

110<sup>TH</sup> CONGRESS  
2<sup>D</sup> SESSION

# H. R. 6331

To amend titles XVIII and XIX of the Social Security Act to extend expiring provisions under the Medicare Program, to improve beneficiary access to preventive and mental health services, to enhance low-income benefit programs, and to maintain access to care in rural areas, including pharmacy access, and for other purposes.

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## IN THE HOUSE OF REPRESENTATIVES

JUNE 20, 2008

Mr. RANGEL (for himself and Mr. DINGELL) introduced the following bill; which was referred to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned

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## A BILL

To amend titles XVIII and XIX of the Social Security Act to extend expiring provisions under the Medicare Program, to improve beneficiary access to preventive and mental health services, to enhance low-income benefit programs, and to maintain access to care in rural areas, including pharmacy access, and for other purposes.

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

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

2 (a) **SHORT TITLE.**—This Act may be cited as the  
 3 “Medicare Improvements for Patients and Providers Act  
 4 of 2008”.

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

Sec. 1. Short title; table of contents.

**TITLE I—MEDICARE**

**Subtitle A—Beneficiary Improvements**

**PART I—PREVENTION, MENTAL HEALTH, AND MARKETING**

- Sec. 101. Improvements to coverage of preventive services.
- Sec. 102. Elimination of discriminatory copayment rates for Medicare out-patient psychiatric services.
- Sec. 103. Prohibitions and limitations on certain sales and marketing activities under Medicare Advantage plans and prescription drug plans.
- Sec. 104. Improvements to the Medigap program.

**PART II—LOW-INCOME PROGRAMS**

- Sec. 111. Extension of qualifying individual (QI) program.
- Sec. 112. Application of full LIS subsidy assets test under Medicare Savings Program.
- Sec. 113. Eliminating barriers to enrollment.
- Sec. 114. Elimination of Medicare part D late enrollment penalties paid by subsidy eligible individuals.
- Sec. 115. Eliminating application of estate recovery.
- Sec. 116. Exemptions from income and resources for determination of eligibility for low-income subsidy.
- Sec. 117. Judicial review of decisions of the Commissioner of Social Security under the Medicare part D low-income subsidy program.
- Sec. 118. Translation of model form.
- Sec. 119. Medicare enrollment assistance.

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

- Sec. 121. Expansion and extension of the Medicare Rural Hospital Flexibility Program.
- Sec. 122. Rebasing for sole community hospitals.
- Sec. 123. Demonstration project on community health integration models in certain rural counties.
- Sec. 124. Extension of the reclassification of certain hospitals.
- Sec. 125. Revocation of unique deeming authority of the Joint Commission.

**Subtitle C—Provisions Relating to Part B**

**PART 1—PHYSICIANS’ SERVICES**

- Sec. 131. Physician payment, efficiency, and quality improvements.
- Sec. 132. Incentives for electronic prescribing.
- Sec. 133. Expanding access to primary care services.
- Sec. 134. Extension of floor on Medicare work geographic adjustment under the Medicare physician fee schedule.
- Sec. 135. Imaging provisions.
- Sec. 136. Extension of treatment of certain physician pathology services under Medicare.
- Sec. 137. Accommodation of physicians ordered to active duty in the Armed Services.
- Sec. 138. Adjustment for Medicare mental health services.
- Sec. 139. Improvements for Medicare anesthesia teaching programs.

#### PART 2—OTHER PAYMENT AND COVERAGE IMPROVEMENTS

- Sec. 141. Extension of exceptions process for Medicare therapy caps.
- Sec. 142. Extension of payment rule for brachytherapy and therapeutic radiopharmaceuticals.
- Sec. 143. Speech-language pathology services.
- Sec. 144. Coverage of pulmonary and cardiac rehabilitation.
- Sec. 145. Clinical laboratory tests.
- Sec. 146. Improved access to ambulance services.
- Sec. 147. Extension and expansion of the Medicare hold harmless provision under the prospective payment system for hospital outpatient department (HOPD) services for certain hospitals.
- Sec. 148. Clarification of payment for clinical laboratory tests furnished by critical access hospitals.
- Sec. 149. Adding certain entities as originating sites for payment of telehealth services.
- Sec. 150. MedPAC study and report on improving chronic care demonstration programs.
- Sec. 151. Increase of FQHC payment limits.
- Sec. 152. Kidney disease education and awareness provisions.
- Sec. 153. Renal dialysis provisions.
- Sec. 154. Delay in and reform of Medicare DMEPOS competitive acquisition program.

#### Subtitle D—Provisions Relating to Part C

- Sec. 161. Phase-out of indirect medical education (IME).
- Sec. 162. Revisions to requirements for Medicare Advantage private fee-for-service plans.
- Sec. 163. Revisions to quality improvement programs.
- Sec. 164. Revisions relating to specialized Medicare Advantage plans for special needs individuals.
- Sec. 165. Limitation on out-of-pocket costs for dual eligibles and qualified Medicare beneficiaries enrolled in a specialized Medicare Advantage plan for special needs individuals.
- Sec. 166. Adjustment to the Medicare Advantage stabilization fund.
- Sec. 167. Access to Medicare reasonable cost contract plans.
- Sec. 168. MedPAC study and report on quality measures.
- Sec. 169. MedPAC study and report on Medicare Advantage payments.

#### Subtitle E—Provisions Relating to Part D

#### PART I—IMPROVING PHARMACY ACCESS

- Sec. 171. Prompt payment by prescription drug plans and MA–PD plans under part D.
- Sec. 172. Regular update of prescription drug pricing standard.

#### PART II—OTHER PROVISIONS

- Sec. 175. Inclusion of barbiturates and benzodiazepines as covered part D drugs.
- Sec. 176. Formulary requirements with respect to certain categories or classes of drugs.

#### Subtitle F—Other Provisions

- Sec. 181. Use of part D data.
- Sec. 182. Revision of definition of medically accepted indication for drugs.
- Sec. 183. Contract with a consensus-based entity regarding performance measurement.
- Sec. 184. Cost-sharing for clinical trials.
- Sec. 185. Addressing health care disparities.
- Sec. 186. Demonstration to improve care to previously uninsured.
- Sec. 187. Office of the Inspector General report on compliance with and enforcement of national standards on culturally and linguistically appropriate services (CLAS) in Medicare.
- Sec. 188. Medicare Improvement Funding.
- Sec. 189. Inclusion of Medicare providers and suppliers in Federal Payment Levy and Administrative Offset Program.

#### TITLE J—MEDICAID

- Sec. 201. Extension of transitional medical assistance (TMA) and abstinence education program.
- Sec. 202. Medicaid DSH extension.
- Sec. 203. Pharmacy reimbursement under Medicaid.
- Sec. 204. Review of administrative claim determinations.
- Sec. 205. County Medicaid health insuring organizations.

#### TITLE K—MISCELLANEOUS

- Sec. 301. Extension of TANF supplemental grants.
- Sec. 302. 70 percent federal matching for foster care and adoption assistance for the District of Columbia.
- Sec. 303. Extension of Special Diabetes Grant Programs.
- Sec. 304. IOM reports on best practices for conducting systematic reviews of clinical effectiveness research and for developing clinical protocols.

1                   **TITLE I—MEDICARE**  
2                   **Subtitle A—Beneficiary**  
3                   **Improvements**

4       **PART I—PREVENTION, MENTAL HEALTH, AND**  
5                   **MARKETING**

6       **SEC. 101. IMPROVEMENTS TO COVERAGE OF PREVENTIVE**  
7                   **SERVICES.**

8           (a) COVERAGE OF ADDITIONAL PREVENTIVE SERV-  
9 ICES.—

10               (1) COVERAGE.—Section 1861 of the Social Se-  
11 curity Act (42 U.S.C. 1395x), as amended by section  
12 114 of the Medicare, Medicaid, and SCHIP Exten-  
13 sion Act of 2007 (Public Law 110–173), is amend-  
14 ed—

15                   (A) in subsection (s)(2)—

16                       (i) in subparagraph (Z), by striking  
17 “and” after the semicolon at the end;

18                       (ii) in subparagraph (AA), by adding  
19 “and” after the semicolon at the end; and

20                       (iii) by adding at the end the fol-  
21 lowing new subparagraph:

22                   “(BB) additional preventive services (described  
23 in subsection (ddd)(1));”; and

24                   (B) by adding at the end the following new  
25 subsection:

1                   “Additional Preventive Services

2           “(ddd)(1) The term ‘additional preventive services’  
3 means services not otherwise described in this title that  
4 identify medical conditions or risk factors and that the  
5 Secretary determines are—

6                   “(A) reasonable and necessary for the preven-  
7 tion or early detection of an illness or disability;

8                   “(B) recommended with a grade of A or B by  
9 the United States Preventive Services Task Force;  
10 and

11                   “(C) appropriate for individuals entitled to ben-  
12 efits under part A or enrolled under part B.

13           “(2) In making determinations under paragraph (1)  
14 regarding the coverage of a new service, the Secretary  
15 shall use the process for making national coverage deter-  
16 minations (as defined in section 1869(f)(1)(B)) under this  
17 title. As part of the use of such process, the Secretary  
18 may conduct an assessment of the relation between pre-  
19 dicted outcomes and the expenditures for such service and  
20 may take into account the results of such assessment in  
21 making such determination.”.

22                   (2) PAYMENT AND COINSURANCE FOR ADDI-  
23 TIONAL PREVENTIVE SERVICES.—Section 1833(a)(1)  
24 of the Social Security Act (42 U.S.C. 1395l(a)(1))  
25 is amended—

1 (A) by striking “and” before “(V)”; and

2 (B) by inserting before the semicolon at  
3 the end the following: “, and (W) with respect  
4 to additional preventive services (as defined in  
5 section 1861(ddd)(1)), the amount paid shall be  
6 (i) in the case of such services which are clinical  
7 diagnostic laboratory tests, the amount deter-  
8 mined under subparagraph (D), and (ii) in the  
9 case of all other such services, 80 percent of the  
10 lesser of the actual charge for the service or the  
11 amount determined under a fee schedule estab-  
12 lished by the Secretary for purposes of this sub-  
13 paragraph”.

14 (3) CONFORMING AMENDMENT REGARDING  
15 COVERAGE.—Section 1862(a)(1)(A) of the Social Se-  
16 curity Act (42 U.S.C. 1395y(a)(1)(A)) is amended  
17 by inserting “or additional preventive services (as  
18 described in section 1861(ddd)(1))” after “suc-  
19 ceeding subparagraph”.

20 (4) RULE OF CONSTRUCTION.—Nothing in the  
21 provisions of, or amendments made by, this sub-  
22 section shall be construed to provide coverage under  
23 title XVIII of the Social Security Act of items and  
24 services for the treatment of a medical condition  
25 that is not otherwise covered under such title.

1 (b) REVISIONS TO INITIAL PREVENTIVE PHYSICAL  
2 EXAMINATION.—

3 (1) IN GENERAL.—Section 1861(ww) of the So-  
4 cial Security Act (42 U.S.C. 1395x(ww)) is amend-  
5 ed—

6 (A) in paragraph (1)—

7 (i) by inserting “body mass index,”  
8 after “weight”;

9 (ii) by striking “, and an electro-  
10 cardiogram”; and

11 (iii) by inserting “and end-of-life plan-  
12 ning (as defined in paragraph (3)) upon  
13 the agreement with the individual” after  
14 “paragraph (2)”;

15 (B) in paragraph (2), by adding at the end  
16 the following new subparagraphs:

17 “(M) An electrocardiogram.

18 “(N) Additional preventive services (as defined  
19 in subsection (ddd)(1)).”; and

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

22 “(3) For purposes of paragraph (1), the term ‘end-  
23 of-life planning’ means verbal or written information re-  
24 garding—



1           “(A) an individual’s ability to prepare an ad-  
2 vance directive in the case that an injury or illness  
3 causes the individual to be unable to make health  
4 care decisions; and

5           “(B) whether or not the physician is willing to  
6 follow the individual’s wishes as expressed in an ad-  
7 vance directive.”.

8           (2) WAIVER OF APPLICATION OF DEDUCT-  
9 IBLE.—The first sentence of section 1833(b) of the  
10 Social Security Act (42 U.S.C. 1395l(b)) is amend-  
11 ed—

12                   (A) by striking “and” before “(8)”; and

13                   (B) by inserting “, and (9) such deductible  
14 shall not apply with respect to an initial preven-  
15 tive physical examination (as defined in section  
16 1861(w))” before the period at the end.

17           (3) EXTENSION OF ELIGIBILITY PERIOD FROM  
18 SIX MONTHS TO ONE YEAR.—Section 1862(a)(1)(K)  
19 of the Social Security Act (42 U.S.C.  
20 1395y(a)(1)(K)) is amended by striking “6 months”  
21 and inserting “1 year”.

22           (4) TECHNICAL CORRECTION.—Section  
23 1862(a)(1)(K) of the Social Security Act (42 U.S.C.  
24 1395y(a)(1)(K)) is amended by striking “not later”  
25 and inserting “more”.

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

4 **SEC. 102. ELIMINATION OF DISCRIMINATORY COPAYMENT**  
5 **RATES FOR MEDICARE OUTPATIENT PSY-**  
6 **CHIATRIC SERVICES.**

7 Section 1833(c) of the Social Security Act (42 U.S.C.  
8 1395l(c)) is amended to read as follows:

9 “(c)(1) Notwithstanding any other provision of this  
10 part, with respect to expenses incurred in a calendar year  
11 in connection with the treatment of mental, psycho-  
12 neurotic, and personality disorders of an individual who  
13 is not an inpatient of a hospital at the time such expenses  
14 are incurred, there shall be considered as incurred ex-  
15 penses for purposes of subsections (a) and (b)—

16 “(A) for expenses incurred in years prior to  
17 2010, only 62½ percent of such expenses;

18 “(B) for expenses incurred in 2010 or 2011,  
19 only 68¾ percent of such expenses;

20 “(C) for expenses incurred in 2012, only 75  
21 percent of such expenses;

22 “(D) for expenses incurred in 2013, only 81¼  
23 percent of such expenses; and

24 “(E) for expenses incurred in 2014 or any sub-  
25 sequent calendar year, 100 percent of such expenses.

1       “(2) For purposes of subparagraphs (A) through (D)  
2 of paragraph (1), the term ‘treatment’ does not include  
3 brief office visits (as defined by the Secretary) for the sole  
4 purpose of monitoring or changing drug prescriptions used  
5 in the treatment of such disorders or partial hospitaliza-  
6 tion services that are not directly provided by a physi-  
7 cian.”.

8 **SEC. 103. PROHIBITIONS AND LIMITATIONS ON CERTAIN**  
9                   **SALES AND MARKETING ACTIVITIES UNDER**  
10                   **MEDICARE ADVANTAGE PLANS AND PRE-**  
11                   **SCRIPTION DRUG PLANS.**

12       (a) PROHIBITIONS.—

13           (1) MEDICARE ADVANTAGE PROGRAM.—

14               (A) IN GENERAL.—Section 1851 of the So-  
15               cial Security Act (42 U.S.C. 1395w–21) is  
16               amended—

17                   (i) in subsection (h)(4)—

18                           (I) in subparagraph (A)—

19                                   (aa) by striking “cash or  
20                                   other monetary rebates” and in-  
21                                   serting “, subject to subsection  
22                                   (j)(2)(C), cash, gifts, prizes, or  
23                                   other monetary rebates”; and

1 (bb) by striking “, and” at  
 2 the end and inserting a semi-  
 3 colon;

4 (II) in subparagraph (B), by  
 5 striking the period at the end and in-  
 6 serting a semicolon; and

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

9 “(C) shall not permit a Medicare Advan-  
 10 tage organization (or the agents, brokers, and  
 11 other third parties representing such organiza-  
 12 tion) to conduct the prohibited activities de-  
 13 scribed in subsection (j)(1); and”;

14 (ii) by adding at the end the following  
 15 new subsection:

16 “(j) PROHIBITED ACTIVITIES DESCRIBED AND LIM-  
 17 TATIONS ON THE CONDUCT OF CERTAIN OTHER ACTIVI-  
 18 TIES.—

19 “(1) PROHIBITED ACTIVITIES DESCRIBED.—  
 20 The following prohibited activities are described in  
 21 this paragraph:

22 “(A) UNSOLICITED MEANS OF DIRECT  
 23 CONTACT.—Any unsolicited means of direct  
 24 contact of prospective enrollees, including solici-  
 25 titing door-to-door or any outbound tele-

1 marketing without the prospective enrollee initi-  
2 ating contact.

3 “(B) CROSS-SELLING.—The sale of other  
4 non-health related products (such as annuities  
5 and life insurance) during any sales or mar-  
6 keting activity or presentation conducted with  
7 respect to a Medicare Advantage plan.

8 “(C) MEALS.—The provision of meals of  
9 any sort, regardless of value, to prospective en-  
10 rollees at promotional and sales activities.

11 “(D) SALES AND MARKETING IN HEALTH  
12 CARE SETTINGS AND AT EDUCATIONAL  
13 EVENTS.—Sales and marketing activities for  
14 the enrollment of individuals in Medicare Ad-  
15 vantage plans that are conducted—

16 “(i) in health care settings in areas  
17 where health care is delivered to individ-  
18 uals (such as physician offices and phar-  
19 macies), except in the case where such ac-  
20 tivities are conducted in common areas in  
21 health care settings; and

22 “(ii) at educational events.”.

23 (2) MEDICARE PRESCRIPTION DRUG PRO-  
24 GRAM.—Section 1860D–4 of the Social Security Act

1 (42 U.S.C. 1395w–104) is amended by adding at  
2 the end the following new subsection:

3 “(l) REQUIREMENTS WITH RESPECT TO SALES AND  
4 MARKETING ACTIVITIES.—The following provisions shall  
5 apply to a PDP sponsor (and the agents, brokers, and  
6 other third parties representing such sponsor) in the same  
7 manner as such provisions apply to a Medicare Advantage  
8 organization (and the agents, brokers, and other third par-  
9 ties representing such organization):

10 “(1) The prohibition under section  
11 1851(h)(4)(C) on conducting activities described in  
12 section 1851(j)(1).”.

13 (3) EFFECTIVE DATE.—The amendments made  
14 by this subsection shall apply to plan years begin-  
15 ning on or after January 1, 2009.

16 (b) LIMITATIONS.—

17 (1) MEDICARE ADVANTAGE PROGRAM.—Section  
18 1851 of the Social Security Act (42 U.S.C. 1395w–  
19 21), as amended by subsection (a)(1), is amended—

20 (A) in subsection (h)(4), by adding at the  
21 end the following new subparagraph:

22 “(D) shall only permit a Medicare Advan-  
23 tage organization (and the agents, brokers, and  
24 other third parties representing such organiza-  
25 tion) to conduct the activities described in sub-

1 section (j)(2) in accordance with the limitations  
2 established under such subsection.”; and

3 (B) in subsection (j), by adding at the end  
4 the following new paragraph:

5 “(2) LIMITATIONS.—The Secretary shall estab-  
6 lish limitations with respect to at least the following:

7 “(A) SCOPE OF MARKETING APPOINT-  
8 MENTS.—The scope of any appointment with  
9 respect to the marketing of a Medicare Advan-  
10 tage plan. Such limitation shall require advance  
11 agreement with a prospective enrollee on the  
12 scope of the marketing appointment and docu-  
13 mentation of such agreement by the Medicare  
14 Advantage organization. In the case where the  
15 marketing appointment is in person, such docu-  
16 mentation shall be in writing.

17 “(B) CO-BRANDING.—The use of the name  
18 or logo of a co-branded network provider on  
19 Medicare Advantage plan membership and mar-  
20 keting materials.

21 “(C) LIMITATION OF GIFTS TO NOMINAL  
22 DOLLAR VALUE.—The offering of gifts and  
23 other promotional items other than those that  
24 are of nominal value (as determined by the Sec-

1           retary) to prospective enrollees at promotional  
2           activities.

3           “(D) COMPENSATION.—The use of com-  
4           pensation other than as provided under guide-  
5           lines established by the Secretary. Such guide-  
6           lines shall ensure that the use of compensation  
7           creates incentives for agents and brokers to en-  
8           roll individuals in the Medicare Advantage plan  
9           that is intended to best meet their health care  
10          needs.

11          “(E) REQUIRED TRAINING, ANNUAL RE-  
12          TRAINING, AND TESTING OF AGENTS, BROKERS,  
13          AND OTHER THIRD PARTIES.—The use by a  
14          Medicare Advantage organization of any indi-  
15          vidual as an agent, broker, or other third party  
16          representing the organization that has not com-  
17          pleted an initial training and testing program  
18          and does not complete an annual retraining and  
19          testing program.”.

20          (2) MEDICARE PRESCRIPTION DRUG PRO-  
21          GRAM.—Section 1860D–4(l) of the Social Security  
22          Act, as added by subsection (a)(2), is amended by  
23          adding at the end the following new paragraph:

24                 “(2) The requirement under section  
25                 1851(h)(4)(D) to conduct activities described in sec-



1       tion 1851(j)(2) in accordance with the limitations  
2       established under such subsection.”.

3           (3) EFFECTIVE DATE.—The amendments made  
4       by this subsection shall take effect on a date speci-  
5       fied by the Secretary (but in no case later than No-  
6       vember 15, 2008).

7       (c) REQUIRED INCLUSION OF PLAN TYPE IN PLAN  
8       NAME.—

9           (1) MEDICARE ADVANTAGE PROGRAM.—Section  
10       1851(h) of the Social Security Act (42 U.S.C.  
11       1395w–21(h)) is amended by adding at the end fol-  
12       lowing new paragraph:

13           “(6) REQUIRED INCLUSION OF PLAN TYPE IN  
14       PLAN NAME.—For plan years beginning on or after  
15       January 1, 2010, a Medicare Advantage organiza-  
16       tion must ensure that the name of each Medicare  
17       Advantage plan offered by the Medicare Advantage  
18       organization includes the plan type of the plan  
19       (using standard terminology developed by the Sec-  
20       retary).”.

21           (2) PRESCRIPTION DRUG PLANS.—Section  
22       1860D–4(l) of the Social Security Act, as added by  
23       subsection (a)(2) and amended by subsection (b)(2),  
24       is amended by adding at the end the following new  
25       paragraph:

1           “(3) The inclusion of the plan type in the plan  
2           name under section 1851(h)(6).”.

3           (d) STRENGTHENING THE ABILITY OF STATES TO  
4           ACT IN COLLABORATION WITH THE SECRETARY TO AD-  
5           DRESS FRAUDULENT OR INAPPROPRIATE MARKETING  
6           PRACTICES.—

7           (1) MEDICARE ADVANTAGE PROGRAM.—Section  
8           1851(h) of the Social Security Act (42 U.S.C.  
9           1395w–21(h), as amended by subsection (c)(1), is  
10          amended by adding at the end the following new  
11          paragraph:

12           “(7) STRENGTHENING THE ABILITY OF STATES  
13           TO ACT IN COLLABORATION WITH THE SECRETARY  
14           TO ADDRESS FRAUDULENT OR INAPPROPRIATE MAR-  
15           KETING PRACTICES.—

16           “(A) APPOINTMENT OF AGENTS AND BRO-  
17           KERS.—Each Medicare Advantage organization  
18           shall—

19                   “(i) only use agents and brokers who  
20                   have been licensed under State law to sell  
21                   Medicare Advantage plans offered by the  
22                   Medicare Advantage organization;

23                   “(ii) in the case where a State has a  
24                   State appointment law, abide by such law;  
25                   and

1           “(iii) report to the applicable State  
2           the termination of any such agent or  
3           broker, including the reasons for such ter-  
4           mination (as required under applicable  
5           State law).

6           “(B) COMPLIANCE WITH STATE INFORMA-  
7           TION REQUESTS.—Each Medicare Advantage  
8           organization shall comply in a timely manner  
9           with any request by a State for information re-  
10          garding the performance of a licensed agent,  
11          broker, or other third party representing the  
12          Medicare Advantage organization as part of an  
13          investigation by the State into the conduct of  
14          the agent, broker, or other third party.”.

15          (2) PRESCRIPTION DRUG PLANS.—Section  
16          1860D–4(l) of the Social Security Act, as amended  
17          by subsection (c)(2), is amended by adding at the  
18          end the following new paragraph:

19                 “(4) The requirements regarding the appoint-  
20                 ment of agents and brokers and compliance with  
21                 State information requests under subparagraphs (A)  
22                 and (B), respectively, of section 1851(h)(7).”.

23          (3) EFFECTIVE DATE.—The amendments made  
24          by this subsection shall apply to plan years begin-  
25          ning on or after January 1, 2009.

