the respective subsection im-

1           poses any requirement for a physician to be cer-  
2           tified, accredited, or otherwise meet require-  
3           ments, with respect to the provision of any di-  
4           agnostic imaging services, as a condition of pay-  
5           ment under subsection (b)(4)(C)(i), with re-  
6           spect to the professional or technical compo-  
7           nent, for such service.

8           “(B) Subsection (e)(1)(B)(iv) of such sec-  
9           tion, insofar as it applies to a facility with re-  
10          spect to the provision of ultrasounds.

11          “(C) Subsection (e)(1)(B)(v).

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

15          “(E) Subsection (g)(6) of such section, re-  
16          lating to an inspection demonstration program.

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

19          “(G) Subsection (p) of such section, relat-  
20          ing to breast cancer screening surveillance re-  
21          search grants.

22          “(H) Paragraphs (1)(B) and (2) of sub-  
23          section (r) of such section, related to funding.



1           “(5) ACCREDITATION BODIES.—For purposes  
2 of paragraph (1), in applying section 354(e)(1) of  
3 the Public Health Service, the following shall apply:

4           “(A) APPROVAL OF TWO ACCREDITATION  
5 BODIES FOR EACH TREATMENT MODALITY.—In  
6 the case that there is more than one accredita-  
7 tion body for a treatment modality that quali-  
8 fies for approval under this subsection, the Sec-  
9 retary shall approve at least two accreditation  
10 bodies for such treatment modality.

11           “(B) ADDITIONAL ACCREDITATION BODY  
12 STANDARDS.—In addition to the standards de-  
13 scribed in subparagraph (B) of such section for  
14 accreditation bodies, the Secretary shall estab-  
15 lish standards that require—

16           “(i) the timely integration of new  
17 technology by accreditation bodies for pur-  
18 poses of accrediting facilities under this  
19 subsection; and

20           “(ii) the accreditation body involved to  
21 evaluate the annual medical physicist sur-  
22 vey (or annual medical survey of another  
23 appropriate qualified expert chosen by the  
24 accreditation body) of a facility upon on-  
25 site review of such facility.

1           “(6) ADDITIONAL QUALITY STANDARDS.—For  
2 purposes of paragraph (1), in applying subsection  
3 (f)(1) of section 354 of the Public Health Service—

4           “(A) the quality standards under such sub-  
5 section shall, with respect to a facility include—

6           “(i) standards for qualifications of  
7 medical personnel who are not physicians  
8 and who perform diagnostic imaging serv-  
9 ices at the facility that require such per-  
10 sonnel to ensure that individuals, prior to  
11 performing medical imaging, demonstrate  
12 compliance with the standards established  
13 under subsection (a) through successful  
14 completion of certification by a nationally  
15 recognized professional organization, licen-  
16 sure, completion of an examination, perti-  
17 nent coursework or degree program,  
18 verified pertinent experience, or through  
19 other ways determined appropriate by an  
20 accreditation body (with the approval of  
21 the Secretary, or through some combina-  
22 tion thereof);

23           “(ii) standards requiring the facility  
24 to maintain records of the credentials of

1 physicians and other medical personnel de-  
2 scribed in clause (i);

3 “(iii) standards for qualifications and  
4 responsibilities of medical directors and  
5 other personnel with supervising roles at  
6 the facility;

7 “(iv) standards that require the facil-  
8 ity has procedures to ensure the safety of  
9 patients of the facility; and

10 “(v) standards for the establishment  
11 of a quality control program at the facility  
12 to be implemented as described in subpara-  
13 graph (E) of such subsection;

14 “(B) the quality standards described in  
15 subparagraph (B) of such subsection shall be  
16 deemed to include standards that require the  
17 establishment and maintenance of a quality as-  
18 surance and quality control program at each fa-  
19 cility that is adequate and appropriate to en-  
20 sure the reliability, clarity, and accuracy of the  
21 technical quality of diagnostic images produced  
22 at such facilities; and

23 “(C) the quality standard described in sub-  
24 paragraph (C) of such subsection, relating to a  
25 requirement for personnel who perform speci-

1           fied services, shall include in such requirement  
2           that such personnel must meet continuing med-  
3           ical education standards as specified by an ac-  
4           creditation body (with the approval of the Sec-  
5           retary) and update such standards at least once  
6           every three years.

7           “(7) ADDITIONAL REQUIREMENTS.—Notwith-  
8           standing any provision of section 354 of the Public  
9           Health Service Act, the following shall apply to the  
10          accreditation process under this subsection for pur-  
11          poses of subsection (b)(4)(C)(i):

12                   “(A) Any diagnostic imaging services facil-  
13                   ity accredited before January 1, 2010 (or Janu-  
14                   ary 1, 2012 in the case of ultrasounds), by an  
15                   accrediting body approved by the Secretary  
16                   shall be deemed a facility accredited by an ap-  
17                   proved accreditation body for purposes of such  
18                   subsection as of such date if the facility submits  
19                   to the Secretary proof of such accreditation by  
20                   transmittal of the certificate of accreditation,  
21                   including by electronic means.

22                   “(B) The Secretary may require the ac-  
23                   creditation under this subsection of an emerg-  
24                   ing technology used in the provision of a diag-  
25                   nostic imaging service as a condition of pay-

1           ment under subsection (b)(4)(C)(i) for such  
2           service at such time as the Secretary deter-  
3           mines there is sufficient empirical and scientific  
4           information to properly carry out the accredita-  
5           tion process for such technology.

6           “(8) DEFINITIONS.—For purposes of this sub-  
7           section:

8                   “(A) AUDIT.—The term ‘audit’ means an  
9                   onsite evaluation, with respect to a diagnostic  
10                  imaging services facility, by the Secretary, State  
11                  or local agency on behalf of the Secretary, or  
12                  accreditation body approved under this sub-  
13                  section that includes the following:

14                           “(i) Equipment verification.

15                           “(ii) Evaluation of policies and proce-  
16                           dures for compliance with accreditation re-  
17                           quirements.

18                           “(iii) Evaluation of personnel quali-  
19                           fications and credentialing.

20                           “(iv) Evaluation of the technical qual-  
21                           ity of images.

22                           “(v) Evaluation of patient reports.

23                           “(vi) Evaluation of peer-review mech-  
24                           anisms and other quality assurance activi-  
25                           ties.

1                   “(vii) Evaluation of quality control  
2                   procedures, results, and follow-up actions.

3                   “(viii) Evaluation of medical physi-  
4                   cists (or other appropriate professionals  
5                   chosen by the accreditation body) and  
6                   magnetic resonance scientist surveys.

7                   “(ix) Evaluation of consumer com-  
8                   plaint mechanisms.

9                   “(x) Provision of recommendations for  
10                  improvement based on findings with re-  
11                  spect to clauses (i) through (ix).

12                  “(B) DIAGNOSTIC IMAGING SERVICES FA-  
13                  CILITY.—The term ‘diagnostic imaging services  
14                  facility’ has the meaning given the term ‘facil-  
15                  ity’ in section 354(a)(3) of the Public Health  
16                  Service Act (42 U.S.C. 263b(a)(3)) subject to  
17                  the reference changes specified in paragraph  
18                  (2), but does not include any facility that does  
19                  not furnish diagnostic imaging services for  
20                  which payment may be made under this section.

21                  “(C) IMAGE.—The term ‘image’ means the  
22                  portrayal of internal structures of the human  
23                  body for the purpose of detecting and deter-  
24                  mining the presence or extent of disease or in-  
25                  jury and may be produced through various

1 techniques or modalities, including radiant en-  
2 ergy or ionizing radiation and ultrasound and  
3 magnetic resonance. Such term does not include  
4 image guided procedures.

5 “(D) MEDICAL IMAGING SERVICE.—The  
6 term ‘medical imaging service’ means a service  
7 that involves the science of an image. Such  
8 term does not include image guided proce-  
9 dures.”.

10 (b) ADJUSTMENT IN PRACTICE EXPENSE TO RE-  
11 FLECT HIGHER PRESUMED UTILIZATION.—Section 1848  
12 of the Social Security Act (42 U.S.C. 1395w(b)(4)) is  
13 amended—

14 (1) in subsection (b)(4)—

15 (A) in the heading, by striking “RULE”  
16 and inserting “RULES”;

17 (B) in subparagraph (B), by striking “sub-  
18 paragraph (A)” and inserting “this paragraph”;  
19 and

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

22 “(C) ADJUSTMENT IN PRACTICE EXPENSE  
23 TO REFLECT HIGHER PRESUMED UTILIZA-  
24 TION.—In computing the number of practice  
25 expense relative value units under subsection

1 (c)(2)(C)(ii) with respect to imaging services  
2 described in subparagraph (B), the Secretary  
3 shall adjust such number of units so it reflects  
4 a 75 percent (rather than 50 percent) presumed  
5 rate of utilization of imaging equipment.”; and

6 (2) in subsection (c)(2)(B)(v)(II), by inserting  
7 “AND OTHER PROVISIONS” after “OPD PAYMENT  
8 CAP”

9 (c) ADJUSTMENT IN TECHNICAL COMPONENT “DIS-  
10 COUNT” ON SINGLE-SESSION IMAGING TO CONSECUTIVE  
11 BODY PARTS.—Section 1848(b)(4) of such Act is further  
12 amended by adding at the end the following new subpara-  
13 graph:

14 “(D) ADJUSTMENT IN TECHNICAL COMPO-  
15 NENT DISCOUNT ON SINGLE-SESSION IMAGING  
16 INVOLVING CONSECUTIVE BODY PARTS.—The  
17 Secretary shall increase the reduction in ex-  
18 penditures attributable to the multiple proce-  
19 dure payment reduction applicable to the tech-  
20 nical component for imaging under the final  
21 rule published by the Secretary in the Federal  
22 Register on November 21, 2005 (42 CFR 405,  
23 et al.) from 25 percent to 50 percent.”.

24 (d) ADJUSTMENT IN ASSUMED INTEREST RATE FOR  
25 CAPITAL PURCHASES.—Section 1848(b)(4) of such Act is



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

3           “(E) ADJUSTMENT IN ASSUMED INTEREST  
4           RATE FOR CAPITAL PURCHASES.—In computing  
5           the practice expense component for imaging  
6           services under this section, the Secretary shall  
7           change the interest rate assumption for capital  
8           purchases of imaging devices to reflect the pre-  
9           vailing rate in the market, but in no case higher  
10          than 11 percent.”.

11          (e) DISALLOWANCE OF GLOBAL BILLING.—Effective  
12 for claims filed for imaging services (as defined in sub-  
13 section (b)(4)(B) of section 1848 of the Social Security  
14 Act) furnished on or after the first day of the first month  
15 that begins more than 1 year after the date of the enact-  
16 ment of this Act, the Secretary of Health and Human  
17 Services shall not accept (or pay) a claim under such sec-  
18 tion unless the claim is made separately for each compo-  
19 nent of such services.

20          (f) EFFECTIVE DATE.—Except as otherwise pro-  
21 vided, this section, and the amendments made by this sec-  
22 tion, shall apply to services furnished on or after January  
23 1, 2008.

1 **SEC. 310. REPEAL OF PHYSICIANS ADVISORY COUNCIL.**

2 Section 1868(a) of the Social Security Act (42 U.S.C.  
3 1395ee(a)), relating to the Practicing Physicians Advisory  
4 Council, is repealed.

5 **TITLE IV—MEDICARE**  
6 **ADVANTAGE REFORMS**  
7 **Subtitle A—Payment Reform**

8 **SEC. 401. EQUALIZING PAYMENTS BETWEEN MEDICARE AD-**  
9 **VANTAGE PLANS AND FEE-FOR-SERVICE**  
10 **MEDICARE.**

11 (a) PHASE IN OF PAYMENT BASED ON FEE-FOR-  
12 SERVICE COSTS.—Section 1853 of the Social Security Act  
13 (42 U.S.C. 1395w-23) is amended—

14 (1) in subsection (j)(1)(A)—

15 (A) by striking “beginning with 2007” and  
16 inserting “for 2007 and 2008”; and

17 (B) by inserting after “(k)(1)” the fol-  
18 lowing: “, or, beginning with 2009,  $\frac{1}{12}$  of the  
19 blended benchmark amount determined under  
20 subsection (l)(1)”; and

21 (2) by adding at the end the following new sub-  
22 section:

23 “(l) DETERMINATION OF BLENDED BENCHMARK  
24 AMOUNT.—

1           “(1) IN GENERAL.—For purposes of subsection  
2           (j), subject to paragraphs (2) and (3), the term  
3           ‘blended benchmark amount’ means for an area—  
4                   “(A) for 2009 the sum of—  
5                           “(i)  $\frac{2}{3}$  of the applicable amount (as  
6                           defined in subsection (k)(1)) for the area  
7                           and year; and  
8                           “(ii)  $\frac{1}{3}$  of the amount specified in  
9                           subsection (c)(1)(D)(i) for the area and  
10                           year;  
11                   “(B) for 2010 the sum of—  
12                           “(i)  $\frac{1}{3}$  of the applicable amount for  
13                           the area and year; and  
14                           “(ii)  $\frac{2}{3}$  of the amount specified in  
15                           subsection (c)(1)(D)(i) for the area and  
16                           year; and  
17                   “(C) for a subsequent year the amount  
18                   specified in subsection (c)(1)(D)(i) for the area  
19                   and year.  
20           “(2) FEE-FOR-SERVICE PAYMENT FLOOR.—In  
21           no case shall the blended benchmark amount for an  
22           area and year be less than the amount specified in  
23           subsection (c)(1)(D)(i) for the area and year.

1           “(3) EXCEPTION FOR PACE PLANS.—This sub-  
2           section shall not apply to payments to a PACE pro-  
3           gram under section 1894.”.

4           (b) PHASE IN OF PAYMENT BASED ON IME  
5           COSTS.—

6           (1) IN GENERAL.—Section 1853(c)(1)(D)(i) of  
7           such Act (42 U.S.C. 1395w-23(c)(1)(D)(i)) is  
8           amended by inserting “and costs attributable to pay-  
9           ments under section 1886(d)(5)(B)” after  
10          “1886(h)”.

11          (2) EFFECTIVE DATE.—The amendment made  
12          by paragraph (1) shall apply to the capitation rate  
13          for years beginning with 2009.

14          (c) LIMITATION ON PLAN ENROLLMENT IN CASES OF  
15          EXCESS BIDS FOR 2009 AND 2010.—

16          (1) IN GENERAL.—In the case of a Medicare  
17          Part C organization that offers a Medicare Part C  
18          plan in the 50 States or the District of Columbia for  
19          which—

20                  (A) bid amount described in paragraph (2)  
21                  for a Medicare Part C plan for 2009 or 2010,  
22                  exceeds

23                  (B) the percent specified in paragraph (4)  
24                  of the fee-for-service amount described in para-  
25                  graph (3),

1 the Medicare Part C plan may not enroll any new  
2 enrollees in the plan during the annual, coordinated  
3 election period (under section 1851(e)(3)(B) of such  
4 Act (42 U.S.C. 1395w-21(e)(3)(B)) for the year or  
5 during the year (if the enrollment becomes effective  
6 during the year).

7 (2) BID AMOUNT FOR PART A AND B SERV-  
8 ICES.—

9 (A) IN GENERAL.—Except as provided in  
10 subparagraph (B), the bid amount described in  
11 this paragraph is the unadjusted Medicare Part  
12 C statutory non-drug monthly bid amount (as  
13 defined in section 1854(b)(2)(E) of the Social  
14 Security Act (42 U.S.C. 1395w-24(b)(2)(E)).

15 (B) TREATMENT OF MSA PLANS.—In the  
16 case of an MSA plan (as defined in section  
17 1859(b)(3) of the Social Security Act, 42  
18 U.S.C. 1935w-28(b)(3)), the bid amount de-  
19 scribed in this paragraph is the amount de-  
20 scribed in section 1854(a)(3)(A) of such Act  
21 (42 U.S.C. 1395w-24(a)(3)(A)).

22 (3) FEE-FOR-SERVICE AMOUNT DESCRIBED.—

23 (A) IN GENERAL.—Subject to subpara-  
24 graph (B), the fee-for-service amount described  
25 in this paragraph for an Medicare Part C local

1 area is the amount described in section  
2 1853(c)(1)(D)(i) of the Social Security Act (42  
3 U.S.C. 1395w-23) for such area.

4 (B) TREATMENT OF MULTI-COUNTY  
5 PLANS.—In the case of an MA plan the service  
6 area for which covers more than one Medicare  
7 Part C local area, the fee-for-service amount  
8 described in this paragraph is the amount de-  
9 scribed in section 1853(c)(1)(D)(i) of the Social  
10 Security Act for each such area served, weight-  
11 ed for each such area by the proportion of the  
12 enrollment of the plan that resides in the coun-  
13 ty (as determined based on amounts posted by  
14 the Administrator of the Centers for Medicare  
15 & Medicaid Services in the April bid notice  
16 for the year involved).

17 (4) PERCENTAGE PHASE DOWN.—For purposes  
18 of paragraph (1), the percentage specified in this  
19 paragraph—

20 (A) for 2009 is 106 percent; and

21 (B) for 2010 is 103 percent.

22 (5) EXEMPTION OF AGE-INS.—For purposes of  
23 paragraph (1), the term “new enrollee” with respect  
24 to a Medicare Part C plan offered by a Medicare  
25 Part C organization, does not include an individual

1 who was enrolled in a plan offered by the organiza-  
2 tion in the month immediately before the month in  
3 which the individual was eligible to enroll in such a  
4 Medicare Part C plan offered by the organization.

5 (d) ANNUAL REBASING OF FEE-FOR-SERVICE  
6 RATES.—Section 1853(c)(1)(D)(ii) of the Social Security  
7 Act (42 U.S.C. 1395w-23(c)(1)(D)(ii)) is amended—

8 (1) by inserting “(before 2009)” after “for sub-  
9 sequent years”; and

10 (2) by inserting before the period at the end the  
11 following: “and for each year beginning with 2009”.

12 (e) REPEAL OF PPO STABILIZATION FUND.—Sec-  
13 tion 1858 of the Social Security Act (42 U.S.C. 1395) is  
14 amended—

15 (1) by striking subsection (e); and

16 (2) in subsection (f)(1), by striking “subject to  
17 subsection (e),”.

## 18 **Subtitle B—Beneficiary Protections**

### 19 **SEC. 411. NAIC DEVELOPMENT OF MARKETING, ADVER-** 20 **TISING, AND RELATED PROTECTIONS.**

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

24 “(m) APPLICATION OF MODEL MARKETING AND EN-  
25 ROLLMENT STANDARDS.—

1           “(1) IN GENERAL.—The National Association  
2 of Insurance Commissioners (in this subsection re-  
3 ferred to as the ‘NAIC’) is requested to develop, and  
4 to submit to the Secretary of Health and Human  
5 Services not later than 12 months after the date of  
6 the enactment of this Act, model regulations (in this  
7 section referred to as ‘model regulations’) regarding  
8 Medicare plan marketing, enrollment, broker and  
9 agent training and certification, agent and broker  
10 commissions, and market conduct by plans, agents  
11 and brokers for implementation (under paragraph  
12 (7)) under this part and part D, including for en-  
13 forcement by States under section 1856(b)(3).

14           “(2) MARKETING GUIDELINES.—

15           “(A) IN GENERAL.—The model regulations  
16 shall address the sales and advertising tech-  
17 niques used by Medicare private plans, agents  
18 and brokers in selling plans, including defining  
19 and prohibiting cold calls, unsolicited door-to-  
20 door sales, cross-selling, and co-branding.

21           “(B) SPECIAL CONSIDERATIONS.—The  
22 model regulations shall specifically address the  
23 marketing—



1 “(i) of plans to full benefit dual-eli-  
2 ble individuals and qualified medicare  
3 beneficiaries;

4 “(ii) of plans to populations with lim-  
5 ited English proficiency;

6 “(iii) of plans to beneficiaries in sen-  
7 ior living facilities; and

8 “(iv) of plans at educational events.

9 “(3) ENROLLMENT GUIDELINES.—

10 “(A) IN GENERAL.—The model regulations  
11 shall address the disclosures Medicare private  
12 plans, agents, and brokers must make when en-  
13 rolling beneficiaries, and a process—

14 “(i) for affirmative beneficiary sign  
15 off before enrollment in a plan; and

16 “(ii) in the case of Medicare Part C  
17 plans, for plans to conduct a beneficiary  
18 call-back to confirm beneficiary sign off  
19 and enrollment.

20 “(B) SPECIFIC CONSIDERATIONS.—The  
21 model regulations shall specially address bene-  
22 fiary understanding of the Medicare plan  
23 through required disclosure (or beneficiary  
24 verification) of each of the following:

1                   “(i) The type of Medicare private plan  
2                   involved.

3                   “(ii) Attributes of the plan, including  
4                   premiums, cost sharing, formularies (if ap-  
5                   plicable), benefits, and provider access lim-  
6                   itations in the plan.

7                   “(iii) Comparative quality of the plan.

8                   “(iv) The fact that plan attributes  
9                   may change annually.

10                  “(4) APPOINTMENT, CERTIFICATION AND  
11                  TRAINING OF AGENTS AND BROKERS.—The model  
12                  regulations shall establish procedures and require-  
13                  ments for appointment, certification (and periodic  
14                  recertification), and training of agents and brokers  
15                  that market or sell Medicare private plans consistent  
16                  with existing State appointment and certification  
17                  procedures and with this paragraph.

18                  “(5) AGENT AND BROKER COMMISSIONS.—

19                         “(A) IN GENERAL.—The model regulations  
20                         shall establish standards for fair and appro-  
21                         priate commissions for agents and brokers con-  
22                         sistent with this paragraph.

23                         “(B) LIMITATION ON TYPES OF COMMIS-  
24                         SION.—The model regulations shall specifically  
25                         prohibit the following:

- 1 “(i) Differential commissions—
- 2 “(I) for Medicare Part C plans
- 3 based on the type of Medicare private
- 4 plan; or
- 5 “(II) prescription drug plans
- 6 under part D based on the type of
- 7 prescription drug plan.
- 8 “(ii) Commissions in the first year
- 9 that are more than 200 percent of subse-
- 10 quent year commissions.
- 11 “(iii) The payment of extra bonuses
- 12 or incentives (such as trips, gifts, and
- 13 other non-commission cash payments).
- 14 “(C) AGENT DISCLOSURE.—In developing
- 15 the model regulations, the NAIC shall consider
- 16 requiring agents and brokers to disclose com-
- 17 missions to a beneficiary upon request of the
- 18 beneficiary before enrollment.
- 19 “(D) PREVENTION OF FRAUD.—The model
- 20 regulations shall consider the opportunity for
- 21 fraud and abuse and beneficiary steering in set-
- 22 ting standards under this paragraph and shall
- 23 provide for the ability of State commissioners to
- 24 investigate commission structures.
- 25 “(6) MARKET CONDUCT.—

1           “(A) IN GENERAL.—The model regulations  
2           shall establish standards for the market con-  
3           duct of organizations offering Medicare private  
4           plans, and of agents and brokers selling such  
5           plans, and for State review of plan market con-  
6           duct.

7           “(B) MATTERS TO BE INCLUDED.—Such  
8           standards shall include standards for—

9                   “(i) timely payment of claims;

10                   “(ii) beneficiary complaint reporting  
11                   and disclosure; and

12                   “(iii) State reporting of market con-  
13                   duct violations and sanctions.

14           “(7) IMPLEMENTATION.—

15                   “(A) PUBLICATION OF NAIC MODEL REGU-  
16                   LATIONS.—If the model regulations are sub-  
17                   mitted on a timely basis under paragraph (1)—

18                           “(i) the Secretary shall publish them  
19                           in the Federal Register upon receipt and  
20                           request public comment on the issue of  
21                           whether such regulations are consistent  
22                           with the requirements established in this  
23                           subsection for such regulations;

24                           “(ii) not later than 6 months after the  
25                           date of such publication, the Secretary

1 shall determine whether such regulations  
2 are so consistent with such requirements  
3 and shall publish notice of such determina-  
4 tion in the Federal Register; and

5 “(iii) if the Secretary makes the de-  
6 termination under clause (ii) that such reg-  
7 ulations are consistent with such require-  
8 ments, in the notice published under clause  
9 (ii) the Secretary shall publish notice of  
10 adoption of such model regulations as con-  
11 stituting the marketing and enrollment  
12 standards adopted under this subsection to  
13 be applied under this title; and

14 “(iv) if the Secretary makes the deter-  
15 mination under such clause that such regu-  
16 lations are not consistent with such re-  
17 quirements, the procedures of clauses (ii)  
18 and (iii) of subparagraph (B) shall apply  
19 (in relation to the notice published under  
20 clause (ii)), in the same manner as such  
21 clauses would apply in the case of publica-  
22 tion of a notice under subparagraph (B)(i).

23 “(B) NO MODEL REGULATIONS.—If the  
24 model regulations are not submitted on a timely  
25 basis under paragraph (1)—

1 “(i) the Secretary shall publish notice  
2 of such fact in the Federal Register;

3 “(ii) not later than 6 months after the  
4 date of publication of such notice, the Sec-  
5 retary shall propose regulations that pro-  
6 vide for marketing and enrollment stand-  
7 ards that incorporate the requirements of  
8 this subsection for the model regulations  
9 and request public comments on such pro-  
10 posed regulations; and

11 “(iii) not later than 6 months after  
12 the date of publication of such proposed  
13 regulations, the Secretary shall publish  
14 final regulations that shall constitute the  
15 marketing and enrollment standards  
16 adopted under this subsection to be applied  
17 under this title.

18 “(C) REFERENCES TO MARKETING AND  
19 ENROLLMENT STANDARDS.—In this title, a ref-  
20 erence to marketing and enrollment standards  
21 adopted under this subsection is deemed a ref-  
22 erence to the regulations constituting such  
23 standards adopted under subparagraph (A) or  
24 (B), as the case may be.

1           “(D) EFFECTIVE DATE OF STANDARDS.—

2           In order to provide for the orderly and timely  
3           implementation of marketing and enrollment  
4           standards adopted under this subsection, the  
5           Secretary, in consultation with the NAIC, shall  
6           specify (by program instruction or otherwise)  
7           effective dates with respect to all components of  
8           such standards consistent with the following:

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

16                   “(ii) In the case of other components,  
17                  the effective date shall be such date, not  
18                  later than 1 year after the date of promul-  
19                  gation of the standards, as the Secretary  
20                  specifies.

21           “(E) CONSULTATION.— In promulgating  
22           marketing and enrollment standards under this  
23           paragraph, the NAIC or Secretary shall consult  
24           with a working group composed of representa-  
25           tives of issuers of Medicare private plans, con-

1           sumer groups, medicare beneficiaries, State  
2           Health Insurance Assistance Programs, and  
3           other qualified individuals. Such representatives  
4           shall be selected in a manner so as to assure  
5           balanced representation among the interested  
6           groups.

7           “(8) ENFORCEMENT.—

8                   “(A) IN GENERAL.—Any Medicare private  
9                   plan that violates marketing and enrollment  
10                   standards is subject to sanctions under section  
11                   1857(g).

12                   “(B) STATE RESPONSIBILITIES.—Nothing  
13                   in this subsection or section 1857(g) shall pro-  
14                   hibit States from imposing sanctions against  
15                   Medicare private plans, agents, or brokers for  
16                   violations of the marketing and enrollment  
17                   standards adopted under section 1852(m).  
18                   States shall have the sole authority to regulate  
19                   agents and brokers.

20                   “(9) MEDICARE PRIVATE PLAN DEFINED.—In  
21                   this subsection, the term ‘Medicare private plan’  
22                   means a Medicare Part C plan and a prescription  
23                   drug plan under part D.”.

24           (b) EXPANSION OF EXCEPTION TO PREEMPTION OF  
25           STATE ROLE.—



1           (1) IN GENERAL.—Section 1856(b)(3) of the  
2           Social Security Act (42 U.S.C. 1395w-26(b)(3)) is  
3           amended by striking “(other than State licensing  
4           laws or State laws relating to plan solvency)” and  
5           inserting “(other than State laws relating to licens-  
6           ing or plan solvency and State laws or regulations  
7           adopting the marketing and enrollment standards  
8           adopted under section 1852(m)).”.

9           (2) EFFECTIVE DATE.—The amendment made  
10          by paragraph (1) shall apply to plans offered on or  
11          after July 1, 2008.

12          (c) APPLICATION TO PRESCRIPTION DRUG PLANS.—

13           (1) IN GENERAL.—Section 1860D–1 of such  
14          Act is amended by adding at the end the following  
15          new subsection:

16          “(d) APPLICATION OF MARKETING AND ENROLL-  
17          MENT STANDARDS.—The marketing and enrollment  
18          standards adopted under section 1852(m) shall apply to  
19          prescription drug plans (and sponsors of such plans) in  
20          the same manner as they apply to Medicare Part C plans  
21          and organizations offering such plans.”.

22           (2) REFERENCE TO CURRENT LAW PROVI-  
23          SIONS.—The amendment made by subsection (a)  
24          and (b) apply, pursuant to section 1860D–  
25          1(b)(1)(B)(ii) of the Social Security Act (42 U.S.C.

1 1395w-101(b)(1)(B)(ii)), to prescription drug plans  
2 under part D of title XVIII of such Act.

3 (d) CONTRACT REQUIREMENT TO MEET MARKETING  
4 AND ADVERTISING STANDARDS.—

5 (1) IN GENERAL.—Section 1857(d) of the So-  
6 cial Security Act (42 U.S.C. 1395w-27(d)), as  
7 amended by subsection (b)(1), is further amended by  
8 adding at the end the following new paragraph:

9 “(7) MARKETING AND ADVERTISING STAND-  
10 ARDS.—The contract shall require the organization  
11 to meet all standards adopted under section  
12 1852(m) (including those enforced by the State in-  
13 volved pursuant to section 1856(b)(3)) relating to  
14 marketing and advertising conduct”.

15 (2) EFFECTIVE DATE.—The amendment made  
16 by paragraph (1) shall apply to contracts for plan  
17 years beginning on or after January 1, 2011.

18 (e) APPLICATION OF SANCTIONS.—

19 (1) APPLICATION TO VIOLATION OF MARKETING  
20 AND ENROLLMENT STANDARDS.—Section 1857(g) of  
21 such Act (42 U.S.C. 1395w-27(g)) is amended—

22 (A) by striking “or” at the end of subpara-  
23 graph (F);

24 (B) by adding “or” at the end of subpara-  
25 graph (G); and

1 (C) by inserting after subparagraph (G)  
2 the following new subparagraph:

3 “(H) violates marketing and enrollment  
4 standards adopted under section 1852(m);”.

5 (2) ENHANCED CIVIL MONEY SANCTIONS.—  
6 Such section is further amended—

7 (A) in paragraph (2)(A), by striking  
8 “\$25,000”, “\$100,000”, and “\$15,000” and  
9 inserting “\$50,000”, “\$200,000”, and  
10 “\$30,000”, respectively; and

11 (B) in subparagraphs (A), (B), and (D) of  
12 paragraph (3), by striking “\$25,000”,  
13 “\$10,000”, and “\$100,000”, respectively, and  
14 inserting “\$50,000”, “\$20,000”, and  
15 “\$200,000”, respectively.

16 (3) EFFECTIVE DATE.—The amendments made  
17 by paragraph (2) shall apply to violations occurring  
18 on or after the date of the enactment of this Act.

19 (f) DISCLOSURE OF MARKET AND ADVERTISING  
20 CONTRACT VIOLATIONS AND IMPOSED SANCTIONS.—Sec-  
21 tion 1857 of such Act is amended by adding at the end  
22 the following new subsection

23 “(j) DISCLOSURE OF MARKET AND ADVERTISING  
24 CONTRACT VIOLATIONS AND IMPOSED SANCTIONS.—For  
25 years beginning with 2009, the Secretary shall post on its

1 public website for the Medicare program an annual report  
2 that—

3 “(1) lists each MA organization for which the  
4 Secretary made during the year a determination  
5 under subsection (c)(2) the basis of which is de-  
6 scribed in paragraph (1)(E); and

7 “(2) that describes any applicable sanctions  
8 under subsection (g) applied to such organization  
9 pursuant to such determination.”.

10 (g) STANDARD DEFINITIONS OF BENEFITS AND  
11 FORMATS FOR USE IN MARKETING MATERIALS.—Section  
12 1851(h) of such Act (42 U.S.C. 1395w-21(h)) is amended  
13 by adding at the end the following new paragraph:

14 “(6) STANDARD DEFINITIONS OF BENEFITS  
15 AND FORMATS FOR USE IN MARKETING MATE-  
16 RIALS.—

17 “(A) IN GENERAL.—Not later than Janu-  
18 ary 1, 2010, the Secretary, in consultation with  
19 the National Association of Insurance Commis-  
20 sioners and a working group of the type de-  
21 scribed in section 1852(m)(7)(E), shall develop  
22 standard descriptions and definitions for bene-  
23 fits under this title for use in marketing mate-  
24 rial distributed by Medicare Part C organiza-

1           tions and formats for including such descrip-  
2           tions in such marketing material.

3                   “(B) REQUIRED USE OF STANDARD DEFINI-  
4           NITIONS.— For plan years beginning on or  
5           after January 1, 2011, the Secretary shall dis-  
6           approve the distribution of marketing material  
7           under paragraph (1)(B) if such marketing ma-  
8           terial does not use, without modification, the  
9           applicable descriptions and formats specified  
10          under subparagraph (A).”.

11          (h) SUPPORT FOR STATE HEALTH INSURANCE AS-  
12       SISTANCE PROGRAMS (SHIPS).—Section 1857(e)(2) of  
13       the Social Security Act (42 U.S.C. 1395w-27(e)(2)) is  
14       amended—

15               (1) in subparagraph (B), by adding at the end  
16       the following: “Of the amounts so collected, no less  
17       than \$55,000,000 for fiscal year 2009, \$65,000,000  
18       for fiscal year 2010, \$75,000,000 for fiscal year  
19       2011, and \$85,000,000 for fiscal year 2012 shall be  
20       used to support Medicare Part C and Part D coun-  
21       seling and assistance provided by State Health In-  
22       surance Assistance Programs.”;

23               (2) in subparagraph (C)—

24                   (A) by striking “and” after  
25                   “\$100,000,000”; and

1 (B) by striking “an amount equal to  
2 \$200,000,000” and inserting “and ending with  
3 fiscal year 2008 an amount equal to  
4 \$200,000,000, for fiscal year 2009 an amount  
5 equal to \$255,000,000, for fiscal year 2010 an  
6 amount equal to \$265,000,000, for fiscal year  
7 2011 an amount equal to \$275,000,000, and  
8 for fiscal year 2012 an amount equal to  
9 \$285,000,000”; and

10 (3) in subparagraph (D)(ii)—

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

13 (B) in subclause (V), by striking the period  
14 at the end and inserting “before fiscal year  
15 2009; and”; and

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

18 “(VI) for fiscal year 2009 and each  
19 succeeding fiscal year the applicable por-  
20 tion (as so defined) of the amount specified  
21 in subparagraph (C) for that fiscal year.”.

22 **SEC. 412. LIMITATION ON OUT-OF-POCKET COSTS FOR INDI-**  
23 **VIDUAL HEALTH SERVICES.**

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

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

6           (2) in subparagraph (B)(i), by striking “ or an  
7 actuarially equivalent level of cost-sharing as deter-  
8 mined in this part”; and

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

11                   “(ii) PERMITTING USE OF FLAT CO-  
12 PAYMENT OR PER DIEM RATE.—Nothing in  
13 clause (i) shall be construed as prohibiting  
14 a Medicare part C plan from using a flat  
15 copayment or per diem rate, in lieu of the  
16 cost-sharing that would be imposed under  
17 part A or B, so long as the amount of the  
18 cost-sharing imposed does not exceed the  
19 amount of the cost-sharing that would be  
20 imposed under the respective part if the in-  
21 dividual were not enrolled in a plan under  
22 this part.”.

23           (b) LIMITATION FOR DUAL ELIGIBLES AND QUALI-  
24 FIED MEDICARE BENEFICIARIES.—Section 1852(a) of

1 such Act is amended by adding at the end the following  
2 new paragraph:

3           “(7) LIMITATION ON COST-SHARING FOR DUAL  
4 ELIGIBLES AND QUALIFIED MEDICARE BENE-  
5 FICIARIES.—In the case of a individual who is a full-  
6 benefit dual eligible individual (as defined in section  
7 1935(e)(6)) or a qualified medicare beneficiary (as  
8 defined in section 1905(p)(1)) who is enrolled in a  
9 Medicare Part C plan, the plan may not impose  
10 cost-sharing that exceeds the amount of cost-sharing  
11 that would be permitted with respect to the indi-  
12 vidual under this title and title XIX if the individual  
13 were not enrolled with such plan.”.

14 (c) EFFECTIVE DATES.—

15           (1) The amendments made by subsection (a)  
16 shall apply to plan years beginning on or after Janu-  
17 ary 1, 2009.

18           (2) The amendments made by subsection (b)  
19 shall apply to plan years beginning on or after Janu-  
20 ary 1, 2008.

21 **SEC. 413. MA PLAN ENROLLMENT MODIFICATIONS.**

22 (a) IMPROVED PLAN ENROLLMENT,  
23 DISENROLLMENT, AND CHANGE OF ENROLLMENT.—

24           (1) CONTINUOUS OPEN ENROLLMENT FOR  
25 FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS AND



1 QUALIFIED MEDICARE BENEFICIARIES (QMB).—Sec-  
2 tion 1851(e)(2)(D) of the Social Security Act (42  
3 U.S.C. 1395w-21(e)(2)(D)) is amended—

4 (A) in the heading, by inserting ;“, FULL-  
5 BENEFIT DUAL ELIGIBLE INDIVIDUALS, AND  
6 QUALIFIED MEDICARE BENEFICIARIES” after  
7 “INSTITUTIONALIZED INDIVIDUALS”; and

8 (B) in the matter before clause (i), by in-  
9 serting “, a full-benefit dual eligible individual  
10 (as defined in section 1935(c)(6)), or a quali-  
11 fied medicare beneficiary (as defined in section  
12 1905(p)(1))” after “institutionalized (as defined  
13 by the Secretary)”; and

14 (C) in clause (i), by inserting “or  
15 disenroll” after “enroll”.

16 (2) SPECIAL ELECTION PERIODS FOR ADDI-  
17 TIONAL CATEGORIES OF INDIVIDUALS.—Section  
18 1851(e)(4) of such Act (42 U.S.C. 1395w(e)(4)) is  
19 amended—

20 (A) in subparagraph (C), by striking at the  
21 end “or”;

22 (B) in subparagraph (D), by inserting “,  
23 taking into account the health or well-being of  
24 the individual” before the period and redesi-

1 nating such subparagraph as subparagraph (G);  
2 and

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

5 “(D) the individual is described in section  
6 1902(a)(10)(E)(iii) (relating to specified low-in-  
7 come medicare beneficiaries); or

8 “(E) the individual is enrolled in an MA  
9 plan and enrollment in the plan is suspended  
10 under paragraph (2)(B) or (3)(C) of section  
11 1857(g) because of a failure of the plan to meet  
12 applicable requirements.”.

13 (3) ELIMINATION OF CONTINUOUS OPEN EN-  
14 ROLLMENT OF ORIGINAL FEE-FOR-SERVICE ENROLL-  
15 EES IN MEDICARE ADVANTAGE NON-PRESCRIPTION  
16 DRUG PLANS.—Subparagraph (E) of section  
17 1851(e)(2) of the Social Security Act, as added by  
18 section 206 of division B of the Tax Relief and  
19 Health Care Act of 2006 (Public Law 109–432), is  
20 repealed.

21 (4) EFFECTIVE DATE.—The amendments made  
22 by this subsection shall take effect on the date of the  
23 enactment of this Act.

24 (b) ACCESS TO MEDIGAP COVERAGE FOR INDIVID-  
25 UALS WHO LEAVE MA PLANS.—

1           (1) IN GENERAL.—Section 1882(s)(3) of the  
2 Social Security Act (42 U.S.C. 1395ss(s)(3)) is  
3 amended—

4           (A) in each of clauses (v)(III) and (vi) sub-  
5 paragraph (B), by striking “12 months” and  
6 inserting “24 months”; and

7           (B) in each of subclauses (I) and (II) of  
8 subparagraph (F)(i), by striking “12 months”  
9 and inserting “24 months”.

10          (2) EFFECTIVE DATE.—The amendments made  
11 by paragraph (1) shall apply to terminations of en-  
12 rollments in MA plans occurring on or after the date  
13 of the enactment of this Act.

14          (c) IMPROVED ENROLLMENT POLICIES.—

15           (1) NO AUTO-ENROLLMENT OF MEDICAID  
16 BENEFICIARIES.—

17           (A) IN GENERAL.—Section 1851(e) of such  
18 Act (42 U.S.C. 1395w-21(e)) is amended by  
19 adding at the end the following new paragraph:

20           “(7) NO AUTO-ENROLLMENT OF MEDICAID  
21 BENEFICIARIES.—In no case may the Secretary pro-  
22 vide for the enrollment in a MA plan of a Medicare  
23 Advantage eligible individual who is eligible to re-  
24 ceive medical assistance under title XIX as a full-  
25 benefit dual eligible individual or a qualified medi-

1 care beneficiary, without the affirmative application  
2 of such individual (or authorized representative of  
3 the individual) to be enrolled in such plan.”.

4 (B) NO APPLICATION TO PRESCRIPTION  
5 DRUG PLANS.—Section 1860D–1(b)(1)(B)(iii)  
6 of such Act (42 U.S.C. 1395w-  
7 101(b)(1)(B)(iii)) is amended—

8 (i) by striking “paragraph (2) and”  
9 and by inserting “paragraph (2),”; and

10 (ii) by inserting “, and paragraph  
11 (7),” after “paragraph (4)”.

12 (C) EFFECTIVE DATE.—The amendments  
13 made by this paragraph shall apply to enroll-  
14 ments that are effective on or after the date of  
15 the enactment of this Act.

16 **SEC. 414. INFORMATION FOR BENEFICIARIES ON MA PLAN**  
17 **ADMINISTRATIVE COSTS.**

18 (a) DISCLOSURE OF MEDICAL LOSS RATIOS AND  
19 OTHER EXPENSE DATA.—Section 1851 of the Social Se-  
20 curity Act (42 U.S.C. 1395w-21) is amended by adding  
21 at the end the following new subsection:

22 “(j) PUBLICATION OF MEDICAL LOSS RATIOS AND  
23 OTHER COST-RELATED INFORMATION.—

24 “(1) IN GENERAL.—The Secretary shall pub-  
25 lish, not later than October 1 of each year (begin-

1       ning with 2009), for each Medicare Part C plan con-  
2       tract, the following:

3               “(A) The medical loss ratio of the plan in  
4               the previous year.

5               “(B) The per enrollee payment under this  
6               part to the plan, as adjusted to reflect a risk  
7               score (based on factors described in section  
8               1853(a)(1)(C)(i)) of 1.0.

9               “(C) The average risk score (as so based).

10              “(2) SUBMISSION OF DATA.—

11              “(A) IN GENERAL.—Each Medicare Part C  
12              organization shall submit to the Secretary, in a  
13              form and manner specified by the Secretary,  
14              data necessary for the Secretary to publish the  
15              information described in paragraph (1) on a  
16              timely basis, including the information de-  
17              scribed in paragraph (3).

18              “(B) DATA FOR 2008 AND 2009.—The data  
19              submitted under subparagraph (A) for 2008  
20              and for 2009 shall be consistent in content with  
21              the data reported as part of the Medicare Part  
22              C plan bid in June 2007 for 2008.

23              “(C) MEDICAL LOSS RATIO DATA.—The  
24              data to be submitted under subparagraph (A)  
25              relating to medical loss ratio for a year—

1           “(i) shall be submitted not later than  
2           June 1 of the following year; and

3           “(ii) beginning with 2010, shall be  
4           submitted based on the standardized ele-  
5           ments and definitions developed under  
6           paragraph (4).

7           “(D) AUDITED DATA.—Data submitted  
8           under this paragraph shall be data that has  
9           been audited by an independent third party  
10          auditor.

11          “(3) MLR INFORMATION.—The information de-  
12          scribed in this paragraph with respect to a Medicare  
13          Part C plan for a year is as follows:

14               “(A) The costs for the plan in the previous  
15               year for each of the following:

16                   “(i) Total medical expenses, sepa-  
17                   rately indicated for benefits for the original  
18                   medicare fee-for-service program option  
19                   and for supplemental benefits.

20                   “(ii) Non-medical expenses, shown  
21                   separately for each of the following cat-  
22                   egories of expenses:

23                               “(I) Marketing and sales.

24                               “(II) Direct administration.

25                               “(III) Indirect administration.

1                   “(IV) Net cost of private reinsur-  
2                   ance.

3                   “(B) Gain or loss margin.

4                   “(C) Total revenue requirement, computed  
5                   as the total of medical and nonmedical expenses  
6                   and gain or loss margin, multiplied by the gain  
7                   or loss margin.

8                   “(D) Percent of revenue ratio, computed  
9                   as the total revenue requirement expressed as a  
10                  percentage of revenue.

11                  “(4) DEVELOPMENT OF DATA REPORTING  
12                  STANDARDS.—

13                  “(A) IN GENERAL.—The Secretary shall  
14                  develop and implement standardized data ele-  
15                  ments and definitions for reporting under this  
16                  subsection, for contract years beginning with  
17                  2010, of data necessary for the calculation of  
18                  the medical loss ratio for Medicare Part C  
19                  plans. Not later than December 31, 2008, the  
20                  Secretary shall publish a report describing the  
21                  elements and definitions so developed.

22                  “(B) CONSULTATION.—The Secretary  
23                  shall consult with representatives of Medicare  
24                  Part C organizations, experts on health plan ac-  
25                  counting systems, and representatives of the

1 National Association of Insurance Commis-  
2 sioners, in the development of such data ele-  
3 ments and definitions

4 “(5) MEDICAL LOSS RATIO DEFINED.—For  
5 purposes of this part, the term ‘medical loss ratio’  
6 means, with respect to an MA plan for a year, the  
7 ratio of—

8 “(A) the aggregate benefits (excluding  
9 nonmedical expenses described in paragraph  
10 (3)(A)(ii)) paid under the plan for the year, to

11 “(B) the aggregate amount of premiums  
12 (including basic and supplemental beneficiary  
13 premiums) and payments made under sections  
14 1853 and 1860D–15) collected for the plan and  
15 year.

16 Such ratio shall be computed without regard to  
17 whether the benefits or premiums are for required or  
18 supplemental benefits under the plan.”.

19 (b) AUDIT OF ADMINISTRATIVE COSTS AND COMPLI-  
20 ANCE WITH THE FEDERAL ACQUISITION REGULATION.—

21 (1) IN GENERAL.—Section 1857(d)(2)(B) of  
22 such Act (42 U.S.C. 1395w-27(d)(2)(B)) is amend-  
23 ed—

24 (A) by striking “or (ii)” and inserting  
25 “(ii)”; and



1 (B) by inserting before the period at the  
2 end the following: “, or (iii) to compliance with  
3 the requirements of subsection (e)(4) and the  
4 extent to which administrative costs comply  
5 with the applicable requirements for such costs  
6 under the Federal Acquisition Regulation”.

7 (2) EFFECTIVE DATE.—The amendments made  
8 by this subsection shall apply for contract years be-  
9 ginning after the date of the enactment of this Act.

10 (c) MINIMUM MEDICAL LOSS RATIO.—Section  
11 1857(e) of the Social Security Act (42 U.S.C. 1395w-  
12 27(e)) is amended by adding at the end the following new  
13 paragraph:

14 “(4) REQUIREMENT FOR MINIMUM MEDICAL  
15 LOSS RATIO.—If the Secretary determines for a con-  
16 tract year (beginning with 2010) that an MA plan  
17 has failed to have a medical loss ratio (as defined in  
18 section 1851(j)(4)) of at least .85—

19 “(A) for that contract year, the Secretary  
20 shall reduce the blended benchmark amount  
21 under subsection (l) for the second succeeding  
22 contract year by the numer of percentage points  
23 by which such loss ratio was less than 85 per-  
24 cent;

1           “(B) for 3 consecutive contract years, the  
2           Secretary shall not permit the enrollment of  
3           new enrollees under the plan for coverage dur-  
4           ing the second succeeding contract year; and

5           “(C) the Secretary shall terminate the plan  
6           contract if the plan fails to have such a medical  
7           loss ratio for 5 consecutive contract years.”.

8           (d) INFORMATION ON MEDICARE PART C PLAN EN-  
9           ROLLMENT AND SERVICES.—Section 1851 of such Act, as  
10          amended by subsection (a), is further amended by adding  
11          at the end the following new subsection:

12          “(k) PUBLICATION OF ENROLLMENT AND OTHER IN-  
13          FORMATION.—

14                 “(1) MONTHLY PUBLICATION OF PLAN-SPE-  
15                 CIFIC ENROLLMENT DATA.—The Secretary shall  
16                 publish (on the public website of the Centers for  
17                 Medicare & Medicaid Services or otherwise) not later  
18                 than 30 days after the end of each month (beginning  
19                 with January 2008) on the actual enrollment in each  
20                 Medicare Part C plan by contract and by county.

21                 “(2) AVAILABILITY OF OTHER INFORMATION.—  
22                 The Secretary shall make publicly available data and  
23                 other information in a format that may be readily  
24                 used for analysis of the Medicare Part C program  
25                 under this part and will contribute to the under-

1 standing of the organization and operation of such  
2 program.”.

3 (e) MEDPAC REPORT ON VARYING MINIMUM MED-  
4 ICAL LOSS RATIOS.—

5 (1) STUDY.—The Medicare Payment Advisory  
6 Commission shall conduct a study of the need and  
7 feasibility of providing for different minimum medical  
8 loss ratios for different types of Medicare Part C  
9 plans, including coordinated care plans, group model  
10 plans, coordinated care independent practice associa-  
11 tion plans, preferred provider organization plans,  
12 and private fee-for-services plans.

13 (2) REPORT.—Not later than 1 year after the  
14 date of the enactment of this Act, submit to Con-  
15 gress a report on the study conducted under para-  
16 graph (1).

17 **Subtitle C—Quality and Other**  
18 **Provisions**

19 **SEC. 421. REQUIRING ALL MA PLANS TO MEET EQUAL**  
20 **STANDARDS.**

21 (a) COLLECTION AND REPORTING OF INFORMA-  
22 TION.—

23 (1) IN GENERAL.—Section 1852(e)(1) of the  
24 Social Security Act (42 U.S.C. 1395w-112(e)(1)) is

1       amended by striking “(other than an MA private  
2       fee-for-service plan or an MSA plan)”.

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

7                       “(C) DATA COLLECTION REQUIREMENTS  
8                       BY PRIVATE FEE-FOR-SERVICE PLANS AND MSA  
9                       PLANS.—

10                               “(i) USING MEASURES FOR PPOS FOR  
11                               CONTRACT YEAR 2009.—For contract year  
12                               2009, the Medicare Part C organization of-  
13                               fering a private fee-for-service plan or an  
14                               MSA plan shall submit to the Secretary for  
15                               such plan the same information on the  
16                               same performance measures for which such  
17                               information is required to be submitted for  
18                               Medicare Part C plans that are preferred  
19                               provider organization plans for that year.

20                               “(ii) APPLICATION OF SAME MEAS-  
21                               URES AS COORDINATED CARE PLANS BE-  
22                               GINNING IN CONTRACT YEAR 2010.—For a  
23                               contract year beginning with 2010, a Medi-  
24                               care Part C organization offering a private  
25                               fee-for-service plan or an MSA plan shall

1 submit to the Secretary for such plan the  
2 same information on the same performance  
3 measures for which such information is re-  
4 quired to be submitted for such contract  
5 year Medicare Part C plans described in  
6 section 1851(a)(2)(A)(i) for contract year  
7 such contract year.”.

8 (3) EFFECTIVE DATE.—The amendment made  
9 by paragraph (1) shall apply to contract years begin-  
10 ning on or after January 1, 2009.

11 (b) EMPLOYER PLANS.—

12 (1) IN GENERAL.—The first sentence of para-  
13 graph (2) of section 1857(i) of such Act (42 U.S.C.  
14 1395w-27(i)) is amended by inserting before the pe-  
15 riod at the end the following: “, but only if 90 per-  
16 cent of the Medicare part C eligible individuals en-  
17 rolled under such plan reside in a county in which  
18 the Medicare Part C organization offers a Medicare  
19 Part C local plan”.

20 (2) LIMITATION ON APPLICATION OF WAIVER  
21 AUTHORITY.—Paragraphs (1) and (2) of such sec-  
22 tion are each amended by inserting “that were in ef-  
23 fect before the date of the enactment of the Chil-  
24 dren’s Health and Medicare Protection Act of 2007”  
25 after “waive or modify requirements”.



1 quality of health services provided to racial  
2 and ethnic minorities.

3 “(ii) DATA TO MEASURE RACIAL AND  
4 ETHNIC DISPARITIES IN THE AMOUNT AND  
5 QUALITY OF CARE PROVIDED TO ENROLL-  
6 EES.—The Secretary shall provide for  
7 Medicare Part C organizations to submit  
8 data under this paragraph, including data  
9 similar to those submitted for other quality  
10 measures, that permits analysis of dispari-  
11 ties among racial and ethnic minorities in  
12 health services, quality of care, and health  
13 status among Medicare Part C plan enroll-  
14 ees for use in submitting the reports under  
15 paragraph (5).”.

16 (2) EFFECTIVE DATE.—The amendments made  
17 by this subsection shall apply to reporting of quality  
18 measures for plan years beginning on or after Janu-  
19 ary 1, 2010.

20 (b) BIENNIAL REPORT ON RACIAL AND ETHNIC MI-  
21 NORITIES.—Section 1852(e) of such Act (42 U.S.C.  
22 1395w-22(e)) is amended by adding at the end the fol-  
23 lowing new paragraph:

24 “(5) REPORT TO CONGRESS.—

1           “(A) IN GENERAL.—Not later than 2 years  
2           after the date of the enactment of this para-  
3           graph, and biennially thereafter, the Secretary  
4           shall submit to Congress a report regarding  
5           how quality assurance programs conducted  
6           under this subsection measure and report on  
7           disparities in the amount and quality of health  
8           care services furnished to racial and ethnic mi-  
9           norities.

10           “(B) CONTENTS OF REPORT.—Each such  
11           report shall include the following:

12                   “(i) A description of the means by  
13                   which such programs focus on such racial  
14                   and ethnic minorities.

15                   “(ii) An evaluation of the impact of  
16                   such programs on eliminating health dis-  
17                   parities and on improving health outcomes,  
18                   continuity and coordination of care, man-  
19                   agement of chronic conditions, and con-  
20                   sumer satisfaction.

21                   “(iii) Recommendations on ways to re-  
22                   duce clinical outcome disparities among ra-  
23                   cial and ethnic minorities.

24                   “(iv) Data for each MA plan from  
25                   HEDIS and other source reporting the dis-



1                   parities in the amount and quality of  
2                   health services furnished to racial and eth-  
3                   nic minorities.”.

4 **SEC. 423. STRENGTHENING AUDIT AUTHORITY.**

5           (a) FOR PART C PAYMENTS RISK ADJUSTMENT.—  
6 Section 1857(d)(1) of the Social Security Act (42 U.S.C.  
7 1395w-27(d)(1)) is amended by inserting after “section  
8 1858(c)” the following: “, and data submitted with re-  
9 spect to risk adjustment under section 1853(a)(3)”.

10          (b) ENFORCEMENT OF AUDITS AND DEFICI-  
11 CIENCIES.—

12           (1) IN GENERAL.—Section 1857(e) of such Act  
13 is amended by adding at the end the following new  
14 paragraph:

15           “(4) ENFORCEMENT OF AUDITS AND DEFICI-  
16 CIENCIES.—

17           “(A) INFORMATION IN CONTRACT.—The  
18 Secretary shall require that each contract with  
19 a Medicare Part C organization under this sec-  
20 tion shall include terms that inform the organi-  
21 zation of the provisions in subsection (d).

22           “(B) ENFORCEMENT AUTHORITY.—The  
23 Secretary is authorized, in connection with con-  
24 ducting audits and other activities under sub-  
25 section (d), to take such actions, including pur-

1 suit of financial recoveries, necessary to address  
2 deficiencies identified in such audits or other  
3 activities.”.

4 (2) APPLICATION UNDER PART D.—For provi-  
5 sion applying the amendment made by paragraph  
6 (1) to prescription drug plans under part D, see sec-  
7 tion 1860D–12(b)(3)(D) of the Social Security Act.

8 (c) EFFECTIVE DATE.—The amendments made by  
9 this section shall take effect the date of the enactment  
10 of this Act and shall apply to audits and activities con-  
11 ducted for contract years beginning on or after January  
12 1, 2009.

13 **SEC. 424. IMPROVING RISK ADJUSTMENT FOR MA PAY-**  
14 **MENTS.**

15 (a) IN GENERAL.—Not later than 1 year after the  
16 date of the enactment of this Act, the Secretary of Health  
17 and Human Services shall submit to Congress a report  
18 that evaluates the adequacy of the Medicare Advantage  
19 risk adjustment system under section 1853(a)(1)(C) of the  
20 Social Security Act (42 U.S.C. 1395–23(a)(1)(C)).

21 (b) PARTICULARS.—The report under subsection (a)  
22 shall include an evaluation of at least the following:

23 (1) The need and feasibility of improving the  
24 adequacy of the risk adjustment system in predicting

1 costs for beneficiaries with co-morbid conditions and  
2 associated cognitive impairments.

3 (2) The need and feasibility of including further  
4 gradations of diseases and conditions (such as the  
5 degree of severity of congestive heart failure).

6 (3) The feasibility of measuring difference in  
7 coding over time between Medicare part C plans and  
8 the medicare traditional fee-for-service program and,  
9 to the extent this difference exists, the options for  
10 addressing it.

11 (4) The feasibility and value of including part  
12 D and other drug utilization data in the risk adjust-  
13 ment model.

14 **SEC. 425. ELIMINATING SPECIAL TREATMENT OF PRIVATE**  
15 **FEE-FOR-SERVICE PLANS.**

16 (a) ELIMINATION OF EXTRA BILLING PROVISION.—  
17 Section 1852(k)(2) of the Social Security Act (42 U.S.C.  
18 1395w-22(k)(2)) is amended—

19 (1) in subparagraph (A)(i), by striking “115  
20 percent” and inserting “100 percent”; and

21 (2) in subparagraph (C)(i), by striking “ (in-  
22 cluding any liability for balance billing consistent  
23 with this subsection)”.

1 (b) REVIEW OF BID INFORMATION.—Section  
2 1854(a)(6)(B) of such Act (42 U.S.C. 1395w-  
3 24(a)(6)(B)) is amended—

4 (1) in clause (i), by striking “clauses (iii) and  
5 (iv)” and inserting “clause (iii)”; and

6 (2) by striking clause (iv).

7 (c) EFFECTIVE DATE.—The amendments made by  
8 this section shall apply to contract years beginning with  
9 2009.

10 **SEC. 426. RENAMING OF MEDICARE ADVANTAGE PROGRAM.**

11 (a) IN GENERAL.—The program under part C of title  
12 XVIII of the Social Security Act is henceforth to be known  
13 as the “Medicare Part C program”.

14 (b) CHANGE IN REFERENCES.—

15 (1) AMENDING SOCIAL SECURITY ACT.—The  
16 Social Security Act is amended by striking “Medi-  
17 care Advantage”, “MA”, and “Medicare+Choice”  
18 and inserting “Medicare Part C” each place it ap-  
19 pears, with the appropriate, respective typographic  
20 formatting, including typeface and capitalization.

21 (2) ADDITIONAL REFERENCES.—Notwith-  
22 standing section 201(b) of the Medicare Prescription  
23 Drug, Improvement, and Modernization Act of 2003  
24 (Public Law 108–173), any reference to the pro-  
25 gram under part C of title XVIII of the Social Secu-

1 rity Act shall be deemed a reference to the “Medi-  
2 care Part C” program and, with respect to such  
3 part, any reference to “Medicare+Choice”. “Medi-  
4 care Advantage”, or “MA” is deemed a reference to  
5 the program under such part.

## 6 **Subtitle D—Extension of** 7 **Authorities**

### 8 **SEC. 431. EXTENSION AND REVISION OF AUTHORITY FOR** 9 **SPECIAL NEEDS PLANS (SNPS).**

10 (a) EXTENDING RESTRICTION ON ENROLLMENT AU-  
11 THORITY FOR SNPS FOR 3 YEARS.—Subsection (f) of sec-  
12 tion 1859 of the Social Security Act (42 U.S.C. 1395w-  
13 28) is amended by striking “2009” and inserting “2012”.

14 (b) STRUCTURE OF AUTHORITY FOR SNPS.—

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

17 (A) in subsection (b)(6)(A), by striking all  
18 that follows “means” and inserting the fol-  
19 lowing: “an MA plan—

20 “(i) that serves special needs individ-  
21 uals (as defined in subparagraph (B));

22 “(ii) as of January 1, 2009, either—

23 “(I) at least 90 percent of the  
24 enrollees in which are described in  
25 subparagraph (B)(i), as determined

1 under regulations in effect as of July  
2 1, 2007; or

3 “(II) at least 90 percent of the  
4 enrollees in which are described in  
5 subparagraph (B)(ii) and are full-ben-  
6 efit dual eligible individuals (as de-  
7 fined in section 1935(c)(6)) or quali-  
8 fied medicare beneficiaries (as defined  
9 in section 1905(p)(1)); and

10 “(iii) as of January 1, 2009, meets  
11 the applicable requirements of paragraph  
12 (2) or (3) of subsection (f), as the case  
13 may be.”;

14 (B) in subsection (b)(6)(B)(iii), by insert-  
15 ing “only for contract years beginning before  
16 January 1, 2009,” after “(iii)”;

17 (C) in subsection (f)—

18 (i) by amending the heading to read  
19 as follows: “REQUIREMENTS FOR ENROLL-  
20 MENT IN PART C PLANS FOR SPECIAL  
21 NEEDS BENEFICIARIES”;

22 (ii) by designating the sentence begin-  
23 ning “In the case of” as paragraph (1)  
24 with the heading “REQUIREMENTS FOR

1 ENROLLMENT” and with appropriate in-  
2 dentation; and

3 (iii) by adding at the end the fol-  
4 lowing new paragraphs:

5 “(2) ADDITIONAL REQUIREMENTS FOR INSTI-  
6 TUTIONAL SNPS.—In the case of a specialized MA  
7 plan for special needs individuals described in sub-  
8 section (b)(6)(A)(ii)(I), the applicable requirements  
9 of this subsection are as follows:

10 “(A) The plan has an agreement with the  
11 State that includes provisions regarding co-  
12 operation on the coordination of care for such  
13 individuals. Such agreement shall include a de-  
14 scription of the manner that the State Medicaid  
15 program under title XIX will pay for the costs  
16 of services for individuals eligible under such  
17 title for medical assistance for acute care and  
18 long-term care services.

19 “(B) The plan has a contract with long-  
20 term care facilities and other providers in the  
21 area sufficient to provide care for enrollees de-  
22 scribed in subsection (b)(6)(B)(i).

23 “(C) The plan reports to the Secretary in-  
24 formation on additional quality measures speci-

1           fied by the Secretary under section  
2           1852(e)(3)(D)(iv)(I) for such plans.

3           “(3) ADDITIONAL REQUIREMENTS FOR DUAL  
4           SNPS.—In the case of a specialized MA plan for spe-  
5           cial needs individuals described in subsection  
6           (b)(6)(A)(ii)(II), the applicable requirements of this  
7           subsection are as follows:

8                   “(A) The plan has an agreement with the  
9                   State Medicaid agency that—

10                           “(i) includes provisions regarding co-  
11                           operation on the coordination of the fi-  
12                           nancing of care for such individuals;

13                           “(ii) includes a description of the  
14                           manner that the State Medicaid program  
15                           under title XIX will pay for the costs of  
16                           cost-sharing and supplemental services for  
17                           individuals enrolled in the plan eligible  
18                           under such title for medical assistance for  
19                           acute and long-term care services; and

20                           “(iii) effective January 1, 2011, pro-  
21                           vides for capitation payments to cover  
22                           costs of supplemental benefits for individ-  
23                           uals described in subsection  
24                           (b)(6)(A)(ii)(II).



1           “(B) The out-of-pocket costs for services  
2           under parts A and B that are charged to enroll-  
3           ees may not exceed the out-of-pocket costs for  
4           same services permitted for such individuals  
5           under title XIX.

6           “(C) The plan reports to the Secretary in-  
7           formation on additional quality measures speci-  
8           fied by the Secretary under section  
9           1852(e)(3)(D)(iv)(II) for such plans.”.

10           (2) QUALITY STANDARDS AND QUALITY RE-  
11           PORTING.—Section 1852(e)(3) of such Act (42  
12           U.S.C. 1395w-22(e)(3) is amended—

13           (A) in subparagraph (A)(i), by adding at  
14           the end the following: “In the case of a special-  
15           ized Medicare Part C plan for special needs in-  
16           dividuals described in paragraph (2) or (3) of  
17           section 1859(f), the organization shall provide  
18           for the reporting on quality measures developed  
19           for the plan under subparagraph (D)(iii).”; and

20           (B) in subparagraph (D), as added by sec-  
21           tion 422(a)(1), by adding at the end the fol-  
22           lowing new clause:

23           “(iii) SPECIFICATION OF ADDITIONAL  
24           QUALITY MEASUREMENTS FOR SPECIAL-  
25           IZED PART C PLANS.—For implementation

1 for plan years beginning not later than  
2 January 1, 2010, the Secretary shall de-  
3 velop new quality measures appropriate to  
4 meeting the needs of—

5 “(I) beneficiaries enrolled in spe-  
6 cialized Medicare Part C plans for  
7 special needs individuals (described in  
8 section 1859(b)(6)(A)(ii)(I)) that  
9 serve predominantly individuals who  
10 are dual-eligible individuals eligible for  
11 medical assistance under title XIX by  
12 measuring the special needs for care  
13 of individuals who are both Medicare  
14 and Medicaid beneficiaries; and

15 “(II) beneficiaries enrolled in  
16 specialized Medicare Part C plans for  
17 special needs individuals (described in  
18 section 1859(b)(6)(A)(ii)(II)) that  
19 serve predominantly institutionalized  
20 individuals by measuring the special  
21 needs for care of individuals who are  
22 a resident in long-term care institu-  
23 tion.”.

24 (3) EFFECTIVE DATE; GRANDFATHER.—The  
25 amendments made by paragraph (1) shall take effect

1 for enrollments occurring on or after January 1,  
2 2009, and shall not apply—

3 (A) to plans with a contract with a State  
4 Medicaid agency to operate an integrated Med-  
5 icaid-Medicare program, that had been ap-  
6 proved by Centers for Medicare & Medicaid  
7 Services on January 1, 2004; and

8 (B) to plans that are operational as of the  
9 date of the enactment of this Act as approved  
10 Medicare demonstration projects and that pro-  
11 vide services predominantly to individuals with  
12 end-stage renal disease.

13 (4) TRANSITION FOR NON-QUALIFYING SNPS.—

14 (A) RESTRICTIONS IN 2008 FOR CHRONIC  
15 CARE SNPS.—In the case of a specialized MA  
16 plan for special needs individuals (as defined in  
17 section 1859(b)(6)(A) of the Social Security Act  
18 (42 U.S.C. 1395w-28(b)(6)(A)) that, as of De-  
19 cember 31, 2007, is not described in either sub-  
20 clause (I) or subclause (II) of clause (ii) of such  
21 section, as amended by paragraph (1), then as  
22 of January 1, 2008—

23 (i) the plan may not be offered unless  
24 it was offered before such date;

1 (ii) no new members may be enrolled  
2 with the plan; and

3 (iii) there may be no expansion of the  
4 service area of such plan.

5 (B) TRANSITION OF ENROLLEES.—The  
6 Secretary of Health and Human Services shall  
7 provide for an orderly transition of those spe-  
8 cialized MA plans for special needs individuals  
9 (as defined in section 1859(b)(6)(A) of the So-  
10 cial Security Act (42 U.S.C. 1395w-  
11 28(b)(6)(A)), as of the date of the enactment of  
12 this Act), and their enrollees, that no longer  
13 qualify as such plans under such section, as  
14 amended by this subsection.

15 **SEC. 432. EXTENSION AND REVISION OF AUTHORITY FOR**  
16 **MEDICARE REASONABLE COST CONTRACTS.**

17 (a) EXTENSION FOR 3 YEARS OF PERIOD REASON-  
18 ABLE COST PLANS CAN REMAIN IN THE MARKET.—Sec-  
19 tion 1876(h)(5)(C)(ii) of the Social Security Act (42  
20 U.S.C. 1395mm(h)(5)(C)(ii)) is amended, in the matter  
21 preceding subclause (I), by striking “January 1, 2008”  
22 and inserting “January 1, 2011”.

23 (b) APPLICATION OF CERTAIN MEDICARE ADVAN-  
24 TAGE REQUIREMENTS TO COST CONTRACTS EXTENDED  
25 OR RENEWED AFTER ENACTMENT.—Section 1876(h) of

1 such Act (42 U.S.C. 1395mm(h)), as amended by sub-  
2 section (a), is amended—

3 (1) by redesignating paragraph (5) as para-  
4 graph (6); and

5 (2) by inserting after paragraph (4) the fol-  
6 lowing new paragraph:

7 “(5)(A) Any reasonable cost reimbursement  
8 contract with an eligible organization under this sub-  
9 section that is extended or renewed on or after the  
10 date of enactment of the Children’s Health and  
11 Medicare Protection Act of 2007 shall provide that  
12 the provisions of the Medicare Part C program de-  
13 scribed in subparagraph (B) shall apply to such or-  
14 ganization and such contract in a substantially simi-  
15 lar manner as such provisions apply to Medicare  
16 Part C organizations and Medicare Part C plans  
17 under part C.

18 “(B) The provisions described in this sub-  
19 paragraph are as follows:

20 “(i) Section 1851(h) (relating to the  
21 approval of marketing material and appli-  
22 cation forms).

23 “(ii) Section 1852(e) (relating to the  
24 requirement of having an ongoing quality  
25 improvement program and treatment of ac-

1           creditation in the same manner as such  
2           provisions apply to Medicare Part C local  
3           plans that are preferred provider organiza-  
4           tion plans).

5           “(iii) Section 1852(f) (relating to  
6           grievance mechanisms).

7           “(iv) Section 1852(g) (relating to cov-  
8           erage determinations, reconsiderations, and  
9           appeals).

10          “(v) Section 1852(j)(4) (relating to  
11          limitations on physician incentive plans).

12          “(vi) Section 1854(c) (relating to the  
13          requirement of uniform premiums among  
14          individuals enrolled in the plan).

15          “(vii) Section 1854(g) (relating to re-  
16          strictions on imposition of premium taxes  
17          with respect to payments to organizations).

18          “(viii) Section 1856(b)(3) (relating to  
19          relation to State laws).