1 **SEC. 104. IMPROVEMENTS TO THE MEDIGAP PROGRAM.**

2 (a) IMPLEMENTATION OF NAIC RECOMMENDA-  
3 TIONS.—

4 (1) IN GENERAL.—The Secretary of Health and  
5 Human Services (in this section referred to as the  
6 “Secretary”) shall provide for implementation of the  
7 changes in the NAIC model law and regulations ap-  
8 proved by the National Association of Insurance  
9 Commissioners in its Model #651 (“Model Regula-  
10 tion to Implement the NAIC Medicare Supplement  
11 Insurance Minimum Standards Model Act”) on  
12 March 11, 2007, as modified to reflect the changes  
13 made under this Act and the Genetic Information  
14 Nondiscrimination Act of 2008 (Public Law 110–  
15 233).

16 (2) IMPLEMENTATION DATES.—

17 (A) IN GENERAL.—The modifications to  
18 Model #651 required under paragraph (1) shall  
19 be completed by the National Association of In-  
20 surance Commissioners not later than October  
21 31, 2008. Except as provided in subparagraph  
22 (B), each State shall have 1 year from the date  
23 the National Association of Insurance Commis-  
24 sioners adopts the revised NAIC model law and  
25 regulations (as changed by Model #651, as so  
26 modified) to conform the regulatory program

1 established by the State to such revised NAIC  
2 model law and regulations.

3 (B) EXTENSION OF EFFECTIVE DATE FOR  
4 STATE LAW AMENDMENT.—In the case of a  
5 State which the Secretary determines requires  
6 State legislation in order to conform the regu-  
7 latory program established by the State to such  
8 revised NAIC model law and regulations, the  
9 State shall not be regarded as failing to comply  
10 with the requirements of this section solely on  
11 the basis of its failure to meet such require-  
12 ments before the first day of the first calendar  
13 quarter beginning after the close of the first  
14 regular session of the State legislature that be-  
15 gins after the date of the enactment of this Act.  
16 For purposes of the previous sentence, in the  
17 case of a State that has a 2-year legislative ses-  
18 sion, each year of the session is considered to  
19 be a separate regular session of the State legis-  
20 lature.

21 (C) TRANSITION DATES.—No carrier may  
22 issue a new or revised Medicare supplemental  
23 policy or certificate under section 1882 of the  
24 Social Security Act (42 U.S.C. 1395ss) that  
25 meets the requirements of such revised NAIC

1 model law and regulations for coverage effective  
2 prior to June 1, 2010. A carrier may continue  
3 to offer or issue a Medicare supplemental policy  
4 under such section that meets the requirements  
5 of the NAIC model law and regulations and  
6 State law (as in effect prior to the adoption of  
7 such revised NAIC model law and regulations)  
8 prior to June 1, 2010. Nothing shall preclude  
9 carriers from marketing new or revised Medi-  
10 care supplemental policies or certificates that  
11 meet the requirements of such revised NAIC  
12 model law and regulations on or after the date  
13 on which the State conforms the regulatory pro-  
14 gram established by the State to such revised  
15 NAIC model law and regulations.

16 (b) REQUIRED OFFERING OF A RANGE OF POLI-  
17 CIES.—Section 1882(o) of the Social Security Act (42  
18 U.S.C. 1395s(o)), as amended by section 104(b)(3) of the  
19 Genetic Information Nondiscrimination Act of 2008 (Pub-  
20 lic Law 110–233), is amended by adding at the end the  
21 following new paragraph:

22 “(5) In addition to the requirement under para-  
23 graph (2), the issuer of the policy must make avail-  
24 able to the individual at least Medicare supplemental

1 policies with benefit packages classified as ‘C’ or  
2 ‘F’.”.

3 (c) CLARIFICATION.—Any health insurance policy  
4 that provides reimbursement for expenses incurred for  
5 items and services for which payment may be made under  
6 title XVIII of the Social Security Act but which are not  
7 reimbursable by reason of the applicability of deductibles,  
8 coinsurance, copayments or other limitations imposed by  
9 a Medicare Advantage plan (including a Medicare Advan-  
10 tage private fee-for-service plan) under part C of such title  
11 shall comply with the requirements of section 1882(o) of  
12 the such Act (42 U.S.C. 1395ss(o)).

## 13 **PART II—LOW-INCOME PROGRAMS**

### 14 **SEC. 111. EXTENSION OF QUALIFYING INDIVIDUAL (QI)** 15 **PROGRAM.**

16 (a) EXTENSION.—Section 1902(a)(10)(E)(iv) of the  
17 Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is  
18 amended by striking “June 2008” and inserting “Decem-  
19 ber 2009”.

20 (b) EXTENDING TOTAL AMOUNT AVAILABLE FOR  
21 ALLOCATION.—Section 1933(g) of such Act (42 U.S.C.  
22 1396u–3(g)) is amended—

23 (1) in paragraph (2)—

24 (A) by striking “and” at the end of sub-  
25 paragraph (H);

1 (B) in subparagraph (I)—

2 (i) by striking “June 30” and insert-  
3 ing “September 30”;

4 (ii) by striking “\$200,000,000” and  
5 inserting “\$300,000,000”; and

6 (iii) by striking the period at the end  
7 and inserting a semicolon; and

8 (C) by adding at the end the following new  
9 subparagraphs:

10 “(J) for the period that begins on October  
11 1, 2008, and ends on December 31, 2008, the  
12 total allocation amount is \$100,000,000;

13 “(K) for the period that begins on January  
14 1, 2009, and ends on September 30, 2009, the  
15 total allocation amount is \$350,000,000; and

16 “(L) for the period that begins on October  
17 1, 2009, and ends on December 31, 2009, the  
18 total allocation amount is \$150,000,000.”; and

19 (2) in paragraph (3), in the matter preceding  
20 subparagraph (A), by striking “or (H)” and insert-  
21 ing “(H), (J), or (L)”.

22 **SEC. 112. APPLICATION OF FULL LIS SUBSIDY ASSETS TEST**  
23 **UNDER MEDICARE SAVINGS PROGRAM.**

24 Section 1905(p)(1)(C) of such Act (42 U.S.C.  
25 1396d(p)(1)(C)) is amended by inserting before the period



1 at the end the following: “or, effective beginning with Jan-  
2 uary 1, 2010, whose resources (as so determined) do not  
3 exceed the maximum resource level applied for the year  
4 under subparagraph (D) of section 1860D–14(a)(3) (de-  
5 termined without regard to the life insurance policy exclu-  
6 sion provided under subparagraph (G) of such section) ap-  
7 plicable to an individual or to the individual and the indi-  
8 vidual’s spouse (as the case may be)”.

9 **SEC. 113. ELIMINATING BARRIERS TO ENROLLMENT.**

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

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

18 “(1) DISTRIBUTION OF APPLICATIONS AND IN-  
19 FORMATION TO INDIVIDUALS WHO ARE POTEN-  
20 Tially ELIGIBLE FOR LOW-INCOME SUBSIDY PRO-  
21 GRAM.—For each individual who submits an applica-  
22 tion for low-income subsidies under section 1860D–  
23 14, requests an application for such subsidies, or is  
24 otherwise identified as an individual who is poten-

1 tially eligible for such subsidies, the Commissioner  
2 shall do the following:

3 “(A) Provide information describing the  
4 low-income subsidy program under section  
5 1860D–14 and the Medicare Savings Program  
6 (as defined in paragraph (7)).

7 “(B) Provide an application for enrollment  
8 under such low-income subsidy program (if not  
9 already received by the Commissioner).

10 “(C) In accordance with paragraph (3),  
11 transmit data from such an application for pur-  
12 poses of initiating an application for benefits  
13 under the Medicare Savings Program.

14 “(D) Provide information on how the indi-  
15 vidual may obtain assistance in completing such  
16 application and an application under the Medi-  
17 care Savings Program, including information on  
18 how the individual may contact the State health  
19 insurance assistance program (SHIP).

20 “(E) Make the application described in  
21 subparagraph (B) and the information de-  
22 scribed in subparagraphs (A) and (D) available  
23 at local offices of the Social Security Adminis-  
24 tration.

1           “(2) TRAINING PERSONNEL IN EXPLAINING  
2           BENEFIT PROGRAMS AND ASSISTING IN COMPLETING  
3           LIS APPLICATION.—The Commissioner shall provide  
4           training to those employees of the Social Security  
5           Administration who are involved in receiving applica-  
6           tions for benefits described in paragraph (1)(B) in  
7           order that they may promote beneficiary under-  
8           standing of the low-income subsidy program and the  
9           Medicare Savings Program in order to increase par-  
10          ticipation in these programs. Such employees shall  
11          provide assistance in completing an application de-  
12          scribed in paragraph (1)(B) upon request.

13          “(3) TRANSMITTAL OF DATA TO STATES.—Be-  
14          ginning on January 1, 2010, with the consent of an  
15          individual completing an application for benefits de-  
16          scribed in paragraph (1)(B), the Commissioner shall  
17          electronically transmit to the appropriate State Med-  
18          icaid agency data from such application, as deter-  
19          mined by the Commissioner, which transmittal shall  
20          initiate an application of the individual for benefits  
21          under the Medicare Savings Program with the State  
22          Medicaid agency. In order to ensure that such data  
23          transmittal provides effective assistance for purposes  
24          of State adjudication of applications for benefits  
25          under the Medicare Savings Program, the Commis-

1 sioner shall consult with the Secretary, after the  
2 Secretary has consulted with the States, regarding  
3 the content, form, frequency, and manner in which  
4 data (on a uniform basis for all States) shall be  
5 transmitted under this subparagraph.

6 “(4) COORDINATION WITH OUTREACH.—The  
7 Commissioner shall coordinate outreach activities  
8 under this subsection in connection with the low-in-  
9 come subsidy program and the Medicare Savings  
10 Program.

11 “(5) REIMBURSEMENT OF SOCIAL SECURITY  
12 ADMINISTRATION ADMINISTRATIVE COSTS.—

13 “(A) INITIAL MEDICARE SAVINGS PRO-  
14 GRAM COSTS; ADDITIONAL LOW-INCOME SUB-  
15 SIDY COSTS.—

16 “(i) INITIAL MEDICARE SAVINGS PRO-  
17 GRAM COSTS.—There are hereby appro-  
18 priated to the Commissioner to carry out  
19 this subsection, out of any funds in the  
20 Treasury not otherwise appropriated,  
21 \$24,100,000. The amount appropriated  
22 under this clause shall be available on Octo-  
23 ber 1, 2008, and shall remain available  
24 until expended.

1           “(ii) ADDITIONAL AMOUNT FOR LOW-  
2 INCOME SUBSIDY ACTIVITIES.—There are  
3 hereby appropriated to the Commissioner,  
4 out of any funds in the Treasury not oth-  
5 erwise appropriated, \$24,800,000 for fiscal  
6 year 2009 to carry out low-income subsidy  
7 activities under section 1860D–14 and the  
8 Medicare Savings Program (in accordance  
9 with this subsection), to remain available  
10 until expended. Such funds shall be in ad-  
11 dition to the Social Security Administra-  
12 tion’s Limitation on Administrative Ex-  
13 penditure appropriations for such fiscal  
14 year.

15           “(B) SUBSEQUENT FUNDING UNDER  
16 AGREEMENTS.—

17           “(i) IN GENERAL.—Effective for fiscal  
18 years beginning on or after October 1,  
19 2010, the Commissioner and the Secretary  
20 shall enter into an agreement which shall  
21 provide funding to cover the administrative  
22 costs of the Commissioner’s activities  
23 under this subsection. Such agreement  
24 shall—

1           “(I) provide funds to the Com-  
2           missioner for the full cost of the So-  
3           cial Security Administration’s work  
4           related to the Medicare Savings Pro-  
5           gram required under this section;

6           “(II) provide such funding quar-  
7           terly in advance of the applicable  
8           quarter based on estimating method-  
9           ology agreed to by the Commissioner  
10          and the Secretary; and

11          “(III) require an annual account-  
12          ing and reconciliation of the actual  
13          costs incurred and funds provided  
14          under this subsection.

15          “(ii) APPROPRIATION.—There are  
16          hereby appropriated to the Secretary solely  
17          for the purpose of providing payments to  
18          the Commissioner pursuant to an agree-  
19          ment specified in clause (i) that is in ef-  
20          fect, out of any funds in the Treasury not  
21          otherwise appropriated, not more than  
22          \$3,000,000 for fiscal year 2011 and each  
23          fiscal year thereafter.

24          “(C) LIMITATION.—In no case shall funds  
25          from the Social Security Administration’s Limi-

1           tation on Administrative Expenses be used to  
2           carry out activities related to the Medicare Sav-  
3           ings Program. For fiscal years beginning on or  
4           after October 1, 2010, no such activities shall  
5           be undertaken by the Social Security Adminis-  
6           tration unless the agreement specified in sub-  
7           paragraph (B) is in effect and full funding has  
8           been provided to the Commissioner as specified  
9           in such subparagraph.

10          “(6) GAO ANALYSIS AND REPORT.—

11                 “(A) ANALYSIS.—The Comptroller General  
12                 of the United States shall prepare an analysis  
13                 of the impact of this subsection—

14                         “(i) in increasing participation in the  
15                         Medicare Savings Program, and

16                         “(ii) on States and the Social Security  
17                         Administration.

18                 “(B) REPORT.—Not later than January 1,  
19                 2012, the Comptroller General shall submit to  
20                 Congress, the Commissioner, and the Secretary  
21                 a report on the analysis conducted under sub-  
22                 paragraph (A).

23          “(7) MEDICARE SAVINGS PROGRAM DEFINED.—

24                 For purposes of this subsection, the term ‘Medicare  
25                 Savings Program’ means the program of medical as-

1       sistance for payment of the cost of Medicare cost-  
2       sharing under the Medicaid program pursuant to  
3       sections 1902(a)(10)(E) and 1933.”.

4       (b) MEDICAID AGENCY CONSIDERATION OF DATA  
5 TRANSMITTAL.—

6           (1) IN GENERAL.—Section 1935(a) of such Act  
7       (42 U.S.C. 1396u–5(a)) is amended by adding at  
8       the end the following new paragraph:

9           “(4) CONSIDERATION OF DATA TRANSMITTED  
10       BY THE SOCIAL SECURITY ADMINISTRATION FOR  
11       PURPOSES OF MEDICARE SAVINGS PROGRAM.—The  
12       State shall accept data transmitted under section  
13       1144(e)(3) and act on such data in the same man-  
14       ner and in accordance with the same deadlines as if  
15       the data constituted an initiation of an application  
16       for benefits under the Medicare Savings Program  
17       (as defined for purposes of such section) that had  
18       been submitted directly by the applicant. The date  
19       of the individual’s application for the low income  
20       subsidy program from which the data have been de-  
21       rived shall constitute the date of filing of such appli-  
22       cation for benefits under the Medicare Savings Pro-  
23       gram.”.

24           (2) CONFORMING AMENDMENTS.—Section  
25       1935(a) of such Act (42 U.S.C. 1396u–5(a)) is



1 amended in the subsection heading by striking  
2 “AND” and by inserting “, AND MEDICARE COST-  
3 SHARING” after “ASSISTANCE”.

4 (c) EFFECTIVE DATE.—Except as otherwise pro-  
5 vided, the amendments made by this section shall take ef-  
6 fect on January 1, 2010.

7 **SEC. 114. ELIMINATION OF MEDICARE PART D LATE EN-**  
8 **ROLLMENT PENALTIES PAID BY SUBSIDY ELI-**  
9 **GIBLE INDIVIDUALS.**

10 (a) WAIVER OF LATE ENROLLMENT PENALTY.—

11 (1) IN GENERAL.—Section 1860D–13(b) of the  
12 Social Security Act (42 U.S.C. 1395w–113(b)) is  
13 amended by adding at the end the following new  
14 paragraph:

15 “(8) WAIVER OF PENALTY FOR SUBSIDY-ELIGI-  
16 BLE INDIVIDUALS.—In no case shall a part D eligi-  
17 ble individual who is determined to be a subsidy eli-  
18 gible individual (as defined in section 1860D–  
19 14(a)(3)) be subject to an increase in the monthly  
20 beneficiary premium established under subsection  
21 (a).”.

22 (2) CONFORMING AMENDMENT.—Section  
23 1860D–14(a)(1)(A) of the Social Security Act (42  
24 U.S.C. 1395w–114(a)(1)(A)) is amended by striking  
25 “equal to” and all that follows through the period

1 and inserting “equal to 100 percent of the amount  
2 described in subsection (b)(1), but not to exceed the  
3 premium amount specified in subsection (b)(2)(B).”.

4 (b) EFFECTIVE DATE.—The amendments made by  
5 this section shall apply to subsidies for months beginning  
6 with January 2009.

7 **SEC. 115. ELIMINATING APPLICATION OF ESTATE RECOV-**  
8 **ERY.**

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

14 (b) EFFECTIVE DATE.—The amendment made by  
15 subsection (a) shall take effect as of January 1, 2010.

16 **SEC. 116. EXEMPTIONS FROM INCOME AND RESOURCES**  
17 **FOR DETERMINATION OF ELIGIBILITY FOR**  
18 **LOW-INCOME SUBSIDY.**

19 (a) IN GENERAL.—Section 1860D–14(a)(3) of the  
20 Social Security Act (42 U.S.C. 1395w–114(a)(3)) is  
21 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 life insurance  
3           policy exclusion provided under subparagraph (G)”  
4           before “);

5           (3) in subparagraph (E)(i), in the matter before  
6           subclause (I), by inserting “subject to the life insur-  
7           ance policy exclusion provided under subparagraph  
8           (G)” before “); and

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

11                   “(G) LIFE INSURANCE POLICY EXCLU-  
12                   SION.—In determining the resources of an indi-  
13                   vidual (and the eligible spouse of the individual,  
14                   if any) under section 1613 for purposes of sub-  
15                   paragraphs (D) and (E) no part of the value of  
16                   any life insurance policy shall be taken into ac-  
17                   count.”.

18          (b) EFFECTIVE DATE.—The amendments made by  
19          this section shall take effect with respect to applications  
20          filed on or after January 1, 2010.

1 **SEC. 117. JUDICIAL REVIEW OF DECISIONS OF THE COM-**  
2 **MISSIONER OF SOCIAL SECURITY UNDER**  
3 **THE MEDICARE PART D LOW-INCOME SUB-**  
4 **SIDY PROGRAM.**

5 (a) IN GENERAL.—Section 1860D–14(a)(3)(B)(iv) of  
6 the Social Security Act (42 U.S.C. 1395w–  
7 114(a)(3)(B)(iv)) is amended—

8 (1) in subclause (I), by striking “and” at the  
9 end;

10 (2) in subclause (II), by striking the period at  
11 the end and inserting “; and”; and

12 (3) by adding at the end the following new sub-  
13 clause:

14 “(III) judicial review of the final  
15 decision of the Commissioner made  
16 after a hearing shall be available to  
17 the same extent, and with the same  
18 limitations, as provided in subsections  
19 (g) and (h) of section 205.”.

20 (b) EFFECTIVE DATE.—The amendments made by  
21 subsection (a) shall take effect as if included in the enact-  
22 ment of section 101 of the Medicare Prescription Drug,  
23 Improvement, and Modernization Act of 2003.

24 **SEC. 118. TRANSLATION OF MODEL FORM.**

25 (a) IN GENERAL.—Section 1905(p)(5)(A) of the So-  
26 cial Security Act (42 U.S.C. 1396d(p)(5)(A)) is amended

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

8 (b) EFFECTIVE DATE.—The amendment made by  
9 subsection (a) shall take effect on January 1, 2010.

10 **SEC. 119. MEDICARE ENROLLMENT ASSISTANCE.**

11 (a) ADDITIONAL FUNDING FOR STATE HEALTH IN-  
12 SURANCE ASSISTANCE PROGRAMS.—

13 (1) GRANTS.—

14 (A) IN GENERAL.—The Secretary of  
15 Health and Human Services (in this section re-  
16 ferred to as the “Secretary”) shall use amounts  
17 made available under subparagraph (B) to  
18 make grants to States for State health insur-  
19 ance assistance programs receiving assistance  
20 under section 4360 of the Omnibus Budget  
21 Reconciliation Act of 1990.

22 (B) FUNDING.—For purposes of making  
23 grants under this subsection, the Secretary  
24 shall provide for the transfer, from the Federal  
25 Hospital Insurance Trust Fund under section

1           1817 of the Social Security Act (42 U.S.C.  
2           1395i) and the Federal Supplementary Medical  
3           Insurance Trust Fund under section 1841 of  
4           such Act (42 U.S.C. 1395t), in the same pro-  
5           portion as the Secretary determines under sec-  
6           tion 1853(f) of such Act (42 U.S.C. 1395w-  
7           23(f)), of \$7,500,000 to the Centers for Medi-  
8           care & Medicaid Services Program Management  
9           Account for fiscal year 2009, to remain avail-  
10          able until expended.

11           (2) AMOUNT OF GRANTS.—The amount of a  
12          grant to a State under this subsection from the total  
13          amount made available under paragraph (1) shall be  
14          equal to the sum of the amount allocated to the  
15          State under paragraph (3)(A) and the amount allo-  
16          cated to the State under subparagraph (3)(B).

17           (3) ALLOCATION TO STATES.—

18           (A) ALLOCATION BASED ON PERCENTAGE  
19          OF LOW-INCOME BENEFICIARIES.—The amount  
20          allocated to a State under this subparagraph  
21          from  $\frac{2}{3}$  of the total amount made available  
22          under paragraph (1) shall be based on the num-  
23          ber of individuals who meet the requirement  
24          under subsection (a)(3)(A)(ii) of section  
25          1860D-14 of the Social Security Act (42

1 U.S.C. 1395w-114) but who have not enrolled  
2 to receive a subsidy under such section 1860D-  
3 14 relative to the total number of individuals  
4 who meet the requirement under such sub-  
5 section (a)(3)(A)(ii) in each State, as estimated  
6 by the Secretary.

7 (B) ALLOCATION BASED ON PERCENTAGE  
8 OF RURAL BENEFICIARIES.—The amount allo-  
9 cated to a State under this subparagraph from  
10  $\frac{1}{3}$  of the total amount made available under  
11 paragraph (1) shall be based on the number of  
12 part D eligible individuals (as defined in section  
13 1860D-1(a)(3)(A) of such Act (42 U.S.C.  
14 1395w-101(a)(3)(A))) residing in a rural area  
15 relative to the total number of such individuals  
16 in each State, as estimated by the Secretary.

17 (4) PORTION OF GRANT BASED ON PERCENT-  
18 AGE OF LOW-INCOME BENEFICIARIES TO BE USED  
19 TO PROVIDE OUTREACH TO INDIVIDUALS WHO MAY  
20 BE SUBSIDY ELIGIBLE INDIVIDUALS OR ELIGIBLE  
21 FOR THE MEDICARE SAVINGS PROGRAM.—Each  
22 grant awarded under this subsection with respect to  
23 amounts allocated under paragraph (3)(A) shall be  
24 used to provide outreach to individuals who may be  
25 subsidy eligible individuals (as defined in section

1 1860D–14(a)(3)(A) of the Social Security Act (42  
2 U.S.C. 1395w–114(a)(3)(A)) or eligible for the  
3 Medicare Savings Program (as defined in subsection  
4 (f)).

5 (b) ADDITIONAL FUNDING FOR AREA AGENCIES ON  
6 AGING.—

7 (1) GRANTS.—

8 (A) IN GENERAL.—The Secretary, acting  
9 through the Assistant Secretary for Aging, shall  
10 make grants to States for area agencies on  
11 aging (as defined in section 102 of the Older  
12 Americans Act of 1965 (42 U.S.C. 3002)) and  
13 Native American programs carried out under  
14 the Older Americans Act of 1965 (42 U.S.C.  
15 3001 et seq.).

16 (B) FUNDING.—For purposes of making  
17 grants under this subsection, the Secretary  
18 shall provide for the transfer, from the Federal  
19 Hospital Insurance Trust Fund under section  
20 1817 of the Social Security Act (42 U.S.C.  
21 1395i) and the Federal Supplementary Medical  
22 Insurance Trust Fund under section 1841 of  
23 such Act (42 U.S.C. 1395t), in the same pro-  
24 portion as the Secretary determines under sec-  
25 tion 1853(f) of such Act (42 U.S.C. 1395w–



1           23(f)), of \$7,500,000 to the Administration on  
2           Aging for fiscal year 2009, to remain available  
3           until expended.

4           (2) AMOUNT OF GRANT AND ALLOCATION TO  
5           STATES BASED ON PERCENTAGE OF LOW-INCOME  
6           AND RURAL BENEFICIARIES.—The amount of a  
7           grant to a State under this subsection from the total  
8           amount made available under paragraph (1) shall be  
9           determined in the same manner as the amount of a  
10          grant to a State under subsection (a), from the total  
11          amount made available under paragraph (1) of such  
12          subsection, is determined under paragraph (2) and  
13          subparagraphs (A) and (B) of paragraph (3) of such  
14          subsection.