20          “(ix) The provisions of part C relating  
21          to timelines for contract renewal and bene-  
22          ficiary notification.”.

1 **TITLE V—PROVISIONS RELAT-**  
2 **ING TO MEDICARE PART A**

3 **SEC. 501. INPATIENT HOSPITAL PAYMENT UPDATES.**

4 (a) FOR ACUTE HOSPITALS.—Clause (i) of section  
5 1886(b)(3)(B) of the Social Security Act (42 U.S.C.  
6 1395ww(b)(3)(B)) is amended—

7 (1) in subclause (XIX), by striking “and”;

8 (2) by redesignating subclause (XX) as sub-  
9 clause (XXII); and

10 (3) by inserting after subclause (XIX) the fol-  
11 lowing new subclauses:

12 “(XX) for fiscal year 2007,  
13 subject to clause (viii), the mar-  
14 ket basket percentage increase  
15 for hospitals in all areas,

16 “(XXI) for fiscal year 2008,  
17 subject to clause (viii), the mar-  
18 ket basket percentage increase  
19 minus 0.25 percentage point for  
20 hospitals in all areas, and”.

21 (b) FOR OTHER HOSPITALS.—Clause (ii) of such sec-  
22 tion is amended—

23 (1) in subclause (VII) by striking “and”;

24 (2) by redesignating subclause (VIII) as sub-  
25 clause (X); and

1           (3) by inserting after subclause (VII) the fol-  
2           lowing new subclauses:

3                           “(VIII) fiscal years 2003  
4                           through 2007, is the market bas-  
5                           ket percentage increase,

6                           “(IX) fiscal year 2008, is  
7                           the market basket percentage in-  
8                           crease minus 0.25 percentage  
9                           point, and”.

10       (c) DELAYED EFFECTIVE DATE.—

11           (1) ACUTE CARE HOSPITALS.—The amend-  
12           ments made by subsection (a) shall not apply to dis-  
13           charges occurring before January 1, 2008.

14           (2) OTHER HOSPITALS.—The amendments  
15           made by subsection (b) shall be applied, only with  
16           respect to cost reporting periods beginning during  
17           fiscal year 2008 and not with respect to the com-  
18           putation for any succeeding cost reporting period, by  
19           substituting “0.1875 percentage point” for “0.25  
20           percentage point”.

21       **SEC. 502. PAYMENT FOR INPATIENT REHABILITATION FA-**  
22                           **CILITY (IRF) SERVICES.**

23       (a) PAYMENT UPDATE.—

24           (1) IN GENERAL.—Section 1886(j)(3)(C) of the  
25           Social Security Act (42 U.S.C. 1395ww(j)(3)(C)) is



1 amended by adding at the end the following: “The  
2 increase factor to be applied under this subpara-  
3 graph for fiscal year 2008 shall be 1 percent.”

4 (2) DELAYED EFFECTIVE DATE.—The amend-  
5 ment made by paragraph (1) shall not apply to pay-  
6 ment units occurring before January 1, 2008.

7 (b) INPATIENT REHABILITATION FACILITY CLASSI-  
8 FICATION CRITERIA.—

9 (1) IN GENERAL.—Section 5005 of the Deficit  
10 Reduction Act of 2005 (Public Law 109–171) is  
11 amended—

12 (A) in subsection (a), by striking “apply  
13 the applicable percent specified in subsection  
14 (b)” and inserting “require a compliance rate  
15 that is no greater than the 60 percent compli-  
16 ance rate that became effective for cost report-  
17 ing periods beginning on or after July 1,  
18 2006,”; and

19 (B) by amending subsection (b) to read as  
20 follows:

21 “(b) CONTINUED USE OF COMORBIDITIES.—For por-  
22 tions of cost reporting periods occurring on or after the  
23 date of the enactment of the Children’s Health and Medi-  
24 care Protection Act of 2007, the Secretary shall include  
25 patients with comorbidities as described in section

1 412.23(b)(2)(i) of title 42, Code of Federal Regulations  
2 (as in effect as of January 1, 2007), in the inpatient popu-  
3 lation that counts towards the percent specified in sub-  
4 section (a).”.

5 (2) EFFECTIVE DATE.—The amendment made  
6 by paragraph (1)(A) shall apply to portions of cost  
7 reporting periods beginning on or after the date of  
8 the enactment of this Act.

9 (c) PAYMENT FOR CERTAIN MEDICAL CONDITIONS  
10 TREATED IN INPATIENT REHABILITATION FACILITIES.—

11 (1) IN GENERAL.—Section 1886(j) of the Social  
12 Security Act (42 U.S.C. 1395ww(j)) is amended—

13 (A) by redesignating paragraph (7) as  
14 paragraph (8);

15 (B) by inserting after paragraph (6) the  
16 following new paragraph:

17 “(7) SPECIAL PAYMENT RULE FOR CERTAIN  
18 MEDICAL CONDITIONS.—

19 “(A) IN GENERAL.—Subject to subpara-  
20 graph (H), in the case of discharges occurring  
21 on or after October 1, 2008, in lieu of the  
22 standardized payment amount (as determined  
23 pursuant to the preceding provisions of this  
24 subsection) that would otherwise be applicable  
25 under this subsection, the Secretary shall sub-

1           stitute, for payment units with respect to an  
2           applicable medical condition (as defined in sub-  
3           paragraph (G)(i)) that is treated in an inpa-  
4           tient rehabilitation facility, the modified stand-  
5           ardized payment amount determined under sub-  
6           paragraph (B).

7           “(B) MODIFIED STANDARDIZED PAYMENT  
8           AMOUNT.—The modified standardized payment  
9           amount for an applicable medical condition  
10          shall be based on the amount determined under  
11          subparagraph (C) for such condition, as ad-  
12          justed under subparagraphs (D), (E), and (F).

13          “(C) AMOUNT DETERMINED.—

14                 “(i) IN GENERAL.—The amount de-  
15                 termined under this subparagraph for an  
16                 applicable medical condition shall be based  
17                 on the sum of the following:

18                         “(I) An amount equal to the av-  
19                         erage per stay skilled nursing facility  
20                         payment rate for the applicable med-  
21                         ical condition (as determined under  
22                         clause (ii)).

23                         “(II) An amount equal to 25 per-  
24                         cent of the difference between the  
25                         overhead costs (as defined in subpara-

1 graph (G)(ii) component of the aver-  
2 age inpatient rehabilitation facility per  
3 stay payment amount for the applica-  
4 ble medical condition (as determined  
5 under the preceding paragraphs of  
6 this subsection) and the overhead  
7 costs component of the average per  
8 stay skilled nursing facility payment  
9 rate for such condition (as determined  
10 under clause (ii)).

11 “(III) An amount equal to 33  
12 percent of the difference between the  
13 patient care costs (as defined in sub-  
14 paragraph (G)(iii)) component of the  
15 average inpatient rehabilitation facil-  
16 ity per stay payment amount for the  
17 applicable medical condition (as deter-  
18 mined under the preceding para-  
19 graphs of this subsection) and the pa-  
20 tient care costs component of the av-  
21 erage per stay skilled nursing facility  
22 payment rate for such condition (as  
23 determined under clause (ii)).

24 “(ii) DETERMINATION OF AVERAGE  
25 PER STAY SKILLED NURSING FACILITY

1                   PAYMENT RATE.—For purposes of clause  
2                   (i), the Secretary shall convert skilled  
3                   nursing facility payment rates for applica-  
4                   ble medical conditions, as determined  
5                   under section 1888(e), to average per stay  
6                   skilled nursing facility payment rates for  
7                   each such condition.

8                   “(D) ADJUSTMENTS.—The Secretary shall  
9                   adjust the amount determined under subpara-  
10                  graph (C) for an applicable medical condition  
11                  using the adjustments to the prospective pay-  
12                  ment rates for inpatient rehabilitation facilities  
13                  described in paragraphs (2), (3), (4), and (6).

14                  “(E) UPDATE FOR INFLATION.—Except in  
15                  the case of a fiscal year for which the Secretary  
16                  rebases the amounts determined under subpara-  
17                  graph (C) for applicable medical conditions pur-  
18                  suant to subparagraph (F), the Secretary shall  
19                  annually update the amounts determined under  
20                  subparagraph (C) for each applicable medical  
21                  condition by the increase factor for inpatient re-  
22                  habilitation facilities (as described in paragraph  
23                  (3)(C)).

24                  “(F) REBASING.—The Secretary shall pe-  
25                  riodically (but in no case less than once every

1           5 years) rebase the amounts determined under  
2           subparagraph (C) for applicable medical condi-  
3           tions using the methodology described in such  
4           subparagraph and the most recent and complete  
5           cost report and claims data available.

6           “(G) DEFINITIONS.—In this paragraph:

7                   “(i) APPLICABLE MEDICAL CONDI-  
8                   TION.—The term ‘applicable medical condi-  
9                   tion’ means—

10                           “(I) unilateral knee replacement;

11                           “(II) unilateral hip replacement;

12                           and

13                           “(III) unilateral hip fracture.

14                   “(ii) OVERHEAD COSTS.—The term  
15                   ‘overhead costs’ means those Medicare-al-  
16                   lowable costs that are contained in the  
17                   General Service cost centers of the Medi-  
18                   care cost reports for inpatient rehabilita-  
19                   tion facilities and for skilled nursing facili-  
20                   ties, respectively, as determined by the  
21                   Secretary.

22                   “(iii) PATIENT CARE COSTS.—The  
23                   term ‘patient care costs’ means total Medi-  
24                   care-allowable costs minus overhead costs.

1           “(H) SUNSET.—The provisions of this  
2 paragraph shall cease to apply as of the date  
3 the Secretary implements an integrated, site-  
4 neutral payment methodology under this title  
5 for post-acute care.”; and

6           (C) in paragraph (8), as redesignated by  
7 paragraph (1)—

8           (i) in subparagraph (C), by striking  
9 “and” at the end;

10           (ii) in subparagraph (D), by striking  
11 the period at the end and inserting “,  
12 and”; and

13           (iii) by adding at the end the fol-  
14 lowing new subparagraph:

15           “(E) modified standardized payment  
16 amounts under paragraph (7).”.

17           (2) SPECIAL RULE FOR DISCHARGES OCCUR-  
18 RING IN THE SECOND HALF OF FISCAL YEAR 2008.—

19           (A) IN GENERAL.—In the case of dis-  
20 charges from an inpatient rehabilitation facility  
21 occurring during the period beginning on April  
22 1, 2008, and ending on September 30, 2008,  
23 for applicable medical conditions (as defined in  
24 paragraph (7)(G)(i) of section 1886(j) of the  
25 Social Security Act (42 U.S.C. 1395ww(j)), as

1 inserted by paragraph (1)(B), in lieu of the  
2 standardized payment amount determined pur-  
3 suant to such section, the standardized payment  
4 amount shall be \$9,507 for unilateral knee re-  
5 placement, \$10,398 for unilateral hip replace-  
6 ment, and \$10,958 for unilateral hip fracture.  
7 Such amounts are the amounts that are esti-  
8 mated would be determined under paragraph  
9 (7)(C) of such section 1886(j) for such condi-  
10 tions if such paragraph applied for such period.  
11 Such standardized payment amounts shall be  
12 multiplied by the relative weights for each case-  
13 mix group and tier, as published in the final  
14 rule of the Secretary of Health and Human  
15 Services for inpatient rehabilitation facility  
16 services prospective payment for fiscal year  
17 2008, to obtain the applicable payment  
18 amounts for each such condition for each case-  
19 mix group and tier.

20 (B) IMPLEMENTATION.—Notwithstanding  
21 any other provision of law, the Secretary of  
22 Health and Human Services may implement  
23 this subsection by program instruction or other-  
24 wise. Paragraph (8)(E) of such section 1886(j)  
25 of the Social Security Act, as added by para-



1 graph (1)(C), shall apply for purposes of this  
2 subsection in the same manner as such para-  
3 graph applies for purposes of paragraph (7) of  
4 such section 1886(j).

5 (d) RECOMMENDATIONS FOR CLASSIFYING INPA-  
6 TIENT REHABILITATION HOSPITALS AND UNITS.—

7 (1) REPORT TO CONGRESS.—Not later than 12  
8 months after the date of the enactment of this Act,  
9 the Secretary of Health and Human Services, in  
10 consultation with physicians (including geriatricians  
11 and physiatrists), administrators of inpatient reha-  
12 bilitation, acute care hospitals, skilled nursing facili-  
13 ties, and other settings providing rehabilitation serv-  
14 ices, Medicare beneficiaries, trade organizations rep-  
15 resenting inpatient rehabilitation hospitals and units  
16 and skilled nursing facilities, and the Medicare Pay-  
17 ment Advisory Commission, shall submit to the  
18 Committee on Ways and Means of the House of  
19 Representatives and the Committee on Finance of  
20 the Senate a report that includes—

21 (A) an examination of Medicare bene-  
22 ficiaries' access to medically necessary rehabili-  
23 tation services;

24 (B) alternatives or refinements to the 75  
25 percent rule policy for determining exclusion

1 criteria for inpatient rehabilitation hospital and  
2 unit designation under the Medicare program,  
3 including determining clinical appropriateness  
4 of inpatient rehabilitation hospital and unit ad-  
5 missions and alternative criteria which would  
6 consider a patient's functional status, diagnosis,  
7 co-morbidities, and other relevant factors; and

8 (C) an examination that identifies any con-  
9 dition for which individuals are commonly ad-  
10 mitted to inpatient rehabilitation hospitals that  
11 is not included as a condition described in sec-  
12 tion 412.23(b)(2)(iii) of title 42, Code of Fed-  
13 eral Regulations, to determine the appropriate  
14 setting of care, and any variation in patient  
15 outcomes and costs, across settings of care, for  
16 treatment of such conditions.

17 For the purposes of this subsection, the term "75  
18 percent rule" means the requirement of section  
19 412.23(b)(2) of title 42, Code of Federal Regula-  
20 tions, that 75 percent of the patients of a rehabilita-  
21 tion hospital or converted rehabilitation unit are in  
22 1 or more of 13 listed treatment categories.

23 (2) CONSIDERATIONS.—In developing the re-  
24 port described in paragraph (1), the Secretary shall  
25 include the following:

1 (A) The potential effect of the 75 percent  
2 rule on access to rehabilitation care by Medi-  
3 care beneficiaries for the treatment of a condi-  
4 tion, whether or not such condition is described  
5 in section 412.23(b)(2)(iii) of title 42, Code of  
6 Federal Regulations.

7 (B) An analysis of the effectiveness of re-  
8 habilitation care for the treatment of condi-  
9 tions, whether or not such conditions are de-  
10 scribed in section 412.23(b)(2)(iii) of title 42,  
11 Code of Federal Regulations, available to Medi-  
12 care beneficiaries in various health care set-  
13 tings, taking into account variation in patient  
14 outcomes and costs across different settings of  
15 care, and which may include whether the Medi-  
16 care program and Medicare beneficiaries may  
17 incur higher costs of care for the entire episode  
18 of illness due to readmissions, extended lengths  
19 of stay, and other factors.

20 **SEC. 503. LONG-TERM CARE HOSPITALS.**

21 (a) LONG-TERM CARE HOSPITAL PAYMENT UP-  
22 DATE.—

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

1       “(m) PROSPECTIVE PAYMENT FOR LONG-TERM  
2 CARE HOSPITALS.—

3               “(1) REFERENCE TO ESTABLISHMENT AND IM-  
4 PLEMENTATION OF SYSTEM.—For provisions related  
5 to the establishment and implementation of a pro-  
6 spective payment system for payments under this  
7 title for inpatient hospital services furnished by a  
8 long-term care hospital described in subsection  
9 (d)(1)(B)(iv), see section 123 of the Medicare, Med-  
10 icaid, and SCHIP Balanced Budget Refinement Act  
11 of 1999 and section 307(b) of Medicare, Medicaid,  
12 and SCHIP Benefits Improvement and Protection  
13 Act of 2000.

14               “(2) UPDATE FOR RATE YEAR 2008.—In imple-  
15 menting the system described in paragraph (1) for  
16 discharges occurring during the rate year ending in  
17 2008 for a hospital, the base rate for such dis-  
18 charges for the hospital shall be the same as the  
19 base rate for discharges for the hospital occurring  
20 during the previous rate year.”.

21               “(2) DELAYED EFFECTIVE DATE.—Subsection  
22 (m)(2) of section 1886 of the Social Security Act, as  
23 added by paragraph (1), shall not apply to dis-  
24 charges occurring on or after July 1, 2007, and be-  
25 fore January 1, 2008.

1 (b) PAYMENT FOR LONG-TERM CARE HOSPITAL  
2 SERVICES; PATIENT AND FACILITY CRITERIA.—

3 (1) DEFINITION OF LONG-TERM CARE HOS-  
4 PITAL.—

5 (A) DEFINITION.—Section 1861 of the So-  
6 cial Security Act (42 U.S.C. 1395x) is amended  
7 by adding at the end the following new sub-  
8 section:

9 “Long-Term Care Hospital  
10 “(ccc) The term ‘long-term care hospital’ means an  
11 institution which—

12 “(1) is primarily engaged in providing inpatient  
13 services, by or under the supervision of a physician,  
14 to Medicare beneficiaries whose medically complex  
15 conditions require a long hospital stay and programs  
16 of care provided by a long-term care hospital;

17 “(2) has an average inpatient length of stay (as  
18 determined by the Secretary) for Medicare bene-  
19 ficiaries of greater than 25 days, or as otherwise de-  
20 fined in section 1886(d)(1)(B)(iv);

21 “(3) satisfies the requirements of subsection  
22 (e);

23 “(4) meets the following facility criteria:

24 “(A) the institution has a patient review  
25 process, documented in the patient medical

1 record, that screens patients prior to admission  
2 for appropriateness of admission to a long-term  
3 care hospital, validates within 48 hours of ad-  
4 mission that patients meet admission criteria  
5 for long-term care hospitals, regularly evaluates  
6 patients throughout their stay for continuation  
7 of care in a long-term care hospital, and as-  
8 sesses the available discharge options when pa-  
9 tients no longer meet such continued stay cri-  
10 teria;

11 “(B) the institution has active physician  
12 involvement with patients during their treat-  
13 ment through an organized medical staff, physi-  
14 cian-directed treatment with physician on-site  
15 availability on a daily basis to review patient  
16 progress, and consulting physicians on call and  
17 capable of being at the patient’s side within a  
18 moderate period of time, as determined by the  
19 Secretary;

20 “(C) the institution has interdisciplinary  
21 team treatment for patients, requiring inter-  
22 disciplinary teams of health care professionals,  
23 including physicians, to prepare and carry out  
24 an individualized treatment plan for each pa-  
25 tient; and

1           “(5) meets patient criteria relating to patient  
2           mix and severity appropriate to the medically com-  
3           plex cases that long-term care hospitals are designed  
4           to treat, as measured under section 1886(m).”.

5                   (B) NEW PATIENT CRITERIA FOR LONG-  
6           TERM CARE HOSPITAL PROSPECTIVE PAY-  
7           MENT.—Section 1886 of such Act (42 U.S.C.  
8           1395ww), as amended by subsection (a), is fur-  
9           ther amended by adding at the end the fol-  
10          lowing new subsection:

11          “(n) PATIENT CRITERIA FOR PROSPECTIVE PAY-  
12          MENT TO LONG-TERM CARE HOSPITALS.—

13                   “(1) IN GENERAL.—To be eligible for prospec-  
14          tive payment under this section as a long-term care  
15          hospital, a long-term care hospital must admit not  
16          less than a majority of patients who have a high  
17          level of severity, as defined by the Secretary, and  
18          who are assigned to one or more of the following  
19          major diagnostic categories:

20                           “(A) Circulatory diagnoses.

21                           “(B) Digestive, endocrine, and metabolic  
22          diagnoses.

23                           “(C) Infection disease diagnoses.

24                           “(D) Neurological diagnoses.

25                           “(E) Renal diagnoses.

1                   “(F) Respiratory diagnoses.

2                   “(G) Skin diagnoses.

3                   “(H) Other major diagnostic categories as  
4                   selected by the Secretary.

5                   “(2) MAJOR DIAGNOSTIC CATEGORY DE-  
6                   FINED.—In paragraph (1), the term ‘major diag-  
7                   nostic category’ means the medical categories formed  
8                   by dividing all possible principle diagnosis into mu-  
9                   tually exclusive diagnosis areas which are referred to  
10                  in 67 Federal Register 49985 (August 1, 2002).”.

11                  (C) ESTABLISHMENT OF REHABILITATION  
12                  UNITS WITHIN CERTAIN LONG-TERM CARE HOS-  
13                  PITALS.—If the Secretary of Health and  
14                  Human Services does not include rehabilitation  
15                  services within a major diagnostic category  
16                  under section 1886(n)(2) of the Social Security  
17                  Act, as added by subparagraph (B), the Sec-  
18                  retary shall approve for purposes of title XVIII  
19                  of such Act distinct part inpatient rehabilitation  
20                  hospital units in long-term care hospitals con-  
21                  sistent with the following:

22                         (i) A hospital that, on or before Octo-  
23                         ber 1, 2004, was classified by the Sec-  
24                         retary as a long-term care hospital, as de-  
25                         scribed in section 1886(d)(1)(B)(iv)(I) of



1 such Act (42 U.S.C.  
2 1395ww(d)(1)(V)(iv)(I)), and was accred-  
3 ited by the Commission on Accreditation of  
4 Rehabilitation Facilities, may establish a  
5 hospital rehabilitation unit that is a dis-  
6 tinct part of the long-term care hospital, if  
7 the distinct part meets the requirements  
8 (including conditions of participation) that  
9 would otherwise apply to a distinct-part re-  
10 habilitation unit if the distinct part were  
11 established by a subsection (d) hospital in  
12 accordance with the matter following  
13 clause (v) of section 1886(d)(1)(B) of such  
14 Act, including any regulations adopted by  
15 the Secretary in accordance with this sec-  
16 tion, except that the one-year waiting pe-  
17 riod described in section 412.30(c) of title  
18 42, Code of Federal Regulations, applica-  
19 ble to the conversion of hospital beds into  
20 a distinct-part rehabilitation unit shall not  
21 apply to such units.

22 (ii) Services provided in inpatient re-  
23 habilitation units established under clause  
24 (i) shall not be reimbursed as long-term  
25 care hospital services under section 1886

1 of such Act and shall be subject to pay-  
2 ment policies established by the Secretary  
3 to reimburse services provided by inpatient  
4 hospital rehabilitation units.

5 (D) EFFECTIVE DATE.—The amendments  
6 made by subparagraphs (A) and (B), and the  
7 provisions of subparagraph (C), shall apply to  
8 discharges occurring on or after January 1,  
9 2008.

10 (2) IMPLEMENTATION OF FACILITY AND PA-  
11 TIENT CRITERIA.—

12 (A) REPORT.—No later than 1 year after  
13 the date of the enactment of this Act, the Sec-  
14 retary of Health and Human Services (in this  
15 section referred to as the “Secretary”) shall  
16 submit to the appropriate committees of Con-  
17 gress a report containing recommendations re-  
18 garding the promulgation of the national long-  
19 term care hospital facility and patient criteria  
20 for application under paragraphs (4) and (5) of  
21 section 1861(ccc) and section 1886(n) of the  
22 Social Security Act, as added by subparagraphs  
23 (A) and (B), respectively, of paragraph (1). In  
24 the report, the Secretary shall consider rec-  
25 ommendations contained in a report to Con-

1           gress by the Medicare Payment Advisory Com-  
2           mission in June 2004 for long-term care hos-  
3           pital-specific facility and patient criteria to en-  
4           sure that patients admitted to long-term care  
5           hospitals are medically complex and appropriate  
6           to receive long-term care hospital services.

7           (B) IMPLEMENTATION.—No later than 1  
8           year after the date of submittal of the report  
9           under subparagraph (A), the Secretary shall,  
10          after rulemaking, implement the national long-  
11          term care hospital facility and patient criteria  
12          referred to in such subparagraph. Such long-  
13          term care hospital facility and patient criteria  
14          shall be used to screen patients in determining  
15          the medical necessity and appropriateness of a  
16          Medicare beneficiary's admission to, continued  
17          stay at, and discharge from, long-term care hos-  
18          pitals under the Medicare program and shall  
19          take into account the medical judgment of the  
20          patient's physician, as provided for under sec-  
21          tions 1814(a)(3) and 1835(a)(2)(B) of the So-  
22          cial Security Act (42 U.S.C. 1395f(a)(3),  
23          1395n(a)(2)(B)).

24          (3) EXPANDED REVIEW OF MEDICAL NECES-  
25          SITY.—

1           (A) IN GENERAL.—The Secretary of  
2           Health and Human Services shall provide,  
3           under contracts with one or more appropriate  
4           fiscal intermediaries or medicare administrative  
5           contractors under section 1874A(a)(4)(G) of  
6           the Social Security Act (42 U.S.C.  
7           1395kk(a)(4)(G)), for reviews of the medical  
8           necessity of admissions to long-term care hos-  
9           pitals (described in section 1886(d)(1)(B)(iv) of  
10          such Act) and continued stay at such hospitals,  
11          of individuals entitled to, or enrolled for, bene-  
12          fits under part A of title XVIII of such Act on  
13          a hospital-specific basis consistent with this  
14          paragraph. Such reviews shall be made for dis-  
15          charges occurring on or after October 1, 2007.

16          (B) REVIEW METHODOLOGY.—The medical  
17          necessity reviews under paragraph (A) shall be  
18          conducted for each such long-term care hospital  
19          on an annual basis in accordance with rules (in-  
20          cluding a sample methodology) specified by the  
21          Secretary. Such sample methodology shall—

22                  (i) provide for a statistically valid and  
23                  representative sample of admissions of  
24                  such individuals sufficient to provide re-

1           sults at a 95 percent confidence interval;  
2           and

3                   (ii) guarantee that at least 75 percent  
4           of overpayments received by long-term care  
5           hospitals for medically unnecessary admis-  
6           sions and continued stays of individuals in  
7           long-term care hospitals will be identified  
8           and recovered and that related days of care  
9           will not be counted toward the length of  
10          stay requirement contained in section  
11          1886(d)(1)(B)(iv) of the Social Security  
12          Act (42 U.S.C. 1395ww(d)(1)(B)(iv)).

13           (C) CONTINUATION OF REVIEWS.—Under  
14          contracts under this paragraph, the Secretary  
15          shall establish a denial rate with respect to such  
16          reviews that, if exceeded, could require further  
17          review of the medical necessity of admissions  
18          and continued stay in the hospital involved.

19           (D) TERMINATION OF REQUIRED RE-  
20          VIEWS.—

21                   (i) IN GENERAL.—Subject to clause  
22          (iii), the previous provisions of this sub-  
23          section shall cease to apply as of the date  
24          specified in clause (ii).

1 (ii) DATE SPECIFIED.—The date spec-  
2 ified in this clause is the later of January  
3 1, 2013, or the date of implementation of  
4 national long-term care hospital facility  
5 and patient criteria under section para-  
6 graph (2)(B).

7 (iii) CONTINUATION.—As of the date  
8 specified in clause (ii), the Secretary shall  
9 determine whether to continue to guar-  
10 antee, through continued medical review  
11 and sampling under this paragraph, recov-  
12 ery of at least 75 percent of overpayments  
13 received by long-term care hospitals due to  
14 medically unnecessary admissions and con-  
15 tinued stays.

16 (4) LIMITED, QUALIFIED MORATORIUM OF  
17 LONG-TERM CARE HOSPITALS.—

18 (A) IN GENERAL.—Subject to subpara-  
19 graph (B), the Secretary shall impose a tem-  
20 porary moratorium on the certification of new  
21 long-term care hospitals (and satellite facilities),  
22 and new long-term care hospital and satellite  
23 facility beds, for purposes of the Medicare pro-  
24 gram under title XVIII of the Social Security  
25 Act. The moratorium shall terminate at the end

1 of the 4-year period beginning on the date of  
2 the enactment of this Act.

3 (B) EXCEPTIONS.—

4 (i) IN GENERAL.—The moratorium  
5 under subparagraph (A) shall not apply as  
6 follows:

7 (I) To a long-term care hospital,  
8 satellite facility, or additional beds  
9 under development as of the date of  
10 the enactment of this Act.

11 (II) To a new long-term care hos-  
12 pital in an area in which there is not  
13 a long-term care hospital, if the Sec-  
14 retary determines it to be in the best  
15 interest to provide access to long-term  
16 care hospital services to Medicare  
17 beneficiaries residing in such area.  
18 There shall be a presumption in favor  
19 of the moratorium, which may be re-  
20 butted by evidence the Secretary  
21 deems sufficient to show the need for  
22 long-term care hospital services in  
23 that area.

24 (III) To an existing long-term  
25 care hospital that requests to increase

1 its number of long-term care hospital  
2 beds, if the Secretary determines  
3 there is a need at the long-term care  
4 hospital for additional beds to accom-  
5 modate—

6 (aa) infectious disease issues  
7 for isolation of patients;

8 (bb) bedside dialysis serv-  
9 ices;

10 (cc) single-sex accommoda-  
11 tion issues;

12 (dd) behavioral issues;

13 (ee) any requirements of  
14 State or local law; or

15 (ff) other clinical issues the  
16 Secretary determines warrant ad-  
17 ditional beds, in the best interest  
18 of Medicare beneficiaries.

19 (IV) To an existing long-term  
20 care hospital that requests an increase  
21 in beds because of the closure of a  
22 long-term care hospital or significant  
23 decrease in the number of long-term  
24 care hospital beds, in a State where



1                   there is only one other long-term care  
2                   hospital.

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

6                   (ii) “UNDER DEVELOPMENT” DE-  
7                   FINED.—For purposes of clause (i)(I), a  
8                   long-term care hospital or satellite facility  
9                   is considered to be “under development” as  
10                  of a date if any of the following have oc-  
11                  curred on or before such date:

12                  (I) The hospital or a related  
13                  party has a binding written agreement  
14                  with an outside, unrelated party for  
15                  the construction, reconstruction, lease,  
16                  rental, or financing of the long-term  
17                  care hospital.

18                  (II) Actual construction, renova-  
19                  tion or demolition for the long-term  
20                  care hospital has begun.

21                  (III) A certificate of need has  
22                  been approved in a State where one is  
23                  required or other necessary approvals  
24                  from appropriate State agencies have

1           been received for the operation of the  
2           hospital.

3                       (IV) The hospital documents that  
4           it is within a 6-month long-term care  
5           hospital demonstration period re-  
6           quired by section 412.23(e)(1)–(3) of  
7           title 42, Code of Federal Regulations,  
8           to demonstrate that it has a greater  
9           than 25 day average length of stay.

10                      (V) There is other evidence pre-  
11           sented that the Secretary determines  
12           would indicate that the hospital or  
13           satellite is under development.

14                      (5) NO APPLICATION OF 25 PERCENT PATIENT  
15           THRESHOLD PAYMENT ADJUSTMENT TO FREE-  
16           STANDING AND GRANDFATHERED LTCHS.—The Sec-  
17           retary shall not apply, during the 5-year period be-  
18           ginning on the date of the enactment of this Act,  
19           section 412.536 of title 42, Code of Federal Regula-  
20           tions, or any similar provision, to freestanding long-  
21           term care hospitals and the Secretary shall not apply  
22           such section or section 412.534 of title 42, Code of  
23           Federal Regulations, or any similar provisions, to a  
24           long-term care hospital identified by section 4417(a)  
25           of the Balanced Budget Act of 1997 (Public Law

1 105–33). A long-term care hospital identified by  
2 such section 4417(a) shall be deemed to be a free-  
3 standing long-term care hospital for the purpose of  
4 this section. Section 412.536 of title 42, Code of  
5 Federal Regulations, shall be void and of no effect.

6 (6) PAYMENT FOR HOSPITALS-WITHIN-HOS-  
7 PITALS.—

8 (A) IN GENERAL.—Payments to an appli-  
9 cable long-term care hospital or satellite facility  
10 which is located in a rural area or which is co-  
11 located with an urban single or MSA dominant  
12 hospital under paragraphs (d)(1), (e)(1), and  
13 (e)(4) of section 412.534 of title 42, Code of  
14 Federal Regulations, shall not be subject to any  
15 payment adjustment under such section if no  
16 more than 75 percent of the hospital’s Medicare  
17 discharges (other than discharges described in  
18 paragraphs (d)(2) or (e)(3) of such section) are  
19 admitted from a co-located hospital.

20 (B) CO-LOCATED LONG-TERM CARE HOS-  
21 PITALS AND SATELLITE FACILITIES.—

22 (i) IN GENERAL.—Payment to an ap-  
23 plicable long-term care hospital or satellite  
24 facility which is co-located with another  
25 hospital shall not be subject to any pay-

1                   ment adjustment under section 412.534 of  
2                   title 42, Code of Federal Regulations, if no  
3                   more than 50 percent of the hospital's  
4                   Medicare discharges (other than discharges  
5                   described in section 412.534(c)(3) of such  
6                   title) are admitted from a co-located hos-  
7                   pital.

8                   (ii) APPLICABLE LONG-TERM CARE  
9                   HOSPITAL OR SATELLITE FACILITY DE-  
10                  FINED.—In this paragraph, the term “ap-  
11                  plicable long-term care hospital or satellite  
12                  facility” means a hospital or satellite facil-  
13                  ity that is subject to the transition rules  
14                  under section 412.534(g) of title 42, Code  
15                  of Federal Regulations.

16                  (C) EFFECTIVE DATE.—Subparagraphs  
17                  (A) and (B) shall apply to discharges occurring  
18                  on or after October 1, 2007, and before October  
19                  1, 2012.

20                  (7) NO APPLICATION OF VERY SHORT-STAY  
21                  OUTLIER POLICY.—The Secretary shall not apply,  
22                  during the 5-year period beginning on the date of  
23                  the enactment of this Act, the amendments finalized  
24                  on May 11, 2007 (72 Federal Register 26904) made  
25                  to the short-stay outlier payment provision for long-

1 term care hospitals contained in section  
2 412.529(e)(3)(i) of title 42, Code of Federal Regula-  
3 tions, or any similar provision.

4 (8) NO APPLICATION OF ONE TIME ADJUST-  
5 MENT TO STANDARD AMOUNT.—The Secretary shall  
6 not, during the 5-year period beginning on the date  
7 of the enactment of this Act, make the one-time pro-  
8 spective adjustment to long-term care hospital pro-  
9 spective payment rates provided for in section  
10 412.523(d)(3) of title 42, Code of Federal Regula-  
11 tions, or any similar provision.

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

14 (1) IN GENERAL.—Subsection (d)(1)(B) of sec-  
15 tion 1886 of the Social Security Act (42 U.S.C.  
16 1395ww) is amended—

17 (A) in clause (iv)—

18 (i) in subclause (I), by striking  
19 “(iv)(I)” and inserting “(iv)” and by strik-  
20 ing “or” at the end; and

21 (ii) in subclause (II)—

22 (I) by striking “, or” at the end  
23 and inserting a semicolon; and

1 (II) by redesignating such sub-  
2 clause as clause (vi) and by moving it  
3 to immediately follow clause (v); and  
4 (B) in clause (v), by striking the semicolon  
5 at the end and inserting “, or”.

6 (2) CONFORMING PAYMENT REFERENCES.—  
7 Subsection (b) of such section is amended—

8 (A) in paragraph (2)(E)(ii), by adding at  
9 the end the following new subclause:

10 “(III) Hospitals described in  
11 clause (vi) of such subsection.”;

12 (B) in paragraph (3)(F)(iii), by adding at  
13 the end the following new subclause:

14 “(VI) Hospitals described in  
15 clause (vi) of such subsection.”;

16 (C) in paragraphs (3)(G)(ii), (3)(H)(i),  
17 and (3)(H)(ii)(I), by inserting “or (vi)” after  
18 “clause (iv)” each place it appears;

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

21 “(IV) Hospitals described in  
22 clause (vi) of such subsection.”;

23 (E) in paragraph (3)(J), by striking “sub-  
24 section (d)(1)(B)(iv)” and inserting “clause (iv)  
25 or (vi) of subsection (d)(1)(B)”;

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

3 “(iv) Hospitals described in clause (vi)  
4 of such subsection.”.

5 (3) ADDITIONAL CONFORMING AMENDMENTS.—

6 The second sentence of subsection (d)(1)(B) of such  
7 section is amended—

8 (A) by inserting “(as in effect as of such  
9 date)” after “clause (iv)”; and

10 (B) by inserting “(or, in the case of a hos-  
11 pital classified under clause (iv)(II), as so in ef-  
12 fect, shall be classified under clause (vi) on and  
13 after the effective date of such clause)” after  
14 “so classified”.

15 (4) TRANSITION RULE.—In the case of a hos-  
16 pital that is classified under clause (iv)(II) of section  
17 1886(d)(1)(B) of the Social Security Act imme-  
18 diately before the date of the enactment of this Act  
19 and which is classified under clause (vi) of such sec-  
20 tion after such date of enactment, payments under  
21 section 1886 of such Act for cost reporting periods  
22 beginning after the date of the enactment of this Act  
23 shall be based upon payment rates in effect for the  
24 cost reporting period for such hospital beginning  
25 during fiscal year 2001, increased for each suc-

1 ceeding cost reporting period (beginning before the  
2 date of the enactment of this Act) by the applicable  
3 percentage increase under section 1886(b)(3)(B)(ii)  
4 of such Act.

5 (5) CLARIFICATION OF TREATMENT OF SAT-  
6 ELLITE FACILITIES AND REMOTE LOCATIONS.—A  
7 long-stay cancer hospital described in section  
8 1886(d)(1)(B)(vi) of the Social Security Act, as des-  
9 ignated under paragraph (1), shall include satellites  
10 or remote site locations for such hospital established  
11 before or after the date of the enactment of this Act  
12 if the provider-based requirements under section  
13 413.65 of title 42, Code of Federal Regulations, ap-  
14 plicable certification requirements under title XVIII  
15 of the Social Security, and such other applicable  
16 State licensure and certificate of need requirements  
17 are met with respect to such satellites or remote site  
18 locations.

19 **SEC. 504. INCREASING THE DSH ADJUSTMENT CAP.**

20 Section 1886(d)(5)(F)(xiv) of the Social Security Act  
21 (42 U.S.C. 1395ww(d)(5)(F)(xiv)) is amended—

22 (1) subclause (II), by striking “12 percent” and  
23 inserting “the percent specified in subclause (III)”;  
24 and



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

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

5           “(a) before October 1, 2007, 12 percent;

6           “(b) during fiscal year 2008, 16 percent;

7           “(c) during fiscal year 2009, 18 percent;

8       and

9           “(d) on or after October 1, 2009, 12 per-  
10       cent.”.

11 **SEC. 505. PPS-EXEMPT CANCER HOSPITALS.**

12       (a) AUTHORIZING REBASING FOR PPS-EXEMPT  
13       CANCER HOSPITALS.—Section 1886(b)(3)(F) of the So-  
14       cial Security Act (42 U.S.C. 1395ww(b)(3)(F)) is amend-  
15       ed by adding at the end the following new clause:

16           “(iv) In the case of a hospital (or unit  
17       described in the matter following clause (v)  
18       of subsection (d)(1)(B)) that received pay-  
19       ment under this subsection for inpatient  
20       hospital services furnished during cost re-  
21       porting periods beginning before October  
22       1, 1999, that is within a class of hospital  
23       described in clause (iii) (other than sub-  
24       clause (IV), relating to long-term care hos-  
25       pitals, and that requests the Secretary (in

1 a form and manner specified by the Sec-  
2 retary) to effect a rebasing under this  
3 clause for the hospital, the Secretary may  
4 compute the target amount for the hos-  
5 pital's 12-month cost reporting period be-  
6 ginning during fiscal year 2008 as an  
7 amount equal to the average described in  
8 clause (ii) but determined as if any ref-  
9 erence in such clause to 'the date of the  
10 enactment of this subparagraph' were a  
11 reference to 'the date of the enactment of  
12 this clause'.".

13 (b) MEDPAC REPORT ON PPS-EXEMPT CANCER  
14 HOSPITALS.—Not later than March 1, 2009, the Medicare  
15 Payment Advisory Commission (established under section  
16 1805 of the Social Security Act (42 U.S.C. 1395b-6)) shall  
17 submit to the Secretary and Congress a report evaluating  
18 the following:

19 (1) Measures of payment adequacy and Medi-  
20 care margins for PPS-exempt cancer hospitals, as  
21 established under section 1886(d)(1)(B)(v) of the  
22 Social Security Act (42 U.S.C.  
23 1395ww(d)(1)(B)(v)).

24 (2) To the extent a PPS-exempt cancer hospital  
25 was previously affiliated with another hospital, the

1 margins of the PPS-exempt hospital and the other  
2 hospital as separate entities and the margins of such  
3 hospitals that existed when the hospitals were pre-  
4 viously affiliated.

5 (3) Payment adequacy for cancer discharges  
6 under the Medicare inpatient hospital prospective  
7 payment system.

8 **SEC. 506. SKILLED NURSING FACILITY PAYMENT UPDATE.**

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

12 (1) in subclause (III), by striking “and”;

13 (2) by redesignating subsection (IV) as sub-  
14 clause (VI); and

15 (3) by inserting after subclause (III) the fol-  
16 lowing new subclauses:

17 “(IV) for each of fiscal years  
18 2004, 2005, 2006, and 2007, the rate  
19 computed for the previous fiscal year  
20 increased by the skilled nursing facil-  
21 ity market basket percentage change  
22 for the fiscal year involved;

23 “(V) for fiscal year 2008, the  
24 rate computed for the previous fiscal  
25 year; and”.

1 (b) DELAYED EFFECTIVE DATE.—Section  
2 1888(e)(4)(E)(ii)(V) of the Social Security Act, as in-  
3 serted by subsection (a)(3), shall not apply to payment  
4 for days before January 1, 2008.

5 **SEC. 507. REVOCATION OF UNIQUE DEEMING AUTHORITY**  
6 **OF THE JOINT COMMISSION FOR THE AC-**  
7 **CREDITATION OF HEALTHCARE ORGANIZA-**  
8 **TIONS.**

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

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

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

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

17 (A) in subsection (a)(1), as so redesign-  
18 nated, by striking “In addition, if” and insert-  
19 ing “If”;

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

21 (i) by striking “released to him by the  
22 Joint Commission on Accreditation of Hos-  
23 pitals,” and inserting “released to the Sec-  
24 retary by”; and

1 (ii) by striking the comma after “As-  
2 sociation”;

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

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

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

1 be essentially equivalent to those of such a national  
2 accreditation body.”.

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

7 (4) Section 1875(b) of such Act (42 U.S.C.  
8 1395ll(b)) is amended by striking “the Joint Com-  
9 mission on Accreditation of Hospitals,” and insert-  
10 ing “national accreditation bodies under section  
11 1865(a)”.

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

15 (6) Section 1852(e)(4)(C) of such Act (42  
16 U.S.C. 1395w-22(e)(4)(C)) is amended by striking  
17 “section 1865(b)(2)” and inserting “section  
18 1865(a)(2)”.

19 (c) AUTHORITY TO RECOGNIZE JCAHO AS A NA-  
20 TIONAL ACCREDITATION BODY.—The Secretary of Health  
21 and Human Services may recognize the Joint Commission  
22 on Accreditation of Healthcare Organizations as a na-  
23 tional accreditation body under section 1865 of the Social  
24 Security Act (42 U.S.C. 1395bb), as amended by this sec-

1 tion, upon such terms and conditions, and upon submis-  
2 sion of such information, as the Secretary may require.

3 (d) EFFECTIVE DATE; TRANSITION RULE.—(1) Sub-  
4 ject to paragraph (2), the amendments made by this sec-  
5 tion shall apply with respect to accreditations of hospitals  
6 granted on or after the date that is 18 months after the  
7 date of the enactment of this Act.

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

17 **TITLE VI—OTHER PROVISIONS**  
18 **RELATING TO MEDICARE**

19 **PART B**

20 **Subtitle A—Payment and Coverage**  
21 **Improvements**

22 **SEC. 601. PAYMENT FOR THERAPY SERVICES.**

23 (a) EXTENSION OF EXCEPTIONS PROCESS FOR  
24 MEDICARE THERAPY CAPS.—Section 1833(g)(5) of the  
25 Social Security Act (42 U.S.C. 1395l(g)(5)), as amended

1 by section 201 of the Medicare Improvements and Exten-  
2 sion Act of 2006 (division B of Public Law 109–432), is  
3 amended by striking “2007” and inserting “2009”.

4 (b) STUDY AND REPORT.—

5 (1) STUDY.—The Secretary of Health and  
6 Human Services, in consultation with appropriate  
7 stakeholders, shall conduct a study on refined and  
8 alternative payment systems to the Medicare pay-  
9 ment cap under section 1833(g) of the Social Secu-  
10 rity Act (42 U.S.C. 1395l(g)) for physical therapy  
11 services and speech-language pathology services, de-  
12 scribed in paragraph (1) of such section and occupa-  
13 tional therapy services described in paragraph (3) of  
14 such section. Such study shall consider, with respect  
15 to payment amounts under Medicare, the following:

16 (A) The creation of multiple payment caps  
17 for such services to better reflect costs associ-  
18 ated with specific health conditions.

19 (B) The development of a prospective pay-  
20 ment system, including an episode-based system  
21 of payments, for such services.

22 (C) The data needed for the development  
23 of a system of multiple payment caps (or an al-  
24 ternative payment methodology) for such serv-  
25 ices and the availability of such data.



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

4 **SEC. 602. MEDICARE SEPARATE DEFINITION OF OUT-**  
5                           **PATIENT SPEECH-LANGUAGE PATHOLOGY**  
6                           **SERVICES.**

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

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

11                  (2) by inserting after paragraph (1) the fol-  
12                  lowing new paragraph:

13                       “(2) The term ‘outpatient speech-language pa-  
14                       thology services’ has the meaning given the term  
15                       ‘outpatient physical therapy services’ in subsection  
16                       (p), except that in applying such subsection—

17                               “(A) ‘speech-language pathology’ shall be  
18                               substituted for ‘physical therapy’ each place it  
19                               appears; and

20                               “(B) ‘speech-language pathologist’ shall be  
21                               substituted for ‘physical therapist’ each place it  
22                               appears.”.

23           (b) CONFORMING AMENDMENTS.—

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

1 (A) by striking “and outpatient” and in-  
2 serting “, outpatient”; and

3 (B) by inserting before the period at the  
4 end the following: “, and outpatient speech-lan-  
5 guage pathology services (other than services to  
6 which the second sentence of section 1861(p)  
7 applies through the application of section  
8 1861(l)(2))”.

9 (2) Subparagraphs (A) and (B) of section  
10 1833(a)(8) of such Act (42 U.S.C. 1395l(a)(8)) are  
11 each amended by striking “(which includes out-  
12 patient speech-language pathology services)” and in-  
13 serting “, outpatient speech-language pathology  
14 services,”.

15 (3) Section 1833(g)(1) of such Act (42 U.S.C.  
16 1395l(g)(1)) is amended—

17 (A) by inserting “and speech-language pa-  
18 thology services of the type described in such  
19 section through the application of section  
20 1861(l)(2)” after “1861(p)”; and

21 (B) by inserting “and speech-language pa-  
22 thology services” after “and physical therapy  
23 services”.

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

1 (A) by striking “section 1861(g)” and in-  
2 serting “subsection (g) or (l)(2) of section  
3 1861” each place it appears; and

4 (B) by inserting “or outpatient speech-lan-  
5 guage pathology services, respectively” after  
6 “occupational therapy services”.

7 (5) Section 1861(p) of such Act (42 U.S.C.  
8 1395x(p)) is amended by striking the fourth sen-  
9 tence.

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

14 (7) Section 1862(a)(20) of such Act (42 U.S.C.  
15 1395y(a)(20)) is amended—

16 (A) by striking “outpatient occupational  
17 therapy services or outpatient physical therapy  
18 services” and inserting “outpatient physical  
19 therapy services, outpatient speech-language pa-  
20 thology services, or outpatient occupational  
21 therapy services”; and

22 (B) by striking “section 1861(g)” and in-  
23 serting “subsection (g) or (l)(2) of section  
24 1861”.

1 (8) Section 1866(e)(1) of such Act (42 U.S.C.  
2 1395cc(e)(1)) is amended—

3 (A) by striking “section 1861(g)” and in-  
4 serting “subsection (g) or (ll)(2) of section  
5 1861” the first two places it appears;

6 (B) by striking “defined) or” and inserting  
7 “defined),”; and

8 (C) by inserting before the semicolon at  
9 the end the following: “, or (through the oper-  
10 ation of section 1861(ll)(2)) with respect to the  
11 furnishing of outpatient speech-language pa-  
12 thology”.

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

16 (d) CONSTRUCTION.—Nothing in this section shall be  
17 construed to affect existing regulations and policies of the  
18 Centers for Medicare & Medicaid Services that require  
19 physician oversight of care as a condition of payment for  
20 speech-language pathology services under part B of the  
21 medicare program.

22 **SEC. 603. INCREASED REIMBURSEMENT RATE FOR CER-**  
23 **TIFIED NURSE-MIDWIVES.**

24 (a) IN GENERAL.—Section 1833(a)(1)(K) of the So-  
25 cial Security Act (42 U.S.C.1395l(a)(1)(K)) is amended

1 by striking “(but in no event” and all that follows through  
2 “performed by a physician”).

3 (b) **EFFECTIVE DATE.**—The amendment made by  
4 subsection (a) shall apply to services furnished on or after  
5 April 1, 2008.

6 **SEC. 604. ADJUSTMENT IN OUTPATIENT HOSPITAL FEE**  
7 **SCHEDULE INCREASE FACTOR.**

8 The first sentence of section 1833(t)(3)(C)(iv) of the  
9 Social Security Act (42 U.S.C. 1395l(t)(3)(C)(iv)) is  
10 amended by inserting before the period at the end the fol-  
11 lowing: “and reduced by 0.25 percentage point for such  
12 factor for such services furnished in 2008”.

13 **SEC. 605. EXCEPTION TO 60-DAY LIMIT ON MEDICARE SUB-**  
14 **STITUTE BILLING ARRANGEMENTS IN CASE**  
15 **OF PHYSICIANS ORDERED TO ACTIVE DUTY**  
16 **IN THE ARMED FORCES.**

17 (a) **IN GENERAL.**—Section 1842(b)(6)(D)(iii) of the  
18 Social Security Act (42 U.S.C. 1395u(b)(6)(D)(iii)) is  
19 amended by inserting after “of more than 60 days” the  
20 following: “or are provided over a longer continuous period  
21 during all of which the first physician has been called or  
22 ordered to active duty as a member of a reserve component  
23 of the Armed Forces”.

1 (b) EFFECTIVE DATE.—The amendment made by  
2 subsection (a) shall apply to services furnished on or after  
3 the date of the enactment of this section.

4 **SEC. 606. EXCLUDING CLINICAL SOCIAL WORKER SERVICES**  
5 **FROM COVERAGE UNDER THE MEDICARE**  
6 **SKILLED NURSING FACILITY PROSPECTIVE**  
7 **PAYMENT SYSTEM AND CONSOLIDATED PAY-**  
8 **MENT.**

9 (a) IN GENERAL.—Section 1888(e)(2)(A)(ii) of the  
10 Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)) is  
11 amended by inserting “clinical social worker services,”  
12 after “qualified psychologist services,”.

13 (b) CONFORMING AMENDMENT.—Section  
14 1861(hh)(2) of the Social Security Act (42 U.S.C.  
15 1395x(hh)(2)) is amended by striking “and other than  
16 services furnished to an inpatient of a skilled nursing facil-  
17 ity which the facility is required to provide as a require-  
18 ment for participation”.

19 (c) EFFECTIVE DATE.—The amendments made by  
20 this section shall apply to items and services furnished on  
21 or after January 1, 2008.

1 **SEC. 607. COVERAGE OF MARRIAGE AND FAMILY THERA-**  
2 **PIST SERVICES AND MENTAL HEALTH COUN-**  
3 **SELOR SERVICES.**

4 (a) COVERAGE OF MARRIAGE AND FAMILY THERA-  
5 PIST SERVICES.—

6 (1) COVERAGE OF SERVICES.—Section  
7 1861(s)(2) of the Social Security Act (42 U.S.C.  
8 1395x(s)(2)) is amended—

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

11 (B) in subparagraph (AA), by adding  
12 “and” at the end; and

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

15 “(BB) marriage and family therapist services  
16 (as defined in subsection (ccc));”.

17 (2) DEFINITION.—Section 1861 of the Social  
18 Security Act (42 U.S.C. 1395x) is amended by add-  
19 ing at the end the following new subsection:

20 “(ccc) MARRIAGE AND FAMILY THERAPIST SERV-  
21 ICES.—(1) The term ‘marriage and family therapist serv-  
22 ices’ means services performed by a marriage and family  
23 therapist (as defined in paragraph (2)) for the diagnosis  
24 and treatment of mental illnesses, which the marriage and  
25 family therapist is legally authorized to perform under  
26 State law (or the State regulatory mechanism provided by

1 State law) of the State in which such services are per-  
2 formed, provided such services are covered under this title,  
3 as would otherwise be covered if furnished by a physician  
4 or as incident to a physician's professional service, but  
5 only if no facility or other provider charges or is paid any  
6 amounts with respect to the furnishing of such services.

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

9 “(A) possesses a master's or doctoral degree  
10 which qualifies for licensure or certification as a  
11 marriage and family therapist pursuant to State  
12 law;

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

16 “(C) is licensed or certified as a marriage and  
17 family therapist in the State in which marriage and  
18 family therapist services are performed.”.

19 (3) PROVISION FOR PAYMENT UNDER PART  
20 b.—Section 1832(a)(2)(B) of the Social Security Act  
21 (42 U.S.C. 1395k(a)(2)(B)) is amended by adding  
22 at the end the following new clause:

23 “(v) marriage and family therapist  
24 services;”.

25 (4) AMOUNT OF PAYMENT.—



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

4 (i) by striking “and” before “(V)”;  
5 and

6 (ii) by inserting before the semicolon  
7 at the end the following: “, and (W) with  
8 respect to marriage and family therapist  
9 services under section 1861(s)(2)(BB), the  
10 amounts paid shall be 80 percent of the  
11 lesser of (i) the actual charge for the serv-  
12 ices or (ii) 75 percent of the amount deter-  
13 mined for payment of a psychologist under  
14 subparagraph (L)”.

15 (B) DEVELOPMENT OF CRITERIA WITH RE-  
16 SPECT TO CONSULTATION WITH A PHYSICIAN.—  
17 The Secretary of Health and Human Services  
18 shall, taking into consideration concerns for pa-  
19 tient confidentiality, develop criteria with re-  
20 spect to payment for marriage and family ther-  
21 apist services for which payment may be made  
22 directly to the marriage and family therapist  
23 under part B of title XVIII of the Social Secu-  
24 rity Act (42 U.S.C. 1395j et seq.) under which  
25 such a therapist must agree to consult with a

1 patient's attending or primary care physician in  
2 accordance with such criteria.

3 (5) EXCLUSION OF MARRIAGE AND FAMILY  
4 THERAPIST SERVICES FROM SKILLED NURSING FA-  
5 CILITY PROSPECTIVE PAYMENT SYSTEM.—Section  
6 1888(e)(2)(A)(ii) of the Social Security Act (42  
7 U.S.C. 1395yy(e)(2)(A)(ii)), is amended by inserting  
8 “marriage and family therapist services (as defined  
9 in subsection (ccc)(1)),” after “qualified psychologist  
10 services,”.

11 (6) COVERAGE OF MARRIAGE AND FAMILY  
12 THERAPIST SERVICES PROVIDED IN RURAL HEALTH  
13 CLINICS AND FEDERALLY QUALIFIED HEALTH CEN-  
14 TERS.—Section 1861(aa)(1)(B) of the Social Secu-  
15 rity Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by  
16 striking “or by a clinical social worker (as defined  
17 in subsection (hh)(1)),” and inserting “, by a clinical  
18 social worker (as defined in subsection (hh)(1)), or  
19 by a marriage and family therapist (as defined in  
20 subsection (ccc)(2)),”.

21 (7) INCLUSION OF MARRIAGE AND FAMILY  
22 THERAPISTS AS PRACTITIONERS FOR ASSIGNMENT  
23 OF CLAIMS.—Section 1842(b)(18)(C) of the Social  
24 Security Act (42 U.S.C. 1395u(b)(18)(C)) is amend-  
25 ed by adding at the end the following new clause:

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

3           (b) COVERAGE OF MENTAL HEALTH COUNSELOR  
4 SERVICES.—

5           (1) COVERAGE OF SERVICES.—Section  
6           1861(s)(2) of the Social Security Act (42 U.S.C.  
7           1395x(s)(2)), as amended in subsection (a)(1), is  
8           further amended—

9                   (A) in subparagraph (AA), by striking  
10           “and” at the end;

11                   (B) in subparagraph (BB), by inserting  
12           “and” at the end; and

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

15                   “(CC) mental health counselor services (as  
16           defined in subsection (ddd)(2));”.

17           (2) DEFINITION.—Section 1861 of the Social  
18           Security Act (42 U.S.C. 1395x), as amended by sub-  
19           section (a)(2), is further amended by adding at the  
20           end the following new subsection:

21           “(ddd) MENTAL HEALTH COUNSELOR; MENTAL  
22 HEALTH COUNSELOR SERVICES.—(1) The term ‘mental  
23 health counselor’ means an individual who—

24                   “(A) possesses a master’s or doctor’s degree  
25           which qualifies the individual for licensure or certifi-

1 cation for the practice of mental health counseling in  
2 the State in which the services are performed;

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

6 “(C) is licensed or certified as a mental health  
7 counselor or professional counselor by the State in  
8 which the services are performed.

9 “(2) The term ‘mental health counselor services’  
10 means services performed by a mental health counselor (as  
11 defined in paragraph (1)) for the diagnosis and treatment  
12 of mental illnesses which the mental health counselor is  
13 legally authorized to perform under State law (or the  
14 State regulatory mechanism provided by the State law) of  
15 the State in which such services are performed, provided  
16 such services are covered under this title, as would other-  
17 wise be covered if furnished by a physician or as incident  
18 to a physician’s professional service, but only if no facility  
19 or other provider charges or is paid any amounts with re-  
20 spect to the furnishing of such services.”.

21 (3) PROVISION FOR PAYMENT UNDER PART  
22 b.—Section 1832(a)(2)(B) of the Social Security Act  
23 (42 U.S.C. 1395k(a)(2)(B)), as amended by sub-  
24 section (a)(3), is further amended by adding at the  
25 end the following new clause:

1                   “(vi) mental health counselor serv-  
2                   ices;”.

3                   (4) AMOUNT OF PAYMENT.—

4                   (A) IN GENERAL.—Section 1833(a)(1) of  
5                   the Social Security Act (42 U.S.C.  
6                   1395l(a)(1)), as amended by subsection (a)(4),  
7                   is further amended—

8                   (i) by striking “and” before “(W)”;  
9                   and

10                   (ii) by inserting before the semicolon  
11                   at the end the following: “, and (X) with  
12                   respect to mental health counselor services  
13                   under section 1861(s)(2)(CC), the amounts  
14                   paid shall be 80 percent of the lesser of (i)  
15                   the actual charge for the services or (ii) 75  
16                   percent of the amount determined for pay-  
17                   ment of a psychologist under subparagraph  
18                   (L)”.

19                   (B) DEVELOPMENT OF CRITERIA WITH RE-  
20                   SPECT TO CONSULTATION WITH A PHYSICIAN.—

21                   The Secretary of Health and Human Services  
22                   shall, taking into consideration concerns for pa-  
23                   tient confidentiality, develop criteria with re-  
24                   spect to payment for mental health counselor  
25                   services for which payment may be made di-

1           rectly to the mental health counselor under part  
2           B of title XVIII of the Social Security Act (42  
3           U.S.C. 1395j et seq.) under which such a coun-  
4           selor must agree to consult with a patient’s at-  
5           tending or primary care physician in accordance  
6           with such criteria.

7           (5) EXCLUSION OF MENTAL HEALTH COUN-  
8           SELOR SERVICES FROM SKILLED NURSING FACILITY  
9           PROSPECTIVE PAYMENT SYSTEM.—Section  
10          1888(e)(2)(A)(ii) of the Social Security Act (42  
11          U.S.C. 1395yy(e)(2)(A)(ii)), as amended by sub-  
12          section (a)(5), is amended by inserting “mental  
13          health counselor services (as defined in section  
14          1861(ddd)(2)),” after “marriage and family thera-  
15          apist services (as defined in subsection (ccc)(1)),”.

16          (6) COVERAGE OF MENTAL HEALTH COUN-  
17          SELOR SERVICES PROVIDED IN RURAL HEALTH  
18          CLINICS AND FEDERALLY QUALIFIED HEALTH CEN-  
19          TERS.—Section 1861(aa)(1)(B) of the Social Secu-  
20          rity Act (42 U.S.C. 1395x(aa)(1)(B)), as amended  
21          by subsection (a)(6), is amended by striking “or by  
22          a marriage and family therapist (as defined in sub-  
23          section (ccc)(2)),” and inserting “by a marriage and  
24          family therapist (as defined in subsection (ccc)(2)),

1 or a mental health counselor (as defined in sub-  
2 section (ddd)(1)),”.

3 (7) INCLUSION OF MENTAL HEALTH COUN-  
4 SELORS AS PRACTITIONERS FOR ASSIGNMENT OF  
5 CLAIMS.—Section 1842(b)(18)(C) of the Social Se-  
6 curity Act (42 U.S.C. 1395u(b)(18)(C)), as amended  
7 by subsection (a)(7), is amended by adding at the  
8 end the following new clause:

9 “(viii) A mental health counselor (as defined in  
10 section 1861(fff)(1)).”.

11 (c) EFFECTIVE DATE.—The amendments made by  
12 this section shall apply to items and services furnished on  
13 or after January 1, 2008.

14 **SEC. 608. RENTAL AND PURCHASE OF POWER-DRIVEN**  
15 **WHEELCHAIRS.**

16 (a) IN GENERAL.—Section 1834(a)(7) of the Social  
17 Security Act (42 U.S.C. 1395m(a)(7)) is amended—

18 (1) in subparagraph (A)—

19 (A) clause (i)(I), by striking “Except as  
20 provided in clause (iii), payment” and inserting  
21 “Payment”;

22 (B) by striking clause (iii); and

23 (C) in clause (iv)—

24 (i) by redesignating such clause as  
25 clause (iii); and

1 (ii) by striking “or in the case of a  
2 power-driven wheelchair for which a pur-  
3 chase agreement has been entered into  
4 under clause (iii)”;

5 (2) in subparagraph (C)(ii)(II), by striking “or  
6 (A)(iii)”.

7 (b) EFFECTIVE DATE.—

8 (1) IN GENERAL.—Subject to paragraph (1),  
9 the amendments made by subsection (a) shall take  
10 effect on January 1, 2008, and shall apply to power-  
11 driven wheelchairs furnished on or after such date.

12 (2) APPLICATION TO COMPETITIVE ACQUISI-  
13 TION.—The amendments made by subsection (a)  
14 shall not apply to contracts entered into under sec-  
15 tion 1847 of the Social Security Act (42 U.S.C.  
16 1395w-3) pursuant to a bid submitted under such  
17 section before July 21, 2007.

18 **SEC. 609. RENTAL AND PURCHASE OF OXYGEN EQUIPMENT.**

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

22 (1) in clause (i)—

23 (A) by striking “Payment” and inserting  
24 “Subject to clause (iii), payment”; and



1 (B) by striking “36 months” and inserting  
2 “13 months”;

3 (2) in clause (ii)(I), by striking “36th contin-  
4 uous month” and inserting “13th continuous  
5 month”; and

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

8 “(iii) SPECIAL RULE FOR OXYGEN  
9 GENERATING PORTABLE EQUIPMENT.—In  
10 the case of oxygen generating portable  
11 equipment referred to in the final rule pub-  
12 lished in the Federal Register on Novem-  
13 ber 9, 2006 (71 Fed. Reg. 65897–65899),  
14 in applying clauses (i) and (ii)(I) each ref-  
15 erence to ‘13 months’ is deemed a ref-  
16 erence to ‘36 months’.”.

17 (b) EFFECTIVE DATE.—

18 (1) IN GENERAL.—Subject to paragraph (3),  
19 the amendments made by subsection (a) shall apply  
20 to oxygen equipment furnished on or after January  
21 1, 2008.

22 (2) TRANSITION.—In the case of an individual  
23 receiving oxygen equipment on December 31, 2007,  
24 for which payment is made under section 1834(a) of  
25 the Social Security Act (42 U.S.C. 1395m(a)), the

1 13-month period described in paragraph (5)(F)(i) of  
2 such section, as amended by subsection (a), shall  
3 begin on January 1, 2008, but in no case shall the  
4 rental period for such equipment exceed 36 months.

5 (3) APPLICATION TO COMPETITIVE ACQUISITION.—The amendments made by subsection (a)  
6 shall not apply to contracts entered into under section 1847 of the Social Security Act (42 U.S.C.  
7 1395w-3) pursuant to a bid submitted under such  
8 section before July 21, 2007.  
9

10  
11 (c) STUDY AND REPORT.—

12 (1) STUDY.—The Secretary of Health and  
13 Human Services shall conduct a study to examine  
14 the service component and the equipment component  
15 of the provision of oxygen to Medicare beneficiaries.  
16 The study shall assess—

17 (A) the type of services provided and variation across suppliers in providing such services;  
18  
19

20 (B) whether the services are medically necessary or affect patient outcomes;  
21

22 (C) whether the Medicare program pays appropriately for equipment in connection with  
23 the provision of oxygen;  
24

1 (D) whether such program pays appro-  
2 priately for necessary services;

3 (E) whether such payment in connection  
4 with the provision of oxygen should be divided  
5 between equipment and services, and if so, how;  
6 and

7 (F) how such payment rate compares to a  
8 competitively bid rate.

9 (2) REPORT.—Not later than 18 months after  
10 the date of the enactment of this Act, the Secretary  
11 of Health and Human Services shall submit to Con-  
12 gress a report on the study conducted under para-  
13 graph (1).

14 **SEC. 610. ADJUSTMENT FOR MEDICARE MENTAL HEALTH**  
15 **SERVICES.**

16 (a) IN GENERAL.—For purposes of payment for serv-  
17 ices furnished under the physician fee schedule under sec-  
18 tion 1848 of the Social Security Act (42 U.S.C. 1395w-  
19 4) during the applicable period, the Secretary of Health  
20 and Human Services shall increase the amount otherwise  
21 payable for applicable services by 5 percent.

22 (b) DEFINITIONS.—For purposes of subsection (a):

23 (1) APPLICABLE PERIOD.—The term “applica-  
24 ble period” means the period beginning on January  
25 1, 2008, and ending on December 31 of the year be-

1       fore the effective date of the first review after Janu-  
2       ary 1, 2008, of work relative value units conducted  
3       under section 1848(c)(2)(B)(i) of the Social Security  
4       Act.

5           (2) APPLICABLE SERVICES.—The term “appli-  
6       cable services” means procedure codes for services—

7           (A) in the categories of psychiatric thera-  
8       peutic procedures furnished in office or other  
9       outpatient facility settings, or inpatient hos-  
10      pital, partial hospital or residential care facility  
11      settings; and

12          (B) which cover insight oriented, behavior  
13      modifying, or supportive psychotherapy and  
14      interactive psychotherapy services in the  
15      Healthcare Common Procedure Coding System  
16      established by the Secretary of Health and  
17      Human Services under section 1848(c)(5) of  
18      such Act.

19          (c) IMPLEMENTATION.—Notwithstanding any other  
20      provision of law, the Secretary of Health and Human  
21      Services may implement this section by program instruc-  
22      tion or otherwise.

1 **SEC. 611. EXTENSION OF BRACHYTHERAPY SPECIAL RULE.**

2 Section 1833(t)(16)(C) of the Social Security Act (42  
3 U.S.C. 1395l(t)(16)(C)) is amended by striking “2008”  
4 and inserting “2009”.

5 **SEC. 612. PAYMENT FOR PART B DRUGS.**

6 (a) APPLICATION OF CONSISTENT VOLUME  
7 WEIGHTING IN COMPUTATION OF ASP.—In order to as-  
8 sure that payments for drugs and biologicals under section  
9 1847A of the Social Security Act (42 U.S.C. 1395w-3a)  
10 are correct and consistent with law, the Secretary of  
11 Health and Human Services shall, for payment for drugs  
12 and biologicals furnished on or after July 1, 2008, com-  
13 pute the volume-weighted average sales price using equa-  
14 tion #2 (specified in appendix A of the report of the In-  
15 spector General of the Department of Health and Human  
16 Services on “Calculation of Volume-Weighted Average  
17 Sales Price for Medicare Part B Prescription Drugs”  
18 (February 2006; OEI-03-05-00310)) used by the Office  
19 of Inspector General to calculate a volume-weighted ASP.

20 (b) IMPROVEMENTS IN THE COMPETITIVE ACQUISI-  
21 TION PROGRAM (CAP).—

22 (1) CONTINUOUS OPEN ENROLLMENT; AUTO-  
23 MATIC REENROLLMENT WITHOUT NEED FOR RE-  
24 APPLICATION.—Subsection (a)(1)(A) of section  
25 1847B of the Social Security Act (42 U.S.C. 1395w-  
26 3b) is amended—

1 (A) in clause (ii), by striking “annually”  
2 and inserting “on an ongoing basis”;

3 (B) in clause (iii), by striking “an annual  
4 selection” and inserting “a selection (which  
5 may be changed on an annual basis)” ; and

6 (C) by adding at the end the following:  
7 “An election and selection described in clauses  
8 (ii) and (iii) shall continue to be effective with-  
9 out the need for any periodic reelection or re-  
10 application or selection.”.

11 (2) PERMITTING VENDER TO DELIVER DRUGS  
12 TO SITE OF ADMINISTRATION.—Subsection (b)(4)(E)  
13 of such section is amended—

14 (A) by striking “or” at the end of clause  
15 (I);

16 (B) by striking the period at the end of  
17 clause (ii) and inserting “; or”; and

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

20 “(iii) prevent a contractor from deliv-  
21 ering drugs and biologicals to the site in  
22 which the drugs or biologicals will be ad-  
23 ministered.”.

1           (3) PHYSICIAN OUTREACH AND EDUCATION.—  
2           Subsection (a)(1) of such section is amended by add-  
3           ing at the end the following new subparagraph:

4                   “(E) PHYSICIAN OUTREACH AND EDU-  
5                   CATION.—The Secretary shall conduct a pro-  
6                   gram of outreach to education physicians con-  
7                   cerning the program and the ongoing oppor-  
8                   tunity of physicians to elect to obtain drugs and  
9                   biologicals under the program.”.

10           (4) REBIDDING OF CONTRACTS.—The Secretary  
11           of Health and Human Services shall provide for the  
12           rebidding of contracts under section 1847B(c) of the  
13           Social Security Act (42 U.S.C. 1395w-3b(c)) only  
14           for periods on or after the expiration of the contract  
15           in effect under such section as of the date of the en-  
16           actment of this Act.