15          (3) REQUIRED USE OF FUNDS.—

16                (A) ALL FUNDS.—Subject to subparagraph  
17                (B), each grant awarded under this subsection  
18                shall be used to provide outreach to eligible  
19                Medicare beneficiaries regarding the benefits  
20                available under title XVIII of the Social Secu-  
21                rity Act.

22                (B) OUTREACH TO INDIVIDUALS WHO MAY  
23                BE SUBSIDY ELIGIBLE INDIVIDUALS OR ELIGI-  
24                BLE FOR THE MEDICARE SAVINGS PROGRAM.—  
25                Subsection (a)(4) shall apply to each grant

1           awarded under this subsection in the same  
2           manner as it applies to a grant under sub-  
3           section (a).

4           (c) ADDITIONAL FUNDING FOR AGING AND DIS-  
5 ABILITY RESOURCE CENTERS.—

6           (1) GRANTS.—

7                   (A) IN GENERAL.—The Secretary shall  
8           make grants to Aging and Disability Resource  
9           Centers under the Aging and Disability Re-  
10          source Center grant program that are estab-  
11          lished centers under such program on the date  
12          of the enactment of this Act.

13                   (B) FUNDING.—For purposes of making  
14          grants under this subsection, the Secretary  
15          shall provide for the transfer, from the Federal  
16          Hospital Insurance Trust Fund under section  
17          1817 of the Social Security Act (42 U.S.C.  
18          1395i) and the Federal Supplementary Medical  
19          Insurance Trust Fund under section 1841 of  
20          such Act (42 U.S.C. 1395t), in the same pro-  
21          portion as the Secretary determines under sec-  
22          tion 1853(f) of such Act (42 U.S.C. 1395w-  
23          23(f)), of \$5,000,000 to the Administration on  
24          Aging for fiscal year 2009, to remain available  
25          until expended.

1           (2) REQUIRED USE OF FUNDS.—Each grant  
2 awarded under this subsection shall be used to pro-  
3 vide outreach to individuals regarding the benefits  
4 available under the Medicare prescription drug ben-  
5 efit under part D of title XVIII of the Social Secu-  
6 rity Act and under the Medicare Savings Program.

7           (d) COORDINATION OF EFFORTS TO INFORM OLDER  
8 AMERICANS ABOUT BENEFITS AVAILABLE UNDER FED-  
9 ERAL AND STATE PROGRAMS.—

10           (1) IN GENERAL.—The Secretary, acting  
11 through the Assistant Secretary for Aging, in co-  
12 operation with related Federal agency partners, shall  
13 make a grant to, or enter into a contract with, a  
14 qualified, experienced entity under which the entity  
15 shall—

16           (A) maintain and update web-based deci-  
17 sion support tools, and integrated, person-cen-  
18 tered systems, designed to inform older individ-  
19 uals (as defined in section 102 of the Older  
20 Americans Act of 1965 (42 U.S.C. 3002))  
21 about the full range of benefits for which the  
22 individuals may be eligible under Federal and  
23 State programs;

24           (B) utilize cost-effective strategies to find  
25 older individuals with the greatest economic

1 need (as defined in such section 102) and in-  
2 form the individuals of the programs;

3 (C) develop and maintain an information  
4 clearinghouse on best practices and the most  
5 cost-effective methods for finding older individ-  
6 uals with greatest economic need and informing  
7 the individuals of the programs; and

8 (D) provide, in collaboration with related  
9 Federal agency partners administering the Fed-  
10 eral programs, training and technical assistance  
11 on the most effective outreach, screening, and  
12 follow-up strategies for the Federal and State  
13 programs.

14 (2) FUNDING.—For purposes of making a  
15 grant or entering into a contract under paragraph  
16 (1), the Secretary shall provide for the transfer,  
17 from the Federal Hospital Insurance Trust Fund  
18 under section 1817 of the Social Security Act (42  
19 U.S.C. 1395i) and the Federal Supplementary Med-  
20 ical Insurance Trust Fund under section 1841 of  
21 such Act (42 U.S.C. 1395t), in the same proportion  
22 as the Secretary determines under section 1853(f) of  
23 such Act (42 U.S.C. 1395w–23(f)), of \$5,000,000 to  
24 the Administration on Aging for fiscal year 2009, to  
25 remain available until expended.

1           (e) REPROGRAMMING FUNDS FROM MEDICARE,  
2 MEDICAID, AND SCHIP EXTENSION ACT OF 2007.—The  
3 Secretary shall only use the \$5,000,000 in funds allocated  
4 to make grants to States for Area Agencies on Aging and  
5 Aging Disability and Resource Centers for the period of  
6 fiscal years 2008 through 2009 under section 118 of the  
7 Medicare, Medicaid, and SCHIP Extension Act of 2007  
8 (Public Law 110–173) for the sole purpose of providing  
9 outreach to individuals regarding the benefits available  
10 under the Medicare prescription drug benefit under part  
11 D of title XVIII of the Social Security Act. The Secretary  
12 shall republish the request for proposals issued on April  
13 17, 2008, in order to comply with the preceding sentence.

14           (f) MEDICARE SAVINGS PROGRAM DEFINED.—For  
15 purposes of this section, the term “Medicare Savings Pro-  
16 gram” means the program of medical assistance for pay-  
17 ment of the cost of Medicare cost-sharing under the Med-  
18 icaid program pursuant to sections 1902(a)(10)(E) and  
19 1933 of the Social Security Act (42 U.S.C.  
20 1396a(a)(10)(E), 1396u–3).

1    **Subtitle B—Provisions Relating to**  
2                                   **Part A**

3    **SEC. 121. EXPANSION AND EXTENSION OF THE MEDICARE**  
4                                   **RURAL HOSPITAL FLEXIBILITY PROGRAM.**

5           (a) IN GENERAL.—Section 1820(g) of the Social Se-  
6    curity Act (42 U.S.C. 1395i–4(g)) is amended by adding  
7    at the end the following new paragraph:

8                   “(6) PROVIDING MENTAL HEALTH SERVICES  
9                   AND OTHER HEALTH SERVICES TO VETERANS AND  
10                   OTHER RESIDENTS OF RURAL AREAS.—

11                   “(A) GRANTS TO STATES.—The Secretary  
12                   may award grants to States that have sub-  
13                   mitted applications in accordance with subpara-  
14                   graph (B) for increasing the delivery of mental  
15                   health services or other health care services  
16                   deemed necessary to meet the needs of veterans  
17                   of Operation Iraqi Freedom and Operation En-  
18                   during Freedom living in rural areas (as de-  
19                   fined for purposes of section 1886(d) and in-  
20                   cluding areas that are rural census tracts, as  
21                   defined by the Administrator of the Health Re-  
22                   sources and Services Administration), including  
23                   for the provision of crisis intervention services  
24                   and the detection of post-traumatic stress dis-  
25                   order, traumatic brain injury, and other signa-

1           ture injuries of veterans of Operation Iraqi  
2           Freedom and Operation Enduring Freedom,  
3           and for referral of such veterans to medical fa-  
4           cilities operated by the Department of Veterans  
5           Affairs, and for the delivery of such services to  
6           other residents of such rural areas.

7           “(B) APPLICATION.—

8           “(i) IN GENERAL.—An application is  
9           in accordance with this subparagraph if  
10          the State submits to the Secretary at such  
11          time and in such form as the Secretary  
12          may require an application containing the  
13          assurances described in subparagraphs  
14          (A)(ii) and (A)(iii) of subsection (b)(1).

15          “(ii) CONSIDERATION OF REGIONAL  
16          APPROACHES, NETWORKS, OR TECH-  
17          NOLOGY.—The Secretary may, as appro-  
18          priate in awarding grants to States under  
19          subparagraph (A), consider whether the  
20          application submitted by a State under  
21          this subparagraph includes 1 or more pro-  
22          posals that utilize regional approaches,  
23          networks, health information technology,  
24          telehealth, or telemedicine to deliver serv-  
25          ices described in subparagraph (A) to indi-

1           viduals described in that subparagraph.  
2           For purposes of this clause, a network  
3           may, as the Secretary determines appro-  
4           priate, include federally qualified health  
5           centers (as defined in section 1861(aa)(4)),  
6           rural health clinics (as defined in section  
7           1861(aa)(2)), home health agencies (as de-  
8           fined in section 1861(o)), community men-  
9           tal health centers (as defined in section  
10          1861(ff)(3)(B)) and other providers of  
11          mental health services, pharmacists, local  
12          government, and other providers deemed  
13          necessary to meet the needs of veterans.

14           “(iii) COORDINATION AT LOCAL  
15          LEVEL.—The Secretary shall require, as  
16          appropriate, a State to demonstrate con-  
17          sultation with the hospital association of  
18          such State, rural hospitals located in such  
19          State, providers of mental health services,  
20          or other appropriate stakeholders for the  
21          provision of services under a grant award-  
22          ed under this paragraph.

23           “(iv) SPECIAL CONSIDERATION OF  
24          CERTAIN APPLICATIONS.—In awarding  
25          grants to States under subparagraph (A),



1           the Secretary shall give special consider-  
2           ation to applications submitted by States  
3           in which veterans make up a high percent-  
4           age (as determined by the Secretary) of  
5           the total population of the State. Such  
6           consideration shall be given without regard  
7           to the number of veterans of Operation  
8           Iraqi Freedom and Operation Enduring  
9           Freedom living in the areas in which men-  
10          tal health services and other health care  
11          services would be delivered under the appli-  
12          cation.

13           “(C) COORDINATION WITH VA.—The Sec-  
14          retary shall, as appropriate, consult with the  
15          Director of the Office of Rural Health of the  
16          Department of Veterans Affairs in awarding  
17          and administering grants to States under sub-  
18          paragraph (A).

19           “(D) USE OF FUNDS.—A State awarded a  
20          grant under this paragraph may, as appro-  
21          priate, use the funds to reimburse providers of  
22          services described in subparagraph (A) to indi-  
23          viduals described in that subparagraph.

24           “(E) LIMITATION ON USE OF GRANT  
25          FUNDS FOR ADMINISTRATIVE EXPENSES.—A

1 State awarded a grant under this paragraph  
2 may not expend more than 15 percent of the  
3 amount of the grant for administrative ex-  
4 penses.

5 “(F) INDEPENDENT EVALUATION AND  
6 FINAL REPORT.—The Secretary shall provide  
7 for an independent evaluation of the grants  
8 awarded under subparagraph (A). Not later  
9 than 1 year after the date on which the last  
10 grant is awarded to a State under such sub-  
11 paragraph, the Secretary shall submit a report  
12 to Congress on such evaluation. Such report  
13 shall include an assessment of the impact of  
14 such grants on increasing the delivery of mental  
15 health services and other health services to vet-  
16 erans of the United States Armed Forces living  
17 in rural areas (as so defined and including such  
18 areas that are rural census tracts), with par-  
19 ticular emphasis on the impact of such grants  
20 on the delivery of such services to veterans of  
21 Operation Enduring Freedom and Operation  
22 Iraqi Freedom, and to other individuals living  
23 in such rural areas.”.

1 (b) USE OF FUNDS FOR FEDERAL ADMINISTRATIVE  
2 EXPENSES.—Section 1820(g)(5) of the Social Security  
3 Act (42 U.S.C. 1395i–4(g)(5)) is amended—

4 (1) by striking “beginning with fiscal year  
5 2005” and inserting “for each of fiscal years 2005  
6 through 2008”; and

7 (2) by inserting “and, of the total amount ap-  
8 propriated for grants under paragraphs (1), (2), and  
9 (6) for a fiscal year (beginning with fiscal year  
10 2009)” after “2005”.

11 (c) EXTENSION OF AUTHORIZATION FOR FLEX  
12 GRANTS.—Section 1820(j) of the Social Security Act (42  
13 U.S.C. 1395i–4(j)) is amended—

14 (1) by striking “and for” and inserting “for”;  
15 and

16 (2) by inserting “, for making grants to all  
17 States under paragraphs (1) and (2) of subsection  
18 (g), \$55,000,000 in each of fiscal years 2009 and  
19 2010, and for making grants to all States under  
20 paragraph (6) of subsection (g), \$50,000,000 in  
21 each of fiscal years 2009 and 2010, to remain avail-  
22 able until expended” before the period at the end.

23 (d) MEDICARE RURAL HOSPITAL FLEXIBILITY PRO-  
24 GRAM.—Section 1820(g)(1) of the Social Security Act (42  
25 U.S.C. 1395i–4(g)(1)) is amended—

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

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

5           (3) by adding at the end the following new sub-  
6           paragraph:

7                   “(D) providing support for critical access  
8                   hospitals for quality improvement, quality re-  
9                   porting, performance improvements, and  
10                   benchmarking.”.

11           (e) ASSISTANCE TO SMALL CRITICAL ACCESS HOS-  
12           PITALS TRANSITIONING TO SKILLED NURSING FACILI-  
13           TIES AND ASSISTED LIVING FACILITIES.—Section  
14           1820(g) of the Social Security Act (42 U.S.C. 1395i-  
15           4(g)), as amended by subsection (a), is amended by adding  
16           at the end the following new paragraph:

17                   “(7)       CRITICAL       ACCESS       HOSPITALS  
18                   TRANSITIONING TO SKILLED NURSING FACILITIES  
19                   AND ASSISTED LIVING FACILITIES.—

20                   “(A) GRANTS.—The Secretary may award  
21                   grants to eligible critical access hospitals that  
22                   have submitted applications in accordance with  
23                   subparagraph (B) for assisting such hospitals  
24                   in the transition to skilled nursing facilities and  
25                   assisted living facilities.

1           “(B) APPLICATION.—An applicable critical  
2 access hospital seeking a grant under this para-  
3 graph shall submit an application to the Sec-  
4 retary on or before such date and in such form  
5 and manner as the Secretary specifies.

6           “(C) ADDITIONAL REQUIREMENTS.—The  
7 Secretary may not award a grant under this  
8 paragraph to an eligible critical access hospital  
9 unless—

10           “(i) local organizations or the State in  
11 which the hospital is located provides  
12 matching funds; and

13           “(ii) the hospital provides assurances  
14 that it will surrender critical access hos-  
15 pital status under this title within 180  
16 days of receiving the grant.

17           “(D) AMOUNT OF GRANT.—A grant to an  
18 eligible critical access hospital under this para-  
19 graph may not exceed \$1,000,000.

20           “(E) FUNDING.—There are appropriated  
21 from the Federal Hospital Insurance Trust  
22 Fund under section 1817 for making grants  
23 under this paragraph, \$5,000,000 for fiscal  
24 year 2008.

1           “(F) ELIGIBLE CRITICAL ACCESS HOS-  
2           PITAL DEFINED.—For purposes of this para-  
3           graph, the term ‘eligible critical access hospital’  
4           means a critical access hospital that has an av-  
5           erage daily acute census of less than 0.5 and an  
6           average daily swing bed census of greater than  
7           10.0.”.

8 **SEC. 122. REBASING FOR SOLE COMMUNITY HOSPITALS.**

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

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

20           “(ii) For purposes of this subparagraph, the term  
21 ‘subparagraph (L) rebased target amount’ has the mean-  
22 ing given the term ‘target amount’ in subparagraph (C),  
23 except that—

1           “(I) there shall be substituted for the base cost  
2 reporting period the 12-month cost reporting period  
3 beginning during fiscal year 2006;

4           “(II) any reference in subparagraph (C)(i) to  
5 the ‘first cost reporting period’ described in such  
6 subparagraph is deemed a reference to the first cost  
7 reporting period beginning on or after January 1,  
8 2009; and

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

12       (b)       CONFORMING        AMENDMENTS.—Section  
13 1886(b)(3) of the Social Security Act (42 U.S.C.  
14 1395ww(b)(3)) is amended—

15           (1) in subparagraph (C), in the matter pre-  
16 ceding clause (i), by striking “subparagraph (I)”  
17 and inserting “subparagraphs (I) and (L)”; and

18           (2) in subparagraph (I)(i), in the matter pre-  
19 ceding subclause (I), by striking “For” and inserting  
20 “Subject to subparagraph (L), for”.

21 **SEC. 123. DEMONSTRATION PROJECT ON COMMUNITY**  
22 **HEALTH INTEGRATION MODELS IN CERTAIN**  
23 **RURAL COUNTIES.**

24       (a) IN GENERAL.—The Secretary shall establish a  
25 demonstration project to allow eligible entities to develop

1 and test new models for the delivery of health care services  
2 in eligible counties for the purpose of improving access to,  
3 and better integrating the delivery of, acute care, extended  
4 care, and other essential health care services to Medicare  
5 beneficiaries.

6 (b) PURPOSE.—The purpose of the demonstration  
7 project under this section is to—

8 (1) explore ways to increase access to, and im-  
9 prove the adequacy of, payments for acute care, ex-  
10 tended care, and other essential health care services  
11 provided under the Medicare and Medicaid programs  
12 in eligible counties; and

13 (2) evaluate regulatory challenges facing such  
14 providers and the communities they serve.

15 (c) REQUIREMENTS.—The following requirements  
16 shall apply under the demonstration project:

17 (1) Health care providers in eligible counties se-  
18 lected to participate in the demonstration project  
19 under subsection (d)(3) shall (when determined ap-  
20 propriate by the Secretary), instead of the payment  
21 rates otherwise applicable under the Medicare pro-  
22 gram, be reimbursed at a rate that covers at least  
23 the reasonable costs of the provider in furnishing  
24 acute care, extended care, and other essential health  
25 care services to Medicare beneficiaries.



1           (2) Methods to coordinate the survey and cer-  
2           tification process under the Medicare program and  
3           the Medicaid program across all health service cat-  
4           egories included in the demonstration project shall  
5           be tested with the goal of assuring quality and safe-  
6           ty while reducing administrative burdens, as appro-  
7           priate, related to completing such survey and certifi-  
8           cation process.

9           (3) Health care providers in eligible counties se-  
10          lected to participate in the demonstration project  
11          under subsection (d)(3) and the Secretary shall work  
12          with the State to explore ways to revise reimburse-  
13          ment policies under the Medicaid program to im-  
14          prove access to the range of health care services  
15          available in such eligible counties.

16          (4) The Secretary shall identify regulatory re-  
17          quirements that may be revised appropriately to im-  
18          prove access to care in eligible counties.

19          (5) Other essential health care services nec-  
20          essary to ensure access to the range of health care  
21          services in eligible counties selected to participate in  
22          the demonstration project under subsection (d)(3)  
23          shall be identified. Ways to ensure adequate funding  
24          for such services shall also be explored.

25          (d) APPLICATION PROCESS.—

## 1 (1) ELIGIBILITY.—

2 (A) IN GENERAL.—Eligibility to partici-  
3 pate in the demonstration project under this  
4 section shall be limited to eligible entities.

5 (B) ELIGIBLE ENTITY DEFINED.—In this  
6 section, the term “eligible entity” means an en-  
7 tity that—

8 (i) is a Rural Hospital Flexibility Pro-  
9 gram grantee under section 1820(g) of the  
10 Social Security Act (42 U.S.C. 1395i-  
11 4(g)); and

12 (ii) is located in a State in which at  
13 least 65 percent of the counties in the  
14 State are counties that have 6 or less resi-  
15 dents per square mile.

## 16 (2) APPLICATION.—

17 (A) IN GENERAL.—An eligible entity seek-  
18 ing to participate in the demonstration project  
19 under this section shall submit an application to  
20 the Secretary at such time, in such manner,  
21 and containing such information as the Sec-  
22 retary may require.

23 (B) LIMITATION.—The Secretary shall se-  
24 lect eligible entities located in not more than 4

1 States to participate in the demonstration  
2 project under this section.

3 (3) SELECTION OF ELIGIBLE COUNTIES.—An  
4 eligible entity selected by the Secretary to partici-  
5 pate in the demonstration project under this section  
6 shall select not more than 6 eligible counties in the  
7 State in which the entity is located in which to con-  
8 duct the demonstration project.

9 (4) ELIGIBLE COUNTY DEFINED.—In this sec-  
10 tion, the term “eligible county” means a county that  
11 meets the following requirements:

12 (A) The county has 6 or less residents per  
13 square mile.

14 (B) As of the date of the enactment of this  
15 Act, a facility designated as a critical access  
16 hospital which meets the following requirements  
17 was located in the county:

18 (i) As of the date of the enactment of  
19 this Act, the critical access hospital fur-  
20 nished 1 or more of the following:

21 (I) Home health services.

22 (II) Hospice care.

23 (III) Rural health clinic services.

1                   (ii) As of the date of the enactment of  
2                   this Act, the critical access hospital has an  
3                   average daily inpatient census of 5 or less.

4                   (C) As of the date of the enactment of this  
5                   Act, skilled nursing facility services were avail-  
6                   able in the county in—

7                   (i) a critical access hospital using  
8                   swing beds; or

9                   (ii) a local nursing home.

10                  (e) ADMINISTRATION.—

11                  (1) IN GENERAL.—The demonstration project  
12                  under this section shall be administered jointly by  
13                  the Administrator of the Office of Rural Health Pol-  
14                  icy of the Health Resources and Services Adminis-  
15                  tration and the Administrator of the Centers for  
16                  Medicare & Medicaid Services, in accordance with  
17                  paragraphs (2) and (3).

18                  (2) HRSA DUTIES.—In administering the dem-  
19                  onstration project under this section, the Adminis-  
20                  trator of the Office of Rural Health Policy of the  
21                  Health Resources and Services Administration  
22                  shall—

23                  (A) award grants to the eligible entities se-  
24                  lected to participate in the demonstration  
25                  project; and

1 (B) work with such entities to provide  
2 technical assistance related to the requirements  
3 under the project.

4 (3) CMS DUTIES.—In administering the dem-  
5 onstration project under this section, the Adminis-  
6 trator of the Centers for Medicare & Medicaid Serv-  
7 ices shall determine which provisions of titles XVIII  
8 and XIX of the Social Security Act (42 U.S.C. 1395  
9 et seq.; 1396 et seq.) the Secretary should waive  
10 under the waiver authority under subsection (i) that  
11 are relevant to the development of alternative reim-  
12 bursement methodologies, which may include, as ap-  
13 propriate, covering at least the reasonable costs of  
14 the provider in furnishing acute care, extended care,  
15 and other essential health care services to Medicare  
16 beneficiaries and coordinating the survey and certifi-  
17 cation process under the Medicare and Medicaid pro-  
18 grams, as appropriate, across all service categories  
19 included in the demonstration project.

20 (f) DURATION.—

21 (1) IN GENERAL.—The demonstration project  
22 under this section shall be conducted for a 3-year  
23 period beginning on October 1, 2009.

24 (2) BEGINNING DATE OF DEMONSTRATION  
25 PROJECT.—The demonstration project under this

1 section shall be considered to have begun in a State  
2 on the date on which the eligible counties selected to  
3 participate in the demonstration project under sub-  
4 section (d)(3) begin operations in accordance with  
5 the requirements under the demonstration project.

6 (g) FUNDING.—

7 (1) CMS.—

8 (A) IN GENERAL.—The Secretary shall  
9 provide for the transfer, in appropriate part  
10 from the Federal Hospital Insurance Trust  
11 Fund established under section 1817 of the So-  
12 cial Security Act (42 U.S.C. 1395i) and the  
13 Federal Supplementary Medical Insurance  
14 Trust Fund established under section 1841 of  
15 such Act (42 U.S.C. 1395t), of such sums as  
16 are necessary for the costs to the Centers for  
17 Medicare & Medicaid Services of carrying out  
18 its duties under the demonstration project  
19 under this section.

20 (B) BUDGET NEUTRALITY.—In conducting  
21 the demonstration project under this section,  
22 the Secretary shall ensure that the aggregate  
23 payments made by the Secretary do not exceed  
24 the amount which the Secretary estimates

1           would have been paid if the demonstration  
2           project under this section was not implemented.

3           (2) HRSA.—There are authorized to be appro-  
4           priated to the Office of Rural Health Policy of the  
5           Health Resources and Services Administration  
6           \$800,000 for each of fiscal years 2010, 2011, and  
7           2012 for the purpose of carrying out the duties of  
8           such Office under the demonstration project under  
9           this section, to remain available for the duration of  
10          the demonstration project.

11          (h) REPORT.—

12           (1) INTERIM REPORT.—Not later than the date  
13          that is 2 years after the date on which the dem-  
14          onstration project under this section is implemented,  
15          the Administrator of the Office of Rural Health Pol-  
16          icy of the Health Resources and Services Adminis-  
17          tration, in coordination with the Administrator of  
18          the Centers for Medicare & Medicaid Services, shall  
19          submit a report to Congress on the status of the  
20          demonstration project that includes initial rec-  
21          ommendations on ways to improve access to, and the  
22          availability of, health care services in eligible coun-  
23          ties based on the findings of the demonstration  
24          project.