17           (c) TREATMENT OF CERTAIN DRUGS.—Section  
18           1847A(b) of the Social Security Act (42 U.S.C. 1395w-  
19           3a(b)) is amended—

20                   (1) in paragraph (1), by inserting “paragraph  
21                   (6) and” after “Subject to”; and

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

24                   “(6) SPECIAL RULE.—In applying subsection  
25                   (c)(6)(C)(ii), beginning with January 1, 2008, the

1 average sales price for drugs or biologicals described  
2 in section 1842(o)(1)(G) is the lower of the average  
3 sales price calculated including drugs or biologicals  
4 to which such subsection applies and the average  
5 sales price that would have been calculated if such  
6 subsection were not applied.”.

7 (d) EFFECTIVE DATE.—Except as otherwise pro-  
8 vided, the amendments made by this section shall apply  
9 to drugs furnished on or after January 1, 2008.

## 10 **Subtitle B—Extension of Medicare** 11 **Rural Access Protections**

### 12 **SEC. 621. 2-YEAR EXTENSION OF FLOOR ON MEDICARE** 13 **WORK GEOGRAPHIC ADJUSTMENT.**

14 Section 1848(e)(1)(E) of such Act (42 U.S.C.  
15 1395w-4(e)(1)(E)) is amended by striking “2008” and in-  
16 serting “2010”.

### 17 **SEC. 622. 2-YEAR EXTENSION OF SPECIAL TREATMENT OF** 18 **CERTAIN PHYSICIAN PATHOLOGY SERVICES** 19 **UNDER MEDICARE.**

20 Section 542(c) of the Medicare, Medicaid, and  
21 SCHIP Benefits Improvement and Protection Act of  
22 2000, as amended by section 732 of the Medicare Pre-  
23 scription Drug, Improvement, and Modernization Act of  
24 2003, and section 104 of the Medicare Improvements and  
25 Extension Act of 2006 (division B of Public Law 109–



1 432), is amended by striking “and 2007” and inserting  
2 “2007, 2008, and 2009”.

3 **SEC. 623. 2-YEAR EXTENSION OF MEDICARE REASONABLE**  
4 **COSTS PAYMENTS FOR CERTAIN CLINICAL**  
5 **DIAGNOSTIC LABORATORY TESTS FUR-**  
6 **NISHED TO HOSPITAL PATIENTS IN CERTAIN**  
7 **RURAL AREAS.**

8 Section 416(b) of the Medicare Prescription Drug,  
9 Improvement, and Modernization Act of 2003 (Public Law  
10 108–173; 117 Stat. 2282; 42 U.S.C. 1395l–4(b)), as  
11 amended by section 105 of the Medicare Improvement and  
12 Extension Act of 2006 (division B of Public Law 109–  
13 432), is amended by striking “3-year” and inserting “5-  
14 year”.

15 **SEC. 624. 2-YEAR EXTENSION OF MEDICARE INCENTIVE**  
16 **PAYMENT PROGRAM FOR PHYSICIAN SCAR-**  
17 **CITY AREAS .**

18 (a) IN GENERAL.—Section 1833(u)(1) of the Social  
19 Security Act (42 U.S.C. 1395l(u)(1)) is amended by strik-  
20 ing “2008” and inserting “2010”.

21 (b) TRANSITION.—With respect to physicians’ serv-  
22 ices furnished during 2008 and 2009, for purposes of sub-  
23 section (a), the Secretary of Health and Human Services  
24 shall use the primary care scarcity areas and the specialty  
25 care scarcity areas (as identified in section 1833(u)(4))

1 that the Secretary was using under such subsection with  
2 respect to physicians' services furnished on December 31,  
3 2007.

4 **SEC. 625. 2-YEAR EXTENSION OF MEDICARE INCREASE PAY-**  
5 **MENTS FOR GROUND AMBULANCE SERVICES**  
6 **IN RURAL AREAS.**

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

9 (1) in subparagraph (A)—

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

13 (B) in clause (i), by inserting “for services  
14 furnished on or after July 1, 2004, and before  
15 January 1, 2007, and on or after January 1,  
16 2008, and before January 1, 2010,” after “in  
17 such paragraph,”; and

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

21 (2) in subparagraph (B)—

22 (A) in the heading, by striking “AFTER  
23 2006” and inserting “FOR SUBSEQUENT PERI-  
24 ODS”;

1 (B) by inserting “clauses (i) and (ii) of”  
2 before “subparagraph (A)”; and  
3 (C) by striking “in such subparagraph”  
4 and inserting “in the respective clause”.

5 **SEC. 626. EXTENDING HOLD HARMLESS FOR SMALL RURAL**  
6 **HOSPITALS UNDER THE HOPD PROSPECTIVE**  
7 **PAYMENT SYSTEM.**

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

10 (1) by striking “January 1, 2009” and insert-  
11 ing “January 1, 2010”;

12 (2) by striking “2007, or 2008,”; and

13 (3) by striking “90 percent, and 85 percent, re-  
14 spectively,” and inserting “, and with respect to  
15 such services furnished after 2006 the applicable  
16 percentage shall be 90 percent.”.

17 **Subtitle C—End Stage Renal**  
18 **Disease Program**

19 **SEC. 631. CHRONIC KIDNEY DISEASE DEMONSTRATION**  
20 **PROJECTS.**

21 (a) IN GENERAL.—The Secretary of Health and  
22 Human Services (in this section referred to as the “Sec-  
23 retary”), acting through the Director of the National In-  
24 stitutes of Health, shall establish demonstration projects  
25 to—

1           (1) increase public and medical community  
2 awareness (particularly of those who treat patients  
3 with diabetes and hypertension) about the factors  
4 that lead to chronic kidney disease, how to prevent  
5 it, how to diagnose it, and how to treat it;

6           (2) increase screening and use of prevention  
7 techniques for chronic kidney disease for Medicare  
8 beneficiaries and the general public (particularly  
9 among patients with diabetes and hypertension,  
10 where prevention techniques are well established and  
11 early detection makes prevention possible); and

12           (3) enhance surveillance systems and expand re-  
13 search to better assess the prevalence and incidence  
14 of chronic kidney disease, (building on work done by  
15 Centers for Disease Control and Prevention).

16 (b) SCOPE AND DURATION.—

17           (1) SCOPE.—The Secretary shall select at least  
18 3 States in which to conduct demonstration projects  
19 under this section. In selecting the States under this  
20 paragraph, the Secretary shall take into account the  
21 size of the population of individuals with end-stage  
22 renal disease who are enrolled in part B of title  
23 XVIII of the Social Security Act and ensure the par-  
24 ticipation of individuals who reside in rural and  
25 urban areas.

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

5 (c) EVALUATION AND REPORT.—

6           (1) EVALUATION.—The Secretary shall conduct  
7 an evaluation of the demonstration projects con-  
8 ducted under this section.

9           (2) REPORT.—Not later than 12 months after  
10 the date on which the demonstration projects under  
11 this section are completed, the Secretary shall sub-  
12 mit to Congress a report on the evaluation con-  
13 ducted under paragraph (1) together with rec-  
14 ommendations for such legislation and administra-  
15 tive action as the Secretary determines appropriate.

16 **SEC. 632. MEDICARE COVERAGE OF KIDNEY DISEASE PA-**  
17 **TIENT EDUCATION SERVICES.**

18 (a) COVERAGE OF KIDNEY DISEASE EDUCATION  
19 SERVICES.—

20           (1) COVERAGE.—Section 1861(s)(2) of the So-  
21 cial Security Act (42 U.S.C. 1395x(s)(2)) is amend-  
22 ed—

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

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

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

5 “(BB) kidney disease education services  
6 (as defined in subsection (ccc));”.

7 (2) SERVICES DESCRIBED.—Section 1861 of  
8 the Social Security Act (42 U.S.C. 1395x) is amend-  
9 ed by adding at the end the following new sub-  
10 section:

11 “Kidney Disease Education Services

12 “(ccc)(1) The term ‘kidney disease education serv-  
13 ices’ means educational services that are—

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

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

21 “(C) designed—

22 “(i) to provide comprehensive information  
23 (consistent with the standards developed under  
24 paragraph (3)) regarding—

1                   “(I) the management of comorbidities,  
2                   including for purposes of delaying the need  
3                   for dialysis;

4                   “(II) the prevention of uremic com-  
5                   plications; and

6                   “(III) each option for renal replace-  
7                   ment therapy (including hemodialysis and  
8                   peritoneal dialysis at home and in-center  
9                   as well as vascular access options and  
10                  transplantation);

11                  “(ii) to ensure that the individual has the  
12                  opportunity to actively participate in the choice  
13                  of therapy; and

14                  “(iii) to be tailored to meet the needs of  
15                  the individual involved.

16                  “(2) The term ‘qualified person’ means a physician,  
17                  physician assistant, nurse practitioner, or clinical nurse  
18                  specialist who furnishes services for which payment may  
19                  be made under the fee schedule established under section  
20                  1848. Such term does not include a renal dialysis facility.

21                  “(3) The Secretary shall set standards for the con-  
22                  tent of such information to be provided under paragraph  
23                  (1)(C)(i) after consulting with physicians, other health  
24                  professionals, health educators, professional organizations,  
25                  accrediting organizations, kidney patient organizations, di-

1 dialysis facilities, transplant centers, network organizations  
2 described in section 1881(c)(2), and other knowledgeable  
3 persons. To the extent possible the Secretary shall consult  
4 with a person or entity described in the previous sentence,  
5 other than a dialysis facility, that has not received indus-  
6 try funding from a drug or biological manufacturer or di-  
7 alysis facility.

8       “(4) In promulgating regulations to carry out this  
9 subsection, the Secretary shall ensure that each individual  
10 who is eligible for benefits for kidney disease education  
11 services under this title receives such services in a timely  
12 manner to maximize the benefit of those services.

13       “(5) The Secretary shall monitor the implementation  
14 of this subsection to ensure that individuals who are eligi-  
15 ble for benefits for kidney disease education services re-  
16 ceive such services in the manner described in paragraph  
17 (4).

18       “(6) No individual shall be eligible to be provided  
19 more than 6 sessions of kidney disease education services  
20 under this title.”.

21               (3) PAYMENT UNDER THE PHYSICIAN FEE  
22 SCHEDULE.—Section 1848(j)(3) of the Social Secu-  
23 rity Act (42 U.S.C. 1395w-4(j)(3)) is amended by  
24 inserting “(2)(BB),” after “(2)(AA),”.



1           (4) LIMITATION ON NUMBER OF SESSIONS.—  
2           Section 1862(a)(1) of the Social Security Act (42  
3           U.S.C. 1395y(a)(1)) is amended—

4                   (A) in subparagraph (M), by striking  
5                   “and” at the end;

6                   (B) in subparagraph (N), by striking the  
7                   semicolon at the end and inserting “, and”; and

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

10                   “(O) in the case of kidney disease edu-  
11                   cation services (as defined in section  
12                   1861(ccc)), which are furnished in excess of the  
13                   number of sessions covered under such sec-  
14                   tion;”.

15           (5) GAO REPORT.—Not later than September  
16           1, 2010, the Comptroller General of the United  
17           States shall submit to Congress a report on the fol-  
18           lowing:

19                   (A) The number of Medicare beneficiaries  
20                   who are eligible to receive benefits for kidney  
21                   disease education services (as defined in section  
22                   1861(ccc) of the Social Security Act, as added  
23                   by paragraph (2)) under title XVIII of such Act  
24                   and who receive such services.

1           (B) The extent to which there is a suffi-  
2           cient amount of physicians, physician assist-  
3           ants, nurse practitioners, and clinical nurse spe-  
4           cialists to furnish kidney disease education serv-  
5           ices (as so defined) under such title and wheth-  
6           er or not renal dialysis facilities (and appro-  
7           priate employees of such facilities) should be in-  
8           cluded as an entity eligible under such section  
9           to furnish such services.

10           (C) Recommendations, if appropriate, for  
11           renal dialysis facilities (and appropriate employ-  
12           ees of such facilities) to structure kidney dis-  
13           ease education services (as so defined) in a  
14           manner that is objective and unbiased and that  
15           provides a range of options and alternative loca-  
16           tions for renal replacement therapy and man-  
17           agement of co-morbidities that may delay the  
18           need for dialysis.

19           (b) EFFECTIVE DATE.—The amendments made by  
20           this section shall apply to services furnished on or after  
21           January 1, 2009.

1 **SEC. 633. REQUIRED TRAINING FOR PATIENT CARE DIALY-**  
2 **SIS TECHNICIANS.**

3 Section 1881 of the Social Security Act (42 U.S.C.  
4 1395rr) is amended by adding the following new sub-  
5 section:

6 “(h)(1) Except as provided in paragraph (2), a pro-  
7 vider of services or a renal dialysis facility may not use,  
8 for more than 12 months during 2009, or for any period  
9 beginning on January 1, 2010, any individual as a patient  
10 care dialysis technician unless the individual—

11 “(A) has completed a training program in the  
12 care and treatment of an individual with chronic  
13 kidney failure who is undergoing dialysis treatment;  
14 and

15 “(B) has been certified by a nationally recog-  
16 nized certification entity for dialysis technicians.

17 “(2)(A) A provider of services or a renal dialysis facil-  
18 ity may permit an individual enrolled in a training pro-  
19 gram described in paragraph (1)(A) to serve as a patient  
20 care dialysis technician while they are so enrolled.

21 “(B) The requirements described in subparagraphs  
22 (A), (B), and (C) of paragraph (1) do not apply to an  
23 individual who has performed dialysis-related services for  
24 at least 5 years.

25 “(3) For purposes of paragraph (1), if, since the most  
26 recent completion by an individual of a training program

1 described in paragraph (1)(A), there has been a period  
2 of 24 consecutive months during which the individual has  
3 not furnished dialysis-related services for monetary com-  
4 pensation, such individual shall be required to complete  
5 a new training program or become recertified as described  
6 in paragraph (1)(B).

7 “(4) A provider of services or a renal dialysis facility  
8 shall provide such regular performance review and regular  
9 in-service education as assures that individuals serving as  
10 patient care dialysis technicians for the provider or facility  
11 are competent to perform dialysis-related services.”.

12 **SEC. 634. MEDPAC REPORT ON TREATMENT MODALITIES**  
13 **FOR PATIENTS WITH KIDNEY FAILURE.**

14 (a) EVALUATION.—

15 (1) IN GENERAL.—Not later than March 1,  
16 2009, the Medicare Payment Advisory Commission  
17 (established under section 1805 of the Social Secu-  
18 rity Act) shall submit to the Secretary and Congress  
19 a report evaluating the barriers that exist to increas-  
20 ing the number of individuals with end-stage renal  
21 disease who elect to receive home dialysis services  
22 under the Medicare program under title XVIII of  
23 the Social Security Act (42 U.S.C. 1395 et seq.).

24 (2) REPORT DETAILS.—The report shall include  
25 the following:

1 (A) A review of Medicare home dialysis  
2 demonstration projects initiated before the date  
3 of the enactment of this Act, and the results of  
4 such demonstration projects and recommenda-  
5 tions for future Medicare home dialysis dem-  
6 onstration projects or Medicare program  
7 changes that will test models that can improve  
8 Medicare beneficiary access to home dialysis.

9 (B) A comparison of current Medicare  
10 home dialysis costs and payments with current  
11 in-center and hospital dialysis costs and pay-  
12 ments.

13 (C) An analysis of the adequacy of Medi-  
14 care reimbursement for patient training for  
15 home dialysis (including hemodialysis and peri-  
16 toneal dialysis) and recommendations for ensur-  
17 ing appropriate payment for such home dialysis  
18 training.

19 (D) A catalogue and evaluation of the in-  
20 centives and disincentives in the current reim-  
21 bursement system that influence whether pa-  
22 tients receive home dialysis services or other  
23 treatment modalities.

1           (E) An evaluation of patient education  
2 services and how such services impact the treat-  
3 ment choices made by patients.

4           (F) Recommendations for implementing in-  
5 centives to encourage patients to elect to receive  
6 home dialysis services or other treatment mo-  
7 dalities under the Medicare program

8           (3) SCOPE OF REVIEW.—In preparing the re-  
9 port under paragraph (1), the Medicare Payment  
10 Advisory Commission shall consider a variety of per-  
11 spectives, including the perspectives of physicians,  
12 other health care professionals, hospitals, dialysis fa-  
13 cilities, health plans, purchasers, and patients.

14 **SEC. 635. ADJUSTMENT FOR ERYTHROPOIETIN STIMU-**  
15 **LATING AGENTS (ESAS).**

16           (a) IN GENERAL.—Subsection (b)(13) of section  
17 1881 of the Social Security Act (42 U.S.C. 1395rr) is  
18 amended—

19           (1) in subparagraph (A)(iii), by striking “For  
20 such drugs” and inserting “Subject to subparagraph  
21 (C), for such drugs”; and

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

24           “(C)(i) The payment amounts under this title for  
25 erythropoietin furnished during 2008 or 2009 to an indi-

1 individual with end stage renal disease by a large dialysis fa-  
2 cility (as defined in subparagraph (D)) (whether to indi-  
3 viduals in the facility or at home), in an amount equal  
4 to \$8.75 per thousand units (rounded to the nearest 100  
5 units) or, if less, 102 percent of the average sales price  
6 (as determined under section 1847A) for such drug or bio-  
7 logical.

8       “(ii) The payment amounts under this title for  
9 darbepoetin alfa furnished during 2008 or 2009 to an in-  
10 dividual with end stage renal disease by a large dialysis  
11 facility (as defined in clause (iii)) (whether to individuals  
12 in the facility or at home), in an amount equal to \$2.92  
13 per microgram or, if less, 102 percent of the average sales  
14 price (as determined under section 1847A) for such drug  
15 or biological.

16       “(iii) For purposes of this subparagraph, the term  
17 ‘large dialysis facility’ means a provider of services or  
18 renal dialysis facility that is owned or managed by a cor-  
19 porate entity that, as of July 24, 2007, owns or manages  
20 300 or more such providers or facilities, and includes a  
21 successor to such a corporate entity”.

22       (b) NO IMPACT ON DRUG ADD-ON PAYMENT.—Noth-  
23 ing in the amendments made by subsection (a) shall be  
24 construed to affect the amount of any payment adjust-

1 ment made under section 1881(b)(12)(B)(ii) of the Social  
2 Security Act (42 U.S.C. 1395rr(b)(12)(B)(ii)).

3 **SEC. 636. SITE NEUTRAL COMPOSITE RATE.**

4 Subsection (b)(12)(A) of section 1881 of the Social  
5 Security Act (42 U.S.C. 1395rr) is amended by adding  
6 at the end the following new sentence: “Under such sys-  
7 tem the payment rate for dialysis services furnished on  
8 or after January 1, 2008, by providers of such services  
9 for hospital-based facilities shall be the same as the pay-  
10 ment rate (computed without regard to this sentence) for  
11 such services furnished by renal dialysis facilities that are  
12 not hospital-based, except that in applying the geographic  
13 index under subparagraph (D) to hospital-based facilities,  
14 the labor share shall be based on the labor share otherwise  
15 applied for such facilities.”.

16 **SEC. 637. DEVELOPMENT OF ESRD BUNDLING SYSTEM AND**  
17 **QUALITY INCENTIVE PAYMENTS.**

18 (a) DEVELOPMENT OF ESRD BUNDLING SYSTEM.—  
19 Subsection (b) of section 1881 of the Social Security Act  
20 (42 U.S.C. 1395rr) is further amended—

21 (1) in paragraph (12)(A), by striking “In lieu  
22 of payment” and inserting “Subject to paragraph  
23 (14), in lieu of payment”;

24 (2) in the second sentence of paragraph  
25 (12)(F)—



1 (A) by inserting “or paragraph (14)” after  
2 “this paragraph”; and

3 (B) by inserting “or under the system  
4 under paragraph (14)” after “subparagraph  
5 (B)”;

6 (3) in paragraph (12)(H)—

7 (A) by inserting “or paragraph (14)” after  
8 “under this paragraph” the first place it ap-  
9 pears; and

10 (B) by inserting before the period at the  
11 end the following: “or, under paragraph (14),  
12 the identification of renal dialysis services in-  
13 cluded in the bundled payment, the adjustment  
14 for outliers, the identification of facilities to  
15 which the phase-in may apply, and the deter-  
16 mination of payment amounts under subpara-  
17 graph (A) under such paragraph, and the appli-  
18 cation of paragraph (13)(C)(iii)”;

19 (4) in paragraph (13)—

20 (A) in subparagraph (A), by striking “The  
21 payment amounts” and inserting “subject to  
22 paragraph (14), the payment amounts”; and

23 (B) in subparagraph (B)—

24 (i) in clause (i), by striking “(i)” after  
25 “(B)” and by inserting “, subject to para-

1 graph (14)” before the period at the end;

2 and

3 (ii) by striking clause (ii); and

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

6 “(14)(A) Subject to subparagraph (E), for services  
7 furnished on or after January 1, 2010, the Secretary shall  
8 implement a payment system under which a single pay-  
9 ment is made under this title for renal dialysis services  
10 (as defined in subparagraph (B)) in lieu of any other pay-  
11 ment (including a payment adjustment under paragraph  
12 (12)(B)(ii)) for such services and items furnished pursu-  
13 ant to paragraph (4). In implementing the system the Sec-  
14 retary shall ensure that the estimated total amount of pay-  
15 ments under this title for 2010 for renal dialysis services  
16 shall equal 96 percent of the estimated amount of pay-  
17 ments for such services, including payments under para-  
18 graph (12)(B)(ii), that would have been made if such sys-  
19 tem had not been implemented.

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

22 “(i) items and services included in the  
23 composite rate for renal dialysis services as of  
24 December 31, 2009;

1           “(ii) erythropoietin stimulating agents fur-  
2           nished to individuals with end stage renal dis-  
3           ease;

4           “(iii) other drugs and biologicals and diag-  
5           nostic laboratory tests, that the Secretary iden-  
6           tifies as commonly used in the treatment of  
7           such patients and for which payment was (be-  
8           fore the application of this paragraph) made  
9           separately under this title, and any oral equiva-  
10          lent form of such drugs and biologicals or of  
11          drugs and biologicals described in clause (ii);  
12          and

13          “(iv) home dialysis training for which pay-  
14          ment was (before the application of this para-  
15          graph) made separately under this section.

16 Such term does not include vaccines.

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

21          “(D) Such system—

22                 “(i) shall include a payment adjustment based  
23                 on case mix that may take into account patient  
24                 weight, body mass index, comorbidities, length of

1 time on dialysis, age, race, ethnicity, and other ap-  
2 propriate 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 erythropoietin stimu-  
7 lating agents necessary for anemia management; and

8 “(iii) may include such other payment adjust-  
9 ments as the Secretary determines appropriate, such  
10 as a payment adjustment—

11 “(I) by a geographic index, such as the  
12 index referred to in paragraph (12)(D), as the  
13 Secretary determines to be appropriate;

14 “(II) for pediatric providers of services and  
15 renal dialysis facilities;

16 “(III) for low volume providers of services  
17 and renal dialysis facilities;

18 “(IV) for providers of services or renal di-  
19 alysis facilities located in rural areas; and

20 “(V) for providers of services or renal di-  
21 alysis facilities that are not large dialysis facili-  
22 ties.

23 “(E) The Secretary may provide for a phase-in of the  
24 payment system described in subparagraph (A) for serv-  
25 ices furnished by a provider of services or renal dialysis

1 facility described in any of subclauses (II) through (V) of  
2 subparagraph (D)(iii), but such payment system shall be  
3 fully implemented for services furnished in the case of any  
4 such provider or facility on or after January 1, 2013.

5 “(F) The Secretary shall apply the annual increase  
6 that would otherwise apply under subparagraph (F) of  
7 paragraph (12) to payment amounts established under  
8 such paragraph (if this paragraph did not apply) in an  
9 appropriate manner under this paragraph.”.

10 (6) PROHIBITION OF UNBUNDLING.—Section  
11 1862(a) of such Act (42 U.S.C. 1395y(a)) is amend-  
12 ed—

13 (A) by striking “or” at the end of para-  
14 graph (21);

15 (B) by striking the period at the end of  
16 paragraph (22) and inserting “; or”; and

17 (C) by inserting after paragraph (22) the  
18 following new paragraph:

19 “(23) where such expenses are for renal dialysis  
20 services (as defined in subparagraph (B) of section  
21 1881(b)(14)) for which payment is made under such  
22 section (other than under subparagraph (E) of such  
23 section) unless such payment is made under such  
24 section to a provider of services or a renal dialysis  
25 facility for such services.”.

1           (b) QUALITY INCENTIVE PAYMENTS.—Section 1881  
2 of such Act is amended by adding at the end the following  
3 new subsection:

4           “(i) QUALITY INCENTIVE PAYMENTS IN THE END-  
5 STAGE RENAL DISEASE PROGRAM.—

6                   “(1) QUALITY INCENTIVE PAYMENTS FOR  
7 SERVICES FURNISHED IN 2008, 2009, AND 2010.—

8                           “(A) IN GENERAL.—With respect to renal  
9 dialysis services furnished during a performance  
10 period (as defined in subparagraph (B)) by a  
11 provider of services or renal dialysis facility that  
12 the Secretary determines meets the applicable  
13 performance standard for the period under sub-  
14 paragraph (C) and reports on measures for  
15 2009 and 2010 under subparagraph (D) for  
16 such services, in addition to the amount other-  
17 wise paid under this section, subject to sub-  
18 paragraph (G), there also shall be paid to the  
19 provider or facility an amount equal to the ap-  
20 plicable percentage (specified in subparagraph  
21 (E) for the period) of the Secretary’s estimate  
22 (based on claims submitted not later than two  
23 months after the end of the performance pe-  
24 riod) of the amount specified in subparagraph  
25 (F) for such period.

1           “(B) PERFORMANCE PERIOD.—In this  
2 paragraph, the term ‘performance period’  
3 means each of the following:

4           “(i) The period beginning on July 1,  
5 2008, and ending on December 31, 2008.

6           “(ii) 2009.

7           “(iii) 2010.

8           “(C) PERFORMANCE STANDARD.—

9           “(i) 2008.—For the performance pe-  
10 riod occurring in 2008, the applicable per-  
11 formance standards for a provider or facil-  
12 ity under this subparagraph are—

13           “(I) 92 percent or more of indi-  
14 viduals with end stage renal disease  
15 receiving erythropoetin stimulating  
16 agents who have an average hemato-  
17 crit of 33.0 percent or more; and

18           “(II) less than a percentage,  
19 specified by the Secretary, of individ-  
20 uals with end stage renal disease re-  
21 ceiving erythropoetin stimulating  
22 agents who have an average hemato-  
23 crit of 39.0 percent or more.

24           “(ii) 2009 AND 2010.—For the 2009  
25 and 2010 performance periods, the appli-

1 cable performance standard for a provider  
2 or facility under this subparagraph is suc-  
3 cessful performance (relative to national  
4 average) on—

5 “(I) such measures of anemia  
6 management as the Secretary shall  
7 specify, including measures of hemo-  
8 globin levels or hematocrit levels for  
9 erythropoietin stimulating agents that  
10 are consistent with the labeling for  
11 dosage of erythropoietin stimulating  
12 agents approved by the Food and  
13 Drug Administration for treatment of  
14 anemia in patients with end stage  
15 renal disease, taking into account  
16 variations in hemoglobin ranges or  
17 hematocrit levels of patients; and

18 “(II) such other measures, relat-  
19 ing to subjects described in subpara-  
20 graph (D)(i), as the Secretary may  
21 specify.

22 “(D) REPORTING PERFORMANCE MEAS-  
23 URES.—The performance measures under this  
24 subparagraph to be reported shall include—



1           “(i) such measures as the Secretary  
2           specifies, before the beginning of the per-  
3           formance period involved and taking into  
4           account measures endorsed by the Na-  
5           tional Quality Forum, including, to the ex-  
6           tent feasible measures on—

7                       “(I) iron management;

8                       “(II) dialysis adequacy; and

9                       “(III) vascular access, including  
10           for maximizing the placement of arte-  
11           rial venous fistula; and

12                      “(ii) to the extent feasible, such meas-  
13           ure (or measures) of patient satisfaction as  
14           the Secretary shall specify.

15           The provider or facility submitting information  
16           on such measures shall attest to the complete-  
17           ness and accuracy of such information.

18                      “(E) APPLICABLE PERCENTAGE.—The ap-  
19           plicable percentage specified in this subpara-  
20           graph for—

21                      “(i) the performance period occurring  
22           in 2008, is 1.0 percent;

23                      “(ii) the 2009 performance period, is  
24           2.0 percent; and

1                   “(iii) the 2010 performance period, is  
2                   2.0 percent.

3                   In the case of any performance period which is  
4                   less than an entire year, the applicable percent-  
5                   age specified in this subparagraph shall be mul-  
6                   tiplied by the ratio of the number of months in  
7                   the year to the number of months in such per-  
8                   formance period. In the case of 2010, the appli-  
9                   cable percentage specified in this subparagraph  
10                  shall be multiplied by the Secretary’s estimate  
11                  of the ratio of the aggregate payment amount  
12                  described in subparagraph (F)(i) that would  
13                  apply in 2010 if paragraph (14) did not apply,  
14                  to the aggregate payment base under subpara-  
15                  graph (F)(ii) for 2010.

16                  “(F) PAYMENT BASE.—The payment base  
17                  described in this subparagraph for a provider or  
18                  facility is—

19                  “(i) for performance periods before  
20                  2010, the payment amount determined  
21                  under paragraph (12) for services fur-  
22                  nished by the provider or facility during  
23                  the performance period, including the drug  
24                  payment adjustment described in subpara-  
25                  graph (B)(ii) of such paragraph; and

1                   “(ii) for the 2010 performance period  
2 is the amount determined under paragraph  
3 (14) for services furnished by the provider  
4 or facility during the period.

5                   “(G) LIMITATION ON FUNDING.—

6                   “(i) IN GENERAL.—If the Secretary  
7 determines that the total payments under  
8 this paragraph for a performance period is  
9 projected to exceed the dollar amount spec-  
10 ified in clause (ii) for such period, the Sec-  
11 retary shall reduce, in a pro rata manner,  
12 the amount of such payments for each pro-  
13 vider or facility for such period to elimi-  
14 nate any such projected excess for the pe-  
15 riod.

16                   “(ii) DOLLAR AMOUNT.—The dollar  
17 amount specified in this clause—

18                   “(I) for the performance period  
19 occurring in 2008, is \$50,000,000;

20                   “(II) for the 2009 performance  
21 period is \$100,000,000; and

22                   “(III) for the 2010 performance  
23 period is \$150,000,000.

1           “(H) FORM OF PAYMENT.—The payment  
2           under this paragraph shall be in the form of a  
3           single consolidated payment.

4           “(2) QUALITY INCENTIVE PAYMENTS FOR FA-  
5           CILITIES AND PROVIDERS FOR 2011.—

6           “(A) INCREASED PAYMENT.—For 2011, in  
7           the case of a provider or facility that, for the  
8           performance period (as defined in subparagraph  
9           (B))—

10                   “(i) meets (or exceeds) the perform-  
11                   ance standard for anemia management  
12                   specified in paragraph (1)(C)(ii)(I);

13                   “(ii) has substantially improved per-  
14                   formance or exceeds a performance stand-  
15                   ard (as determined under subparagraph  
16                   (E)); and

17                   “(iii) reports measures specified in  
18                   paragraph (1)(D),

19           with respect to renal dialysis services furnished  
20           by the provider or facility during the quality  
21           bonus payment period (as specified in subpara-  
22           graph (C)) the payment amount otherwise made  
23           to such provider or facility under subsection  
24           (b)(14) shall be increased, subject to subpara-  
25           graph (F), by the applicable percentage speci-

1           fied in subparagraph (D). Payment amounts  
2           under paragraph (1) shall not be counted for  
3           purposes of applying the previous sentence.

4           “(B) PERFORMANCE PERIOD.—In this  
5           paragraph, the term ‘performance period’  
6           means a multi-month period specified by the  
7           Secretary .

8           “(C) QUALITY BONUS PAYMENT PERIOD.—  
9           In this paragraph, the term ‘quality bonus pay-  
10          ment period’ means, with respect to a perform-  
11          ance period, a multi-month period beginning on  
12          January 1, 2011, specified by the Secretary  
13          that begins at least 3 months (but not more  
14          than 9 months) after the end of the perform-  
15          ance period.

16          “(D) APPLICABLE PERCENTAGE.—The ap-  
17          plicable percentage specified in this subpara-  
18          graph is a percentage, not to exceed the 2.0  
19          percent, specified by the Secretary consistent  
20          with subparagraph (F). Such percentage may  
21          vary based on the level of performance and im-  
22          provement. The applicable percentage specified  
23          in this subparagraph shall be multiplied by the  
24          ratio applied under the third sentence of para-  
25          graph (1)(E) for 2010.

1           “(E) PERFORMANCE STANDARD.—Based  
2           on performance of a provider of services or a  
3           renal dialysis facility on performance measures  
4           described in paragraph (1)(D) for a perform-  
5           ance period, the Secretary shall determine a  
6           composite score for such period.

7           “(F) LIMITATION ON FUNDING.—If the  
8           Secretary determines that the total amount to  
9           be paid under this paragraph for a quality  
10          bonus payment period is projected to exceed  
11          \$200,000,000, the Secretary shall reduce, in a  
12          uniform manner, the applicable percentage oth-  
13          erwise applied under subparagraph (D) for  
14          services furnished during the period to elimi-  
15          nate any such projected excess.

16          “(3) APPLICATION.—

17                 “(A) IMPLEMENTATION.—Notwithstanding  
18                 any other provision of law, the Secretary may  
19                 implement by program instruction or otherwise  
20                 this subsection.

21                 “(B) LIMITATIONS ON REVIEW.—

22                         “(i) IN GENERAL.—There shall be no  
23                         administrative or judicial review under sec-  
24                         tion 1869 or 1878 or otherwise of—

1                   “(I) the determination of per-  
2                   formance measures and standards  
3                   under this subsection;

4                   “(II) the determination of suc-  
5                   cessful reporting, including a deter-  
6                   mination of composite scores; and

7                   “(III) the determination of the  
8                   quality incentive payments made  
9                   under this subsection.

10                  “(ii) TREATMENT OF DETERMINA-  
11                  TIONS.—A determination under this sub-  
12                  paragraph shall not be treated as a deter-  
13                  mination for purposes of section 1869.

14                  “(4) TECHNICAL ASSISTANCE.—The Secretary  
15                  shall identify or establish an appropriately skilled  
16                  group or organization, such as the ESRD Networks,  
17                  to provide technical assistance to consistently low-  
18                  performing facilities or providers that are in the bot-  
19                  tom quintile.

20                  “(5) PUBLIC REPORTING.—

21                  “(A) ANNUAL NOTICE.—The Secretary  
22                  shall provide an annual written notification to  
23                  each individual who is receiving renal dialysis  
24                  services from a provider of services or renal di-  
25                  alysis facility that—

1           “(i) informs such individual of the  
2           composite scores described in subpara-  
3           graph (A) and other relevant quality meas-  
4           ures with respect to providers of services  
5           or renal dialysis facilities in the local area;

6           “(ii) compares such scores and meas-  
7           ures to the average local and national  
8           scores and measures; and

9           “(iii) provides information on how to  
10          access additional information on quality of  
11          such services furnished and options for al-  
12          ternative providers and facilities.

13          “(B) CERTIFICATES.—The Secretary shall  
14          provide certificates to facilities and providers  
15          who provide services to individuals with end-  
16          stage renal disease under this title to display in  
17          patient areas. The certificate shall indicate the  
18          composite score obtained by the facility or pro-  
19          vider under the quality initiative.

20          “(C) WEB-BASED QUALITY LIST.—The  
21          Secretary shall establish a web-based list of fa-  
22          cilities and providers who furnish renal dialysis  
23          services under this section that indicates their  
24          composite score of each provider and facility.



1           “(6) RECOMMENDATIONS FOR REPORTING AND  
2           QUALITY INCENTIVE INITIATIVE FOR PHYSI-  
3           CIANS.—The Secretary shall develop recommenda-  
4           tions for applying quality incentive payments under  
5           this subsection to physicians who receive the month-  
6           ly capitated payment under this title. Such rec-  
7           ommendations shall include the following:

8                   “(A) Recommendations to include pediatric  
9                   specific measures for physicians with at least  
10                  50 percent of their patients with end stage  
11                  renal disease being individuals under 18 years  
12                  of age.

13                  “(B) Recommendations on how to struc-  
14                  ture quality incentive payments for physicians  
15                  who demonstrate improvements in quality or  
16                  who attain quality standards, as specified by  
17                  the Secretary.

18           “(7) REPORTS.—

19                   “(A) INITIAL REPORT.—Not later than  
20                  January 1, 2013, the Secretary shall submit to  
21                  Congress a report on the implementation of the  
22                  bundled payment system under subsection  
23                  (b)(14) and the quality initiative under this  
24                  subsection. Such report shall include the fol-  
25                  lowing information:

1           “(i) A comparison of the aggregate  
2           payments under subsection (b)(14) for  
3           items and services to the cost of such items  
4           and services.

5           “(ii) The changes in utilization rates  
6           for erythropoietin stimulating agents.

7           “(iii) The mode of administering such  
8           agents, including information on the pro-  
9           portion of such individuals receiving such  
10          agents intravenously as compared to  
11          subcutaneously.

12          “(iv) The frequency of dialysis.

13          “(v) Other differences in practice pat-  
14          terns, such as the adoption of new tech-  
15          nology, different modes of practice, and  
16          variations in use of drugs other than drugs  
17          described in clause (iii).

18          “(vi) The performance of facilities and  
19          providers under paragraph (2).

20          “(vii) Other recommendations for leg-  
21          islative and administrative actions deter-  
22          mined appropriate by the Secretary.

23          “(B) SUBSEQUENT REPORT.—Not later  
24          than January 1, 2015, the Secretary shall sub-  
25          mit to Congress a report that contains the in-

1 formation described in each of clauses (ii)  
2 through (vii) of subparagraph (A) and a com-  
3 parison of the results of the payment system  
4 under subsection (b)(14) for renal dialysis serv-  
5 ices furnished during the 2-year period begin-  
6 ning on January 1, 2013, and the results of  
7 such payment system for such services fur-  
8 nished during the previous two-year period.”.

9 **SEC. 638. MEDPAC REPORT ON ESRD BUNDLING SYSTEM.**

10 Not later than March 1, 2012, the Medicare Payment  
11 Advisory Commission (established under section 1805 of  
12 the Social Security Act) shall submit to Congress a report  
13 on the implementation of the payment system under sec-  
14 tion 1881(b)(14) of the Social Security Act (as added by  
15 section 7) for renal dialysis services and related services  
16 (defined in subparagraph (B) of such section). Such report  
17 shall include, with respect to such payment system for  
18 such services, an analysis of each of the following:

19 (1) An analysis of the overall adequacy of pay-  
20 ment under such system for all such services.

21 (2) An analysis that compares the adequacy of  
22 payment under such system for services furnished  
23 by—

1 (A) a provider of services or renal dialysis  
2 facility that is described in section  
3 1881(b)(13)(C)(iv) of the Social Security Act;

4 (B) a provider of services or renal dialysis  
5 facility not described in such section;

6 (C) a hospital-based facility;

7 (D) a freestanding renal dialysis facility;

8 (E) a renal dialysis facility located in an  
9 urban area; and

10 (F) a renal dialysis facility located in a  
11 rural area.

12 (3) An analysis of the financial status of pro-  
13 viders of such services and renal dialysis facilities,  
14 including access to capital, return on equity, and re-  
15 turn on capital.

16 (4) An analysis of the adequacy of payment  
17 under such method and the adequacy of the quality  
18 improvement payments under section 1881(i) of the  
19 Social Security Act in ensuring that payments for  
20 such services under the Medicare program are con-  
21 sistent with costs for such services.

22 (5) Recommendations, if appropriate, for modi-  
23 fications to such payment system.

1 **SEC. 639. OIG STUDY AND REPORT ON ERYTHROPOIETIN.**

2 (a) STUDY.—The Inspector General of the Depart-  
3 ment of Health and Human Services shall conduct a study  
4 on the following:

5 (1) The dosing guidelines, standards, protocols,  
6 and algorithms for erythropoietin stimulating  
7 agents recommended or used by providers of services  
8 and renal dialysis facilities that are described in sec-  
9 tion 1881(b)(13)(C)(iv) of the Social Security Act  
10 and providers and facilities that are not described in  
11 such section.

12 (2) The extent to which such guidelines, stand-  
13 ards, protocols, and algorithms are consistent with  
14 the labeling of the Food and Drug Administration  
15 for such agents.

16 (3) The extent to which physicians sign stand-  
17 ing orders for such agents that are consistent with  
18 such guidelines, standards, protocols, and algorithms  
19 recommended or used by the provider or facility in-  
20 volved.

21 (4) The extent to which the prescribing deci-  
22 sions of physicians, with respect to such agents, are  
23 independent of—

24 (A) such relevant guidelines, standards,  
25 protocols, and algorithms; or

1 (B) recommendations of an anemia man-  
2 agement nurse or other appropriate employee of  
3 the provider or facility involved.

4 (5) The role of medical directors of providers of  
5 services and renal dialysis facilities and the financial  
6 relationships between such providers and facilities  
7 and the physicians hired as medical directors of such  
8 providers and facilities, respectively.

9 (b) REPORT.—Not later than January 1, 2009, the  
10 Inspector General of the Department of Health and  
11 Human Services shall submit to Congress a report on the  
12 study conducted under subsection (a), together with such  
13 recommendations as the Inspector General determines ap-  
14 propriate.

## 15 **Subtitle D—Miscellaneous**

### 16 **SEC. 651. LIMITATION ON EXCEPTION TO THE PROHIBI-** 17 **TION ON CERTAIN PHYSICIAN REFERRALS** 18 **FOR HOSPITALS.**

19 (a) IN GENERAL.—Section 1877 of the Social Secu-  
20 rity Act (42 U.S.C. 1395) is amended—

21 (1) in subsection (d)(2)—

22 (A) in subparagraph (A), by striking  
23 “and” at the end;

24 (B) in subparagraph (B), by striking the  
25 period at the end and inserting “; and”; and

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

3 “(C) if the entity is a hospital, the hospital  
4 meets the requirements of paragraph (3)(D).”;  
5 (2) in subsection (d)(3)—

6 (A) in subparagraph (B), by striking  
7 “and” at the end;

8 (B) in subparagraph (C), by striking the  
9 period at the end and inserting “; and”; and

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

12 “(D) the hospital meets the requirements  
13 described in subsection (i)(1) not later than 18  
14 months after the date of the enactment of this  
15 subparagraph.”; and

16 (3) by adding at the end the following new sub-  
17 section:

18 “(i) REQUIREMENTS FOR HOSPITALS TO QUALIFY  
19 FOR HOSPITAL EXCEPTION TO OWNERSHIP OR INVEST-  
20 MENT PROHIBITION.—

21 “(1) REQUIREMENTS DESCRIBED.—For pur-  
22 poses of paragraphs subsection (d)(3)(D), the re-  
23 quirements described in this paragraph for a hos-  
24 pital are as follows:

1           “(A) PROVIDER AGREEMENT.—The hos-  
2           pital had a provider agreement under section  
3           1866 in effect on July 24, 2007.

4           “(B) PROHIBITION OF EXPANSION OF FA-  
5           CILITY CAPACITY.—The number of operating  
6           rooms and beds of the hospital at any time on  
7           or after the date of the enactment of this sub-  
8           section are no greater than the number of oper-  
9           ating rooms and beds as of such date.

10          “(C) PREVENTING CONFLICTS OF INTER-  
11          EST.—

12                 “(i) The hospital submits to the Sec-  
13                 retary an annual report containing a de-  
14                 tailed description of—

15                         “(I) the identity of each physi-  
16                         cian owner and any other owners of  
17                         the hospital; and

18                         “(II) the nature and extent of all  
19                         ownership interests in the hospital.

20                 “(ii) The hospital has procedures in  
21                 place to require that any referring physi-  
22                 cian owner discloses to the patient being  
23                 referred, by a time that permits the pa-  
24                 tient to make a meaningful decision re-



1           garding the receipt of care ,as determined  
2           by the Secretary—

3                   “(I) the ownership interest of  
4                   such referring physician in the hos-  
5                   pital; and

6                   “(II) if applicable, any such own-  
7                   ership interest of the treating physi-  
8                   cian.

9                   “(iii) The hospital does not condition  
10                  any physician ownership interests either di-  
11                  rectly or indirectly on the physician owner  
12                  making or influencing referrals to the hos-  
13                  pital or otherwise generating business for  
14                  the hospital.

15                  “(D) ENSURING BONA FIDE INVEST-  
16                  MENT.—

17                   “(i) Physician owners in the aggregate  
18                   do not own more than 40 percent of the  
19                   total value of the investment interests held  
20                   in the hospital or in an entity whose assets  
21                   include the hospital.

22                   “(ii) The investment interest of any  
23                   individual physician owner does not exceed  
24                   2 percent of the total value of the invest-

1                   ment interests held in the hospital or in an  
2                   entity whose assets include the hospital.

3                   “(iii) Any ownership or investment in-  
4                   terests that the hospital offers to a physi-  
5                   cian owner are not offered on more favor-  
6                   able terms than the terms offered to a per-  
7                   son who is not a physician owner.

8                   “(iv) The hospital does not directly or  
9                   indirectly provide loans or financing for  
10                  any physician owner investments in the  
11                  hospital.

12                  “(v) The hospital does not directly or  
13                  indirectly guarantee a loan, make a pay-  
14                  ment toward a loan, or otherwise subsidize  
15                  a loan, for any individual physician owner  
16                  or group of physician owners that is re-  
17                  lated to acquiring any ownership interest  
18                  in the hospital.

19                  “(vi) Investment returns are distrib-  
20                  uted to investors in the hospital in an  
21                  amount that is directly proportional to the  
22                  investment of capital by the physician  
23                  owner in the hospital.

24                  “(vii) Physician owners do not receive,  
25                  directly or indirectly, any guaranteed re-

1            ceipt of or right to purchase other business  
2            interests related to the hospital, including  
3            the purchase or lease of any property  
4            under the control of other investors in the  
5            hospital or located near the premises of the  
6            hospital.

7                  “(viii) The hospital does not offer a  
8            physician owner the opportunity to pur-  
9            chase or lease any property under the con-  
10          trol of the hospital or any other investor in  
11          the hospital on more favorable terms than  
12          the terms offered to an individual who is  
13          not a physician owner.

14                “(E) PATIENT SAFETY.—

15                        “(i) Insofar as the hospital admits a  
16          patient and does not have any physician  
17          available on the premises to provide serv-  
18          ices during all hours in which the hospital  
19          is providing services to such patient, before  
20          admitting the patient—

21                       “(I) the hospital discloses such  
22                       fact to a patient; and

23                       “(II) following such disclosure,  
24                       the hospital receives from the patient

1 a signed acknowledgment that the pa-  
2 tient understands such fact.

3 “(ii) The hospital has the capacity  
4 to—

5 “(I) provide assessment and ini-  
6 tial treatment for patients; and

7 “(II) refer and transfer patients  
8 to hospitals with the capability to  
9 treat the needs of the patient in-  
10 volved.

11 “(2) PUBLICATION OF INFORMATION RE-  
12 PORTED.—The Secretary shall publish, and update  
13 on an annual basis, the information submitted by  
14 hospitals under paragraph (1)(A)(i) on the public  
15 Internet website of the Centers for Medicare & Med-  
16 icaid Services.

17 “(3) COLLECTION OF OWNERSHIP AND INVEST-  
18 MENT INFORMATION.—For purposes of clauses (i)  
19 and (ii) of paragraph (1)(D), the Secretary shall col-  
20 lect physician ownership and investment information  
21 for each hospital as it existed on the date of the en-  
22 actment of this subsection.

23 “(4) PHYSICIAN OWNER DEFINED.—For pur-  
24 poses of this subsection, the term ‘physician owner’  
25 means a physician (or an immediate family member

1 of such physician) with a direct or an indirect own-  
2 ership interest in the hospital.”.

3 (b) ENFORCEMENT.—

4 (1) ENSURING COMPLIANCE.—The Secretary of  
5 Health and Human Services shall establish policies  
6 and procedures to ensure compliance with the re-  
7 quirements described in such section 1877(i)(1) of  
8 the Social Security Act, as added by subsection  
9 (a)(3), beginning on the date such requirements first  
10 apply. Such policies and procedures may include un-  
11 announced site reviews of hospitals.

12 (2) AUDITS.—Beginning not later than 18  
13 months after the date of the enactment of this Act,  
14 the Secretary of Health and Human Services shall  
15 conduct audits to determine if hospitals violate the  
16 requirements referred to in paragraph (1).

17 **TITLE VII—PROVISIONS RELAT-**  
18 **ING TO MEDICARE PARTS A**  
19 **AND B**

20 **SEC. 701. HOME HEALTH PAYMENT UPDATE FOR 2008.**

21 Section 1895(b)(3)(B)(ii) of the Social Security Act  
22 (42 U.S.C. 1395fff(b)(3)(B)(ii)) is amended—

23 (1) in subclause (IV) at the end, by striking  
24 “and”;

1           (2) by redesignating subclause (V) as subclause  
2           (VII); and

3           (3) by inserting after subclause (IV) the fol-  
4           lowing new subclauses:

5                           “(V) 2007, subject to clause (v),  
6                           the home health market basket per-  
7                           centage increase;

8                           “(VI) 2008, subject to clause (v),  
9                           0 percent; and”.

10 **SEC. 702. 2-YEAR EXTENSION OF TEMPORARY MEDICARE**  
11                           **PAYMENT INCREASE FOR HOME HEALTH**  
12                           **SERVICES FURNISHED IN A RURAL AREA.**

13           Section 421 of the Medicare Prescription Drug, Im-  
14           provement, and Modernization Act of 2003 (Public Law  
15           108–173; 117 Stat. 2283; 42 U.S.C. 1395fff note), as  
16           amended by section 5201(b) of the Deficit Reduction Act  
17           of 2005, is amended—

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

20           (2) in subsection (a), by striking “and episodes  
21           and visits beginning on or after January 1, 2006,  
22           and before January 1, 2007” and inserting “epi-  
23           sodes and visits beginning on or after January 1,  
24           2006, and before January 1, 2007, and episodes and

1 visits beginning on or after January 1, 2008, and  
2 before January 1, 2010”.

3 **SEC. 703. EXTENSION OF MEDICARE SECONDARY PAYER**  
4 **FOR BENEFICIARIES WITH END STAGE**  
5 **RENAL DISEASE FOR LARGE GROUP PLANS.**

6 (a) IN GENERAL.—Section 1862(b)(1)(C) of the So-  
7 cial Security Act (42 U.S.C. 1395y(b)(1)(C)) is amend-  
8 ed—

9 (1) by redesignating clauses (i) and (ii) as sub-  
10 clauses (I) and (II), respectively, and indenting ac-  
11 cordingly;

12 (2) by amending the text preceding subclause  
13 (I), as so redesignated, to read as follows:

14 “(C) INDIVIDUALS WITH END STAGE  
15 RENAL DISEASE.—

16 “(i) IN GENERAL.—A group health  
17 plan (as defined in subparagraph (A)(v))—  
18 ”;

19 (3) in the matter following subclause (II), as so  
20 redesignated—

21 (A) by striking “clause (i)” and inserting  
22 “subclause (I)”;

23 (B) by striking “clause (ii)” and inserting  
24 “subclause (II)”;

1 (C) by striking “clauses (i) and (ii)” and  
2 inserting “subclauses (I) and (II)”; and

3 (D) in the last sentence, by striking “Ef-  
4 fective for items” and inserting “Subject to  
5 clause (ii), effective for items”; and

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

8 “(ii) SPECIAL RULE FOR LARGE  
9 GROUP PLANS.—In applying clause (i) to  
10 a large group health plan (as defined in  
11 subparagraph (B)(iii)). with respect to pe-  
12 riods beginning on or after the date that is  
13 30 months prior to January 1, 2008, sub-  
14 clauses (I) and (II) of such clause shall be  
15 applied by substituting ‘42-month’ for ‘12-  
16 month’ each place it appears.”.

17 **SEC. 704. PLAN FOR MEDICARE PAYMENT ADJUSTMENTS**  
18 **FOR NEVER EVENTS.**

19 (a) IN GENERAL.—The Secretary of Health and  
20 Human Services (in this section referred to as the “Sec-  
21 retary”) shall develop a plan (in this section referred to  
22 as the “never events plan”) to implement, beginning in  
23 fiscal year 2010, a policy to reduce or eliminate payments  
24 under title XVIII of the Social Security Act for never  
25 events.



1 (b) NEVER EVENT DEFINED.—For purposes of this  
2 section, the term “never event” means an event involving  
3 the delivery of (or failure to deliver) physicians’ services,  
4 inpatient or outpatient hospital services, or facility serv-  
5 ices furnished in an ambulatory surgical facility in which  
6 there is an error in medical care that is clearly identifiable,  
7 usually preventable, and serious in consequences to pa-  
8 tients, and that indicates a deficiency in the safety and  
9 process controls of the services furnished with respect to  
10 the physician, hospital, or ambulatory surgical center in-  
11 volved.

12 (c) PLAN DETAILS.—

13 (1) DEFINING NEVER EVENTS.—With respect  
14 to criteria for identifying never events under the  
15 never events plan, the Secretary should consider  
16 whether the event meets the following characteris-  
17 tics:

18 (A) CLEARLY IDENTIFIABLE.—The event  
19 is clearly identifiable and measurable and fea-  
20 sible to include in a reporting system for never  
21 events.

22 (B) USUALLY PREVENTABLE.—The event  
23 is usually preventable taking into consideration  
24 that, because of the complexity of medical care,  
25 certain medical events are not always avoidable.

1           (C) SERIOUS.—The event is serious and  
2           could result in death or loss of a body part, dis-  
3           ability, or more than transient loss of a body  
4           function.

5           (D) DEFICIENCY IN SAFETY AND PROCESS  
6           CONTROLS.—The event is indicative of a prob-  
7           lem in safety systems and process controls used  
8           by the physician, hospital, or ambulatory sur-  
9           gical center involved and is indicative of the re-  
10          liability of the quality of services provided by  
11          the physician, hospital, or ambulatory surgical  
12          center, respectively.

13          (2) IDENTIFICATION AND PAYMENT ISSUES.—  
14          With respect to policies under the never events plan  
15          for identifying and reducing (or eliminating) pay-  
16          ment for never events, the Secretary shall consider—

17                (A) mechanisms used by hospitals and  
18                physicians in reporting and coding of services  
19                that would reliably identify never events; and

20                (B) modifications in billing and payment  
21                mechanisms that would enable the Secretary to  
22                efficiently and accurately reduce or eliminate  
23                payments for never events.

24          (3) PRIORITIES.—Under the never events plan  
25          the Secretary shall identify priorities regarding the

1 services to focus on and, among those, the never  
2 events for which payments should be reduced or  
3 eliminated.

4 (4) CONSULTATION.—In developing the never  
5 events plan, the Secretary shall consult with affected  
6 parties that are relevant to payment reductions in  
7 response to never events.

8 (d) CONGRESSIONAL REPORT.—By not later than  
9 June 1, 2008, the Secretary shall submit a report to Con-  
10 gress on the never events plan developed under this sub-  
11 section and shall include in the report recommendations  
12 on specific methods for implementation of the plan on a  
13 timely basis.

14 **SEC. 705. TREATMENT OF MEDICARE HOSPITAL RECLASSI-**  
15 **FICATIONS.**

16 (a) EXTENDING CERTAIN MEDICARE HOSPITAL  
17 WAGE INDEX RECLASSIFICATIONS THROUGH FISCAL  
18 YEAR 2009.—

19 (1) IN GENERAL.—Section 106(a) of the Medi-  
20 care Improvements and Extension Act of 2006 (divi-  
21 sion B of public Law 109–432) is amended by strik-  
22 ing “September 30, 2007” and inserting “September  
23 30, 2009”.

24 (2) SPECIAL EXCEPTION RECLASSIFICATIONS.—  
25 The Secretary of Health and Human Services shall

1 extend for discharges occurring through September  
2 30, 2009, the special exception reclassification made  
3 under the authority of section 1886(d)(5)(I)(i) of  
4 the Social Security Act (42 U.S.C.  
5 1395ww(d)(5)(I)(i)) and contained in the final rule  
6 promulgated by the Secretary in the Federal Reg-  
7 ister on August 11, 2004 (69 Fed. Reg. 49105,  
8 49107).

9 (b) DISREGARDING SECTION 508 HOSPITAL RECLAS-  
10 SIFICATIONS FOR PURPOSES OF GROUP RECLASSIFICA-  
11 TIONS.—Section 508 of the Medicare Prescription Drug,  
12 Improvement, and Modernization Act of 2003 (Public Law  
13 108–173, 42 U.S.C. 1395ww note) is amended by adding  
14 at the end the following new subsection:

15 “(g) DISREGARDING HOSPITAL RECLASSIFICATIONS  
16 FOR PURPOSES OF GROUP RECLASSIFICATIONS.—For  
17 purposes of the reclassification of a group of hospitals in  
18 a geographic area under section 1886(d), a hospital reclas-  
19 sified under this section (including any such reclassifica-  
20 tion which is extended under section 106(a) of the Medi-  
21 care Improvements and Extension Act of 2006) shall not  
22 be taken into account and shall not prevent the other hos-  
23 pitals in such area from establishing such a group for such  
24 purpose.”.

1                   **TITLE VIII—MEDICAID**  
2                   **Subtitle A—Protecting Existing**  
3                   **Coverage**

4 **SEC. 801. MODERNIZING TRANSITIONAL MEDICAID.**

5           (a) TWO-YEAR EXTENSION.—

6               (1) IN GENERAL.—Sections 1902(e)(1)(B) and  
7               1925(f) of the Social Security Act (42 U.S.C.  
8               1396a(e)(1)(B), 1396r–6(f)) are each amended by  
9               striking “September 30, 2003” and inserting “Sep-  
10              tember 30, 2009”.

11              (2) EFFECTIVE DATE.—The amendments made  
12              by this subsection shall take effect on October 1,  
13              2007.

14           (b) STATE OPTION OF INITIAL 12-MONTH ELIGI-  
15           BILITY.—Section 1925 of the Social Security Act (42  
16           U.S.C. 1396r–6) is amended—

17               (1) in subsection (a)(1), by inserting “but sub-  
18               ject to paragraph (5)” after “Notwithstanding any  
19               other provision of this title”;

20               (2) by adding at the end of subsection (a) the  
21               following:

22                   “(5) OPTION OF 12-MONTH INITIAL ELIGIBILITY  
23                   PERIOD.—A State may elect to treat any reference  
24                   in this subsection to a 6-month period (or 6 months)  
25                   as a reference to a 12-month period (or 12 months).

1 In the case of such an election, subsection (b) shall  
2 not apply.”; and

3 (3) in subsection (b)(1), by inserting “but sub-  
4 ject to subsection (a)(5)” after “Notwithstanding  
5 any other provision of this title”.

6 (c) REMOVAL OF REQUIREMENT FOR PREVIOUS RE-  
7 CEIPT OF MEDICAL ASSISTANCE.—Section 1925(a)(1) of  
8 such Act (42 U.S.C. 1396r–6(a)(1)), as amended by sub-  
9 section (b)(1), is further amended—

10 (1) by inserting “subparagraph (B) and” before  
11 “paragraph (5)”;

12 (2) by redesignating the matter after “RE-  
13 QUIREMENT.—” as a subparagraph (A) with the  
14 heading “IN GENERAL.—” and with the same inden-  
15 tation as subparagraph (B) (as added by paragraph  
16 (3)); and

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

18 “(B) STATE OPTION TO WAIVE REQUIRE-  
19 MENT FOR 3 MONTHS BEFORE RECEIPT OF  
20 MEDICAL ASSISTANCE.—A State may, at its op-  
21 tion, elect also to apply subparagraph (A) in  
22 the case of a family that was receiving such aid  
23 for fewer than three months or that had applied  
24 for and was eligible for such aid for fewer than

1           3 months during the 6 immediately preceding  
2           months described in such subparagraph.”.

3           (d) CMS REPORT ON ENROLLMENT AND PARTICIPA-  
4           TION RATES UNDER TMA.—Section 1925 of such Act (42  
5           U.S.C. 1396r-6), as amended by this section, is further  
6           amended by adding at the end the following new sub-  
7           section:

8           “(g) COLLECTION AND REPORTING OF PARTICIPA-  
9           TION INFORMATION.—

10           “(1) COLLECTION OF INFORMATION FROM  
11           STATES.—Each State shall collect and submit to the  
12           Secretary (and make publicly available), in a format  
13           specified by the Secretary, information on average  
14           monthly enrollment and average monthly participa-  
15           tion rates for adults and children under this section  
16           and of the number and percentage of children who  
17           become ineligible for medical assistance under this  
18           section whose medical assistance is continued under  
19           another eligibility category or who are enrolled under  
20           the State’s child health plan under title XXI. Such  
21           information shall be submitted at the same time and  
22           frequency in which other enrollment information  
23           under this title is submitted to the Secretary.

24           “(2) ANNUAL REPORTS TO CONGRESS.—Using  
25           the information submitted under paragraph (1), the

1 Secretary shall submit to Congress annual reports  
2 concerning enrollment and participation rates de-  
3 scribed in such paragraph.”.

4 (e) EFFECTIVE DATE.—The amendments made by  
5 subsections (b) through (d) shall take effect on the date  
6 of the enactment of this Act.

7 **SEC. 802. FAMILY PLANNING SERVICES.**

8 (a) COVERAGE AS OPTIONAL CATEGORICALLY  
9 NEEDY GROUP.—

10 (1) IN GENERAL.—Section 1902(a)(10)(A)(ii)  
11 of the Social Security Act (42 U.S.C.  
12 1396a(a)(10)(A)(ii)) is amended—

13 (A) in subclause (XVIII), by striking “or”  
14 at the end;

15 (B) in subclause (XIX), by adding “or” at  
16 the end; and

17 (C) by adding at the end the following new  
18 subclause:

19 “(XX) who are described in subsection (ee) (re-  
20 lating to individuals who meet certain income stand-  
21 ards);”.

22 (2) GROUP DESCRIBED.—Section 1902 of the  
23 Social Security Act (42 U.S.C. 1396a), as amended  
24 by section 112(c), is amended by adding at the end  
25 the following new subsection:



1       “(ee)(1) Individuals described in this subsection are  
2 individuals

3               “(A) whose income does not exceed an in-  
4 come eligibility level established by the State  
5 that does not exceed the highest income eligi-  
6 bility level established under the State plan  
7 under this title (or under its State child health  
8 plan under title XXI) for pregnant women; and

9               “(B) who are not pregnant.

10              “(2) At the option of a State, individuals de-  
11 scribed in this subsection may include individuals  
12 who are determined to meet the eligibility require-  
13 ments referred to in paragraph (1) under the terms,  
14 conditions, and procedures applicable to making eli-  
15 gibility determinations for medical assistance under  
16 this title under a waiver to provide the benefits de-  
17 scribed in clause (XV) of the matter following sub-  
18 paragraph (G) of section 1902(a)(10) granted to the  
19 State under section 1115 as of January 1, 2007.”.

20              (3) LIMITATION ON BENEFITS.—Section  
21 1902(a)(10) of the Social Security Act (42 U.S.C.  
22 1396a(a)(10)) is amended in the matter following  
23 subparagraph (G)—

24                      (A) by striking “and (XIV)” and inserting

25                      “(XIV)”;

1 (B) by inserting “, and (XV) the medical  
2 assistance made available to an individual de-  
3 scribed in subsection (ee) shall be limited to  
4 family planning services and supplies described  
5 in section 1905(a)(4)(C) including medical di-  
6 agnosis or treatment services that are provided  
7 pursuant to a family planning service in a fam-  
8 ily planning setting provided during the period  
9 in which such an individual is eligible;” after  
10 “cervical cancer”.

11 (4) CONFORMING AMENDMENTS.—Section  
12 1905(a) of the Social Security Act (42 U.S.C.  
13 1396d(a)) is amended in the matter preceding para-  
14 graph (1)—

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

17 (B) in clause (xii), by adding “or” at the  
18 end; and

19 (C) by inserting after clause (xiii) the fol-  
20 lowing:

21 “(xiv) individuals described in section  
22 1902(ee),”.

23 (b) PRESUMPTIVE ELIGIBILITY.—



1 liminary information, that the individual is de-  
2 scribed in section 1902(ee); and

3 “(B) ends with (and includes) the earlier  
4 of—

5 “(i) the day on which a determination  
6 is made with respect to the eligibility of  
7 such individual for services under the State  
8 plan; or

9 “(ii) in the case of such an individual  
10 who does not file an application by the last  
11 day of the month following the month dur-  
12 ing which the entity makes the determina-  
13 tion referred to in subparagraph (A), such  
14 last day.

15 “(2) QUALIFIED ENTITY.—

16 “(A) IN GENERAL.—Subject to subpara-  
17 graph (B), the term ‘qualified entity’ means  
18 any entity that—

19 “(i) is eligible for payments under a  
20 State plan approved under this title; and

21 “(ii) is determined by the State agen-  
22 cy to be capable of making determinations  
23 of the type described in paragraph (1)(A).

24 “(B) RULE OF CONSTRUCTION.—Nothing  
25 in this paragraph shall be construed as pre-

1 venting a State from limiting the classes of en-  
2 tities that may become qualified entities in  
3 order to prevent fraud and abuse.

4 “(c) ADMINISTRATION.—

5 “(1) IN GENERAL.—The State agency shall pro-  
6 vide qualified entities with—

7 “(A) such forms as are necessary for an  
8 application to be made by an individual de-  
9 scribed in subsection (a) for medical assistance  
10 under the State plan; and

11 “(B) information on how to assist such in-  
12 dividuals in completing and filing such forms.

13 “(2) NOTIFICATION REQUIREMENTS.—A quali-  
14 fied entity that determines under subsection  
15 (b)(1)(A) that an individual described in subsection  
16 (a) is presumptively eligible for medical assistance  
17 under a State plan shall—

18 “(A) notify the State agency of the deter-  
19 mination within 5 working days after the date  
20 on which determination is made; and

21 “(B) inform such individual at the time  
22 the determination is made that an application  
23 for medical assistance is required to be made by  
24 not later than the last day of the month fol-

1           lowing the month during which the determina-  
2           tion is made.

3           “(3) APPLICATION FOR MEDICAL ASSIST-  
4           ANCE.—In the case of an individual described in  
5           subsection (a) who is determined by a qualified enti-  
6           ty to be presumptively eligible for medical assistance  
7           under a State plan, the individual shall apply for  
8           medical assistance by not later than the last day of  
9           the month following the month during which the de-  
10          termination is made.

11          “(d) PAYMENT.—Notwithstanding any other provi-  
12         sion of this title, medical assistance that—

13                 “(1) is furnished to an individual described in  
14                 subsection (a)—

15                         “(A) during a presumptive eligibility pe-  
16                         riod;

17                         “(B) by a entity that is eligible for pay-  
18                         ments under the State plan; and

19                 “(2) is included in the care and services covered  
20                 by the State plan, shall be treated as medical assist-  
21                 ance provided by such plan for purposes of clause  
22                 (4) of the first sentence of section 1905(b).”.

23                 (2) CONFORMING AMENDMENTS.—

24                         (A) Section 1902(a)(47) of the Social Se-  
25                         curity Act (42 U.S.C. 1396a(a)(47)) is amend-

1 ed by inserting before the semicolon at the end  
2 the following: “and provide for making medical  
3 assistance available to individuals described in  
4 subsection (a) of section 1920C during a pre-  
5 sumptive eligibility period in accordance with  
6 such section.”.

7 (B) Section 1903(u)(1)(D)(v) of such Act  
8 (42 U.S.C. 1396b(u)(1)(D)(v)) is amended—

9 (i) by striking “or for” and inserting  
10 “, for”; and

11 (ii) by inserting before the period the  
12 following: “, or for medical assistance pro-  
13 vided to an individual described in sub-  
14 section (a) of section 1920C during a pre-  
15 sumptive eligibility period under such sec-  
16 tion”.

17 (e) CLARIFICATION OF COVERAGE OF FAMILY PLAN-  
18 NING SERVICES AND SUPPLIES.—Section 1937(b) of the  
19 Social Security Act (42 U.S.C. 1396u-7(b)) is amended  
20 by adding at the end the following:

21 “(5) COVERAGE OF FAMILY PLANNING SERV-  
22 ICES AND SUPPLIES.—Notwithstanding the previous  
23 provisions of this section, a State may not provide  
24 for medical assistance through enrollment of an indi-  
25 vidual with benchmark coverage or benchmark-equiv-

1       alent coverage under this section unless such cov-  
2       erage includes for any individual described in section  
3       1905(a)(4)(C), medical assistance for family plan-  
4       ning services and supplies in accordance with such  
5       section.”.

6       (f) EFFECTIVE DATE.—The amendments made by  
7       this section take effect on October 1, 2007.

8       **SEC. 803. AUTHORITY TO CONTINUE PROVIDING ADULT**  
9                               **DAY HEALTH SERVICES APPROVED UNDER A**  
10                              **STATE MEDICAID PLAN.**

11       (a) IN GENERAL.—During the period described in  
12       subsection (b), the Secretary of Health and Human Serv-  
13       ices shall not—

14               (1) withhold, suspend, disallow, or otherwise  
15       deny Federal financial participation under section  
16       1903(a) of the Social Security Act (42 U.S.C.  
17       1396b(a)) for the provision of adult day health care  
18       services, day activity and health services, or adult  
19       medical day care services, as defined under a State  
20       Medicaid plan approved during or before 1994, dur-  
21       ing such period if such services are provided con-  
22       sistent with such definition and the requirements of  
23       such plan; or



1           (2) withdraw Federal approval of any such  
2           State plan or part thereof regarding the provision of  
3           such services (by regulation or otherwise).

4           (b) PERIOD DESCRIBED.—The period described in  
5           this subsection is the period that begins on November 3,  
6           2005, and ends on March 1, 2009.

7           **SEC. 804. STATE OPTION TO PROTECT COMMUNITY**  
8                               **SPOUSES OF INDIVIDUALS WITH DISABIL-**  
9                               **ITIES.**

10          Section 1924(h)(1)(A) of the Social Security Act (42  
11          U.S.C. 1396r-5(h)(1)(A)) is amended by striking “is de-  
12          scribed in section 1902(a)(10)(A)(ii)(VI)” and inserting  
13          “is being provided medical assistance for home and com-  
14          munity-based services under subsection (c), (d), (e), (i),  
15          or (j) of section 1915 or pursuant to section 1115”.