1           (2) FINAL REPORT.—Not later than 1 year  
2 after the completion of the demonstration project,  
3 the Administrator of the Office of Rural Health Pol-  
4 icy of the Health Resources and Services Adminis-  
5 tration, in coordination with the Administrator of  
6 the Centers for Medicare & Medicaid Services, shall  
7 submit a report to Congress on such project, to-  
8 gether with recommendations for such legislation  
9 and administrative action as the Secretary deter-  
10 mines appropriate.

11          (i) WAIVER AUTHORITY.—The Secretary may waive  
12 such requirements of titles XVIII and XIX of the Social  
13 Security Act (42 U.S.C. 1395 et seq.; 1396 et seq.) as  
14 may be necessary and appropriate for the purpose of car-  
15 rying out the demonstration project under this section.

16          (j) DEFINITIONS.—In this section:

17           (1) EXTENDED CARE SERVICES.—The term  
18 “extended care services” means the following:

19                   (A) Home health services.

20                   (B) Covered skilled nursing facility serv-  
21 ices.

22                   (C) Hospice care.

23           (2) COVERED SKILLED NURSING FACILITY  
24 SERVICES.—The term “covered skilled nursing facil-  
25 ity services” has the meaning given such term in



1 section 1888(e)(2)(A) of the Social Security Act (42  
2 U.S.C. 1395yy(e)(2)(A)).

3 (3) CRITICAL ACCESS HOSPITAL.—The term  
4 “critical access hospital” means a facility designated  
5 as a critical access hospital under section 1820(c) of  
6 such Act (42 U.S.C. 1395i–4(c)).

7 (4) HOME HEALTH SERVICES.—The term  
8 “home health services” has the meaning given such  
9 term in section 1861(m) of such Act (42 U.S.C.  
10 1395x(m)).

11 (5) HOSPICE CARE.—The term “hospice care”  
12 has the meaning given such term in section  
13 1861(dd) of such Act (42 U.S.C. 1395x(dd)).

14 (6) MEDICAID PROGRAM.—The term “Medicaid  
15 program” means the program under title XIX of  
16 such Act (42 U.S.C. 1396 et seq.).

17 (7) MEDICARE PROGRAM.—The term “Medicare  
18 program” means the program under title XVIII of  
19 such Act (42 U.S.C. 1395 et seq.).

20 (8) OTHER ESSENTIAL HEALTH CARE SERV-  
21 ICES.—The term “other essential health care serv-  
22 ices” means the following:

23 (A) Ambulance services (as described in  
24 section 1861(s)(7) of the Social Security Act  
25 (42 U.S.C. 1395x(s)(7))).

1 (B) Rural health clinic services.

2 (C) Public health services (as defined by  
3 the Secretary).

4 (D) Other health care services determined  
5 appropriate by the Secretary.

6 (9) RURAL HEALTH CLINIC SERVICES.—The  
7 term “rural health clinic services” has the meaning  
8 given such term in section 1861(aa)(1) of such Act  
9 (42 U.S.C. 1395x(aa)(1)).

10 (10) SECRETARY.—The term “Secretary”  
11 means the Secretary of Health and Human Services.

12 **SEC. 124. EXTENSION OF THE RECLASSIFICATION OF CER-**  
13 **TAIN HOSPITALS.**

14 (a) IN GENERAL.—Subsection (a) of section 106 of  
15 division B of the Tax Relief and Health Care Act of 2006  
16 (42 U.S.C. 1395 note), as amended by section 117 of the  
17 Medicare, Medicaid, and SCHIP Extension Act of 2007  
18 (Public Law 110–173), is amended by striking “Sep-

19 tember 30, 2008” and inserting “September 30, 2009”.  
20 (b) SPECIAL EXCEPTION RECLASSIFICATIONS.—Sec-  
21 tion 117(a)(2) of the Medicare, Medicaid, and SCHIP Ex-  
22 tension Act of 2008 (Public Law 110–173)) is amended  
23 by striking “September 30, 2008” and inserting “the last  
24 date of the extension of reclassifications under section

1 106(a) of the Medicare Improvement and Extension Act  
2 of 2006 (division B of Public Law 109–432)’’.

3 (c) DISREGARDING SECTION 508 HOSPITAL RECLAS-  
4 SIFICATIONS FOR PURPOSES OF GROUP RECLASSIFICA-  
5 TIONS.—Section 508(g) of the Medicare Prescription  
6 Drug, Improvement, and Modernization Act of 2003 (Pub-  
7 lic Law 108–173, 42 U.S.C. 1395ww note), as added by  
8 section 117(b) of the Medicare, Medicaid, and SCHIP Ex-  
9 tension Act of 2008 (Public Law 110–173)), is amended  
10 by striking “during fiscal year 2008” and inserting “be-  
11 ginning on October 1, 2007, and ending on the last date  
12 of the extension of reclassifications under section 106(a)  
13 of the Medicare Improvement and Extension Act of 2006  
14 (division B of Public Law 109–432)’’.

15 **SEC. 125. REVOCATION OF UNIQUE DEEMING AUTHORITY**  
16 **OF THE JOINT COMMISSION.**

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

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

20 (2) by redesignating subsections (b), (c), (d),  
21 and (e) as subsections (a), (b), (c), and (d), respec-  
22 tively.

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

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

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

5 (i) by striking “released to him by the  
6 Joint Commission on Accreditation of Hos-  
7 pitals,” and inserting “released to the Secretary  
8 by”; and

9 (ii) by striking the comma after “Associa-  
10 tion”;

11 (C) in subsection (c), as so redesignated, by  
12 striking “pursuant to subsection (a) or (b)(1)” and  
13 inserting “pursuant to subsection (a)(1)”; and

14 (D) in subsection (d), as so redesignated, by  
15 striking “pursuant to subsection (a) or (b)(1)” and  
16 inserting “pursuant to subsection (a)(1)”.

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

1 credited by a national accreditation body recognized by the  
2 Secretary under section 1865(a), or is accredited by or  
3 approved by a program of the country in which such insti-  
4 tution is located if the Secretary finds the accreditation  
5 or comparable approval standards of such program to be  
6 essentially equivalent to those of such a national accredita-  
7 tion body.”.

8 (3) Section 1864(e) of the Social Security Act (42  
9 U.S.C. 1395aa(e)) is amended by striking “pursuant to  
10 subsection (a) or (b)(1) of section 1865” and inserting  
11 “pursuant to section 1865(a)(1)”.

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

16 (5) Section 1834(a)(20)(B) of the Social Security Act  
17 (42 U.S.C. 1395m(a)(20)(B)) is amended by striking  
18 “section 1865(b)” and inserting “section 1865(a)”.

19 (6) Section 1852(e)(4)(C) of the Social Security Act  
20 (42 U.S.C. 1395w-22(e)(4)(C)) is amended by striking  
21 “section 1865(b)(2)” and inserting “section 1865(a)(2)”.

22 (c) **AUTHORITY TO RECOGNIZE THE JOINT COMMIS-**  
23 **SION AS A NATIONAL ACCREDITATION BODY.**—The Sec-  
24 retary of Health and Human Services may recognize the  
25 Joint Commission as a national accreditation body under

1 section 1865 of the Social Security Act (42 U.S.C.  
2 1395bb), as amended by this section, upon such terms and  
3 conditions, and upon submission of such information, as  
4 the Secretary may require.

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

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

## 18 **Subtitle C—Provisions Relating to** 19 **Part B**

### 20 **PART 1—PHYSICIANS' SERVICES**

#### 21 **SEC. 131. PHYSICIAN PAYMENT, EFFICIENCY, AND QUALITY**

##### 22 **IMPROVEMENTS.**

23 (a) IN GENERAL.—

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

1 (A) FOR THE SECOND HALF OF 2008.—  
2 Section 1848(d)(8) of the Social Security Act  
3 (42 U.S.C. 1395w-4(d)(8)), as added by section  
4 101 of the Medicare, Medicaid, and SCHIP Ex-  
5 tension Act of 2007 (Public Law 110-173), is  
6 amended—

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

9 (ii) in subparagraph (A), by striking  
10 “for the period beginning on January 1,  
11 2008, and ending on June 30, 2008,”; and

12 (iii) in subparagraph (B)—

13 (I) in the heading, by striking  
14 “THE REMAINING PORTION OF 2008  
15 AND”; and

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

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

25 “(9) UPDATE FOR 2009.—

1           “(A) IN GENERAL.—Subject to paragraphs  
2           (7)(B) and (8)(B), in lieu of the update to the  
3           single conversion factor established in para-  
4           graph (1)(C) that would otherwise apply for  
5           2009, the update to the single conversion factor  
6           shall be 1.1 percent.

7           “(B) NO EFFECT ON COMPUTATION OF  
8           CONVERSION FACTOR FOR 2010 AND SUBSE-  
9           QUENT YEARS.—The conversion factor under  
10          this subsection shall be computed under para-  
11          graph (1)(A) for 2010 and subsequent years as  
12          if subparagraph (A) had never applied.”.

13          (3) REVISION OF THE PHYSICIAN ASSISTANCE  
14          AND QUALITY INITIATIVE FUND.—

15                 (A) IN GENERAL.—Subject to subpara-  
16                 graph (B), section 1848(l)(2) of the Social Se-  
17                 curity Act (42 U.S.C. 1395w-4(l)(2)), as  
18                 amended by section 101(a)(2) of the Medicare,  
19                 Medicaid, and SCHIP Extension Act of 2007  
20                 (Public Law 110-173), is amended—

21                         (i) in subparagraph (A)—

22                                 (I) by striking clause (i)(III); and

23                                 (II) by striking clause (ii)(III);

24                                 and

25                                 (ii) in subparagraph (B)—



1 (I) in clause (i), by adding “and”  
2 at the end;

3 (II) in clause (ii), by striking “;  
4 and” and inserting a period; and

5 (III) by striking clause (iii).

6 (B) CONTINGENCY.—If there is enacted,  
7 before, on, or after the date of the enactment  
8 of this Act, a Supplemental Appropriations Act,  
9 2008 that includes a provision amending section  
10 1848(l) of the Social Security Act, the alter-  
11 native amendment described in subparagraph  
12 (C)—

13 (i) shall apply instead of the amend-  
14 ments made by subparagraph (A); and

15 (ii) shall be executed after such provi-  
16 sion in such Supplemental Appropriations  
17 Act.

18 (C) ALTERNATIVE AMENDMENT DE-  
19 SCRIBED.—The alternative amendment de-  
20 scribed in this subparagraph is as follows: Sec-  
21 tion 1848(l)(2) of the Social Security Act (42  
22 U.S.C. 1395w-4(l)(2)), as amended by section  
23 101(a)(2) of the Medicare, Medicaid, and  
24 SCHIP Extension Act of 2007 (Public Law

1 110–173) and by the Supplemental Appropria-  
2 tions Act, 2008, is amended—

3 (i) in subparagraph (A)—

4 (I) by striking subclauses (III)  
5 and (IV) of clause (i); and

6 (II) by striking subclauses (III)  
7 and (IV) of clause (ii); and

8 (ii) in subparagraph (B)—

9 (I) in clause (i), by adding “and”  
10 at the end;

11 (II) in clause (ii), by striking the  
12 semicolon at the end and inserting a  
13 period; and

14 (III) by striking clauses (iii) and  
15 (iv).

16 (b) EXTENSION AND IMPROVEMENT OF THE QUAL-  
17 ITY REPORTING SYSTEM.—

18 (1) SYSTEM.—Section 1848(k)(2) of the Social  
19 Security Act (42 U.S.C. 1395w–4(k)(2)), as amend-  
20 ed by section 101(b)(1) of the Medicare, Medicaid,  
21 and SCHIP Extension Act of 2007 (Public Law  
22 110–173), is amended by adding at the end the fol-  
23 lowing new subparagraphs:

24 “(C) FOR 2010 AND SUBSEQUENT  
25 YEARS.—

1           “(i) IN GENERAL.—Subject to clause  
2           (ii), for purposes of reporting data on qual-  
3           ity measures for covered professional serv-  
4           ices furnished during 2010 and each subse-  
5           quent year, subject to subsection  
6           (m)(3)(C), the quality measures (including  
7           electronic prescribing quality measures)  
8           specified under this paragraph shall be  
9           such measures selected by the Secretary  
10          from measures that have been endorsed by  
11          the entity with a contract with the Sec-  
12          retary under section 1890(a).

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

1           “(D) OPPORTUNITY TO PROVIDE INPUT ON  
2 MEASURES FOR 2009 AND SUBSEQUENT  
3 YEARS.—For each quality measure (including  
4 an electronic prescribing quality measure)  
5 adopted by the Secretary under subparagraph  
6 (B) (with respect to 2009) or subparagraph  
7 (C), the Secretary shall ensure that eligible pro-  
8 fessionals have the opportunity to provide input  
9 during the development, endorsement, or selec-  
10 tion of measures applicable to services they fur-  
11 nish.”.

12           (2) REDESIGNATION OF REPORTING SYSTEM.—  
13 Subsection (c) of section 101 of division B of the  
14 Tax Relief and Health Care Act of 2006 (42 U.S.C.  
15 1395w–4 note), as amended by section 101(b)(2) of  
16 the Medicare, Medicaid, and SCHIP Extension Act  
17 of 2007 (Public Law 110–173), is redesignated as  
18 subsection (m) of section 1848 of the Social Security  
19 Act.

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

23           (A) by amending the heading to read as  
24 follows: “INCENTIVE PAYMENTS FOR QUALITY  
25 REPORTING”;

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

3 “(1) INCENTIVE PAYMENTS.—

4 “(A) IN GENERAL.—For 2007 through  
5 2010, with respect to covered professional serv-  
6 ices furnished during a reporting period by an  
7 eligible professional, if—

8 “(i) there are any quality measures  
9 that have been established under the physi-  
10 cian reporting system that are applicable  
11 to any such services furnished by such pro-  
12 fessional for such reporting period; and

13 “(ii) the eligible professional satisfac-  
14 torily submits (as determined under this  
15 subsection) to the Secretary data on such  
16 quality measures in accordance with such  
17 reporting system for such reporting period,  
18 in addition to the amount otherwise paid under  
19 this part, there also shall be paid to the eligible  
20 professional (or to an employer or facility in the  
21 cases described in clause (A) of section  
22 1842(b)(6)) or, in the case of a group practice  
23 under paragraph (3)(C), to the group practice,  
24 from the Federal Supplementary Medical Insur-  
25 ance Trust Fund established under section

1 1841 an amount equal to the applicable quality  
2 percent of the Secretary's estimate (based on  
3 claims submitted not later than 2 months after  
4 the end of the reporting period) of the allowed  
5 charges under this part for all such covered  
6 professional services furnished by the eligible  
7 professional (or, in the case of a group practice  
8 under paragraph (3)(C), by the group practice)  
9 during the reporting period.

10 “(B) APPLICABLE QUALITY PERCENT.—

11 For purposes of subparagraph (A), the term  
12 ‘applicable quality percent’ means—

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

14 and

15 “(ii) for 2009 and 2010, 2.0 per-  
16 cent.”;

17 (C) by striking paragraph (3) and redesign-  
18 ating paragraph (2) as paragraph (3);

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

20 (i) in the matter preceding subpara-  
21 graph (A), by striking “For purposes” and  
22 inserting the following:

23 “(A) IN GENERAL.—For purposes”;

24 (ii) by redesignating subparagraphs  
25 (A) and (B) as clauses (i) and (ii), respec-

1                   tively, and moving the indentation of such  
2                   clauses 2 ems to the right;

3                   (iii) in subparagraph (A), as added by  
4                   clause (i), by adding at the end the fol-  
5                   lowing flush sentence:

6                   “For years after 2008, quality measures for  
7                   purposes of this subparagraph shall not include  
8                   electronic prescribing quality measures.”; and

9                   (iv) by adding at the end the following  
10                  new subparagraphs:

11                  “(C) SATISFACTORY REPORTING MEAS-  
12                  URES FOR GROUP PRACTICES.—

13                  “(i) IN GENERAL.—By January 1,  
14                  2010, the Secretary shall establish and  
15                  have in place a process under which eligi-  
16                  ble professionals in a group practice (as  
17                  defined by the Secretary) shall be treated  
18                  as satisfactorily submitting data on quality  
19                  measures under subparagraph (A) and as  
20                  meeting the requirement described in sub-  
21                  paragraph (B)(ii) for covered professional  
22                  services for a reporting period (or, for pur-  
23                  poses of subsection (a)(5), for a reporting  
24                  period for a year) if, in lieu of reporting  
25                  measures under subsection (k)(2)(C), the

1 group practice reports measures deter-  
2 mined appropriate by the Secretary, such  
3 as measures that target high-cost chronic  
4 conditions and preventive care, in a form  
5 and manner, and at a time, specified by  
6 the Secretary.

7 “(ii) STATISTICAL SAMPLING  
8 MODEL.—The process under clause (i)  
9 shall provide for the use of a statistical  
10 sampling model to submit data on meas-  
11 ures, such as the model used under the  
12 Physician Group Practice demonstration  
13 project under section 1866A.

14 “(iii) NO DOUBLE PAYMENTS.—Pay-  
15 ments to a group practice under this sub-  
16 section by reason of the process under  
17 clause (i) shall be in lieu of the payments  
18 that would otherwise be made under this  
19 subsection to eligible professionals in the  
20 group practice for satisfactorily submitting  
21 data on quality measures.

22 “(D) AUTHORITY TO REVISE SATISFAC-  
23 TORILY REPORTING DATA.—For years after  
24 2009, the Secretary, in consultation with stake-  
25 holders and experts, may revise the criteria



1 under this subsection for satisfactorily submit-  
2 ting data on quality measures under subpara-  
3 graph (A) and the criteria for submitting data  
4 on electronic prescribing quality measures  
5 under subparagraph (B)(ii).”;

6 (E) in paragraph (5)—

7 (i) in subparagraph (C), by inserting  
8 “for 2007, 2008, and 2009,” after “provi-  
9 sion of law,”;

10 (ii) in subparagraph (D)—

11 (I) in clause (i)—

12 (aa) by inserting “for 2007  
13 and 2008” after “under this sub-  
14 section”; and

15 (bb) by striking “paragraph  
16 (2)” and inserting “this sub-  
17 section”;

18 (II) in clause (ii), by striking  
19 “shall” and inserting “may establish  
20 procedures to”; and

21 (III) in clause (iii)—

22 (aa) by inserting “(or, in the  
23 case of a group practice under  
24 paragraph (3)(C), the group

1 practice)” after “an eligible pro-  
2 fessional”;

3 (bb) by striking “bonus in-  
4 centive payment” and inserting  
5 “incentive payment under this  
6 subsection”; and

7 (cc) by adding at the end  
8 the following new sentence: “If  
9 such payments for such period  
10 have already been made, the Sec-  
11 retary shall recoup such pay-  
12 ments from the eligible profes-  
13 sional (or the group practice).”;

14 (iii) in subparagraph (E)—

15 (I) by striking “(I) IN GEN-  
16 ERAL.—”;

17 (II) by striking clause (ii);

18 (III) by redesignating subclauses  
19 (I) through (IV) as clauses (i)  
20 through (iv), respectively, and moving  
21 the indentation of such clauses 2 ems  
22 to the left;

23 (IV) in clause (ii), as so redesign-  
24 nated, by striking “paragraph (2)”  
25 and inserting “this subsection”; and

1 (V) in clause (iv), as so redesignated—  
2

3 (aa) by striking “the bonus”  
4 and inserting “any”; and

5 (bb) by inserting “and the  
6 payment adjustment under sub-  
7 section (a)(5)(A)” before the pe-  
8 riod at the end;

9 (iv) in subparagraph (F)—

10 (I) by striking “2009, paragraph  
11 (3) shall not apply, and” and insert-  
12 ing “subsequent years,”; and

13 (II) by striking “paragraph (2)”  
14 and inserting “this subsection”; and

15 (v) by adding at the end the following  
16 new subparagraph:

17 “(G) POSTING ON WEBSITE.—The Sec-  
18 retary shall post on the Internet website of the  
19 Centers for Medicare & Medicaid Services, in an  
20 easily understandable format, a list of the  
21 names of the following:

22 “(i) The eligible professionals (or, in  
23 the case of reporting under paragraph  
24 (3)(C), the group practices) who satisfac-

1 torily submitted data on quality measures  
2 under this subsection.

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

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

9 “(C) REPORTING PERIOD.—

10 “(i) IN GENERAL.—Subject to clauses  
11 (ii) and (iii), the term ‘reporting period’  
12 means—

13 “(I) for 2007, the period begin-  
14 ning on July 1, 2007, and ending on  
15 December 31, 2007; and

16 “(II) for 2008, 2009, 2010, and  
17 2011, the entire year.

18 “(ii) AUTHORITY TO REVISE REPORT-  
19 ING PERIOD.—For years after 2009, the  
20 Secretary may revise the reporting period  
21 under clause (i) if the Secretary deter-  
22 mines such revision is appropriate, pro-  
23 duces valid results on measures reported,  
24 and is consistent with the goals of maxi-  
25 mizing scientific validity and reducing ad-

1           ministrative burden. If the Secretary re-  
2           vises such period pursuant to the preceding  
3           sentence, the term ‘reporting period’ shall  
4           mean such revised period.

5           “(iii) REFERENCE.—Any reference in  
6           this subsection to a reporting period with  
7           respect to the application of subsection  
8           (a)(5) shall be deemed a reference to the  
9           reporting period under subparagraph  
10          (D)(iii) of such subsection.”.

11           (4) INCLUSION OF QUALIFIED AUDIOLOGISTS  
12          AS ELIGIBLE PROFESSIONALS.—

13           (A) IN GENERAL.—Section 1848(k)(3)(B)  
14          of the Social Security Act (42 U.S.C. 1395w-  
15          4(k)(3)(B)), is amended by adding at the end  
16          the following new clause:

17           “(iv) Beginning with 2009, a qualified  
18          audiologist (as defined in section  
19          1861(ll)(3)(B)).”.

20           (B) NO CHANGE IN BILLING.—Nothing in  
21          the amendment made by subparagraph (A)  
22          shall be construed to change the way in which  
23          billing for audiology services (as defined in sec-  
24          tion 1861(ll)(2) of the Social Security Act (42

1 U.S.C. 1395x(l)(2)) occurs under title XVIII  
2 of such Act as of July 1, 2008.

3 (5) CONFORMING AMENDMENTS.—Section  
4 1848(m) of the Social Security Act, as added and  
5 amended by paragraphs (2) and (3), is amended—

6 (A) in paragraph (5)—

7 (i) in subparagraph (A)—

8 (I) by striking “section 1848(k)  
9 of the Social Security Act, as added  
10 by subsection (b),” and inserting  
11 “subsection (k)”; and

12 (II) by striking “such section”  
13 and inserting “such subsection”;

14 (ii) in subparagraph (B), by striking  
15 “of the Social Security Act (42 U.S.C.  
16 1395l)”;

17 (iii) in subparagraph (E), in the mat-  
18 ter preceding clause (i), by striking “1869  
19 or 1878 of the Social Security Act or oth-  
20 erwise” and inserting “1869, section 1878,  
21 or otherwise”; and

22 (iv) in subparagraph (F)—

23 (I) by striking “paragraph (2)(B)  
24 of section 1848(k) of the Social Secu-

1                    rity Act (42 U.S.C. 1395w-4(k))” and  
2                    inserting “subsection (k)(2)(B)”;  
3                    (II) by striking “paragraph (4)  
4                    of such section” and inserting “sub-  
5                    section (k)(4)”;

6                    (B) in paragraph (6)—

7                    (i) in subparagraph (A), by striking  
8                    “section 1848(k)(3) of the Social Security  
9                    Act, as added by subsection (b)” and in-  
10                    sserting “subsection (k)(3)”;

11                    (ii) in subparagraph (B), by striking  
12                    “section 1848(k) of the Social Security  
13                    Act, as added by subsection (b)” and in-  
14                    sserting “subsection (k)”;

15                    (C) by striking paragraph (6)(D).

16                    (6) NO AFFECT ON INCENTIVE PAYMENTS FOR  
17                    2007 OR 2008.—Nothing in the amendments made by  
18                    this subsection or section 132 shall affect the oper-  
19                    ation of the provisions of section 1848(m) of the So-  
20                    cial Security Act, as redesignated and amended by  
21                    such subsection and section, with respect to 2007 or  
22                    2008.

23                    (c) PHYSICIAN FEEDBACK PROGRAM TO IMPROVE  
24                    EFFICIENCY AND CONTROL COSTS.—

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

5           “(n) PHYSICIAN FEEDBACK PROGRAM.—

6                 “(1) ESTABLISHMENT.—

7                     “(A) IN GENERAL.—The Secretary shall  
8 establish a Physician Feedback Program (in  
9 this subsection referred to as the ‘Program’)  
10 under which the Secretary shall use claims data  
11 under this title (and may use other data) to  
12 provide confidential reports to physicians (and,  
13 as determined appropriate by the Secretary, to  
14 groups of physicians) that measure the re-  
15 sources involved in furnishing care to individ-  
16 uals under this title. If determined appropriate  
17 by the Secretary, the Secretary may include in-  
18 formation on the quality of care furnished to in-  
19 dividuals under this title by the physician (or  
20 group of physicians) in such reports.