16          **SEC. 805. COUNTY MEDICAID HEALTH INSURING ORGANI-**  
17                               **ZATIONS .**

18          (a) IN GENERAL.—Section 9517(c)(3) of the Consoli-  
19          dated Omnibus Budget Reconciliation Act of 1985 (42  
20          U.S.C. 1396b note), as added by section 4734 of the Om-  
21          nibus Budget Reconciliation Act of 1990 and as amended  
22          by section 704 of the Medicare, Medicaid, and SCHIP  
23          Benefits Improvement and Protection Act of 2000, is  
24          amended—

1 (1) in subparagraph (A), by inserting “, in the  
2 case of any health insuring organization described in  
3 such subparagraph that is operated by a public enti-  
4 ty established by Ventura County, and in the case  
5 of any health insuring organization described in such  
6 subparagraph that is operated by a public entity es-  
7 tablished by Merced County” after “described in  
8 subparagraph (B)”; and

9 (2) in subparagraph (C), by striking “14 per-  
10 cent” and inserting “16 percent”.

11 (b) EFFECTIVE DATE.—The amendments made by  
12 subsection (a) shall take effect on the date of the enact-  
13 ment of this Act.

## 14 **Subtitle B—Payments**

### 15 **SEC. 811. PAYMENTS FOR PUERTO RICO AND TERRITORIES.**

16 (a) PAYMENT CEILING.—Section 1108(g) of the So-  
17 cial Security Act (42 U.S.C. 1308(g)) is amended—

18 (1) in paragraph (2), by striking “paragraph  
19 (3)” and inserting “paragraphs (3) and (4)”; and

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

22 “(4) FISCAL YEARS 2009 THROUGH 2012 FOR  
23 CERTAIN INSULAR AREAS.—The amounts otherwise  
24 determined under this subsection for Puerto Rico,  
25 the Virgin Islands, Guam, the Northern Mariana Is-

1 lands, and American Samoa for fiscal years 2009  
2 through 2012 shall be increased by the following  
3 amounts:

4 “(A) PUERTO RICO.—For Puerto Rico,  
5 \$250,000,000 for fiscal year 2009,  
6 \$350,000,000 for fiscal year 2010,  
7 \$500,000,000 for fiscal year 2011, and  
8 \$600,000,000 for fiscal year 2012.

9 “(B) VIRGIN ISLANDS.—For the Virgin Is-  
10 lands, \$5,000,000 for each of fiscal years 2009  
11 through 2012.

12 “(C) GUAM.—For Guam, \$5,000,000 for  
13 each of fiscal years 2009 through 2012.

14 “(D) NORTHERN MARIANA ISLANDS.—For  
15 the Northern Mariana Islands, \$4,000,000 for  
16 each of fiscal years 2009 through 2012.

17 “(E) AMERICAN SAMOA.—For American  
18 Samoa, \$4,000,000 for each of fiscal years  
19 2009 through 2012.

20 Such amounts shall not be taken into account in ap-  
21 plying paragraph (2) for fiscal years 2009 through  
22 2012 but shall be taken into account in applying  
23 such paragraph for fiscal year 2013 and subsequent  
24 fiscal years.”.

1 (b) REMOVAL OF FEDERAL MATCHING PAYMENTS  
2 FOR IMPROVING DATA REPORTING SYSTEMS FROM THE  
3 OVERALL LIMIT ON PAYMENTS TO TERRITORIES UNDER  
4 TITLE XIX.—Such section is further amended by adding  
5 at the end the following new paragraph:

6 “(5) EXCLUSION OF CERTAIN EXPENDITURES  
7 FROM PAYMENT LIMITS.— With respect to fiscal  
8 year 2008 and each fiscal year thereafter, if Puerto  
9 Rico, the Virgin Islands, Guam, the Northern Mar-  
10 iana Islands, or American Samoa qualify for a pay-  
11 ment under subparagraph (A)(i) or (B) of section  
12 1903(a)(3) for a calendar quarter of such fiscal year  
13 with respect to expenditures for improvements in  
14 data reporting systems described in such subpara-  
15 graph, the limitation on expenditures under title  
16 XIX for such commonwealth or territory otherwise  
17 determined under subsection (f) and this subsection  
18 for such fiscal year shall be determined without re-  
19 gard to payment for such expenditures.”.

20 **SEC. 812. MEDICAID DRUG REBATE.**

21 (a) BRAND.—Paragraph (1)(B)(i) of section 1927(c)  
22 of the Social Security Act (42 U.S.C. 1396r-8(e)) is  
23 amended—

24 (1) by striking “and” at the end of subclause  
25 (IV);

1 (2) in subclause (V)—

2 (A) by inserting “and before January 1,  
3 2008,” after “December 31, 1995”; and

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

6 (3) by adding at the end the following new sub-  
7 clause:

8 “(VI) after December 31, 2007,  
9 is 20.1 percent.”.

10 (b) PBMS TO BEST PRICE DEFINITION.—

11 (1) IN GENERAL.—Section 1927(c)(1)(C)(ii)(I)  
12 of the Social Security Act (42 U.S.C. 1396r-  
13 8(c)(1)(C)(ii)(I)) is amended—

14 (A) by striking “and” before “rebates”;  
15 and

16 (B) by inserting before the semicolon at  
17 the end the following: “, and rebates, discounts,  
18 and other price concessions to pharmaceutical  
19 benefit managers (PBMs)”.

20 (2) EFFECTIVE DATE.—The amendments made  
21 by paragraph (1) shall apply to calendar quarters  
22 beginning on or after January 1, 2008.

1 **SEC. 813. ADJUSTMENT IN COMPUTATION OF MEDICAID**  
2 **FMAP TO DISREGARD AN EXTRAORDINARY**  
3 **EMPLOYER PENSION CONTRIBUTION.**

4 (a) IN GENERAL.—Only for purposes of computing  
5 the Federal medical assistance percentage under section  
6 1905(b) of the Social Security Act (42 U.S.C. 1396d(b))  
7 for a State for a fiscal year (beginning with fiscal year  
8 2006), any significantly disproportionate employer pension  
9 contribution described in subsection (b) shall be dis-  
10 regarded in computing the per capita income of such  
11 State, but shall not be disregarded in computing the per  
12 capita income for the continental United States (and Alas-  
13 ka) and Hawaii.

14 (b) SIGNIFICANTLY DISPROPORTIONATE EMPLOYER  
15 PENSION CONTRIBUTION.—For purposes of subsection  
16 (a), a significantly disproportionate employer pension con-  
17 tribution described in this subsection with respect to a  
18 State for a fiscal year is an employer contribution towards  
19 pensions that is allocated to such State for a period if the  
20 aggregate amount so allocated exceeds 25 percent of the  
21 total increase in personal income in that State for the pe-  
22 riod involved.

23 **SEC. 814. MORATORIUM ON CERTAIN PAYMENT RESTRIC-**  
24 **TIONS.**

25 Notwithstanding any other provision of law, the Sec-  
26 retary of Health and Human Services shall not, prior to

1 the date that is 1 year after the date of enactment of this  
2 Act, take any action (through promulgation of regulation,  
3 issuance of regulatory guidance, use of federal payment  
4 audit procedures, or other administrative action, policy, or  
5 practice, including a Medical Assistance Manual trans-  
6 mittal or letter to State Medicaid directors) to restrict cov-  
7 erage or payment under title XIX of the Social Security  
8 Act for rehabilitation services, or school-based administra-  
9 tion, transportation, or medical services if such restric-  
10 tions are more restrictive in any aspect than those applied  
11 to such coverage or payment as of July 1, 2007.

12 **SEC. 815. TENNESSEE DSH.**

13 The DSH allotments for Tennessee for each fiscal  
14 year beginning with fiscal year 2008 under subsection  
15 (f)(3) of section 1923 of the Social Security Act (42  
16 U.S.C. 13961396r-4) are deemed to be \$30,000,000. The  
17 Secretary of Health and Human Services may impose a  
18 limitation on the total amount of payments made to hos-  
19 pitals under the TennCare Section 1115 waiver only to  
20 the extent that such limitation is necessary to ensure that  
21 a hospital does not receive payment in excess of the  
22 amounts described in subsection (f) of such section or as  
23 necessary to ensure that the waiver remains budget neu-  
24 tral.

1 **SEC. 816. CLARIFICATION TREATMENT OF REGIONAL MED-**  
2 **ICAL CENTER.**

3 (a) IN GENERAL.—Nothing in section 1903(w) of the  
4 Social Security Act (42 U.S.C. 1396b(w)) shall be con-  
5 strued by the Secretary of Health and Human Services  
6 as prohibiting a State's use of funds as the non-Federal  
7 share of expenditures under title XIX of such Act where  
8 such funds are transferred from or certified by a publicly-  
9 owned regional medical center located in another State  
10 and described in subsection (b), so long as the Secretary  
11 determines that such use of funds is proper and in the  
12 interest of the program under title XIX.

13 (b) CENTER DESCRIBED.—A center described in this  
14 subsection is a publicly-owned regional medical center  
15 that—

16 (1) provides level 1 trauma and burn care serv-  
17 ices;

18 (2) provides level 3 neonatal care services;

19 (3) is obligated to serve all patients, regardless  
20 of ability to pay;

21 (4) is located within a Standard Metropolitan  
22 Statistical Area (SMSA) that includes at least 3  
23 States;

24 (5) provides services as a tertiary care provider  
25 for patients residing within a 125-mile radius; and



1           (6) meets the criteria for a disproportionate  
2 share hospital under section 1923 of such Act (42  
3 U.S.C. 1396r-4) in at least one State other than the  
4 State in which the center is located.

## 5           **Subtitle C—Miscellaneous**

### 6   **SEC. 821. DEMONSTRATION PROJECT FOR EMPLOYER BUY-** 7           **IN.**

8           Title XXI of the Social Security Act, as amended by  
9 section 115(a)(1), is further amended by adding at the  
10 end the following new section:

### 11   **“SEC. 2112. DEMONSTRATION PROJECT FOR EMPLOYER** 12           **BUY-IN.**

13           “(a) **AUTHORITY.**—

14           “(1) **IN GENERAL.**—The Secretary shall estab-  
15 lish a demonstration project under which up to 10  
16 States (each referred to in this section as a ‘partici-  
17 pating State’) that meets the conditions of para-  
18 graph (2) may provide, under its State child health  
19 plan (notwithstanding section 2102(b)(3)(C)) for a  
20 period of 5 years, for child health assistance in rela-  
21 tion to family coverage described in subsection (d)  
22 for children who would be targeted low-income chil-  
23 dren but for coverage as beneficiaries under a group  
24 health plan as the children of participants by virtue

1 of a qualifying employer's contribution under sub-  
2 section (b)(2). :

3 “(2) CONDITIONS.—The conditions described in  
4 this paragraph for a State are as follows:

5 “(A) NO WAITING LISTS.—The State does  
6 not impose any waiting list, enrollment cap, or  
7 similar limitation on enrollment of targeted low-  
8 income children under the State child health  
9 plan.

10 “(B) ELIGIBILITY OF ALL CHILDREN  
11 UNDER 200 PERCENT OF POVERTY LINE.—The  
12 State is applying an income eligibility level  
13 under section 2110(b)(1)(B)(ii)(I) that is at  
14 least 200 percent of the poverty line.

15 “(3) QUALIFYING EMPLOYER DEFINED.—In  
16 this section, the term ‘qualifying employer’ means an  
17 employer that has a majority of its workforce com-  
18 posed of full-time workers with family incomes rea-  
19 sonably estimated by the employer (based on wage  
20 information available to the employer) at or below  
21 200 percent of the poverty line. In applying the pre-  
22 vious sentence, two part-time workers shall be treat-  
23 ed as a single full-time worker.

24 “(b) FUNDING.—A demonstration project under this  
25 section in a participating State shall be funded, with re-

1 spect to assistance provided to children described in sub-  
2 section (a)(1), consistent with the following:

3           “(1) LIMITED FAMILY CONTRIBUTION.—The  
4 family involved shall be responsible for providing  
5 payment towards the premium for such assistance of  
6 such amount as the State may specify, except that  
7 the limitations on cost-sharing (including premiums)  
8 under paragraphs (2) and (3) of section 2103(e)  
9 shall apply to all cost-sharing of such family under  
10 this section.

11           “(2) MINIMUM EMPLOYER CONTRIBUTION.—  
12 The qualifying employer involved shall be responsible  
13 for providing payment to the State child health plan  
14 in the State of at least 50 percent of the portion of  
15 the cost (as determined by the State) of the family  
16 coverage in which the employer is enrolling the fam-  
17 ily that exceeds the amount of the family contribu-  
18 tion under paragraph (1) applied towards such cov-  
19 erage.

20           “(3) LIMITATION ON FEDERAL FINANCIAL PAR-  
21 TICIPATION.—In no case shall the Federal financial  
22 participation under section 2105 with respect to a  
23 demonstration project under this section be made for  
24 any portion of the costs of family coverage described  
25 in subsection (d) (including the costs of administra-

1       tion of such coverage) that are not attributable to  
2       children described in subsection (a)(1).

3       “(c) UNIFORM ELIGIBILITY RULES.—In providing  
4       assistance under a demonstration project under this sec-  
5       tion—

6               “(1) a State shall establish uniform rules of eli-  
7       gibility for families to participate; and

8               “(2) a State shall not permit a qualifying em-  
9       ployer to select, within those families that meet such  
10      eligibility rules, which families may participate.

11      “(d) TERMS AND CONDITIONS.—The family coverage  
12      offered to families of qualifying employers under a dem-  
13      onstration project under this section in a State shall be  
14      the same as the coverage and benefits provided under the  
15      State child health plan in the State for targeted low-in-  
16      come children with the highest family income level per-  
17      mitted.”.

18      **SEC. 822. DIABETES GRANTS.**

19      Section 2104 of the Social Security Act (42 U.C.C  
20      1397dd), as amended by section 101, is further amend-  
21      ed—

22               (1) in subsection (a)(11), by inserting before  
23      the period at the end the following: “plus for fiscal  
24      year 2009 the total of the amount specified in sub-  
25      section (j)”;

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

3           “(j) FUNDING FOR DIABETES GRANTS.—From the  
4           amounts appropriated under subsection (a)(11), for fiscal  
5           year 2009 from the amounts—

6           “(1) \$150,000,000 is hereby transferred and  
7           made available in such fiscal year for grants under  
8           section 330B of the Public Health Service Act; and

9           “(2) \$150,000,000 is hereby transferred and  
10          made available in such fiscal year for grants under  
11          section 330C of such Act.”.

12   **SEC. 823. TECHNICAL CORRECTION.**

13          (a) CORRECTION OF REFERENCE TO CHILDREN IN  
14          FOSTER CARE RECEIVING CHILD WELFARE SERVICES.—  
15          Section 1937(a)(2)(B)(viii) of the Social Security Act (42  
16          U.S.C. 1396u-7(a)(2)(B) is amended by striking “aid or  
17          assistance is made available under part B of title IV to  
18          children in foster care” and inserting “child welfare serv-  
19          ices are made available under part B of title IV on the  
20          basis of being a child in foster care”.

21          (b) EFFECTIVE DATE.—The amendment made by  
22          subsection (a) shall take effect as if included in the  
23          amendment made by section 6044(a) of the Deficit Reduc-  
24          tion Act of 2005.

1           **TITLE IX—MISCELLANEOUS**

2   **SEC. 901. MEDICARE PAYMENT ADVISORY COMMISSION**  
3                           **STATUS.**

4           Section 1805(a) of the Social Security Act (42 U.S.C.  
5 1395b-6(a)) is amended by inserting “as an agency of  
6 Congress” after “established”.

7   **SEC. 902. REPEAL OF TRIGGER PROVISION.**

8           Subtitle A of title VIII of the Medicare Prescription  
9 Drug, Improvement, and Modernization Act of 2003 (Pub-  
10 lic Law 108–173) is repealed and the provisions of law  
11 amended by such subtitle are restored as if such subtitle  
12 had never been enacted.

13   **SEC. 903. REPEAL OF COMPARATIVE COST ADJUSTMENT**  
14                           **(CCA) PROGRAM.**

15           Section 1860C–1 of the Social Security Act (42  
16 U.S.C. 1395w-29), as added by section 241(a) of the  
17 Medicare Prescription Drug, Improvement, and Mod-  
18 ernization Act of 2003 (Public Law 108–173), is repealed.

19   **SEC. 904. COMPARATIVE EFFECTIVENESS RESEARCH.**

20           (a) IN GENERAL.—Part A of title XVIII of the Social  
21 Security Act is amended by adding at the end the fol-  
22 lowing new section:

23                   “COMPARATIVE EFFECTIVENESS RESEARCH

24                   “SEC. 1822. (a) CENTER FOR COMPARATIVE EFFEC-  
25 TIVENESS RESEARCH ESTABLISHED.—

1           “(1) IN GENERAL.—The Secretary shall estab-  
2           lish within the Agency of Healthcare Research and  
3           Quality a Center for Comparative Effectiveness Re-  
4           search (in this section referred to as the ‘Center’) to  
5           conduct, support, and synthesize research (including  
6           research conducted or supported under section 1013  
7           of the Medicare Prescription Drug, Improvement,  
8           and Modernization Act of 2003) with respect to the  
9           outcomes, effectiveness, and appropriateness of  
10          health care services and procedures in order to iden-  
11          tify the manner in which diseases, disorders, and  
12          other health conditions can most effectively and ap-  
13          propriately be prevented, diagnosed, treated, and  
14          managed clinically.

15          “(2) DUTIES.—The Center shall—

16                 “(A) conduct, support, and synthesize re-  
17                 search relevant to the comparative clinical effec-  
18                 tiveness of the full spectrum of health care  
19                 treatments, including pharmaceuticals, medical  
20                 devices, medical and surgical procedures, and  
21                 other medical interventions;

22                 “(B) conduct and support systematic re-  
23                 views of clinical research, including original re-  
24                 search conducted subsequent to the date of the  
25                 enactment of this section;

1           “(C) use methodologies such as random-  
2           ized controlled clinical trials as well as other  
3           various types of clinical research, such as obser-  
4           vational studies;

5           “(D) submit to the Comparative Effective-  
6           ness Research Commission, the Secretary, and  
7           Congress appropriate relevant reports described  
8           in subsection (d)(2);

9           “(E) encourage, as appropriate, the devel-  
10          opment and use of clinical registries and the devel-  
11          opment of clinical effectiveness research data  
12          networks from electronic health records, post  
13          marketing drug and medical device surveillance  
14          efforts, and other forms of electronic health  
15          data; and

16          “(F) not later than 180 days after the  
17          date of the enactment of this section, develop  
18          methodological standards to be used when con-  
19          ducting studies of comparative clinical effective-  
20          ness and value (and procedures for use of such  
21          standards) in order to help ensure accurate and  
22          effective comparisons and update such stand-  
23          ards at least biennially.

24          “(b) OVERSIGHT BY COMPARATIVE EFFECTIVENESS  
25          RESEARCH COMMISSION.—



1           “(1) IN GENERAL.—The Secretary shall estab-  
2           lish an independent Comparative Effectiveness Re-  
3           search Commission (in this section referred to as the  
4           ‘Commission’) to oversee and evaluate the activities  
5           carried out by the Center under subsection (a) to en-  
6           sure such activities result in highly credible research  
7           and information resulting from such research.

8           “(2) DUTIES.—The Commission shall—

9                   “(A) determine national priorities for re-  
10                  search described in subsection (a) and in mak-  
11                  ing such determinations consult with patients  
12                  and health care providers and payers;

13                   “(B) monitor the appropriateness of use of  
14                  the CERTF described in subsection (f) with re-  
15                  spect to the timely production of comparative  
16                  effectiveness research determined to be a na-  
17                  tional priority under subparagraph (A);

18                   “(C) identify highly credible research  
19                  methods and standards of evidence for such re-  
20                  search to be considered by the Center;

21                   “(D) review and approve the methodo-  
22                  logical standards (and updates to such stand-  
23                  ards) developed by the Center under subsection  
24                  (a)(2)(F);

1           “(E) enter into an arrangement under  
2           which the Institute of Medicine of the National  
3           Academy of Sciences shall conduct an evalua-  
4           tion and report on standards of evidence for  
5           such research;

6           “(F) support forums to increase stake-  
7           holder awareness and permit stakeholder feed-  
8           back on the efforts of the Agency of Healthcare  
9           Research and Quality to advance methods and  
10          standards that promote highly credible re-  
11          search;

12          “(G) make recommendations for public  
13          data access policies of the Center that would  
14          allow for access of such data by the public while  
15          ensuring the information produced from re-  
16          search involved is timely and credible;

17          “(H) appoint a clinical perspective advisory  
18          panel for each research priority determined  
19          under subparagraph (A), which shall frame the  
20          specific research inquiry to be examined with  
21          respect to such priority to ensure that the infor-  
22          mation produced from such research is clinically  
23          relevant to decisions made by clinicians and pa-  
24          tients at the point of care;

1           “(I) make recommendations for the pri-  
2           ority for periodic reviews of previous compara-  
3           tive effectiveness research and studies con-  
4           ducted by the Center under subsection (a);

5           “(J) routinely review processes of the Cen-  
6           ter with respect to such research to confirm  
7           that the information produced by such research  
8           is objective, credible, consistent with standards  
9           of evidence established under this section, and  
10          developed through a transparent process that  
11          includes consultations with appropriate stake-  
12          holders;

13          “(K) at least annually, provide guidance or  
14          recommendations to health care providers and  
15          consumers for the use of information on the  
16          comparative effectiveness of health care services  
17          by consumers, providers (as defined for pur-  
18          poses of regulations promulgated under section  
19          264(c) of the Health Insurance Portability and  
20          Accountability Act of 1996) and public and pri-  
21          vate purchasers;

22          “(L) make recommendations for a strategy  
23          to disseminate the findings of research con-  
24          ducted and supported under this section that  
25          enables clinicians to improve performance, con-

1           sumers to make more informed health care de-  
2           cisions, and payers to set medical policies that  
3           improve quality and value;

4           “(M) provide for the public disclosure of  
5           relevant reports described in subsection (d)(2);  
6           and

7           “(N) submit to Congress an annual report  
8           on the progress of the Center in achieving na-  
9           tional priorities determined under subparagraph  
10          (A) for the provision of credible comparative ef-  
11          fectiveness information produced from such re-  
12          search to all interested parties.

13          “(3) COMPOSITION OF COMMISSION.—

14          “(A) IN GENERAL.—The members of the  
15          Commission shall consist of—

16                  “(i) the Director of the Agency for  
17                  Healthcare Research and Quality;

18                  “(ii) the Chief Medical Officer of the  
19                  Centers for Medicare & Medicaid  
20                  Services; and

21                  “(iii) up to 15 additional members  
22                  who shall represent broad constituencies of  
23                  stakeholders including clinicians, patients,  
24                  researchers, third-party payers, consumers

1 of Federal and State beneficiary programs.

2 .

3 “(B) QUALIFICATIONS.—

4 “(i) DIVERSE REPRESENTATION OF  
5 PERSPECTIVES.—The members of the  
6 Commission shall represent a broad range  
7 of perspectives and shall collectively have  
8 experience in the following areas:

9 “(I) Epidemiology.

10 “(II) Health services research.

11 “(III) Bioethics.

12 “(IV) Decision sciences.

13 “(V) Economics.

14 “(ii) DIVERSE REPRESENTATION OF  
15 HEALTH CARE COMMUNITY.—At least one  
16 member shall represent each of the fol-  
17 lowing health care communities:

18 “(I) Consumers.

19 “(II) Practicing physicians, in-  
20 cluding surgeons.

21 “(III) Employers.

22 “(IV) Public payers.

23 “(V) Insurance plans.

1                   “(VI) Clinical researchers who  
2                   conduct research on behalf of pharma-  
3                   ceutical or device manufacturers.

4                   “(4) APPOINTMENT.—The Comptroller General  
5                   of the United States, in consultation with the chairs  
6                   of the committees of jurisdiction of the House of  
7                   Representatives and the Senate, shall appoint the  
8                   members of the Commission.

9                   “(5) CHAIRMAN; VICE CHAIRMAN.—The Comp-  
10                  troller General of the United States shall designate  
11                  a member of the Commission, at the time of ap-  
12                  pointment of the member, as Chairman and a mem-  
13                  ber as Vice Chairman for that term of appointment,  
14                  except that in the case of vacancy of the Chairman-  
15                  ship or Vice Chairmanship, the Comptroller General  
16                  may designate another member for the remainder of  
17                  that member’s term.

18                  “(6) TERMS.—

19                  “(A) IN GENERAL.—Except as provided in  
20                  subparagraph (B), each member of the Com-  
21                  mission shall be appointed for a term of 4  
22                  years.

23                  “(B) TERMS OF INITIAL APPOINTEES.—Of  
24                  the members first appointed—

1                   “(i) 10 shall be appointed for a term  
2                   of 4 years; and

3                   “(ii) 9 shall be appointed for a term  
4                   of 3 years.

5                   “(7) COORDINATION.—To enhance effectiveness  
6                   and coordination, the Comptroller General is encour-  
7                   aged, to the greatest extent possible, to seek coordi-  
8                   nation between the Commission and the National  
9                   Advisory Council of the Agency for Healthcare Re-  
10                  search and Quality.

11                  “(8) CONFLICTS OF INTEREST.—In appointing  
12                  the members of the Commission or a clinical per-  
13                  spective advisory panel described in paragraph  
14                  (2)(G), the Comptroller General of the United States  
15                  or the Commission, respectively, shall take into con-  
16                  sideration any financial conflicts of interest.

17                  “(9) COMPENSATION.—While serving on the  
18                  business of the Commission (including traveltime), a  
19                  member of the Commission shall be entitled to com-  
20                  pensation at the per diem equivalent of the rate pro-  
21                  vided for level IV of the Executive Schedule under  
22                  section 5315 of title 5, United States Code; and  
23                  while so serving away from home and the member’s  
24                  regular place of business, a member may be allowed

1 travel expenses, as authorized by the Director of the  
2 Commission.

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

7 “(11) DIRECTOR AND STAFF; EXPERTS AND  
8 CONSULTANTS.—Subject to such review as the Sec-  
9 retary, in consultation with the Comptroller General  
10 deems necessary to assure the efficient administra-  
11 tion of the Commission, the Commission may—

12 “(A) employ and fix the compensation of  
13 an Executive Director (subject to the approval  
14 of the Secretary, in consultation with the  
15 Comptroller General) and such other personnel  
16 as may be necessary to carry out its duties  
17 (without regard to the provisions of title 5,  
18 United States Code, governing appointments in  
19 the competitive service);

20 “(B) seek such assistance and support as  
21 may be required in the performance of its du-  
22 ties from appropriate Federal departments and  
23 agencies;

24 “(C) enter into contracts or make other ar-  
25 rangements, as may be necessary for the con-



1 duct of the work of the Commission (without  
2 regard to section 3709 of the Revised Statutes  
3 (41 U.S.C. 5));

4 “(D) make advance, progress, and other  
5 payments which relate to the work of the Com-  
6 mission;

7 “(E) provide transportation and subsist-  
8 ence for persons serving without compensation;  
9 and

10 “(F) prescribe such rules and regulations  
11 as it deems necessary with respect to the inter-  
12 nal organization and operation of the Commis-  
13 sion.

14 “(12) POWERS.—

15 “(A) OBTAINING OFFICIAL DATA.—The  
16 Commission may secure directly from any de-  
17 partment or agency of the United States infor-  
18 mation necessary to enable it to carry out this  
19 section. Upon request of the Executive Director,  
20 the head of that department or agency shall  
21 furnish that information to the Commission on  
22 an agreed upon schedule.

23 “(B) DATA COLLECTION.—In order to  
24 carry out its functions, the Commission shall—

1           “(i) utilize existing information, both  
2           published and unpublished, where possible,  
3           collected and assessed either by its own  
4           staff or under other arrangements made in  
5           accordance with this section,

6           “(ii) carry out, or award grants or  
7           contracts for, original research and experi-  
8           mentation, where existing information is  
9           inadequate, and

10           “(iii) adopt procedures allowing any  
11           interested party to submit information for  
12           the Commission’s use in making reports  
13           and recommendations.

14           “(C) ACCESS OF GAO TO INFORMATION.—  
15           The Comptroller General shall have unrestricted  
16           access to all deliberations, records, and non-  
17           proprietary data of the Commission, imme-  
18           diately upon request.

19           “(D) PERIODIC AUDIT.—The Commission  
20           shall be subject to periodic audit by the Com-  
21           ptroller General.

22           “(c) RESEARCH REQUIREMENTS.—Any research con-  
23           ducted, supported, or synthesized under this section shall  
24           meet the following requirements:

1           “(1) ENSURING TRANSPARENCY, CREDIBILITY,  
2           AND ACCESS.—

3           “(A) The establishment of the agenda and  
4           conduct of the research shall be insulated from  
5           inappropriate political or stakeholder influence.

6           “(B) Methods of conducting such research  
7           shall be scientifically based.

8           “(C) All aspects of the prioritization of re-  
9           search, conduct of the research, and develop-  
10          ment of conclusions based on the research shall  
11          be transparent to all stakeholders.

12          “(D) The process and methods for con-  
13          ducting such research shall be publicly docu-  
14          mented and available to all stakeholders.

15          “(E) Throughout the process of such re-  
16          search, the Center shall provide opportunities  
17          for all stakeholders involved to review and pro-  
18          vide comment on the methods and findings of  
19          such research.

20          “(2) USE OF CLINICAL PERSPECTIVE ADVISORY  
21          PANELS.—The research shall meet a national re-  
22          search priority determined under subsection  
23          (b)(2)(A) and shall examine the specific research in-  
24          quiry framed by the clinical perspective advisory  
25          panel for the national research priority.

1           “(3) STAKEHOLDER INPUT.—The priorities of  
2           the research, the research, and the dissemination of  
3           the research shall involve the consultation of pa-  
4           tients, health care providers, and health care con-  
5           sumer representatives through transparent mecha-  
6           nisms recommended by the Commission.

7           “(d) PUBLIC ACCESS TO COMPARATIVE EFFECTIVE-  
8           NESS INFORMATION.—

9           “(1) IN GENERAL.—Not later than 90 days  
10          after receipt by the Center or Commission, as appli-  
11          cable, of a relevant report described in paragraph  
12          (2) made by the Center, Commission, or clinical per-  
13          spective advisory panel under this section, appro-  
14          priate information contained in such report shall be  
15          posted on the official public Internet site of the Cen-  
16          ter and of the Commission, as applicable.

17          “(2) RELEVANT REPORTS DESCRIBED.—For  
18          purposes of this section, a relevant report is each of  
19          the following submitted by a grantee or contractor  
20          of the Center:

21                   “(A) An interim progress report.

22                   “(B) A draft final comparative effective-  
23                   ness review.

1           “(C) A final progress report on new re-  
2           search submitted for publication by a peer re-  
3           view journal.

4           “(D) Stakeholder comments.

5           “(E) A final report.

6           “(3) ACCESS BY CONGRESS AND THE COMMIS-  
7           SION TO THE CENTER’S INFORMATION.—Congress  
8           and the Commission shall each have unrestricted ac-  
9           cess to all deliberations, records, and nonproprietary  
10          data of the Center, immediately upon request.

11          “(e) DISSEMINATION AND INCORPORATION OF COM-  
12          PARATIVE EFFECTIVENESS INFORMATION.—

13           “(1) DISSEMINATION.—The Center shall pro-  
14          vide for the dissemination of appropriate findings  
15          produced by research supported, conducted, or syn-  
16          thesized under this section to health care providers,  
17          patients, vendors of health information technology  
18          focused on clinical decision support, appropriate pro-  
19          fessional associations, and Federal and private  
20          health plans.

21           “(2) INCORPORATION.—The Center shall assist  
22          users of health information technology focused on  
23          clinical decision support to promote the timely incor-  
24          poration of the findings described in paragraph (1)

1 into clinical practices and to promote the ease of use  
2 of such incorporation.

3 “(f) REPORTS TO CONGRESS.—

4 “(1) ANNUAL REPORTS.—Beginning not later  
5 than one year after the date of the enactment of this  
6 section, the Director of the Agency of Healthcare  
7 Research and Quality and the Center for Compara-  
8 tive Effectiveness Research shall submit to Congress  
9 an annual report on the activities of the Center and  
10 the Commission, as well as the research, conducted  
11 under this section.

12 “(2) RECOMMENDATION FOR FAIR SHARE PER  
13 CAPITA AMOUNT FOR ALL-PAYER FINANCING.—Be-  
14 ginning not later than December 31, 2009, the Sec-  
15 retary shall submit to Congress an annual rec-  
16 ommendation for a fair share per capita amount de-  
17 scribed in subsection (c)(1) of section 9511 of the  
18 Internal Revenue Code of 1986 for purposes of  
19 funding the CERTF under such section.

20 “(3) ANALYSIS AND REVIEW.—Not later than  
21 December 31, 2011, the Secretary, in consultation  
22 with the Commission, shall submit to Congress a re-  
23 port on all activities conducted or supported under  
24 this section as of such date. Such report shall in-  
25 clude an evaluation of the return on investment re-

1 sulting from such activities, the overall costs of such  
2 activities, and an analysis of the backlog of any re-  
3 search proposals approved by the Commission but  
4 not funded. Such report shall also address whether  
5 Congress should expand the responsibilities of the  
6 Center and of the Commission to include studies of  
7 the effectiveness of various aspects of the health care  
8 delivery system, including health plans and delivery  
9 models, such as health plan features, benefit designs  
10 and performance, and the ways in which health serv-  
11 ices are organized, managed, and delivered.

12 “(g) COORDINATING COUNCIL FOR HEALTH SERV-  
13 ICES RESEARCH.—

14 “(1) ESTABLISHMENT.—The Secretary shall es-  
15 tablish a permanent council (in this section referred  
16 to as the ‘Council’) for the purpose of—

17 “(A) assisting the offices and agencies of  
18 the Department of Health and Human Services,  
19 the Department of Veterans Affairs, the De-  
20 partment of Defense, and any other Federal de-  
21 partment or agency to coordinate the conduct  
22 or support of health services research; and

23 “(B) advising the President and Congress  
24 on—

1           “(i) the national health services re-  
2           search agenda;

3           “(ii) strategies with respect to infra-  
4           structure needs of health services research;  
5           and

6           “(iii) appropriate organizational ex-  
7           penditures in health services research by  
8           relevant Federal departments and agen-  
9           cies.

10          “(2) MEMBERSHIP.—

11           “(A) NUMBER AND APPOINTMENT.—The  
12          Council shall be composed of 20 members. One  
13          member shall be the Director of the Agency for  
14          Healthcare Research and Quality. The Director  
15          shall appoint the other members not later than  
16          30 days after the enactment of this Act.

17           “(B) TERMS.—

18           “(i) IN GENERAL.—Except as pro-  
19          vided in clause (ii), each member of the  
20          Council shall be appointed for a term of 4  
21          years.

22           “(ii) TERMS OF INITIAL AP-  
23          POINTEES.—Of the members first ap-  
24          pointed—



1                   “(I) 8 shall be appointed for a  
2                   term of 4 years; and

3                   “(II) 7 shall be appointed for a  
4                   term of 3 years.

5                   “(iii) VACANCIES.—Any vacancies  
6                   shall not affect the power and duties of the  
7                   Council and shall be filled in the same  
8                   manner as the original appointment.

9                   “(C) QUALIFICATIONS.—

10                   “(i) IN GENERAL.—The members of  
11                   the Council shall include one senior official  
12                   from each of the following agencies:

13                   “(I) The Veterans Health Ad-  
14                   ministration.

15                   “(II) The Department of Defense  
16                   Military Health Care System.

17                   “(III) The Centers for Disease  
18                   Control and Prevention.

19                   “(IV) The National Center for  
20                   Health Statistics.

21                   “(V) The National Institutes of  
22                   Health.

23                   “(VI) The Center for Medicare  
24                   & Medicaid Services.