21                     “(B) RESOURCE USE.—The resources de-  
22 scribed in subparagraph (A) may be meas-  
23 ured—

24                             “(i) on an episode basis;

25                             “(ii) on a per capita basis; or



1                   “(iii) on both an episode and a per  
2                   capita basis.

3                   “(2) IMPLEMENTATION.—The Secretary shall  
4                   implement the Program by not later than January  
5                   1, 2009.

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

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

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

15                   “(B) physicians who treat conditions that  
16                   have a high cost or a high volume, or both,  
17                   under this title;

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

20                   “(D) physicians practicing in certain geo-  
21                   graphic areas; or

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

24                   “(5) AUTHORITY TO EXCLUDE CERTAIN INFOR-  
25                   MATION IF INSUFFICIENT INFORMATION.—The Sec-

1       retary may exclude certain information regarding a  
2       service from a report under the Program with re-  
3       spect to a physician (or group of physicians) if the  
4       Secretary determines that there is insufficient infor-  
5       mation relating to that service to provide a valid re-  
6       port on that service.

7               “(6) ADJUSTMENT OF DATA.—To the extent  
8       practicable, the Secretary shall make appropriate ad-  
9       justments to the data used in preparing reports  
10      under the Program, such as adjustments to take  
11      into account variations in health status and other  
12      patient characteristics.

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

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

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

22              (A) STUDY.—The Comptroller General of  
23      the United States shall conduct a study of the  
24      Physician Feedback Program conducted under  
25      section 1848(n) of the Social Security Act, as

1           added by paragraph (1), including the imple-  
2           mentation of the Program.

3           (B) REPORT.—Not later than March 1,  
4           2011, the Comptroller General of the United  
5           States shall submit a report to Congress con-  
6           taining the results of the study conducted under  
7           subparagraph (A), together with recommenda-  
8           tions for such legislation and administrative ac-  
9           tion as the Comptroller General determines ap-  
10          propriate.

11          (d) PLAN FOR TRANSITION TO VALUE-BASED PUR-  
12          CHASING PROGRAM FOR PHYSICIANS AND OTHER PRACTI-  
13          TIONERS.—

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

20           (2) REPORT.—Not later than May 1, 2010, the  
21          Secretary of Health and Human Services shall sub-  
22          mit a report to Congress containing the plan devel-  
23          oped under paragraph (1), together with rec-  
24          ommendations for such legislation and administra-  
25          tive action as the Secretary determines appropriate.

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

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

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

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

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

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

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

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

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

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

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

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

17 “(i) for 2009 and 2010, 2.0 percent;

18 “(ii) for 2011 and 2012, 1.0 percent;

19 and

20 “(iii) for 2013, 0.5 percent.”;

21 (2) in paragraph (3), as redesignated by section  
22 131(b)—

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

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

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

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

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

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

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

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



1 for purposes of section 1860D–15 that are  
2 necessary for purposes of clause (iii), para-  
3 graph (2)(B)(ii), and paragraph (5)(G).

4 “(v) STANDARDS FOR ELECTRONIC  
5 PRESCRIBING.—To the extent practicable,  
6 in determining whether eligible profes-  
7 sionals meet the requirements under  
8 clauses (ii) and (iii) for purposes of clause  
9 (i), the Secretary shall ensure that eligible  
10 professionals utilize electronic prescribing  
11 systems in compliance with standards es-  
12 tablished for such systems pursuant to the  
13 Part D Electronic Prescribing Program  
14 under section 1860D–4(e).”; and

15 (3) in paragraph (5)(E), by striking clause (iii)  
16 and inserting the following new clause:

17 “(iii) the determination of a successful  
18 electronic prescriber under paragraph (3),  
19 the limitation under paragraph (2)(B), and  
20 the exception under subsection (a)(5)(B);  
21 and”.

22 (b) INCENTIVE PAYMENT ADJUSTMENT.—Section  
23 1848(a) of the Social Security Act (42 U.S.C. 1395w–  
24 4(a)) is amended by adding at the end the following new  
25 paragraph:

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

3           “(A) ADJUSTMENT.—

4           “(i) IN GENERAL.—Subject to sub-  
5       paragraph (B) and subsection (m)(2)(B),  
6       with respect to covered professional serv-  
7       ices furnished by an eligible professional  
8       during 2012 or any subsequent year, if the  
9       eligible professional is not a successful  
10      electronic prescriber for the reporting pe-  
11      riod for the year (as determined under  
12      subsection (m)(3)(B)), the fee schedule  
13      amount for such services furnished by such  
14      professional during the year (including the  
15      fee schedule amount for purposes of deter-  
16      mining a payment based on such amount)  
17      shall be equal to the applicable percent of  
18      the fee schedule amount that would other-  
19      wise apply to such services under this sub-  
20      section (determined after application of  
21      paragraph (3) but without regard to this  
22      paragraph).

23           “(ii) APPLICABLE PERCENT.—For  
24      purposes of clause (i), the term ‘applicable  
25      percent’ means—

1 “(I) for 2012, 99 percent;  
2 “(II) for 2013, 98.5 percent; and  
3 “(III) for 2014 and each subse-  
4 quent year, 98 percent.

5 “(B) SIGNIFICANT HARDSHIP EXCEP-  
6 TION.—The Secretary may, on a case-by-case  
7 basis, exempt an eligible professional from the  
8 application of the payment adjustment under  
9 subparagraph (A) if the Secretary determines,  
10 subject to annual renewal, that compliance with  
11 the requirement for being a successful elec-  
12 tronic prescriber would result in a significant  
13 hardship, such as in the case of an eligible pro-  
14 fessional who practices in a rural area without  
15 sufficient Internet access.

16 “(C) APPLICATION.—

17 “(i) PHYSICIAN REPORTING SYSTEM  
18 RULES.—Paragraphs (5), (6), and (8) of  
19 subsection (k) shall apply for purposes of  
20 this paragraph in the same manner as they  
21 apply for purposes of such subsection.

22 “(ii) INCENTIVE PAYMENT VALIDA-  
23 TION RULES.—Clauses (ii) and (iii) of sub-  
24 section (m)(5)(D) shall apply for purposes

1 of this paragraph in a similar manner as  
2 they apply for purposes of such subsection.

3 “(D) DEFINITIONS.—For purposes of this  
4 paragraph:

5 “(i) ELIGIBLE PROFESSIONAL; COV-  
6 ERED PROFESSIONAL SERVICES.—The  
7 terms ‘eligible professional’ and ‘covered  
8 professional services’ have the meanings  
9 given such terms in subsection (k)(3).

10 “(ii) PHYSICIAN REPORTING SYS-  
11 TEM.—The term ‘physician reporting sys-  
12 tem’ means the system established under  
13 subsection (k).

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

17 (c) GAO REPORT ON ELECTRONIC PRESCRIBING.—  
18 Not later than September 1, 2012, the Comptroller Gen-  
19 eral of the United States shall submit to Congress a report  
20 on the implementation of the incentives for electronic pre-  
21 scribing established under the provisions of, and amend-  
22 ments made by, this section. Such report shall include in-  
23 formation regarding the following:

24 (1) The percentage of eligible professionals (as  
25 defined in section 1848(k)(3) of the Social Security

1 Act (42 U.S.C. 1395w-4(k)(3)) that are using elec-  
2 tronic prescribing systems, including a determination  
3 of whether less than 50 percent of eligible profes-  
4 sionals are using electronic prescribing systems.

5 (2) If less than 50 percent of eligible profes-  
6 sionals are using electronic prescribing systems, rec-  
7 ommendations for increasing the use of electronic  
8 prescribing systems by eligible professionals, such as  
9 changes to the incentive payment adjustments estab-  
10 lished under section 1848(a)(5) of such Act, as  
11 added by subsection (b).

12 (3) The estimated savings to the Medicare pro-  
13 gram under title XVIII of such Act resulting from  
14 the use of electronic prescribing systems.

15 (4) Reductions in avoidable medical errors re-  
16 sulting from the use of electronic prescribing sys-  
17 tems.

18 (5) The extent to which the privacy and secu-  
19 rity of the personal health information of Medicare  
20 beneficiaries is protected when such beneficiaries'  
21 prescription drug data and usage information is  
22 used for purposes other than their direct clinical  
23 care, including—

24 (A) whether information identifying the  
25 beneficiary is, and remains, removed from data

1 regarding the beneficiary's prescription drug  
2 utilization; and

3 (B) the extent to which current law re-  
4 quires sufficient and appropriate oversight and  
5 audit capabilities to monitor the practice of pre-  
6 scription drug data mining.

7 (6) Such other recommendations and adminis-  
8 trative action as the Comptroller General determines  
9 to be appropriate.

10 **SEC. 133. EXPANDING ACCESS TO PRIMARY CARE SERV-**  
11 **ICES.**

12 (a) REVISIONS TO THE MEDICARE MEDICAL HOME  
13 DEMONSTRATION PROJECT.—

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

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

20 (B) by adding at the end the following new  
21 paragraph:

22 “(3) EXPANSION.—The Secretary may expand  
23 the duration and the scope of the project under  
24 paragraph (1), to an extent determined appropriate  
25 by the Secretary, if the Secretary determines that

1 such expansion will result in any of the following  
2 conditions being met:

3 “(A) The expansion of the project is ex-  
4 pected to improve the quality of patient care  
5 without increasing spending under the Medicare  
6 program (not taking into account amounts  
7 available under subsection (g)).

8 “(B) The expansion of the project is ex-  
9 pected to reduce spending under the Medicare  
10 program (not taking into account amounts  
11 available under subsection (g)) without reducing  
12 the quality of patient care.”.

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

17 “(g) FUNDING FROM SMI TRUST FUND.—There  
18 shall be available, from the Federal Supplementary Med-  
19 ical Insurance Trust Fund (under section 1841 of the So-  
20 cial Security Act (42 U.S.C. 1395t)), the amount of  
21 \$100,000,000 to carry out the project.

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

1 (b) APPLICATION OF BUDGET-NEUTRALITY ADJUST-  
2 TOR TO CONVERSION FACTOR.—Section 1848(e)(2)(B) of  
3 the Social Security Act (42 U.S.C. 1395w–4(e)(2)(B)) is  
4 amended by adding at the end the following new clause:

5 “(vi) ALTERNATIVE APPLICATION OF  
6 BUDGET-NEUTRALITY ADJUSTMENT.—Not-  
7 withstanding subsection (d)(9)(A), effective  
8 for fee schedules established beginning  
9 with 2009, with respect to the 5-year re-  
10 view of work relative value units used in  
11 fee schedules for 2007 and 2008, in lieu of  
12 continuing to apply budget-neutrality ad-  
13 justments required under clause (ii) for  
14 2007 and 2008 to work relative value  
15 units, the Secretary shall apply such budg-  
16 et-neutrality adjustments to the conversion  
17 factor otherwise determined for years be-  
18 ginning with 2009.”.

19 **SEC. 134. EXTENSION OF FLOOR ON MEDICARE WORK GEO-**  
20 **GRAPHIC ADJUSTMENT UNDER THE MEDI-**  
21 **CARE PHYSICIAN FEE SCHEDULE.**

22 (a) IN GENERAL.—Section 1848(e)(1)(E) of the So-  
23 cial Security Act (42 U.S.C. 1395w–4(e)(1)(E)), as  
24 amended by section 103 of the Medicare, Medicaid, and  
25 SCHIP Extension Act of 2007 (Public Law 110–173), is



1 amended by striking “before July 1, 2008” and inserting  
2 “before January 1, 2010”.

3 (b) TREATMENT OF PHYSICIANS’ SERVICES FUR-  
4 NISHED IN CERTAIN AREAS.—Section 1848(e)(1)(G) of  
5 the Social Security Act (42 U.S.C. 1395w–4(e)(1)(G)) is  
6 amended by adding at the end the following new sentence:  
7 “For purposes of payment for services furnished in the  
8 State described in the preceding sentence on or after Jan-  
9 uary 1, 2009, after calculating the work geographic index  
10 in subparagraph (A)(iii), the Secretary shall increase the  
11 work geographic index to 1.5 if such index would otherwise  
12 be less than 1.5”.

13 (c) TECHNICAL CORRECTION.—Section 602(1) of the  
14 Medicare Prescription Drug, Improvement, and Mod-  
15 ernization Act of 2003 (Public Law 108–173; 117 Stat.  
16 2301) is amended to read as follows:

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

20 **SEC. 135. IMAGING PROVISIONS.**

21 (a) ACCREDITATION REQUIREMENT.—

22 (1) ACCREDITATION REQUIREMENT.—Section  
23 1834 of the Social Security Act (42 U.S.C. 1395m)  
24 is amended by inserting after subsection (d) the fol-  
25 lowing new subsection:

1       “(e) ACCREDITATION REQUIREMENT FOR ADVANCED  
2 DIAGNOSTIC IMAGING SERVICES.—

3               “(1) IN GENERAL.—

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

13                       “(B) ADVANCED DIAGNOSTIC IMAGING  
14 SERVICES DEFINED.—In this subsection, the  
15 term ‘advanced diagnostic imaging services’ in-  
16 cludes—

17                               “(i) diagnostic magnetic resonance  
18 imaging, computed tomography, and nu-  
19 clear medicine (including positron emission  
20 tomography); and

21                               “(ii) such other diagnostic imaging  
22 services, including services described in  
23 section 1848(b)(4)(B) (excluding X-ray,  
24 ultrasound, and fluoroscopy), as specified  
25 by the Secretary in consultation with phy-

1           sician specialty organizations and other  
2           stakeholders.

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

6           “(2) ACCREDITATION ORGANIZATIONS.—

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

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

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

22                 “(iii) Whether the organization uses  
23                 random site visits, site audits, or other  
24                 strategies for ensuring accredited suppliers

1 maintain adherence to the criteria de-  
2 scribed in paragraph (3).

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

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

10 “(vi) Such other factors as the Sec-  
11 retary determines appropriate.

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

19 “(C) REVIEW AND MODIFICATION OF LIST  
20 OF ACCREDITATION ORGANIZATIONS.—

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

1           sults of such review, the Secretary may, by  
2           regulation, modify the list of accreditation  
3           organizations designated under subpara-  
4           graph (B).

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

23          “(3) CRITERIA FOR ACCREDITATION.—The Sec-  
24          retary shall establish procedures to ensure that the  
25          criteria used by an accreditation organization des-

1       ignated under paragraph (2)(B) to evaluate a sup-  
2       plier that furnishes the technical component of ad-  
3       vanced diagnostic imaging services for the purpose  
4       of accreditation of such supplier is specific to each  
5       imaging modality. Such criteria shall include—

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

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

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

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

24              “(E) standards that require the establish-  
25              ment and maintenance of a quality assurance

1 and quality control program by the supplier  
2 that is adequate and appropriate to ensure the  
3 reliability, clarity, and accuracy of the technical  
4 quality of diagnostic images produced by such  
5 supplier; and

6 “(F) any other standards or procedures  
7 the Secretary determines appropriate.

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

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

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

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

21 “(D) has met such other standards as the  
22 Secretary determines appropriate.

23 “(5) RULE FOR ACCREDITATIONS MADE PRIOR  
24 TO DESIGNATION.—In the case of a supplier that is  
25 accredited before January 1, 2010, by an accredita-

1       tion organization designated by the Secretary under  
2       paragraph (2)(B) as of January 1, 2010, such sup-  
3       plier shall be considered to have been accredited by  
4       an organization designated by the Secretary under  
5       such paragraph as of January 1, 2012, for the re-  
6       maining period such accreditation is in effect.”.

7               (2) CONFORMING AMENDMENTS.—

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

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

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

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

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



1 (B) EFFECTIVE DATE.—The amendments  
2 made by this paragraph shall apply to advanced  
3 diagnostic imaging services furnished on or  
4 after January 1, 2012.

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

7 (1) CONDUCT OF DEMONSTRATION PROJECT.—

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

18 (B) ADVANCED DIAGNOSTIC IMAGING  
19 SERVICES.—In this subsection, the term “ad-  
20 vanced diagnostic imaging services” has the  
21 meaning given such term in section  
22 1834(e)(1)(B) of the Social Security Act, as  
23 added by subsection (a).

24 (C) AUTHORITY TO FOCUS DEMONSTRA-  
25 TION PROJECT.—The Secretary may focus the

1 demonstration project with respect to certain  
2 advanced diagnostic imaging services, such as  
3 services that account for a large amount of ex-  
4 penditures under the Medicare program, serv-  
5 ices that have recently experienced a high rate  
6 of growth, or services for which appropriateness  
7 criteria exists.

8 (2) IMPLEMENTATION AND DESIGN OF DEM-  
9 ONSTRATION PROJECT.—

10 (A) IMPLEMENTATION AND DURATION.—

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

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

18 (B) APPLICATION AND SELECTION OF PAR-  
19 TICIPATING PHYSICIANS.—

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

1 containing such information as the Sec-  
2 retary may require.

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

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

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

20 (C) ADMINISTRATIVE COSTS AND INCEN-  
21 TIVES.—The Secretary shall—

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

1 (ii) provide reasonable incentives to  
2 physicians to encourage participation in  
3 the demonstration project under this sub-  
4 section.

5 (D) USE OF APPROPRIATENESS CRI-  
6 TERIA.—

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

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

16 (I) be developed or endorsed by a  
17 medical specialty society; and

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

22 (E) MODELS FOR COLLECTING DATA RE-  
23 GARDING PHYSICIAN COMPLIANCE WITH SE-  
24 LECTED CRITERIA.—Subject to subparagraph  
25 (H), in carrying out the demonstration project

1 under this subsection, the Secretary shall use  
2 each of the following models for collecting data  
3 regarding physician compliance with appro-  
4 priateness criteria selected under subparagraph  
5 (D):

6 (i) A model described in subparagraph  
7 (F).

8 (ii) A model described in subpara-  
9 graph (G).

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

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

17 (i) uses an electronic or paper intake  
18 form that—

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

1 (II) contains standardized data  
2 elements for diagnosis, service or-  
3 dered, service furnished, and such  
4 other information determined by the  
5 Secretary, in consultation with med-  
6 ical specialty societies and other  
7 stakeholders, to be germane to evalu-  
8 ating the effectiveness of the use of  
9 appropriateness criteria selected under  
10 subparagraph (D); and

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

16 (ii) provides for feedback reports in  
17 accordance with paragraph (3)(B).

18 (G) POINT OF ORDER MODEL DE-  
19 SCRIBED.—A model described in this subpara-  
20 graph is a model that—

21 (i) uses a computerized order-entry  
22 system that requires the transmittal of rel-  
23 evant supporting information at the time  
24 of referral for advanced diagnostic imaging  
25 services and provides automated decision-

1 support feedback to the referring physician  
2 regarding the appropriateness of fur-  
3 nishing such imaging services; and

4 (ii) provides for feedback reports in  
5 accordance with paragraph (3)(B).

6 (H) LIMITATION.—In no case may the  
7 Secretary use prior authorization—

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

13 (ii) under any model used for col-  
14 lecting such data under the demonstration  
15 project.

16 (I) REQUIRED CONTRACTS AND PERFORM-  
17 ANCE STANDARDS FOR CERTAIN ENTITIES.—

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

22 (ii) PERFORMANCE STANDARDS.—The  
23 Secretary shall establish and enforce per-  
24 formance standards for such entities under  
25 the contracts entered into under clause (i),

1 including performance standards with re-  
2 spect to—

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

8 (II) the satisfaction of physicians  
9 participating in the demonstration  
10 project;

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

14 (IV) any other areas determined  
15 appropriate by the Secretary.

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

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



1 cians participating in the demonstration project  
2 under this subsection against—

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

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

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

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

19 (I) the rate of compliance by the  
20 physician with such criteria; and

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

24 (ii) to the extent feasible, a compari-  
25 son of—

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

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

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

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

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

22 (5) EVALUATION AND REPORT.—

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

- 1 (i) assess the timeliness and efficacy  
2 of the demonstration project;
- 3 (ii) assess the performance of entities  
4 under a contract entered into under para-  
5 graph (2)(I)(i);
- 6 (iii) analyze data—
- 7 (I) on the rates of appropriate,  
8 uncertain, and inappropriate advanced  
9 diagnostic imaging services furnished  
10 by physicians participating in the  
11 demonstration project;
- 12 (II) on patterns and trends in  
13 the appropriateness and inappropri-  
14 ateness of such services furnished by  
15 such physicians;
- 16 (III) on patterns and trends in  
17 national and regional variations of  
18 care with respect to the furnishing of  
19 such services; and
- 20 (IV) on the correlation between  
21 the appropriateness of the services  
22 furnished and image results; and
- 23 (iv) address—
- 24 (I) the thresholds used under the  
25 demonstration project to identify ac-

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

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

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

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

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

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

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

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

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

3 (c) GAO STUDY AND REPORTS ON ACCREDITATION  
4 REQUIREMENT FOR ADVANCED DIAGNOSTIC IMAGING  
5 SERVICES.—

6 (1) STUDY.—

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

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

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

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

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

1 (ii) The cost of such accreditation re-  
2 quirement, including costs to facilities of  
3 compliance with such requirement and  
4 costs to the Secretary of administering  
5 such requirement.

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

10 (iv) Such other issues as the Sec-  
11 retary determines appropriate.

12 (2) REPORTS.—

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

17 (B) FINAL REPORT.—Not later than  
18 March 1, 2014, the Comptroller General shall  
19 submit a final report to Congress on the study  
20 conducted under paragraph (1), together with  
21 recommendations for such legislation and ad-  
22 ministrative action as the Comptroller General  
23 determines appropriate.

1 **SEC. 136. EXTENSION OF TREATMENT OF CERTAIN PHYSI-**  
2 **CIAN PATHOLOGY SERVICES UNDER MEDI-**  
3 **CARE.**

4 Section 542(c) of the Medicare, Medicaid, and  
5 SCHIP Benefits Improvement and Protection Act of 2000  
6 (as enacted into law by section 1(a)(6) of Public Law 106–  
7 554), as amended by section 732 of the Medicare Prescrip-  
8 tion Drug, Improvement, and Modernization Act of 2003  
9 (42 U.S.C. 1395w–4 note), section 104 of division B of  
10 the Tax Relief and Health Care Act of 2006 (42 U.S.C.  
11 1395w–4 note), and section 104 of the Medicare, Med-  
12 icaid, and SCHIP Extension Act of 2007 (Public Law  
13 110–173), is amended by striking “2007, and the first 6  
14 months of 2008” and inserting “2007, 2008, and 2009”.

15 **SEC. 137. ACCOMMODATION OF PHYSICIANS ORDERED TO**  
16 **ACTIVE DUTY IN THE ARMED SERVICES.**

17 Section 1842(b)(6)(D)(iii) of the Social Security Act  
18 (42 U.S.C. 1395u(b)(6)(D)(iii)), as amended by section  
19 116 of the Medicare, Medicaid, and SCHIP Extension Act  
20 of 2007 (Public Law 110–173), is amended by striking  
21 “(before July 1, 2008)”.

22 **SEC. 138. ADJUSTMENT FOR MEDICARE MENTAL HEALTH**  
23 **SERVICES.**

24 (a) PAYMENT ADJUSTMENT.—

25 (1) IN GENERAL.—For purposes of payment for  
26 services furnished under the physician fee schedule



1 under section 1848 of the Social Security Act (42  
2 U.S.C. 1395w-4) during the period beginning on  
3 July 1, 2008, and ending on December 31, 2009,  
4 the Secretary of Health and Human Services shall  
5 increase the fee schedule otherwise applicable for  
6 specified services by 5 percent.

7 (2) NONAPPLICATION OF BUDGET-NEU-  
8 TRALITY.—The budget-neutrality provision of sec-  
9 tion 1848(c)(2)(B)(ii) of the Social Security Act (42  
10 U.S.C. 1395w-4(c)(2)(B)(ii)) shall not apply to the  
11 adjustments described in paragraph (1).

12 (b) DEFINITION OF SPECIFIED SERVICES.—In this  
13 section, the term “specified services” means procedure  
14 codes for services in the categories of the Health Care  
15 Common Procedure Coding System, established by the  
16 Secretary of Health and Human Services under section  
17 1848(c)(5) of the Social Security Act (42 U.S.C. 1395w-  
18 4(c)(5)), as of July 1, 2007, and as subsequently modified  
19 by the Secretary, consisting of psychiatric therapeutic pro-  
20 cedures furnished in office or other outpatient facility set-  
21 tings or in inpatient hospital, partial hospital, or residen-  
22 tial care facility settings, but only with respect to such  
23 services in such categories that are in the subcategories  
24 of services which are—

1 (1) insight oriented, behavior modifying, or sup-  
2 portive psychotherapy; or

3 (2) interactive psychotherapy.

4 (c) IMPLEMENTATION.—Notwithstanding any other  
5 provision of law, the Secretary may implement this section  
6 by program instruction or otherwise.

7 **SEC. 139. IMPROVEMENTS FOR MEDICARE ANESTHESIA**  
8 **TEACHING PROGRAMS.**

9 (a) SPECIAL PAYMENT RULE FOR TEACHING ANES-  
10 THESIOLOGISTS.—Section 1848(a) of the Social Security  
11 Act (42 U.S.C. 1395w-4(a)), as amended by section  
12 132(b), is amended—

13 (1) in paragraph (4)(A), by inserting “except as  
14 provided in paragraph (5),” after “anesthesia  
15 cases,”; and

16 (2) by adding at the end the following new  
17 paragraph:

18 “(6) SPECIAL RULE FOR TEACHING ANESTHE-  
19 SIOLOGISTS.—With respect to physicians’ services  
20 furnished on or after January 1, 2010, in the case  
21 of teaching anesthesiologists involved in the training  
22 of physician residents in a single anesthesia case or  
23 two concurrent anesthesia cases, the fee schedule  
24 amount to be applied shall be 100 percent of the fee  
25 schedule amount otherwise applicable under this sec-

1       tion if the anesthesia services were personally per-  
2       formed by the teaching anesthesiologist alone and  
3       paragraph (4) shall not apply if—

4               “(A) the teaching anesthesiologist is  
5               present during all critical or key portions of the  
6               anesthesia service or procedure involved; and

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

12       (b) TREATMENT OF CERTIFIED REGISTERED NURSE

13 ANESTHETISTS.—With respect to items and services fur-  
14 nished on or after January 1, 2010, the Secretary of  
15 Health and Human Services shall make appropriate ad-  
16 justments to payments under the Medicare program under  
17 title XVIII of the Social Security Act for teaching certified  
18 registered nurse anesthetists to implement a policy with  
19 respect to teaching certified registered nurse anesthetists  
20 that—

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

1           (2) maintains the existing payment differences  
2           between teaching anesthesiologists and teaching cer-  
3           tified registered nurse anesthetists.

4           **PART 2—OTHER PAYMENT AND COVERAGE**  
5                           **IMPROVEMENTS**

6   **SEC. 141. EXTENSION OF EXCEPTIONS PROCESS FOR MEDI-**  
7                           **CARE THERAPY CAPS.**

8           Section 1833(g)(5) of the Social Security Act (42  
9   U.S.C. 1395l(g)(5)), as amended by section 105 of the  
10   Medicare, Medicaid, and SCHIP Extension Act of 2007  
11   (Public Law 110–173), is amended by striking “June 30,  
12   2008” and inserting “December 31, 2009”.

13   **SEC. 142. EXTENSION OF PAYMENT RULE FOR**  
14                           **BRACHYTHERAPY AND THERAPEUTIC RADIO-**  
15                           **PHARMACEUTICALS.**

16           Section 1833(t)(16)(C) of the Social Security Act (42  
17   U.S.C. 1395l(t)(16)(C)), as amended by section 106 of the  
18   Medicare, Medicaid, and SCHIP Extension Act of 2007  
19   (Public Law 110–173), is amended by striking “July 1,  
20   2008” each place it appears and inserting “January 1,  
21   2010”.

22   **SEC. 143. SPEECH-LANGUAGE PATHOLOGY SERVICES.**

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

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

3 (2) by inserting after paragraph (1) the fol-  
4 lowing new paragraph:

5 “(2) The term ‘outpatient speech-language pathology  
6 services’ has the meaning given the term ‘outpatient phys-  
7 ical therapy services’ in subsection (p), except that in ap-  
8 plying such subsection—

9 “(A) ‘speech-language pathology’ shall be sub-  
10 stituted for ‘physical therapy’ each place it appears;  
11 and

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

15 (b) CONFORMING AMENDMENTS.—

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

18 (A) by striking “and outpatient” and in-  
19 serting “, outpatient”; and

20 (B) by inserting before the semicolon at  
21 the end the following: “, and outpatient speech-  
22 language pathology services (other than services  
23 to which the second sentence of section 1861(p)  
24 applies through the application of section  
25 1861(l)(2))”.

1           (2) Subparagraphs (A) and (B) of section  
2           1833(a)(8) of the Social Security Act (42 U.S.C.  
3           1395l(a)(8)) are each amended by striking “(which  
4           includes outpatient speech-language pathology serv-  
5           ices)” and inserting “, outpatient speech-language  
6           pathology services,”.

7           (3) Section 1833(g)(1) of the Social Security  
8           Act (42 U.S.C. 1395l(g)(1)) is amended—

9                   (A) by inserting “and speech-language pa-  
10                  thology services of the type described in such  
11                  section through the application of section  
12                  1861(ll)(2)” after “1861(p)”; and

13                   (B) by inserting “and speech-language pa-  
14                  thology services” after “and physical therapy  
15                  services”.

16           (4) The second sentence of section 1835(a) of  
17           the Social Security Act (42 U.S.C. 1395n(a)) is  
18           amended—

19                   (A) by striking “section 1861(g)” and in-  
20                  serting “subsection (g) or (ll)(2) of section  
21                  1861” each place it appears; and

22                   (B) by inserting “or outpatient speech-lan-  
23                  guage pathology services, respectively” after  
24                  “occupational therapy services”.

1           (5) Section 1861(p) of the Social Security Act  
2           (42 U.S.C. 1395x(p)) is amended by striking the  
3           fourth sentence.

4           (6) Section 1861(s)(2)(D) of the Social Secu-  
5           rity Act (42 U.S.C. 1395x(s)(2)(D)) is amended by  
6           inserting “, outpatient speech-language pathology  
7           services,” after “physical therapy services”.

8           (7) Section 1862(a)(20) of the Social Security  
9           Act (42 U.S.C. 1395y(a)(20)) is amended—

10           (A) by striking “outpatient occupational  
11           therapy services or outpatient physical therapy  
12           services” and inserting “outpatient physical  
13           therapy services, outpatient speech-language pa-  
14           thology services, or outpatient occupational  
15           therapy services”; and

16           (B) by striking “section 1861(g)” and in-  
17           serting “subsection (g) or (ll)(2) of section  
18           1861”.

19           (8) Section 1866(e)(1) of the Social Security  
20           Act (42 U.S.C. 1395cc(e)(1)) is amended—

21           (A) by striking “section 1861(g)” and in-  
22           serting “subsection (g) or (ll)(2) of section  
23           1861” the first two places it appears;

24           (B) by striking “defined) or” and inserting  
25           “defined),”; and

1 (C) by inserting before the semicolon at  
2 the end the following: “, or (through the oper-  
3 ation of section 1861(ll)(2)) with respect to the  
4 furnishing of outpatient speech-language pa-  
5 thology”.

6 (9) Section 1877(h)(6) of the Social Security  
7 Act (42 U.S.C. 1395nn(h)(6)) is amended by adding  
8 at the end the following new subparagraph:

9 “(L) Outpatient speech-language pathology  
10 services.”.

11 (c) EFFECTIVE DATE.—The amendments made by  
12 this section shall apply to services furnished on or after  
13 July 1, 2009.

14 (d) CONSTRUCTION.—Nothing in this section shall be  
15 construed to affect existing regulations and policies of the  
16 Centers for Medicare & Medicaid Services that require  
17 physician oversight of care as a condition of payment for  
18 speech-language pathology services under part B of the  
19 Medicare program.

20 **SEC. 144.**

21 (a) COVERAGE OF PULMONARY AND CARDIAC REHA-  
22 BILITATION.—

23 (1) IN GENERAL.—Section 1861 of the Social  
24 Security Act (42 U.S.C. 1395x), as amended by sec-  
25 tion 101(a), is amended—



1 (A) in subsection (s)(2)—

2 (i) in subparagraph (AA), by striking  
3 “and” at the end;

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

6 “(CC) items and services furnished under  
7 a cardiac rehabilitation program (as defined in  
8 subsection (eee)(1)) or under a pulmonary reha-  
9 bilitation program (as defined in subsection  
10 (fff)(1)); and

11 “(DD) items and services furnished under  
12 an intensive cardiac rehabilitation program (as  
13 defined in subsection (eee)(4));” and

14 (B) by adding at the end the following new  
15 subsections:

16 “Cardiac Rehabilitation Program; Intensive Cardiac  
17 Rehabilitation Program

18 “(eee)(1) The term ‘cardiac rehabilitation program’  
19 means a physician-supervised program (as described in  
20 paragraph (2)) that furnishes the items and services de-  
21 scribed in paragraph (3).

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

24 “(A) items and services under the program are  
25 delivered—

1                   “(i) in a physician’s office;

2                   “(ii) in a hospital on an outpatient basis;

3                   or

4                   “(iii) in other settings determined appro-  
5                   priate by the Secretary.

6                   “(B) a physician is immediately available and  
7                   accessible for medical consultation and medical  
8                   emergencies at all times items and services are being  
9                   furnished under the program, except that, in the  
10                  case of items and services furnished under such a  
11                  program in a hospital, such availability shall be pre-  
12                  sumed; and

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

16                         “(i) the individual’s diagnosis;

17                         “(ii) the type, amount, frequency, and du-  
18                         ration of the items and services furnished under  
19                         the plan; and

20                         “(iii) the goals set for the individual under  
21                         the plan.

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

24                         “(A) physician-prescribed exercise;

1           “(B) cardiac risk factor modification, including  
2           education, counseling, and behavioral intervention  
3           (to the extent such education, counseling, and behav-  
4           ioral intervention is closely related to the individual’s  
5           care and treatment and is tailored to the individual’s  
6           needs);

7           “(C) psychosocial assessment;

8           “(D) outcomes assessment; and

9           “(E) such other items and services as the Sec-  
10          retary may determine, but only if such items and  
11          services are—

12                 “(i) reasonable and necessary for the diag-  
13                 nosis or active treatment of the individual’s  
14                 condition;

15                 “(ii) reasonably expected to improve or  
16                 maintain the individual’s condition and func-  
17                 tional level; and

18                 “(iii) furnished under such guidelines re-  
19                 lating to the frequency and duration of such  
20                 items and services as the Secretary shall estab-  
21                 lish, taking into account accepted norms of  
22                 medical practice and the reasonable expectation  
23                 of improvement of the individual.

24          “(4)(A) The term ‘intensive cardiac rehabilitation  
25          program’ means a physician-supervised program (as de-

1 scribed in paragraph (2)) that furnishes the items and  
2 services described in paragraph (3) and has shown, in  
3 peer-reviewed published research, that it accomplished—

4 “(i) one or more of the following:

5 “(I) positively affected the progression of  
6 coronary heart disease; or

7 “(II) reduced the need for coronary bypass  
8 surgery; or

9 “(III) reduced the need for percutaneous  
10 coronary interventions; and

11 “(ii) a statistically significant reduction in 5 or  
12 more of the following measures from their level be-  
13 fore receipt of cardiac rehabilitation services to their  
14 level after receipt of such services:

15 “(I) low density lipoprotein;

16 “(II) triglycerides;

17 “(III) body mass index;

18 “(IV) systolic blood pressure;

19 “(V) diastolic blood pressure; or

20 “(VI) the need for cholesterol, blood pres-  
21 sure, and diabetes medications.

22 “(B) To be eligible for an intensive cardiac rehabilita-  
23 tion program, an individual must have—

24 “(i) had an acute myocardial infarction within  
25 the preceding 12 months;

1           “(ii) had coronary bypass surgery;

2           “(iii) stable angina pectoris;

3           “(iv) had heart valve repair or replacement;

4           “(v) had percutaneous transluminal coronary  
5 angioplasty (PTCA) or coronary stenting; or

6           “(vi) had a heart or heart-lung transplant.

7           “(C) An intensive cardiac rehabilitation program may  
8 be provided in a series of 72 one-hour sessions (as defined  
9 in section 1848(b)(5)), up to 6 sessions per day, over a  
10 period of up to 18 weeks.

11          “(5) The Secretary shall establish standards to en-  
12 sure that a physician with expertise in the management  
13 of individuals with cardiac pathophysiology who is licensed  
14 to practice medicine in the State in which a cardiac reha-  
15 bilitation program (or the intensive cardiac rehabilitation  
16 program, as the case may be) is offered—

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

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

21           “Pulmonary Rehabilitation Program

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

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

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

5 “(A) physician-prescribed exercise;

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

10 “(C) psychosocial assessment;

11 “(D) outcomes assessment; and

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

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

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

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

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

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

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

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

12                   (2) PAYMENT FOR INTENSIVE CARDIAC REHA-  
13           BILITATION PROGRAMS.—

14                   (A) INCLUSION IN PHYSICIAN FEE SCHED-  
15           ULE.—Section 1848(j)(3) of the Social Security  
16           Act (42 U.S.C. 1395w-4(j)(3)) is amended by  
17           inserting “(2)(DD),” after “(2)(AA),”.

18                   (B) CONFORMING AMENDMENT.—Section  
19           1848(b) of the Social Security Act (42 U.S.C.  
20           1395w-4(b)) is amended by adding at the end  
21           the following new paragraph:

22                   “(5) TREATMENT OF INTENSIVE CARDIAC RE-  
23           HABILITATION PROGRAM.—

24                   “(A) IN GENERAL.—In the case of an in-  
25           tensive cardiac rehabilitation program described

1 in section 1861(eee)(4), the Secretary shall sub-  
2 stitute the Medicare OPD fee schedule amount  
3 established under the prospective payment sys-  
4 tem for hospital outpatient department service  
5 under paragraph (3)(D) of section 1833(t) for  
6 cardiac rehabilitation (under HCPCS codes  
7 93797 and 93798 for calendar year 2007, or  
8 any succeeding HCPCS codes for cardiac reha-  
9 bilitation).

10 “(B) DEFINITION OF SESSION.—Each of  
11 the services described in subparagraphs (A)  
12 through (E) of section 1861(eee)(3), when fur-  
13 nished for one hour, is a separate session of in-  
14 tensive cardiac rehabilitation.

15 “(C) MULTIPLE SESSIONS PER DAY.—Pay-  
16 ment may be made for up to 6 sessions per day  
17 of the series of 72 one-hour sessions of inten-  
18 sive cardiac rehabilitation services described in  
19 section 1861(eee)(4)(B).”.

20 (3) EFFECTIVE DATE.—The amendments made  
21 by this subsection shall apply to items and services  
22 furnished on or after January 1, 2010.

23 (b) REPEAL OF TRANSFER OF OWNERSHIP OF OXY-  
24 GEN EQUIPMENT.—



1           (1) IN GENERAL.—Section 1834(a)(5)(F) of  
2           the Social Security Act (42 U.S.C. 1395m(a)(5)(F))  
3           is amended—

4                   (A) in the heading, by striking “OWNER-  
5           SHIP OF EQUIPMENT” and inserting  
6           “RENTAL CAP”; and

7                   (B) by striking clause (ii) and inserting the  
8           following:

9                           “(ii) PAYMENTS AND RULES AFTER  
10           RENTAL CAP.—After the 36th continuous  
11           month during which payment is made for  
12           the equipment under this paragraph—

13                                   “(I) the supplier furnishing such  
14           equipment under this subsection shall  
15           continue to furnish the equipment  
16           during any period of medical need for  
17           the remainder of the reasonable useful  
18           lifetime of the equipment, as deter-  
19           mined by the Secretary;

20                                   “(II) payments for oxygen shall  
21           continue to be made in the amount  
22           recognized for oxygen under para-  
23           graph (9) for the period of medical  
24           need; and

1                   “(III) maintenance and servicing  
2                   payments shall, if the Secretary deter-  
3                   mines such payments are reasonable  
4                   and necessary, be made (for parts and  
5                   labor not covered by the supplier’s or  
6                   manufacturer’s warranty, as deter-  
7                   mined by the Secretary to be appro-  
8                   priate for the equipment), and such  
9                   payments shall be in an amount deter-  
10                  mined to be appropriate by the Sec-  
11                  retary.”.

12                  (2) EFFECTIVE DATE.—The amendments made  
13                  by paragraph (1) shall take effect on January 1,  
14                  2009.

15 **SEC. 145. CLINICAL LABORATORY TESTS.**

16                  (a) REPEAL OF MEDICARE COMPETITIVE BIDDING  
17 DEMONSTRATION PROJECT FOR CLINICAL LABORATORY  
18 SERVICES.—

19                  (1) IN GENERAL.—Section 1847 of the Social  
20                  Security Act (42 U.S.C. 1395w-3) is amended by  
21                  striking subsection (e).

22                  (2) CONFORMING AMENDMENTS.—Section  
23                  1833(a)(1)(D) of the Social Security Act (42 U.S.C.  
24                  1395l(a)(1)(D)) is amended—

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

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

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

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

12 **SEC. 146. IMPROVED ACCESS TO AMBULANCE SERVICES.**

13 (a) EXTENSION OF INCREASED MEDICARE PAY-  
14 MENTS FOR GROUND AMBULANCE SERVICES.—Section  
15 1834(l)(13) of the Social Security Act (42 U.S.C.  
16 1395m(l)(13)) is amended—

17 (1) in subparagraph (A)—

18 (A) in the matter preceding clause (i), by  
19 inserting “and for such services furnished on or  
20 after July 1, 2008, and before January 1,  
21 2010” after “2007,”;

22 (B) in clause (i), by inserting “(or 3 per-  
23 cent if such service is furnished on or after July  
24 1, 2008, and before January 1, 2010)” after “2  
25 percent”; and

1 (C) in clause (ii), by inserting “(or 2 per-  
2 cent if such service is furnished on or after July  
3 1, 2008, and before January 1, 2010)” after “1  
4 percent”; and

5 (2) in subparagraph (B)—

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

8 (B) by inserting “applicable” before “pe-  
9 riod”.

10 (b) AIR AMBULANCE PAYMENT IMPROVEMENTS.—

11 (1) TREATMENT OF CERTAIN AREAS FOR PAY-  
12 MENT FOR AIR AMBULANCE SERVICES UNDER THE  
13 AMBULANCE FEE SCHEDULE.—Notwithstanding any  
14 other provision of law, for purposes of making pay-  
15 ments under section 1834(l) of the Social Security  
16 Act (42 U.S.C. 1395m(l)) for air ambulance services  
17 furnished during the period beginning on July 1,  
18 2008, and ending on December 31, 2009, any area  
19 that was designated as a rural area for purposes of  
20 making payments under such section for air ambu-  
21 lance services furnished on December 31, 2006, shall  
22 be treated as a rural area for purposes of making  
23 payments under such section for air ambulance serv-  
24 ices furnished during such period.

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

3 (A) IN GENERAL.—Section  
4 1834(l)(14)(B)(i) of the Social Security Act (42  
5 U.S.C. 1395m(l)(14)(B)(i)) is amended by  
6 striking “reasonably determines or certifies”  
7 and inserting “certifies or reasonably deter-  
8 mines”.

9 (B) EFFECTIVE DATE.—The amendment  
10 made by subparagraph (A) shall apply to serv-  
11 ices furnished on or after the date of the enact-  
12 ment of this Act.

13 **SEC. 147. EXTENSION AND EXPANSION OF THE MEDICARE**  
14 **HOLD HARMLESS PROVISION UNDER THE**  
15 **PROSPECTIVE PAYMENT SYSTEM FOR HOS-**  
16 **PITAL OUTPATIENT DEPARTMENT (HOPD)**  
17 **SERVICES FOR CERTAIN HOSPITALS.**

18 Section 1833(t)(7)(D)(i) of the Social Security Act  
19 (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

20 (1) in subclause (II)—

21 (A) in the first sentence, by striking  
22 “2009” and inserting “2010”; and

23 (B) by striking the second sentence and in-  
24 serting the following new sentence: “For pur-  
25 poses of the preceding sentence, the applicable

1 percentage shall be 95 percent with respect to  
2 covered OPD services furnished in 2006, 90  
3 percent with respect to such services furnished  
4 in 2007, and 85 percent with respect to such  
5 services furnished in 2008 or 2009.”; and

6 (2) by adding at the end the following new sub-  
7 clause:

8 “(III) In the case of a sole community  
9 hospital (as defined in section  
10 1886(d)(5)(D)(iii)) that has not more than  
11 100 beds, for covered OPD services fur-  
12 nished on or after January 1, 2009, and  
13 before January 1, 2010, for which the  
14 PPS amount is less than the pre-BBA  
15 amount, the amount of payment under this  
16 subsection shall be increased by 85 percent  
17 of the amount of such difference.”.

18 **SEC. 148. CLARIFICATION OF PAYMENT FOR CLINICAL LAB-**  
19 **ORATORY TESTS FURNISHED BY CRITICAL**  
20 **ACCESS HOSPITALS.**

21 (a) IN GENERAL.—Section 1834(g)(4) of the Social  
22 Security Act (42 U.S.C. 1395m(g)(4)) is amended—

23 (1) in the heading, by striking “NO BENE-  
24 FICIARY COST-SHARING FOR” and inserting “TREAT-  
25 MENT OF”; and



1                   “(VII) A skilled nursing facility  
2                   (as defined in section 1819(a)).

3                   “(VIII) A community mental  
4                   health center (as defined in section  
5                   1861(ff)(3)(B)).”.

6           (b)       CONFORMING        AMENDMENT.—Section  
7 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C.  
8 1395yy(e)(2)(A)(ii)) is amended by inserting “telehealth  
9 services furnished under section 1834(m)(4)(C)(ii)(VII),”  
10 after “section 1861(s)(2),”.

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

14 **SEC. 150. MEDPAC STUDY AND REPORT ON IMPROVING**  
15                   **CHRONIC CARE DEMONSTRATION PRO-**  
16                   **GRAMS.**

17       (a) STUDY.—The Medicare Payment Advisory Com-  
18 mission (in this section referred to as the “Commission”)  
19 shall conduct a study on the feasibility and advisability  
20 of establishing a Medicare Chronic Care Practice Research  
21 Network that would serve as a standing network of pro-  
22 viders testing new models of care coordination and other  
23 care approaches for chronically ill beneficiaries, including  
24 the initiation, operation, evaluation, and, if appropriate,  
25 expansion of such models to the broader Medicare patient



1 population. In conducting such study, the Commission  
2 shall take into account the structure, implementation, and  
3 results of prior and existing care coordination and disease  
4 management demonstrations and pilots, including the  
5 Medicare Coordinated Care Demonstration Project under  
6 section 4016 of the Balanced Budget Act of 1997 (42  
7 U.S.C. 1395b–1 note) and the chronic care improvement  
8 programs under section 1807 of the Social Security Act  
9 (42 U.S.C. 1395b–8), commonly known to as “Medicare  
10 Health Support”.

11 (b) REPORT.—Not later than June 15, 2009, the  
12 Commission shall submit to Congress a report containing  
13 the results of the study conducted under subsection (a).

14 **SEC. 151. INCREASE OF FQHC PAYMENT LIMITS.**

15 (a) IN GENERAL.—Section 1833 of the Social Secu-  
16 rity Act (42 U.S.C. 1395l) is amended by adding at the  
17 end the following new subsection:

18 “(v) INCREASE OF FQHC PAYMENT LIMITS.—In the  
19 case of services furnished by federally qualified health cen-  
20 ters (as defined in section 1861(aa)(4)), the Secretary  
21 shall establish payment limits with respect to such services  
22 under this part for services furnished—

23 “(1) in 2010, at the limits otherwise established  
24 under this part for such year increased by \$5; and

1           “(2) in a subsequent year, at the limits estab-  
2           lished under this subsection for the previous year in-  
3           creased by the percentage increase in the MEI (as  
4           defined in section 1842(i)(3)) for such subsequent  
5           year.”.

6           (b) STUDY AND REPORT ON THE EFFECTS AND ADE-  
7 QUACY OF THE MEDICARE FEDERALLY QUALIFIED  
8 HEALTH CENTER PAYMENT STRUCTURE.—

9           (1) STUDY.—The Comptroller General of the  
10          United States shall conduct a study to determine  
11          whether the structure for payments for services fur-  
12          nished by federally qualified health centers (as de-  
13          fined in section 1861(aa)(4) of the Social Security  
14          Act (42 U.S.C. 1395x(aa)(4)) under part B of title  
15          XVIII of the Social Security Act (42 U.S.C. 1395j  
16          et seq.) adequately reimburses federally qualified  
17          health centers for the care furnished to Medicare  
18          beneficiaries. In conducting such study, the Comp-  
19          troller General shall—

20                 (A) use the most current cost report data  
21                 available;

22                 (B) examine the effects of the payment  
23                 limits established with respect to such services  
24                 under such part B on the ability of federally

1 qualified health centers to furnish care to Medi-  
2 care beneficiaries; and

3 (C) examine the cost of furnishing services  
4 covered under the Medicare program as of the  
5 date of the enactment of this Act that were not  
6 covered under such program as of the date on  
7 which the Secretary determined the payment  
8 rate for federally qualified health centers in  
9 1991.