1                   “(VII) The Federal Employees  
2                   Health Benefits Program.

3                   “(ii) NATIONAL, PHILANTHROPIC  
4                   FOUNDATIONS.—The members of the  
5                   Council shall include 4 senior leaders from  
6                   major national, philanthropic foundations  
7                   that fund and use health services research.

8                   “(iii) STAKEHOLDERS.—The remain-  
9                   ing members of the Council shall be rep-  
10                  resentatives of other stakeholders in health  
11                  services research, including private pur-  
12                  chasers, health plans, hospitals and other  
13                  health facilities, and health consumer  
14                  groups.

15                  “(3) ANNUAL REPORT.—The Council shall sub-  
16                  mit to Congress an annual report on the progress of  
17                  the implementation of the national health services  
18                  research agenda.

19                  “(h) FUNDING OF COMPARATIVE EFFECTIVENESS  
20                  RESEARCH.—For fiscal year 2009 and each subsequent  
21                  fiscal year, amounts in the Comparative Effectiveness Re-  
22                  search Trust Fund (referred to in this section as the  
23                  ‘CERTF’) under section 9511 of the Internal Revenue  
24                  Code of 1986 shall be available to the Secretary to carry  
25                  out this section.”.

1 (b) COMPARATIVE EFFECTIVENESS RESEARCH  
2 TRUST FUND; FINANCING FOR TRUST FUND.—

3 (1) ESTABLISHMENT OF TRUST FUND.—

4 (A) IN GENERAL.—Subchapter A of chap-  
5 ter 98 of the Internal Revenue Code of 1986  
6 (relating to trust fund code) is amended by  
7 adding at the end the following new section:

8 **“SEC. 9511. HEALTH CARE COMPARATIVE EFFECTIVENESS**  
9 **RESEARCH TRUST FUND.**

10 “(a) CREATION OF TRUST FUND.—There is estab-  
11 lished in the Treasury of the United States a trust fund  
12 to be known as the ‘Health Care Comparative Effective-  
13 ness Research Trust Fund’ (hereinafter in this section re-  
14 ferred to as the ‘CERTF’), consisting of such amounts  
15 as may be appropriated or credited to such Trust Fund  
16 as provided in this section and section 9602(b).

17 “(b) TRANSFERS TO FUND.—There are hereby ap-  
18 propriated to the Trust Fund the following:

19 “(1) For fiscal year 2008, \$90,000,000.

20 “(2) For fiscal year 2009, \$100,000,000.

21 “(3) For fiscal year 2010, \$110,000,000.

22 “(4) For each fiscal year beginning with fiscal  
23 year 2011—

24 “(A) an amount equivalent to the net reve-  
25 nues received in the Treasury from the fees im-

1           posed under subchapter B of chapter 34 (relat-  
2           ing to fees on health insurance and self-insured  
3           plans) for such fiscal year; and

4                   “(B) subject to subsection (c)(2), amounts  
5           determined by the Secretary of Health and  
6           Human Services to be equivalent to the fair  
7           share per capita amount computed under sub-  
8           section (c)(1) for the fiscal year multiplied by  
9           the average number of individuals entitled to  
10          benefits under part A, or enrolled under part B,  
11          of title XVIII of the Social Security Act during  
12          such fiscal year.

13   The amounts appropriated under paragraphs (1), (2), (3),  
14   and (4)(B) shall be transferred from the Federal Hospital  
15   Insurance Trust Fund and from the Federal Supple-  
16   mentary Medical Insurance Trust Fund (established  
17   under section 1841 of such Act), and from the Medicare  
18   Prescription Drug Account within such Trust Fund, in  
19   proportion (as estimated by the Secretary) to the total ex-  
20   penditures during such fiscal year that are made under  
21   title XVIII of such Act from the respective trust fund or  
22   account.

23           “(c) FAIR SHARE PER CAPITA AMOUNT.—

24                   “(1) COMPUTATION.—

1           “(A) IN GENERAL.—Subject to subpara-  
2 graph (B), the fair share per capita amount  
3 under this paragraph for a fiscal year (begin-  
4 ning with fiscal year 2011) is an amount com-  
5 puted by the Secretary of Health and Human  
6 Services for such fiscal year that, when applied  
7 under this section and subchapter B of chapter  
8 34 of the Internal Revenue Code of 1986, will  
9 result in revenues to the CERTF of  
10 \$375,000,000 for the fiscal year.

11           “(B) ALTERNATIVE COMPUTATION.—

12           “(i) IN GENERAL.—If the Secretary is  
13 unable to compute the fair share per capita  
14 amount under subparagraph (A) for a fis-  
15 cal year, the fair share per capita amount  
16 under this paragraph for the fiscal year  
17 shall be the default amount determined  
18 under clause (ii) for the fiscal year.

19           “(ii) DEFAULT AMOUNT.—The default  
20 amount under this clause for—

21                   “(I) fiscal year 2011 is equal to  
22                   \$2; or

23                   “(II) a subsequent year is equal  
24                   to the default amount under this  
25                   clause for the preceding fiscal year

1 increased by the annual percentage in-  
2 crease in the medical care component  
3 of the consumer price index (United  
4 States city average) for the 12-month  
5 period ending with April of the pre-  
6 ceding fiscal year.

7 Any amount determined under subclause  
8 (II) shall be rounded to the nearest penny.

9 “(2) LIMITATION ON MEDICARE FUNDING.—In  
10 no case shall the amount transferred under sub-  
11 section (b)(4)(B) for any fiscal year exceed  
12 \$90,000,000.

13 “(d) EXPENDITURES FROM FUND.—

14 “(1) IN GENERAL.—Subject to paragraph (2),  
15 amounts in the CERTF are available to the Sec-  
16 retary of Health and Human Services for carrying  
17 out section 1822 of the Social Security Act.

18 “(2) ALLOCATION FOR COMMISSION.—The fol-  
19 lowing amounts in the CERTF for a fiscal year shall  
20 be available to carry out the activities of the Com-  
21 parative Effectiveness Research Commission estab-  
22 lished under section 1822(b) of the Social Security  
23 Act for such fiscal year:

24 “(A) For fiscal year 2008, \$7,000,000.

25 “(B) For fiscal year 2009, \$9,000,000.

1           “(C) For each fiscal year beginning with  
2           2010, \$10,000,000.

3           Nothing in this paragraph shall be construed as pre-  
4           venting additional amounts in the CERTF from  
5           being made available to the Comparative Effective-  
6           ness Research Commission for such activities.

7           “(e) NET REVENUES.—For purposes of this section,  
8           the term ‘net revenues’ means the amount estimated by  
9           the Secretary based on the excess of—

10           “(1) the fees received in the Treasury under  
11           subchapter B of chapter 34, over

12           “(2) the decrease in the tax imposed by chapter  
13           1 resulting from the fees imposed by such sub-  
14           chapter.”.

15           (B) CLERICAL AMENDMENT.—The table of  
16           sections for such subchapter A is amended by  
17           adding at the end thereof the following new  
18           item:

“Sec. 9511. Health Care Comparative Effectiveness Research Trust Fund”.

19           (2) FINANCING FOR FUND FROM FEES ON IN-  
20           SURED AND SELF-INSURED HEALTH PLANS.—

21           (A) GENERAL RULE.—Chapter 34 of the  
22           Internal Revenue Code of 1986 is amended by  
23           adding at the end the following new subchapter:





1           “(C) liabilities relating to ownership or use  
2 of property,

3           “(D) credit insurance,

4           “(E) medicare supplemental coverage, or

5           “(F) such other similar liabilities as the  
6 Secretary may specify by regulations.

7           “(3) TREATMENT OF PREPAID HEALTH COV-  
8 ERAGE ARRANGEMENTS.—

9           “(A) IN GENERAL.—In the case of any ar-  
10 rangement described in subparagraph (B)—

11           “(i) such arrangement shall be treated  
12 as a specified health insurance policy, and

13           “(ii) the person referred to in such  
14 subparagraph shall be treated as the  
15 issuer.

16           “(B) DESCRIPTION OF ARRANGEMENTS.—

17 An arrangement is described in this subpara-  
18 graph if under such arrangement fixed pay-  
19 ments or premiums are received as consider-  
20 ation for any person’s agreement to provide or  
21 arrange for the provision of accident or health  
22 coverage to residents of the United States, re-  
23 gardless of how such coverage is provided or ar-  
24 ranged to be provided.

1 **“SEC. 4376. SELF-INSURED HEALTH PLANS.**

2 “(a) IMPOSITION OF FEE.—In the case of any appli-  
3 cable self-insured health plan for each plan year, there is  
4 hereby imposed a fee equal to the fair share per capita  
5 amount determined under section 9511(c)(1) multiplied by  
6 the average number of lives covered under the plan.

7 “(b) LIABILITY FOR FEE.—

8 “(1) IN GENERAL.—The fee imposed by sub-  
9 section (a) shall be paid by the plan sponsor.

10 “(2) PLAN SPONSOR.—For purposes of para-  
11 graph (1) the term ‘plan sponsor’ means—

12 “(A) the employer in the case of a plan es-  
13 tablished or maintained by a single employer,

14 “(B) the employee organization in the case  
15 of a plan established or maintained by an em-  
16 ployee organization,

17 “(C) in the case of—

18 “(i) a plan established or maintained  
19 by 2 or more employers or jointly by 1 or  
20 more employers and 1 or more employee  
21 organizations,

22 “(ii) a multiple employer welfare ar-  
23 rangement, or

24 “(iii) a voluntary employees’ bene-  
25 ficiary association described in section  
26 501(c)(9),

1 the association, committee, joint board of trust-  
2 ees, or other similar group of representatives of  
3 the parties who establish or maintain the plan,  
4 or

5 “(D) the cooperative or association de-  
6 scribed in subsection (c)(2)(F) in the case of a  
7 plan established or maintained by such a coop-  
8 erative or association.

9 “(c) APPLICABLE SELF-INSURED HEALTH PLAN.—  
10 For purposes of this section, the term ‘applicable self-in-  
11 sured health plan’ means any plan for providing accident  
12 or health coverage if—

13 “(1) any portion of such coverage is provided  
14 other than through an insurance policy, and

15 “(2) such plan is established or maintained—

16 “(A) by one or more employers for the  
17 benefit of their employees or former employees,

18 “(B) by one or more employee organiza-  
19 tions for the benefit of their members or former  
20 members,

21 “(C) jointly by 1 or more employers and 1  
22 or more employee organizations for the benefit  
23 of employees or former employees,

24 “(D) by a voluntary employees’ beneficiary  
25 association described in section 501(c)(9),

1           “(E) by any organization described in sec-  
2           tion 501(c)(6), or

3           “(F) in the case of a plan not described in  
4           the preceding subparagraphs, by a multiple em-  
5           ployer welfare arrangement (as defined in sec-  
6           tion 3(40) of Employee Retirement Income Se-  
7           curity Act of 1974), a rural electric cooperative  
8           (as defined in section 3(40)(B)(iv) of such Act),  
9           or a rural telephone cooperative association (as  
10          defined in section 3(40)(B)(v) of such Act).

11 **“SEC. 4377. DEFINITIONS AND SPECIAL RULES.**

12          “(a) DEFINITIONS.—For purposes of this sub-  
13          chapter—

14               “(1) ACCIDENT AND HEALTH COVERAGE.—The  
15               term ‘accident and health coverage’ means any cov-  
16               erage which, if provided by an insurance policy,  
17               would cause such policy to be a specified health in-  
18               surance policy (as defined in section 4375(c)).

19               “(2) INSURANCE POLICY.—The term ‘insurance  
20               policy’ means any policy or other instrument where-  
21               by a contract of insurance is issued, renewed, or ex-  
22               tended.

23               “(3) UNITED STATES.—The term ‘United  
24               States’ includes any possession of the United States.

25          “(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

1           “(1) IN GENERAL.—For purposes of this sub-  
2 chapter—

3           “(A) the term ‘person’ includes any gov-  
4 ernmental entity, and

5           “(B) notwithstanding any other law or rule  
6 of law, governmental entities shall not be ex-  
7 empt from the fees imposed by this subchapter  
8 except as provided in paragraph (2).

9           “(2) TREATMENT OF EXEMPT GOVERNMENTAL  
10 PROGRAMS.—In the case of an exempt governmental  
11 program, no fee shall be imposed under section 4375  
12 or section 4376 on any covered life under such pro-  
13 gram.

14           “(3) EXEMPT GOVERNMENTAL PROGRAM DE-  
15 FINED.—For purposes of this subchapter, the term  
16 ‘exempt governmental program’ means—

17           “(A) any insurance program established  
18 under title XVIII of the Social Security Act,

19           “(B) the medical assistance program es-  
20 tablished by title XIX or XXI of the Social Se-  
21 curity Act,

22           “(C) any program established by Federal  
23 law for providing medical care (other than  
24 through insurance policies) to individuals (or

1 the spouses and dependents thereof) by reason  
2 of such individuals being—

3 “(i) members of the Armed Forces of  
4 the United States, or

5 “(ii) veterans, and

6 “(D) any program established by Federal  
7 law for providing medical care (other than  
8 through insurance policies) to members of In-  
9 dian tribes (as defined in section 4(d) of the In-  
10 dian Health Care Improvement Act).

11 “(c) TREATMENT AS TAX.—For purposes of subtitle  
12 F, the fees imposed by this subchapter shall be treated  
13 as if they were taxes.

14 “(d) NO COVER OVER TO POSSESSIONS.—Notwith-  
15 standing any other provision of law, no amount collected  
16 under this subchapter shall be covered over to any posses-  
17 sion of the United States.”

18 (B) CLERICAL AMENDMENT.—Chapter 34  
19 of such Code is amended by striking the chap-  
20 ter heading and inserting the following:

21 **“CHAPTER 34—TAXES ON CERTAIN**  
22 **INSURANCE POLICIES**

“SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

“SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

1     **“Subchapter A—Policies Issued By Foreign**  
2                                   **Insurers”.**

3                   (C) EFFECTIVE DATE.—The amendments  
4                   made by this subsection shall apply with respect  
5                   to policies and plans for portions of policy or  
6                   plan years beginning on or after October 1,  
7                   2010.

8     **SEC. 905. IMPLEMENTATION OF HEALTH INFORMATION**  
9                                   **TECHNOLOGY (IT) UNDER MEDICARE.**

10           (a) IN GENERAL.—Not later than January 1, 2010,  
11     the Secretary of Health and Human Services shall submit  
12     to Congress a report that includes—

13                   (1) a plan to develop and implement a health  
14                   information technology (health IT) system for all  
15                   health care providers under the Medicare program  
16                   that meets the specifications described in subsection  
17                   (b); and

18                   (2) an analysis of the impact, feasibility, and  
19                   costs associated with the use of health information  
20                   technology in medically underserved communities.

21           (b) PLAN SPECIFICATION.—The specifications de-  
22     scribed in this subsection, with respect to a health infor-  
23     mation technology system described in subsection (a), are  
24     the following:

1           (1) The system protects the privacy and secu-  
2           rity of individually identifiable health information.

3           (2) The system maintains and provides per-  
4           mitted access to health information in an electronic  
5           format (such as through computerized patient  
6           records or a clinical data repository).

7           (3) The system utilizes interface software that  
8           allows for interoperability.

9           (4) The system includes clinical decision sup-  
10          port.

11          (5) The system incorporates e-prescribing and  
12          computerized physician order entry.

13          (6) The system incorporates patient tracking  
14          and reminders.

15          (7) The system utilizes technology that is open  
16          source (if available) or technology that has been de-  
17          veloped by the government.

18 The report shall include an analysis of the financial and  
19 administrative resources necessary to develop such system  
20 and recommendations regarding the level of subsidies  
21 needed for all such health care providers to adopt the sys-  
22 tem.



1 **SEC. 906. DEVELOPMENT, REPORTING, AND USE OF**  
2 **HEALTH CARE MEASURES.**

3 (a) IN GENERAL.—Part E of title XVIII of the Social  
4 Security Act (42 U.S.C. 1395x et seq.) is amended by in-  
5 serting after section 1889 the following:

6 “DEVELOPMENT, REPORTING, AND USE OF HEALTH CARE  
7 MEASURES

8 “SEC. 1890. (a) FOSTERING DEVELOPMENT OF  
9 HEALTH CARE MEASURES.—The Secretary shall des-  
10 ignate, and have in effect an arrangement with, a single  
11 organization (such as the National Quality Forum) that  
12 meets the requirements described in subsection (c), under  
13 which such organization provides the Secretary with ad-  
14 vice on, and recommendations with respect to, the key ele-  
15 ments and priorities of a national system for establishing  
16 health care measures. The arrangement shall be effective  
17 beginning no sooner than January 1, 2008, and no later  
18 than September 30, 2008.

19 “(b) DUTIES.—The duties of the organization des-  
20 igned under subsection (a) (in this title referred to as  
21 the ‘designated organization’) shall, in accordance with  
22 subsection (d), include—

23 “(1) establishing and managing an integrated  
24 national strategy and process for setting priorities  
25 and goals in establishing health care measures;

1           “(2) coordinating the development and speci-  
2           fications of such measures;

3           “(3) establishing standards for the development  
4           and testing of such measures;

5           “(4) endorsing national consensus health care  
6           measures; and

7           “(5) advancing the use of electronic health  
8           records for automating the collection, aggregation,  
9           and transmission of measurement information.

10          “(c) REQUIREMENTS DESCRIBED.—For purposes of  
11          subsection (a), the requirements described in this sub-  
12          section, with respect to an organization, are the following:

13           “(1) PRIVATE NONPROFIT.—The organization  
14           is a private nonprofit entity governed by a board and  
15           an individual designated as president and chief execu-  
16           tive officer.

17           “(2) BOARD MEMBERSHIP.—The members of  
18           the board of the organization include representatives  
19           of—

20           “(A) health care providers or groups rep-  
21           resenting such providers;

22           “(B) health plans or groups representing  
23           health plans;

24           “(C) groups representing health care con-  
25           sumers;

1           “(D) health care purchasers and employers  
2           or groups representing such purchasers or em-  
3           ployers; and

4           “(E) health care practitioners or groups  
5           representing practitioners.

6           “(3) OTHER MEMBERSHIP REQUIREMENTS.—

7           The membership of the organization is representa-  
8           tive of individuals with experience with—

9           “(A) urban health care issues;

10           “(B) safety net health care issues;

11           “(C) rural and frontier health care issues;

12           and

13           “(D) health care quality and safety issues.

14           “(4) OPEN AND TRANSPARENT.—With respect

15           to matters related to the arrangement described in

16           subsection (a), the organization conducts its busi-

17           ness in an open and transparent manner and pro-

18           vides the opportunity for public comment.

19           “(5) VOLUNTARY CONSENSUS STANDARDS SET-

20           TING ORGANIZATION.—The organization operates as

21           a voluntary consensus standards setting organization

22           as defined for purposes of section 12(d) of the Na-

23           tional Technology Transfer and Advancement Act of

24           1995 (Public Law 104–113) and Office of Manage-

1       ment and Budget Revised Circular A-119 (published  
2       in the Federal Register on February 10, 1998).

3           “(6) EXPERIENCE.—The organization has at  
4       least 7 years experience in establishing national con-  
5       sensus standards.

6           “(d) REQUIREMENTS FOR EFFECTIVENESS MEAS-  
7       URES.—In carrying out its duties under subsection (b),  
8       the designated organization shall ensure the following:

9           “(1) MEASURES.—The designated organization  
10       shall ensure that the measures established or en-  
11       dorsed under subsection (b) are evidence-based, reli-  
12       able, and valid; and include—

13           “(A) measures of clinical processes and  
14       outcomes, patient experience, efficiency, and eq-  
15       uity;

16           “(B) measures to assess effectiveness,  
17       timeliness, patient self-management, patient  
18       centeredness, and safety; and

19           “(C) measures of under use and over use.

20           “(2) PRIORITIES.—

21           “(A) IN GENERAL.—The designated orga-  
22       nization shall ensure that priority is given to es-  
23       tablishing and endorsing—

1 “(i) measures with the greatest poten-  
2 tial impact for improving the effectiveness  
3 and efficiency of health care;

4 “(ii) measures that may be rapidly  
5 implemented by group health plans, health  
6 insurance issuers, physicians, hospitals,  
7 nursing homes, long-term care providers,  
8 and other providers;

9 “(iii) measures which may inform  
10 health care decisions made by consumers  
11 and patients; and

12 “(iv) measures that apply to multiple  
13 services furnished by different providers  
14 during an episode of care.

15 “(B) ANNUAL REPORT ON PRIORITIES;  
16 SECRETARIAL PUBLICATION AND COMMENT.—

17 “(i) ANNUAL REPORT.—The des-  
18 ignated organization shall issue and submit  
19 to the Secretary a report by March 31 of  
20 each year (beginning with 2009) on the or-  
21 ganization’s recommendations for priorities  
22 and goals in establishing and endorsing  
23 health care measures under this section  
24 over the next five years.

1                   “(ii) SECRETARIAL REVIEW AND COM-  
2                   MENT.—After receipt of the report under  
3                   clause (i) for a year, the Secretary shall  
4                   publish the report in the Federal Register,  
5                   including any comments of the Secretary  
6                   on the priorities and goals set forth in the  
7                   report.

8                   “(3) RISK ADJUSTMENT.—The designated orga-  
9                   nization, in consultation with health care measure  
10                  developers and other stakeholders, shall establish  
11                  procedures to assure that health care measures es-  
12                  tablished and endorsed under this section account  
13                  for differences in patient health status, patient char-  
14                  acteristics, and geographic location, as appropriate.

15                  “(4) MAINTENANCE.—The designated organiza-  
16                  tion, in consultation with owners and developers of  
17                  health care measures, shall require the owners or de-  
18                  velopers of such measures to update and enhance  
19                  such measures, including the development of more  
20                  accurate and precise specifications, and retire exist-  
21                  ing outdated measures. Such updating shall occur  
22                  not more often than once during each 12-month pe-  
23                  riod, except in the case of emergent circumstances  
24                  requiring a more immediate update to a measure.

1       “(e) USE OF HEALTH CARE MEASURES; REPORT-  
2   ING.—

3               “(1) USE OF MEASURES.—For purposes of ac-  
4   tivities authorized or required under this title, the  
5   Secretary shall select from health care measures—

6                       “(A) recommended by multi-stakeholder  
7                       groups; and

8                       “(B) endorsed by the designated organiza-  
9                       tion under subsection (b)(4).

10               “(2) REPORTING.—The Secretary shall imple-  
11   ment procedures, consistent with generally accepted  
12   standards, to enable the Department of Health and  
13   Human Services to accept the electronic submission  
14   of data for purposes of—

15                       “(A) effectiveness measurement using the  
16                       health care measures developed pursuant to this  
17                       section; and

18                       “(B) reporting to the Secretary measures  
19                       used to make value-based payments under this  
20                       title.

21               “(f) CONTRACTS.—The Secretary, acting through the  
22   Agency for Healthcare Research and Quality, may con-  
23   tract with organizations to support the development and  
24   testing of health care measures meeting the standards es-  
25   tablished by the designated organization.

1           “(g) DISSEMINATION OF INFORMATION.—In order to  
2 make comparative effectiveness information available to  
3 health care consumers, health professionals, public health  
4 officials, oversight organizations, researchers, and other  
5 appropriate individuals and entities, the Secretary shall  
6 work with multi-stakeholder groups to provide for the dis-  
7 semination of effectiveness information developed pursu-  
8 ant to this title.

9           “(h) FUNDING.—For purposes of carrying out sub-  
10 sections (a), (b), (c), and (d), including for expenses in-  
11 curred for the arrangement under subsection (a) with the  
12 designated organization, there is payable from the Federal  
13 Hospital Insurance Trust Fund (established under section  
14 1817) and the Federal Supplementary Medical Insurance  
15 Trust Fund (established under section 1841)—

16           “(1) for fiscal year 2008, \$15,000,000, multi-  
17 plied by the ratio of the total number of months in  
18 the year to the number of months (and portions of  
19 months) of such year during which the arrangement  
20 under subsection (a) is effective; and

21           “(2) for each of the fiscal years, 2009 through  
22 2012, \$15,000,000.”.

23 **SEC. 907. IMPROVEMENTS TO THE MEDIGAP PROGRAM.**

24           (a) IMPLEMENTATION OF NAIC RECOMMENDA-  
25 TIONS.—The Secretary of Health and Human Services



1 shall provide, under subsections (p)(1)(E) of section 1882  
2 of the Social Security Act (42 U.S.C. 1395s), for imple-  
3 mentation of the changes in the NAIC model law and reg-  
4 ulations recommended by the National Association of In-  
5 surance Commissioners in its Model #651 (“Model Regu-  
6 lation to Implement the NAIC Medicare Supplement In-  
7 surance Minimum Standards Model Act”) on March 11,  
8 2007, as modified to reflect the changes made under this  
9 Act. In carrying out the previous sentence, the benefit  
10 packages classified as “K” and “L” shall be eliminated  
11 and such NAIC recommendations shall be treated as hav-  
12 ing been adopted by such Association as of January 1,  
13 2008.

14 (b) REQUIRED OFFERING OF A RANGE OF POLI-  
15 CIES.—

16 (1) IN GENERAL.—Subsection (o) of such sec-  
17 tion is amended by adding at the end the following  
18 new paragraph:

19 “(4) In addition to the requirement of para-  
20 graph (2), the issuer of the policy must make avail-  
21 able to the individual at least medicare supplemental  
22 policies with benefit packages classified as ‘C’ or  
23 ‘F’.”.

1           (2) EFFECTIVE DATE.—The amendment made  
2           by paragraph (1) shall apply to medicare supple-  
3           mental policies issued on or after January 1, 2008.

4           (c) REMOVAL OF NEW BENEFIT PACKAGES.—Such  
5           section is further amended—

6           (1) in subsection (o)(1), by striking “(p), (v),  
7           and (w)” and inserting “(p) and (v)”;

8           (2) in subsection (v)(3)(A)(i), by striking “or a  
9           benefit package described in subparagraph (A) or  
10          (B) of subsection (w)(2)”;

11          (3) in subsection (w)—

12           (A) by striking “POLICIES” and all that  
13           follows through “The Secretary” and inserting  
14           “POLICIES.—The Secretary”;

15           (B) by striking the second sentence; and

16           (C) by striking paragraph (2) .

## 17           **TITLE X—REVENUES**

### 18           **SEC. 1001. INCREASE IN RATE OF EXCISE TAXES ON TO-** 19           **BACCO PRODUCTS AND CIGARETTE PAPERS** 20           **AND TUBES.**

21          (a) SMALL CIGARETTES.—Paragraph (1) of section  
22          5701(b) of the Internal Revenue Code of 1986 is amended  
23          by striking “\$19.50 per thousand (\$17 per thousand on  
24          cigarettes removed during 2000 or 2001)” and inserting  
25          “\$42 per thousand”.

1 (b) LARGE CIGARETTES.—Paragraph (2) of section  
2 5701(b) of such Code is amended by striking “\$40.95 per  
3 thousand (\$35.70 per thousand on cigarettes removed  
4 during 2000 or 2001)” and inserting “\$88.20 per thou-  
5 sand”.

6 (c) SMALL CIGARS.—Paragraph (1) of section  
7 5701(a) of such Code is amended by striking “\$1.828  
8 cents per thousand (\$1.594 cents per thousand on cigars  
9 removed during 2000 or 2001)” and inserting “\$42 per  
10 thousand”.

11 (d) LARGE CIGARS.—Paragraph (2) of section  
12 5701(a) of such Code is amended—

13 (1) by striking “20.719 percent (18.063 percent  
14 on cigars removed during 2000 or 2001)” and in-  
15 serting “44.63 percent”, and

16 (2) by striking “\$48.75 per thousand (\$42.50  
17 per thousand on cigars removed during 2000 or  
18 2001)” and inserting “\$1 per cigar”.

19 (e) CIGARETTE PAPERS.—Subsection (c) of section  
20 5701 of such Code is amended by striking “1.22 cents  
21 (1.06 cents on cigarette papers removed during 2000 or  
22 2001)” and inserting “2.63 cents”.

23 (f) CIGARETTE TUBES.—Subsection (d) of section  
24 5701 of such Code is amended by striking “2.44 cents

1 (2.13 cents on cigarette tubes removed during 2000 or  
2 2001)” and inserting “5.26 cents”.

3 (g) SNUFF.—Paragraph (1) of section 5701(e) of  
4 such Code is amended by striking “58.5 cents (51 cents  
5 on snuff removed during 2000 or 2001)” and inserting  
6 “\$1.26”.

7 (h) CHEWING TOBACCO.—Paragraph (2) of section  
8 5701(e) of such Code is amended by striking “19.5 cents  
9 (17 cents on chewing tobacco removed during 2000 or  
10 2001)” and inserting “42 cents”.

11 (i) PIPE TOBACCO.—Subsection (f) of section 5701  
12 of such Code is amended by striking “\$1.0969 cents  
13 (95.67 cents on pipe tobacco removed during 2000 or  
14 2001)” and inserting “\$2.36”.

15 (j) ROLL-YOUR-OWN TOBACCO.—

16 (1) IN GENERAL.—Subsection (g) of section  
17 5701 of such Code is amended by striking “\$1.0969  
18 cents (95.67 cents on roll-your-own tobacco removed  
19 during 2000 or 2001)” and inserting “\$7.4667”.

20 (2) INCLUSION OF CIGAR TOBACCO.—Sub-  
21 section (o) of section 5702 of such Code is amended  
22 by inserting “or cigars, or for use as wrappers for  
23 making cigars” before the period at the end.

1 (k) EFFECTIVE DATE.—The amendments made by  
2 this section shall apply to articles removed after December  
3 31, 2007.

4 (l) FLOOR STOCKS TAXES.—

5 (1) IMPOSITION OF TAX.—On cigarettes manu-  
6 factured in or imported into the United States which  
7 are removed before January 1, 2008, and held on  
8 such date for sale by any person, there is hereby im-  
9 posed a tax in an amount equal to the excess of—

10 (A) the tax which would be imposed under  
11 section 5701 of the Internal Revenue Code of  
12 1986 on the article if the article had been re-  
13 moved on such date, over

14 (B) the prior tax (if any) imposed under  
15 section 5701 of such Code on such article.

16 (2) AUTHORITY TO EXEMPT CIGARETTES HELD  
17 IN VENDING MACHINES.—To the extent provided in  
18 regulations prescribed by the Secretary, no tax shall  
19 be imposed by paragraph (1) on cigarettes held for  
20 retail sale on January 1, 2008, by any person in any  
21 vending machine. If the Secretary provides such a  
22 benefit with respect to any person, the Secretary  
23 may reduce the \$500 amount in paragraph (3) with  
24 respect to such person.

1           (3) CREDIT AGAINST TAX.—Each person shall  
2           be allowed as a credit against the taxes imposed by  
3           paragraph (1) an amount equal to \$500. Such credit  
4           shall not exceed the amount of taxes imposed by  
5           paragraph (1) for which such person is liable.

6           (4) LIABILITY FOR TAX AND METHOD OF PAY-  
7           MENT.—

8                   (A) LIABILITY FOR TAX.—A person hold-  
9                   ing cigarettes on January 1, 2008, to which any  
10                   tax imposed by paragraph (1) applies shall be  
11                   liable for such tax.

12                   (B) METHOD OF PAYMENT.—The tax im-  
13                   posed by paragraph (1) shall be paid in such  
14                   manner as the Secretary shall prescribe by reg-  
15                   ulations.

16                   (C) TIME FOR PAYMENT.—The tax im-  
17                   posed by paragraph (1) shall be paid on or be-  
18                   fore April 14, 2008.

19           (5) ARTICLES IN FOREIGN TRADE ZONES.—  
20           Notwithstanding the Act of June 18, 1934 (48 Stat.  
21           998, 19 U.S.C. 81a) and any other provision of law,  
22           any article which is located in a foreign trade zone  
23           on January 1, 2008, shall be subject to the tax im-  
24           posed by paragraph (1) if—

1 (A) internal revenue taxes have been deter-  
2 mined, or customs duties liquidated, with re-  
3 spect to such article before such date pursuant  
4 to a request made under the 1st proviso of sec-  
5 tion 3(a) of such Act, or

6 (B) such article is held on such date under  
7 the supervision of a customs officer pursuant to  
8 the 2d proviso of such section 3(a).

9 (6) DEFINITIONS.—For purposes of this sub-  
10 section—

11 (A) IN GENERAL.—Terms used in this sub-  
12 section which are also used in section 5702 of  
13 the Internal Revenue Code of 1986 shall have  
14 the respective meanings such terms have in  
15 such section.

16 (B) SECRETARY.—The term “Secretary”  
17 means the Secretary of the Treasury or the  
18 Secretary’s delegate.

19 (7) CONTROLLED GROUPS.—Rules similar to  
20 the rules of section 5061(e)(3) of such Code shall  
21 apply for purposes of this subsection.

22 (8) OTHER LAWS APPLICABLE.—All provisions  
23 of law, including penalties, applicable with respect to  
24 the taxes imposed by section 5701 of such Code  
25 shall, insofar as applicable and not inconsistent with

1 the provisions of this subsection, apply to the floor  
2 stocks taxes imposed by paragraph (1), to the same  
3 extent as if such taxes were imposed by such section  
4 5701. The Secretary may treat any person who bore  
5 the ultimate burden of the tax imposed by para-  
6 graph (1) as the person to whom a credit or refund  
7 under such provisions may be allowed or made.

8 **SEC. 1002. EXEMPTION FOR EMERGENCY MEDICAL SERV-**  
9 **ICES TRANSPORTATION.**

10 (a) IN GENERAL.—Subsection (l) of section 4041 of  
11 the Internal Revenue Code of 1986 is amended to read  
12 as follows:

13 “(l) EXEMPTION FOR CERTAIN USES.—

14 “(1) CERTAIN AIRCRAFT.—No tax shall be im-  
15 posed under this section on any liquid sold for use  
16 in, or used in, a helicopter or a fixed-wing aircraft  
17 for purposes of providing transportation with respect  
18 to which the requirements of subsection (f) or (g) of  
19 section 4261 are met.

20 “(2) EMERGENCY MEDICAL SERVICES.—No tax  
21 shall be imposed under this section on any liquid  
22 sold for use in, or used in, any ambulance for pur-  
23 poses of providing transportation for emergency  
24 medical services. The preceding sentence shall not  
25 apply to any liquid used after December 31, 2009.”.



1 (b) FUELS NOT USED FOR TAXABLE PURPOSES.—  
2 Section 6427 of such Code is amended by inserting after  
3 subsection (e) the following new subsection:

4 “(f) USE TO PROVIDE EMERGENCY MEDICAL SERV-  
5 ICES.—Except as provided in subsection (k), if any fuel  
6 on which tax was imposed by section 4081 or 4041 is used  
7 in an ambulance for a purpose described in section  
8 4041(l)(2), the Secretary shall pay (without interest) to  
9 the ultimate purchaser of such fuel an amount equal to  
10 the aggregate amount of the tax imposed on such fuel.  
11 The preceding sentence shall not apply to any liquid used  
12 after December 31, 2009.”.

13 (c) TIME FOR FILING CLAIMS; PERIOD COVERED.—  
14 Paragraphs (1) and (2)(A) of section 6427(i) of such Code  
15 are each amended by inserting “(f),” after “(d),”.

16 (d) CONFORMING AMENDMENT.—Section 6427(d) of  
17 such Code is amended by striking “4041(l)” and inserting  
18 “4041(l)(1)”.

19 (e) EFFECTIVE DATE.—The amendments made by  
20 this section shall apply to fuel used in transportation pro-  
21 vided in quarters beginning after the date of the enact-  
22 ment of this Act.