10 (2) REPORT.—Not later than 15 months after  
11 the date of the enactment of this Act, the Comp-  
12 troller General of the United States shall submit to  
13 Congress a report on the study conducted under  
14 paragraph (1), together with recommendations for  
15 such legislation and administrative action the Comp-  
16 troller General determines appropriate, taking into  
17 consideration the structure and adequacy of the pro-  
18 spective payment methodology used to make pay-  
19 ments to federally qualified health centers under the  
20 Medicaid program under title XIX of the Social Se-  
21 curity Act (42 U.S.C. 1396 et seq.).

22 **SEC. 152. KIDNEY DISEASE EDUCATION AND AWARENESS**  
23 **PROVISIONS.**

24 (a) CHRONIC KIDNEY DISEASE INITIATIVES.—Part  
25 P of title III of the Public Health Service Act (42 U.S.C.

1 280g et seq.) is amended by adding at the end the fol-  
2 lowing new section:

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

4 “(a) IN GENERAL.—The Secretary shall establish  
5 pilot projects to—

6 “(1) increase public and medical community  
7 awareness (particularly of those who treat patients  
8 with diabetes and hypertension) regarding chronic  
9 kidney disease, focusing on prevention;

10 “(2) increase screening for chronic kidney dis-  
11 ease, focusing on Medicare beneficiaries at risk of  
12 chronic kidney disease; and

13 “(3) enhance surveillance systems to better as-  
14 sess the prevalence and incidence of chronic kidney  
15 disease.

16 “(b) SCOPE AND DURATION.—

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

20 “(2) DURATION.—The pilot projects under this  
21 section shall be conducted for a period that is not  
22 longer than 5 years and shall begin on January 1,  
23 2009.

24 “(c) EVALUATION AND REPORT.—The Comptroller  
25 General of the United States shall conduct an evaluation

1 of the pilot projects conducted under this section. Not  
2 later than 12 months after the date on which the pilot  
3 projects are completed, the Comptroller General shall sub-  
4 mit to Congress a report on the evaluation.

5 “(d) AUTHORIZATION OF APPROPRIATIONS.—There  
6 are authorized to be appropriated such sums as may be  
7 necessary for the purpose of carrying out this section.”.

8 (b) MEDICARE COVERAGE OF KIDNEY DISEASE PA-  
9 TIENT EDUCATION SERVICES.—

10 (1) COVERAGE OF KIDNEY DISEASE EDUCATION  
11 SERVICES.—

12 (A) COVERAGE.—Section 1861(s)(2) of the  
13 Social Security Act (42 U.S.C. 1395x(s)(2)), as  
14 amended by section 144(a), is amended—

15 (i) in subparagraph (CC), by striking  
16 “and” after the semicolon at the end;

17 (ii) in subparagraph (DD), by adding  
18 “and” after the semicolon at the end; and

19 (iii) by adding at the end the fol-  
20 lowing new subparagraph:

21 “(EE) kidney disease education services (as de-  
22 fined in subsection (ggg));”.

23 (B) SERVICES DESCRIBED.—Section 1861  
24 of the Social Security Act (42 U.S.C. 1395x),

1 as amended by section 144(a), is amended by  
2 adding at the end the following new subsection:

3 “Kidney Disease Education Services

4 “(ggg)(1) The term ‘kidney disease education serv-  
5 ices’ means educational services that are—

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

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

13 “(C) designed—

14 “(i) to provide comprehensive information  
15 (consistent with the standards set under para-  
16 graph (3)) regarding—

17 “(I) the management of comorbidities,  
18 including for purposes of delaying the need  
19 for dialysis;

20 “(II) the prevention of uremic com-  
21 plications; and

22 “(III) each option for renal replace-  
23 ment therapy (including hemodialysis and  
24 peritoneal dialysis at home and in-center

1 as well as vascular access options and  
2 transplantation);

3 “(ii) to ensure that the individual has the  
4 opportunity to actively participate in the choice  
5 of therapy; and

6 “(iii) to be tailored to meet the needs of  
7 the individual involved.

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

9 “(i) a physician (as defined in section  
10 1861(r)(1)) or a physician assistant, nurse practi-  
11 tioner, or clinical nurse specialist (as defined in sec-  
12 tion 1861(aa)(5)), who furnishes services for which  
13 payment may be made under the fee schedule estab-  
14 lished under section 1848; and

15 “(ii) a provider of services located in a rural  
16 area (as defined in section 1886(d)(2)(D)).

17 “(B) Such term does not include a provider of serv-  
18 ices (other than a provider of services described in sub-  
19 paragraph (A)(ii)) or a renal dialysis facility.

20 “(3) The Secretary shall set standards for the con-  
21 tent of such information to be provided under paragraph  
22 (1)(C)(i) after consulting with physicians, other health  
23 professionals, health educators, professional organizations,  
24 accrediting organizations, kidney patient organizations, di-  
25 alysis facilities, transplant centers, network organizations

1 described in section 1881(c)(2), and other knowledgeable  
2 persons. To the extent possible the Secretary shall consult  
3 with persons or entities described in the previous sentence,  
4 other than a dialysis facility, that has not received indus-  
5 try funding from a drug or biological manufacturer or di-  
6 alysis facility.

7 “(4) No individual shall be furnished more than 6  
8 sessions of kidney disease education services under this  
9 title.”.

10 (C) PAYMENT UNDER THE PHYSICIAN FEE  
11 SCHEDULE.—Section 1848(j)(3) of the Social  
12 Security Act (42 U.S.C. 1395w-4(j)(3)), as  
13 amended by section 144(b), is amended by in-  
14 serting “(2)(EE),” after “(2)(DD),”.

15 (D) LIMITATION ON NUMBER OF SES-  
16 SIONS.—Section 1862(a)(1) of the Social Secu-  
17 rity Act (42 U.S.C. 1395y(a)(1)) is amended—

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

20 (ii) in subparagraph (N), by striking  
21 the semicolon at the end and inserting “,  
22 and”; and

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



1           “(O) in the case of kidney disease education  
2 services (as defined in paragraph (1) of section  
3 1861(ggg)), which are furnished in excess of the  
4 number of sessions covered under paragraph (4) of  
5 such section;”.

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

9 **SEC. 153. RENAL DIALYSIS PROVISIONS.**

10 (a) COMPOSITE RATE.—

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

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

16           (B) in clause (ii)—

17           (i) by inserting “and before January  
18 1, 2009,” after “April 1, 2007,”; and

19           (ii) by striking the period at the end  
20 and inserting a semicolon; and

21           (C) by adding at the end the following new  
22 clauses:

23           “(iii) furnished on or after January 1, 2009,  
24 and before January 1, 2010, by 1.0 percent above

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

7 (2) SITE NEUTRAL COMPOSITE RATE.—Section  
8 1881(b)(12)(A) of the Social Security Act (42  
9 U.S.C. 1395rr(b)(12)(A)) is amended by adding at  
10 the end the following new sentence: “Under such  
11 system, the payment rate for dialysis services fur-  
12 nished on or after January 1, 2009, by providers of  
13 services shall be the same as the payment rate (com-  
14 puted without regard to this sentence) for such serv-  
15 ices furnished by renal dialysis facilities, and in ap-  
16 plying the geographic index under subparagraph (D)  
17 to providers of services, the labor share shall be  
18 based on the labor share otherwise applied for renal  
19 dialysis facilities.”.

20 (b) DEVELOPMENT OF ESRD BUNDLED PAYMENT  
21 SYSTEM.—

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

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

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

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

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

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

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

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

17   Such term does not include vaccines.

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

22          “(D) Such system—

23              “(i) shall include a payment adjustment based  
24              on case mix that may take into account patient  
25              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 erythropoiesis stimu-  
7 lating agents necessary for anemia management;

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

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

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

22 “(II) by a geographic index, such as the  
23 index referred to in paragraph (12)(D), as the  
24 Secretary determines to be appropriate; and

1                   “(III) for providers of services or renal di-  
2                   alysis facilities located in rural areas.

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

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

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

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

1       “(F)(i) Subject to clause (ii), beginning in 2012, the  
2 Secretary shall annually increase payment amounts estab-  
3 lished under this paragraph by an ESRD market basket  
4 percentage increase factor for a bundled payment system  
5 for renal dialysis services that reflects changes over time  
6 in the prices of an appropriate mix of goods and services  
7 included in renal dialysis services minus 1.0 percentage  
8 point.

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

15           “(I) The update under clause (i) shall not  
16 apply.

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

21       “(G) There shall be no administrative or judicial re-  
22 view under section 1869, section 1878, or otherwise of the  
23 determination of payment amounts under subparagraph  
24 (A), the establishment of an appropriate unit of payment  
25 under subparagraph (C), the identification of renal dialy-

1 sis services included in the bundled payment, the adjust-  
2 ments under subparagraph (D), the application of the  
3 phase-in under subparagraph (E), and the establishment  
4 of the market basket percentage increase factors under  
5 subparagraph (F).

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

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

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

14 (2) PROHIBITION OF UNBUNDLING.—Section  
15 1862(a) of the Social Security Act (42 U.S.C.  
16 1395y(a)), as amended by section 135(a)(2), is  
17 amended—

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

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

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

24 “(24) where such expenses are for renal dialysis  
25 services (as defined in subparagraph (B) of section



1 1881(b)(14)) for which payment is made under such  
2 section unless such payment is made under such sec-  
3 tion to a provider of services or a renal dialysis facil-  
4 ity for such services.”.

5 (3) CONFORMING AMENDMENTS.—(A) Section  
6 1881(b) of the Social Security Act (42 U.S.C.  
7 1395rr(b)) is amended—

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

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

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

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

18 (iii) in paragraph (13)—

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

24 (II) in subparagraph (B)—

1 (aa) in clause (i), by striking  
2 “(i)” after “(B)” and by inserting “,  
3 subject to paragraph (14)” before the  
4 period at the end; and

5 (bb) by striking clause (ii).

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

12 (C) Section 623(e) of the Medicare Prescription  
13 Drug, Improvement, and Modernization Act of 2003  
14 (42 U.S.C. 1395rr note) is repealed.

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

1 rate under paragraph (12) of such section as in ef-  
2 fect before the date of the enactment of this Act.

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

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

9 “(1) QUALITY INCENTIVES.—

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

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

1 the Secretary with respect to measures specified  
2 in paragraph (2).

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

10 “(2) MEASURES.—

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

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

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

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

25 “(I) iron management;

1                   “(II) bone mineral metabolism;  
2                   and

3                   “(III) vascular access, including  
4                   for maximizing the placement of arte-  
5                   rial venous fistula.

6                   “(B) USE OF ENDORSED MEASURES.—

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

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

23                  “(C) UPDATING MEASURES.—The Sec-  
24                  retary shall establish a process for updating the

1 measures specified under subparagraph (A) in  
2 consultation with interested parties.

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

8 “(3) PERFORMANCE SCORES.—

9 “(A) TOTAL PERFORMANCE SCORE.—

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

20 “(ii) APPLICATION.—For providers of  
21 services and renal dialysis facilities that do  
22 not meet (or exceed) the total performance  
23 score established by the Secretary, the Sec-  
24 retary shall ensure that the application of  
25 the methodology developed under clause (i)

1 results in an appropriate distribution of re-  
2 ductions in payment under paragraph (1)  
3 among providers and facilities achieving  
4 different levels of total performance scores,  
5 with providers and facilities achieving the  
6 lowest total performance scores receiving  
7 the largest reduction in payment under  
8 paragraph (1)(A).

9 “(iii) WEIGHTING OF MEASURES.—In  
10 calculating the total performance score, the  
11 Secretary shall weight the scores with re-  
12 spect to individual measures calculated  
13 under subparagraph (B) to reflect prior-  
14 ities for quality improvement, such as  
15 weighting scores to ensure that providers  
16 of services and renal dialysis facilities have  
17 strong incentives to meet or exceed anemia  
18 management and dialysis adequacy per-  
19 formance standards, as determined appro-  
20 priate by the Secretary.

21 “(B) PERFORMANCE SCORE WITH RE-  
22 SPECT TO INDIVIDUAL MEASURES.—The Sec-  
23 retary shall also calculate separate performance  
24 scores for each measure, including for dialysis  
25 adequacy and anemia management.

1 “(4) PERFORMANCE STANDARDS.—

2 “(A) ESTABLISHMENT.—Subject to sub-  
3 paragraph (E), the Secretary shall establish  
4 performance standards with respect to meas-  
5 ures selected under paragraph (2) for a per-  
6 formance period with respect to a year (as es-  
7 tablished under subparagraph (D)).

8 “(B) ACHIEVEMENT AND IMPROVE-  
9 MENT.—The performance standards established  
10 under subparagraph (A) shall include levels of  
11 achievement and improvement, as determined  
12 appropriate by the Secretary.

13 “(C) TIMING.—The Secretary shall estab-  
14 lish the performance standards under subpara-  
15 graph (A) prior to the beginning of the per-  
16 formance period for the year involved.

17 “(D) PERFORMANCE PERIOD.—The Sec-  
18 retary shall establish the performance period  
19 with respect to a year. Such performance period  
20 shall occur prior to the beginning of such year.

21 “(E) SPECIAL RULE.—The Secretary shall  
22 initially use as the performance standard for  
23 the measures specified under paragraph  
24 (2)(A)(i) for a provider of services or a renal di-  
25 alysis facility the lesser of—



1           “(i) the performance of such provider  
2           or facility for such measures in the year  
3           selected by the Secretary under the second  
4           sentence of subsection (b)(14)(A)(ii); or

5           “(ii) a performance standard based on  
6           the national performance rates for such  
7           measures in a period determined by the  
8           Secretary.

9           “(5) LIMITATION ON REVIEW.—There shall be  
10          no administrative or judicial review under section  
11          1869, section 1878, or otherwise of the following:

12           “(A) The determination of the amount of  
13           the payment reduction under paragraph (1).

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

17           “(C) The specification of measures under  
18           paragraph (2).

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

23          “(6) PUBLIC REPORTING.—

24           “(A) IN GENERAL.—The Secretary shall  
25           establish procedures for making information re-

1           garding performance under this subsection  
2           available to the public, including—

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

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

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

20                   “(C) CERTIFICATES.—

21                   “(i) IN GENERAL.—The Secretary  
22                   shall provide certificates to providers of  
23                   services and renal dialysis facilities who  
24                   furnish renal dialysis services under this  
25                   section to display in patient areas. The

1 certificate shall indicate the total perform-  
2 ance score achieved by the provider or fa-  
3 cility under paragraph (3).

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

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

18 (d) GAO REPORT ON ESRD BUNDLING SYSTEM AND  
19 QUALITY INITIATIVE.—Not later than March 1, 2013, the  
20 Comptroller General of the United States shall submit to  
21 Congress a report on the implementation of the payment  
22 system under subsection (b)(14) of section 1881 of the  
23 Social Security Act (as added by subsection (b)) for renal  
24 dialysis services and related services (defined in subpara-  
25 graph (B) of such subsection (b)(14)) and the quality ini-

1 tiative under subsection (h) of such section 1881 (as  
2 added by subsection (b)). Such report shall include the fol-  
3 lowing information:

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

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

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

19 (4) The changes, if any, in utilization rates of  
20 drugs and biologicals that the Secretary identifies  
21 under subparagraph (B)(iii) of such subsection  
22 (b)(14), and any oral equivalent or oral substitutable  
23 forms of such drugs and biologicals or of drugs and  
24 biologicals described in clause (ii), that have oc-

1 curred after implementation of the payment system  
2 under such subsection (b)(14).

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

6 **SEC. 154. DELAY IN AND REFORM OF MEDICARE DMEPOS**  
7 **COMPETITIVE ACQUISITION PROGRAM.**

8 (a) TEMPORARY DELAY AND REFORM.—

9 (1) IN GENERAL.—Section 1847(a)(1) of the  
10 Social Security Act (42 U.S.C. 1395w–3(a)(1)) is  
11 amended—

12 (A) in paragraph (1)—

13 (i) in subparagraph (B)(i), in the  
14 matter before subclause (I), by inserting  
15 “consistent with subparagraph (D)” after  
16 “in a manner”;

17 (ii) in subparagraph (B)(i)(II), by  
18 striking “80” and “in 2009” and inserting  
19 “an additional 70” and “in 2011”, respec-  
20 tively;

21 (iii) in subparagraph (B)(i)(III), by  
22 striking “after 2009” and inserting “after  
23 2011 (or, in the case of national mail order  
24 for items and services, after 2010)”; and

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

3 “(D) CHANGES IN COMPETITIVE ACQUISITION PROGRAMS.—  
4

5 “(i) ROUND 1 OF COMPETITIVE ACQUISITION PROGRAM.—Notwithstanding  
6 subparagraph (B)(i)(I) and in implementing the first round of the competitive  
7 acquisition programs under this section—  
8  
9

10 “(I) the contracts awarded under  
11 this section before the date of the enactment of this subparagraph are terminated,  
12 no payment shall be made under this title on or after the date of the enactment  
13 of this subparagraph based on such a contract, and, to the extent that any damages  
14 may be applicable as a result of the termination of such contracts, such damages shall  
15 be payable from the Federal Supplementary Medical Insurance Trust Fund under section 1841;  
16  
17  
18  
19  
20  
21  
22

23 “(II) the Secretary shall conduct  
24 the competition for such round in a manner so that it occurs in 2009 with  
25

1           respect to the same items and services  
2           and the same areas, except as pro-  
3           vided in subclauses (III) and (IV);

4           “(III) the Secretary shall exclude  
5           Puerto Rico so that such round of  
6           competition covers 9, instead of 10, of  
7           the largest metropolitan statistical  
8           areas; and

9           “(IV) there shall be excluded  
10          negative pressure wound therapy  
11          items and services.

12          Nothing in subclause (I) shall be construed  
13          to provide an independent cause of action  
14          or right to administrative or judicial review  
15          with regard to the termination provided  
16          under such subclause.

17          “(ii) ROUND 2 OF COMPETITIVE AC-  
18          QUISITION PROGRAM.—In implementing  
19          the second round of the competitive acqui-  
20          sition programs under this section de-  
21          scribed in subparagraph (B)(i)(II)—

22          “(I) the metropolitan statistical  
23          areas to be included shall be those  
24          metropolitan statistical areas selected

1 by the Secretary for such round as of  
2 June 1, 2008; and

3 “(II) the Secretary may sub-  
4 divide metropolitan statistical areas  
5 with populations (based upon the  
6 most recent data from the Census Bu-  
7 reau) of at least 8,000,000 into sepa-  
8 rate areas for competitive acquisition  
9 purposes.

10 “(iii) EXCLUSION OF CERTAIN AREAS  
11 IN SUBSEQUENT ROUNDS OF COMPETITIVE  
12 ACQUISITION PROGRAMS.—In imple-  
13 menting subsequent rounds of the competi-  
14 tive acquisition programs under this sec-  
15 tion, including under subparagraph  
16 (B)(i)(III), for competitions occurring be-  
17 fore 2015, the Secretary shall exempt from  
18 the competitive acquisition program (other  
19 than national mail order) the following:

20 “(I) Rural areas.

21 “(II) Metropolitan statistical  
22 areas not selected under round 1 or  
23 round 2 with a population of less than  
24 250,000.



1                   “(III) Areas with a low popu-  
2                   lation density within a metropolitan  
3                   statistical area that is otherwise se-  
4                   lected, as determined for purposes of  
5                   paragraph (3)(A).

6                   “(E) VERIFICATION BY OIG.—The Inspec-  
7                   tor General of the Department of Health and  
8                   Human Services shall, through post-award  
9                   audit, survey, or otherwise, assess the process  
10                  used by the Centers for Medicare & Medicaid  
11                  Services to conduct competitive bidding and  
12                  subsequent pricing determinations under this  
13                  section that are the basis for pivotal bid  
14                  amounts and single payment amounts for items  
15                  and services in competitive bidding areas under  
16                  rounds 1 and 2 of the competitive acquisition  
17                  programs under this section and may continue  
18                  to verify such calculations for subsequent  
19                  rounds of such programs.

20                  “(F) SUPPLIER FEEDBACK ON MISSING FI-  
21                  NANCIAL DOCUMENTATION.—

22                  “(i) IN GENERAL.—In the case of a  
23                  bid where one or more covered documents  
24                  in connection with such bid have been sub-  
25                  mitted not later than the covered document

1 review date specified in clause (ii), the Sec-  
2 retary—

3 “(I) shall provide, by not later  
4 than 45 days (in the case of the first  
5 round of the competitive acquisition  
6 programs as described in subpara-  
7 graph (B)(i)(I)) or 90 days (in the  
8 case of a subsequent round of such  
9 programs) after the covered document  
10 review date, for notice to the bidder of  
11 all such documents that are missing  
12 as of the covered document review  
13 date; and

14 “(II) may not reject the bid on  
15 the basis that any covered document  
16 is missing or has not been submitted  
17 on a timely basis, if all such missing  
18 documents identified in the notice pro-  
19 vided to the bidder under subclause  
20 (I) are submitted to the Secretary not  
21 later than 10 business days after the  
22 date of such notice.

23 “(ii) COVERED DOCUMENT REVIEW  
24 DATE.—The covered document review date  
25 specified in this clause with respect to a

1 competitive acquisition program is the  
2 later of—

3 “(I) the date that is 30 days be-  
4 fore the final date specified by the  
5 Secretary for submission of bids  
6 under such program; or

7 “(II) the date that is 30 days  
8 after the first date specified by the  
9 Secretary for submission of bids  
10 under such program.

11 “(iii) LIMITATIONS OF PROCESS.—  
12 The process provided under this subpara-  
13 graph—

14 “(I) applies only to the timely  
15 submission of covered documents;

16 “(II) does not apply to any deter-  
17 mination as to the accuracy or com-  
18 pleteness of covered documents sub-  
19 mitted or whether such documents  
20 meet applicable requirements;

21 “(III) shall not prevent the Sec-  
22 retary from rejecting a bid based on  
23 any basis not described in clause  
24 (i)(II); and

1                   “(IV) shall not be construed as  
2                   permitting a bidder to change bidding  
3                   amounts or to make other changes in  
4                   a bid submission.

5                   “(iv) COVERED DOCUMENT DE-  
6                   FINED.—In this subparagraph, the term  
7                   ‘covered document’ means a financial, tax,  
8                   or other document required to be sub-  
9                   mitted by a bidder as part of an original  
10                  bid submission under a competitive acqui-  
11                  sition program in order to meet required  
12                  financial standards. Such term does not in-  
13                  clude other documents, such as the bid  
14                  itself or accreditation documentation.”;  
15                  and

16                  (B) in paragraph (2)(A), by inserting be-  
17                  fore the period at the end the following: “and  
18                  excluding certain complex rehabilitative power  
19                  wheelchairs recognized by the Secretary as clas-  
20                  sified within group 3 or higher (and related ac-  
21                  cessories when furnished in connection with  
22                  such wheelchairs)”.

23                  (2) BUDGET NEUTRAL OFFSET.—

1 (A) IN GENERAL.—Section 1834(a)(14) of  
2 such Act (42 U.S.C. 1395m(a)(14)) is amend-  
3 ed—

4 (i) by striking “and” at the end of  
5 subparagraphs (H) and (I);

6 (ii) by redesignating subparagraph (J)  
7 as subparagraph (M); and

8 (iii) by inserting after subparagraph  
9 (I) the following new subparagraphs:

10 “(J) for 2009—

11 “(i) in the case of items and services  
12 furnished in any geographic area, if such  
13 items or services were selected for competi-  
14 tive acquisition in any area under the com-  
15 petitive acquisition program under section  
16 1847(a)(1)(B)(i)(I) before July 1, 2008,  
17 including related accessories but only if  
18 furnished with such items and services se-  
19 lected for such competition and diabetic  
20 supplies but only if furnished through mail  
21 order, – 9.5 percent; or

22 “(ii) in the case of other items and  
23 services, the percentage increase in the  
24 consumer price index for all urban con-

1 consumers (U.S. urban average) for the 12-  
2 month period ending with June 2008;

3 “(K) for 2010, 2011, 2012, and 2013, the  
4 percentage increase in the consumer price index  
5 for all urban consumers (U.S. urban average)  
6 for the 12-month period ending with June of  
7 the previous year;

8 “(L) for 2014—

9 “(i) in the case of items and services  
10 described in subparagraph (J)(i) for which  
11 a payment adjustment has not been made  
12 under subsection (a)(1)(F)(ii) in any pre-  
13 vious year, the percentage increase in the  
14 consumer price index for all urban con-  
15 sumers (U.S. urban average) for the 12-  
16 month period ending with June 2013, plus  
17 2.0 percentage points; or

18 “(ii) in the case of other items and  
19 services, the percentage increase in the  
20 consumer price index for all urban con-  
21 sumers (U.S. urban average) for the 12-  
22 month period ending with June 2013;  
23 and”.

24 (B) CONFORMING TREATMENT FOR CER-  
25 TAIN ITEMS AND SERVICES.—The second sen-

1           tence of section 1842(s)(1) of such Act (42  
2           U.S.C. 1395u(s)(1)) is amended by striking  
3           “except that” and all that follows and inserting  
4           the following: “except that for items and serv-  
5           ices described in paragraph (2)(D)—

6           “(A) for 2009 section 1834(a)(14)(J)(i) shall  
7           apply under this paragraph instead of the percent-  
8           age increase otherwise applicable; and

9           “(B) for 2014, if subparagraph (A) is applied  
10          to the items and services and there has not been a  
11          payment adjustment under paragraph (3)(B) for the  
12          items and services for any previous year, the per-  
13          centage increase computed under section  
14          1834(a)(14)(L)(i) shall apply instead of the percent-  
15          age increase otherwise applicable.”.

16          (3)       CONFORMING       DELAY.—Subsections  
17          (a)(1)(F) and (h)(1)(H) of section 1834 of the So-  
18          cial Security Act (42 U.S.C. 1395m) are each  
19          amended by striking “January 1, 2009” and insert-  
20          ing “January 1, 2011”.

21          (4)       CONSIDERATIONS IN APPLICATION.—Sec-  
22          tion 1834 of such Act (42 U.S.C. 1395m) is amend-  
23          ed—

24                 (A) in subsection (a)(1)—

1 (i) in subparagraph (F), by inserting  
2 “subject to subparagraph (G),” before  
3 “that are included”; and

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

6 “(G) USE OF INFORMATION ON COMPETITIVE  
7 TIVE BID RATES.—The Secretary shall specify  
8 by regulation the methodology to be used in ap-  
9 plying the provisions of subparagraph (F)(ii)  
10 and subsection (h)(1)(H)(ii). In promulgating  
11 such regulation, the Secretary shall consider the  
12 costs of items and services in areas in which  
13 such provisions would be applied compared to  
14 the payment rates for such items and services  
15 in competitive acquisition areas.”; and

16 (B) in subsection (h)(1)(H), by inserting  
17 “subject to subsection (a)(1)(G),” before “that  
18 are included”.

19 (b) QUALITY STANDARDS.—

20 (1) APPLICATION OF ACCREDITATION REQUIRE-  
21 MENT.—

22 (A) IN GENERAL.—Section 1834(a)(20) of  
23 the Social Security Act (42 U.S.C.  
24 1395m(a)(20)) is amended—



1 (i) in subparagraph (E), by inserting  
2 “including subparagraph (F),” after  
3 “under this paragraph,”; and

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

6 “(F) APPLICATION OF ACCREDITATION RE-  
7 QUIREMENT.—In implementing quality stand-  
8 ards under this paragraph—

9 “(i) subject to clause (ii), the Sec-  
10 retary shall require suppliers furnishing  
11 items and services described in subpara-  
12 graph (D) on or after October 1, 2009, di-  
13 rectly or as a subcontractor for another en-  
14 tity, to have submitted to the Secretary  
15 evidence of accreditation by an accredita-  
16 tion organization designated under sub-  
17 paragraph (B) as meeting applicable qual-  
18 ity standards; and

19 “(ii) in applying such standards and  
20 the accreditation requirement of clause (i)  
21 with respect to eligible professionals (as  
22 defined in section 1848(k)(3)(B)), and in-  
23 cluding such other persons, such as  
24 orthotists and prosthetists, as specified by

1 the Secretary, furnishing such items and  
2 services—

3 “(I) such standards and accredi-  
4 tation requirement shall not apply to  
5 such professionals and persons unless  
6 the Secretary determines that the  
7 standards being applied are designed  
8 specifically to be applied to such pro-  
9 fessionals and persons; and

10 “(II) the Secretary may exempt  
11 such professionals and persons from  
12 such standards and requirement if the  
13 Secretary determines that licensing,  
14 accreditation, or other mandatory  
15 quality requirements apply to such  
16 professionals and persons with respect  
17 to the furnishing of such items and  
18 services.”.

19 (B) CONSTRUCTION.—Section  
20 1834(a)(20)(F)(ii) of the Social Security Act,  
21 as added by subparagraph (A), shall not be con-  
22 strued as preventing the Secretary of Health  
23 and Human Services from implementing the  
24 first round of competition under section 1847  
25 of such Act on a timely basis.

1           (2) DISCLOSURE OF SUBCONTRACTORS UNDER  
2           COMPETITIVE ACQUISITION PROGRAM.—Section  
3           1847(b)(3) of such Act (42 U.S.C. 1395w-3(b)(3))  
4           is amended by adding at the end the following new  
5           subparagraph:

6                   “(C) DISCLOSURE OF SUBCONTRAC-  
7           TORS.—

8                           “(i) INITIAL DISCLOSURE.—Not later  
9                           than 10 days after the date a supplier en-  
10                           ters into a contract with the Secretary  
11                           under this section, such supplier shall dis-  
12                           close to the Secretary, in a form and man-  
13                           ner specified by the Secretary, the infor-  
14                           mation on—

15                                   “(I) each subcontracting relation-  
16                                   ship that such supplier has in fur-  
17                                   nishing items and services under the  
18                                   contract; and

19   “(II) whether each such subcon-  
20   tractor meets the requirement of sec-  
21   tion 1834(a)(20)(F)(i), if applicable  
22   to such subcontractor.

23   “(ii) SUBSEQUENT DISCLOSURE.—Not  
24   later than 10 days after such a supplier  
25   subsequently enters into a subcontracting

1 relationship described in clause (i)(II),  
2 such supplier shall disclose to the Sec-  
3 retary, in such form and manner, the in-  
4 formation described in subclauses (I) and  
5 (II) of clause (i).”.

6 (3) COMPETITIVE ACQUISITION OMBUDSMAN.—

7 Such section is further amended by adding at the  
8 end the following new subsection:

9 “(f) COMPETITIVE ACQUISITION OMBUDSMAN.—The  
10 Secretary shall provide for a competitive acquisition om-  
11 budsman within the Centers for Medicare & Medicaid  
12 Services in order to respond to complaints and inquiries  
13 made by suppliers and individuals relating to the applica-  
14 tion of the competitive acquisition program under this sec-  
15 tion. The ombudsman may be within the office of the  
16 Medicare Beneficiary Ombudsman appointed under sec-  
17 tion 1808(c). The ombudsman shall submit to Congress  
18 an annual report on the activities under this subsection,  
19 which report shall be coordinated with the report provided  
20 under section 1808(c)(2)(C).”.

21 (c) CHANGE IN REPORTS AND DEADLINES.—

22 (1) GAO REPORT.—Section 302(b)(3) of the  
23 Medicare Prescription Drug, Improvement, and  
24 Modernization Act of 2003 (Public Law 108–173) is  
25 amended—

1 (A) in subparagraph (A)—

2 (i) by inserting “and as amended by  
3 section 2 of the Medicare DMEPOS Com-  
4 petitive Acquisition Reform Act of 2008”  
5 after “as amended by paragraph (1)”; and

6 (ii) by inserting before the period at  
7 the end the following: “and the topics spec-  
8 ified in subparagraph (C)”;

9 (B) in subparagraph (B), by striking “Not  
10 later than January 1, 2009,” and inserting  
11 “Not later than 1 year after the first date that  
12 payments are made under section 1847 of the  
13 Social Security Act,”; and

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

16 “(C) TOPICS.—The topics specified in this  
17 subparagraph, for the study under subpara-  
18 graph (A) concerning the competitive acquisi-  
19 tion program, are the following:

20 “(i) Beneficiary access to items and  
21 services under the program, including the  
22 impact on such access of awarding con-  
23 tracts to bidders that—

1           “(I) did not have a physical pres-  
2           ence in an area where they received a  
3           contract; or

4           “(II) had no previous experience  
5           providing the product category they  
6           were contracted to provide.

7           “(ii) Beneficiary satisfaction with the  
8           program and cost savings to beneficiaries  
9           under the program.

10          “(iii) Costs to suppliers of partici-  
11          pating in the program and recommenda-  
12          tions about ways to reduce those costs  
13          without compromising quality standards or  
14          savings to the Medicare program.

15          “(iv) Impact of the program on small  
16          business suppliers.

17          “(v) Analysis of the impact on utiliza-  
18          tion of different items and services paid  
19          within the same Healthcare Common Pro-  
20          cedure Coding System (HCPCS) code.

21          “(vi) Costs to the Centers for Medi-  
22          care & Medicaid Services, including pay-  
23          ments made to contractors, for admin-  
24          istering the program compared with ad-  
25          ministration of a fee schedule, in compari-

1 son with the relative savings of the pro-  
2 gram.

3 “(vii) Impact on access, Medicare  
4 spending, and beneficiary spending of any  
5 difference in treatment for diabetic testing  
6 supplies depending on how such supplies  
7 are furnished.

8 “(viii) Such other topics as the Comp-  
9 troller General determines to be appro-  
10 priate.”.

11 (2) DELAY IN OTHER DEADLINES.—

12 (A) PROGRAM ADVISORY AND OVERSIGHT  
13 COMMITTEE.—Section 1847(c)(5) of the Social  
14 Security Act (42 U.S.C. 1395w-3(c)(5)) is  
15 amended by striking “December 31, 2009” and  
16 inserting “December 31, 2011”.

17 (B) SECRETARIAL REPORT.—Section  
18 1847(d) of such Act (42 U.S.C. 1395w-3(d)) is  
19 amended by striking “July 1, 2009” and insert-  
20 ing “July 1, 2011”.

21 (C) IG REPORT.—Section 302(e) of the  
22 Medicare Prescription Drug, Improvement, and  
23 Modernization Act of 2003 (Public Law 108-  
24 173) is amended by striking “July 1, 2009”  
25 and inserting “July 1, 2011”.

1           (3) EVALUATION OF CERTAIN CODE.—The Sec-  
2           retary of Health and Human Services shall evaluate  
3           the existing Health Care Common Procedure Coding  
4           System (HCPCS) codes for negative pressure wound  
5           therapy to ensure accurate reporting and billing for  
6           items and services under such codes. In carrying out  
7           such evaluation, the Secretary shall use an existing  
8           process, administered by the Durable Medical Equip-  
9           ment Medicare Administrative Contractors, for the  
10          consideration of coding changes and consider all rel-  
11          evant studies and information furnished pursuant to  
12          such process.

13          (d) OTHER PROVISIONS.—

14               (1) EXEMPTION FROM COMPETITIVE ACQUI-  
15               TION FOR CERTAIN OFF-THE-SHELF ORTHOTICS.—  
16               Section 1847(a) of the Social Security Act (42  
17               U.S.C. 1395w-3(a)) is amended by adding at the  
18               end the following new paragraph:

19                       “(7) EXEMPTION FROM COMPETITIVE ACQUI-  
20                       TION.—The programs under this section shall not  
21                       apply to the following:

22                               “(A)           CERTAIN           OFF-THE-SHELF  
23                               ORTHOTICS.—Items and services described in  
24                               paragraph (2)(C) if furnished—



1           “(i) by a physician or other practi-  
2           tioner (as defined by the Secretary) to the  
3           physician’s or practitioner’s own patients  
4           as part of the physician’s or practitioner’s  
5           professional service; or

6           “(ii) by a hospital to the hospital’s  
7           own patients during an admission or on  
8           the date of discharge.

9           “(B) CERTAIN DURABLE MEDICAL EQUIP-  
10          MENT.—Those items and services described in  
11          paragraph (2)(A)—

12           “(i) that are furnished by a hospital  
13           to the hospital’s own patients during an  
14           admission or on the date of discharge; and

15           “(ii) to which such programs would  
16           not apply, as specified by the Secretary, if  
17           furnished by a physician to the physician’s  
18           own patients as part of the physician’s  
19           professional service.”.

20           (2) CORRECTION IN FACE-TO-FACE EXAMINA-  
21          TION REQUIREMENT.—Section 1834(a)(1)(E)(ii) of  
22          such Act (42 U.S.C. 1395m(a)(1)(E)(ii)) is amended  
23          by striking “1861(r)(1)” and inserting “1861(r)”.

24           (3) SPECIAL RULE IN CASE OF NATIONAL MAIL-  
25          ORDER COMPETITION FOR DIABETIC TESTING

1 STRIPS.—Section 1847(b) of such Act (42 U.S.C.  
2 1395w-3(b)) is amended—

3 (A) by redesignating paragraph (10) as  
4 paragraph (11); and

5 (B) by inserting after paragraph (9) the  
6 following new paragraph:

7 “(10) SPECIAL RULE IN CASE OF COMPETITION  
8 FOR DIABETIC TESTING STRIPS.—

9 “(A) IN GENERAL.—With respect to the  
10 competitive acquisition program for diabetic  
11 testing strips conducted after the first round of  
12 the competitive acquisition programs, if an enti-  
13 ty does not demonstrate to the Secretary that  
14 its bid covers types of diabetic testing strip  
15 products that, in the aggregate and taking into  
16 account volume for the different products, cover  
17 50 percent (or such higher percentage as the  
18 Secretary may specify) of all such types of  
19 products, the Secretary shall reject such bid.  
20 The volume for such types of products may be  
21 determined in accordance with such data (which  
22 may be market based data) as the Secretary  
23 recognizes.

24 “(B) STUDY OF TYPES OF TESTING STRIP  
25 PRODUCTS.—Before 2011, the Inspector Gen-

1           eral of the Department of Health and Human  
2           Services shall conduct a study to determine the  
3           types of diabetic testing strip products by vol-  
4           ume that could be used to make determinations  
5           pursuant to subparagraph (A) for the first com-  
6           petition under the competitive acquisition pro-  
7           gram described in such subparagraph and sub-  
8           mit to the Secretary a report on the results of  
9           the study. The Inspector General shall also con-  
10          duct such a study and submit such a report be-  
11          fore the Secretary conducts a subsequent com-  
12          petitive acquisition program described in sub-  
13          paragraph (A).”.

14           (4) OTHER CONFORMING AMENDMENTS.—Sec-  
15          tion 1847(b)(11) of such Act, as redesignated by  
16          paragraph (3), is amended—

17                   (A) in subparagraph (C), by inserting “and  
18                   the identification of areas under subsection  
19                   (a)(1)(D)(iii)” after “(a)(1)(A)”;

20                   (B) in subparagraph (D), by inserting  
21                   “and implementation of subsection (a)(1)(D)”  
22                   after “(a)(1)(B)”;

23                   (C) in subparagraph (E), by striking “or”  
24                   at the end;

1 (D) in subparagraph (F), by striking the  
2 period at the end and inserting “; or”; and

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

5 “(G) the implementation of the special rule  
6 described in paragraph (10).”.

7 (5) FUNDING FOR IMPLEMENTATION.—In addi-  
8 tion to funds otherwise available, for purposes of im-  
9 plementing the provisions of, and amendments made  
10 by, this section, other than the amendment made by  
11 subsection (c)(1) and other than section  
12 1847(a)(1)(E) of the Social Security Act, the Sec-  
13 retary of Health and Human Services shall provide  
14 for the transfer from the Federal Supplementary  
15 Medical Insurance Trust Fund established under  
16 section 1841 of the Social Security Act (42 U.S.C.  
17 1395t) to the Centers for Medicare & Medicaid Serv-  
18 ices Program Management Account of \$20,000,000  
19 for fiscal year 2008, and \$25,000,000 for each of  
20 fiscal years 2009 through 2012. Amounts trans-  
21 ferred under this paragraph for a fiscal year shall be  
22 available until expended.

23 (e) EFFECTIVE DATE.—The amendments made by  
24 this section shall take effect as of June 30, 2008.

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

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

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

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

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

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

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

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

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

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

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

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

18                   “(I) 2010, 0.60 percent; and

19                   “(II) a subsequent year, the max-  
20 imum cumulative adjustment percent-  
21 age for the previous year increased by  
22 0.60 percentage points.

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

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

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

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

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

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

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

3 **SEC. 162. REVISIONS TO REQUIREMENTS FOR MEDICARE**  
4 **ADVANTAGE PRIVATE FEE-FOR-SERVICE**  
5 **PLANS.**

6 (a) REQUIREMENTS TO ASSURE ACCESS TO NET-  
7 WORK COVERAGE.—

8 (1) INDIVIDUAL MARKET.—Section 1852(d) of  
9 the Social Security Act (42 U.S.C. 1395w–22(d)) is  
10 amended—

11 (A) in paragraph (4), in the second sen-  
12 tence, by striking “The Secretary” and insert-  
13 ing “Subject to paragraph (5), the Secretary”;  
14 and

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

17 “(5) REQUIREMENT OF CERTAIN NON-  
18 EMPLOYER MEDICARE ADVANTAGE PRIVATE FEE-  
19 FOR-SERVICE PLANS TO USE CONTRACTS WITH PRO-  
20 VIDERS.—

21 “(A) IN GENERAL.—For plan year 2011  
22 and subsequent plan years, in the case of a  
23 Medicare Advantage private fee-for-service plan  
24 not described in paragraph (1) or (2) of section  
25 1857(i) operating in a network area (as defined



1 in subparagraph (B)), the plan shall meet the  
2 access standards under paragraph (4) in that  
3 area only through entering into written con-  
4 tracts as provided for under subparagraph (B)  
5 of such paragraph and not, in whole or in part,  
6 through the establishment of payment rates  
7 meeting the requirements under subparagraph  
8 (A) of such paragraph.

9 “(B) NETWORK AREA DEFINED.—For pur-  
10 poses of subparagraph (A), the term ‘network  
11 area’ means, for a plan year, an area which the  
12 Secretary identifies (in the Secretary’s an-  
13 nouncement of the proposed payment rates for  
14 the previous plan year under section  
15 1853(b)(1)(B)) as having at least 2 network-  
16 based plans (as defined in subparagraph (C))  
17 with enrollment under this part as of the first  
18 day of the year in which such announcement is  
19 made.

20 “(C) NETWORK-BASED PLAN DEFINED.—

21 “(i) IN GENERAL.—For purposes of  
22 subparagraph (B), the term ‘network-  
23 based plan’ means—

24 “(I) except as provided in clause

25 (ii), a Medicare Advantage plan that

1 is a coordinated care plan described in  
2 section 1851(a)(2)(A)(i);

3 “(II) a network-based MSA plan;  
4 and

5 “(III) a reasonable cost reim-  
6 bursement plan under section 1876.

7 “(ii) EXCLUSION OF NON-NETWORK  
8 REGIONAL PPOS.—The term ‘network-  
9 based plan’ shall not include an MA re-  
10 gional plan that, with respect to the area,  
11 meets access adequacy standards under  
12 this part substantially through the author-  
13 ity of section 422.112(a)(1)(ii) of title 42,  
14 Code of Federal Regulations, rather than  
15 through written contracts.”

16 (2) EMPLOYER PLANS.—Section 1852(d) of the  
17 Social Security Act (42 U.S.C. 1395w–22(d)), as  
18 amended by paragraph (1), is amended—

19 (A) in paragraph (4), in the second sen-  
20 tence, by striking “paragraph (5)” and insert-  
21 ing “paragraphs (5) and (6)”; and

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

24 “(6) REQUIREMENT OF ALL EMPLOYER MEDI-  
25 CARE ADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS

1 TO USE CONTRACTS WITH PROVIDERS.—For plan  
2 year 2011 and subsequent plan years, in the case of  
3 a Medicare Advantage private fee-for-service plan  
4 that is described in paragraph (1) or (2) of section  
5 1857(i), the plan shall meet the access standards  
6 under paragraph (4) only through entering into writ-  
7 ten contracts as provided for under subparagraph  
8 (B) of such paragraph and not, in whole or in part,  
9 through the establishment of payment rates meeting  
10 the requirements under subparagraph (A) of such  
11 paragraph.”.

12 (3) ACCESS REQUIREMENTS.—

13 (A) IN GENERAL.—Section 1852(d)(4)(B)  
14 of the Social Security Act (42 U.S.C. 1395w-  
15 22(d)(4)(B)) is amended by striking “a suffi-  
16 cient number” through “terms of the plan” and  
17 inserting “a sufficient number and range of  
18 providers within such category to meet the ac-  
19 cess standards in subparagraphs (A) through  
20 (E) of paragraph (1)”.

21 (B) EFFECTIVE DATE.—The amendment  
22 made by subparagraph (A) shall apply to plan  
23 year 2010 and subsequent plan years.

24 (b) CLARIFICATION REGARDING UTILIZATION.—Sec-  
25 tion 1859(b)(2) of the Social Security Act (42 U.S.C.

1 1395w–28(b)(2)) is amended by adding at the end the fol-  
2 lowing flush sentence:

3 “Nothing in subparagraph (B) shall be construed to  
4 preclude a plan from varying rates for such a pro-  
5 vider based on the specialty of the provider, the loca-  
6 tion of the provider, or other factors related to such  
7 provider that are not related to utilization, or to pre-  
8 clude a plan from increasing rates for such a pro-  
9 vider based on increased utilization of specified pre-  
10 ventive or screening services.”.

11 **SEC. 163. REVISIONS TO QUALITY IMPROVEMENT PRO-**  
12 **GRAMS.**

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

19 (b) **DATA COLLECTION REQUIREMENTS FOR MA RE-**  
20 **GIONAL PLANS, MA PRIVATE FEE-FOR-SERVICE PLANS,**  
21 **AND MSA PLANS.**—Section 1852(e)(3)(A) of the Social  
22 Security Act (42 U.S.C. 1395w–22(e)(3)(A)) is amend-  
23 ed—

24 (1) in clause (i), by adding at the end the fol-  
25 lowing new sentence: “With respect to MA private

1 fee-for-service plans and MSA plans, the require-  
2 ments under the preceding sentence may not exceed  
3 the requirements under this subparagraph with re-  
4 spect to MA local plans that are preferred provider  
5 organization plans, except that, for plan year 2010,  
6 the limitation under clause (iii) shall not apply and  
7 such requirements shall apply only with respect to  
8 administrative claims data.”

9 (2) by striking clause (ii); and

10 (3) in clause (iii)—

11 (A) in the heading—

12 (i) by inserting “LOCAL” after “TO”;

13 and

14 (ii) by inserting “AND MA REGIONAL  
15 PLANS” after “ORGANIZATIONS”; and

16 (B) by inserting “and to MA regional  
17 plans” after “organization plans”.

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

21 **SEC. 164. REVISIONS RELATING TO SPECIALIZED MEDI-**  
22 **CARE ADVANTAGE PLANS FOR SPECIAL**  
23 **NEEDS INDIVIDUALS.**

24 (a) EXTENSION OF AUTHORITY TO RESTRICT EN-  
25 ROLLMENT.—Section 1859(f) of the Social Security Act

1 (42 U.S.C. 1395w–28(f)), as amended by section 108(a)  
2 of the Medicare, Medicaid, and SCHIP Extension Act of  
3 2007 (Public Law 110–173) is amended by striking  
4 “2010” and inserting “2011”.

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

14 (c) REQUIREMENTS FOR ENROLLMENT.—

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

17 (A) in subsection (b)(6)(A), by inserting  
18 “and that, as of January 1, 2010, meets the  
19 applicable requirements of paragraph (2), (3),  
20 or (4) of subsection (f), as the case may be” be-  
21 fore the period at the end; and

22 (B) in subsection (f)—

23 (i) by amending the heading to read  
24 as follows: “REQUIREMENTS REGARDING

1 ENROLLMENT IN SPECIALIZED MA PLANS  
2 FOR SPECIAL NEEDS INDIVIDUALS”;

3 (ii) by designating the sentence begin-  
4 ning “In the case of” as paragraph (1)  
5 with the heading “REQUIREMENTS FOR  
6 ENROLLMENT.—” and with appropriate in-  
7 dentation; and

8 (iii) by adding at the end the fol-  
9 lowing new paragraphs:

10 “(2) ADDITIONAL REQUIREMENTS FOR INSTI-  
11 TUTIONAL SNPS.—In the case of a specialized MA  
12 plan for special needs individuals described in sub-  
13 section (b)(6)(B)(i), the applicable requirements de-  
14 scribed in this paragraph are as follows:

15 “(A) Each individual that enrolls in the  
16 plan on or after January 1, 2010, is a special  
17 needs individuals described in subsection  
18 (b)(6)(B)(i). In the case of an individual who is  
19 living in the community but requires an institu-  
20 tional level of care, such individual shall not be  
21 considered a special needs individual described  
22 in subsection (b)(6)(B)(i) unless the determina-  
23 tion that the individual requires an institutional  
24 level of care was made—

1                   “(i) using a State assessment tool of  
2                   the State in which the individual resides;  
3                   and

4                   “(ii) by an entity other than the orga-  
5                   nization offering the plan.

6                   “(B) The plan meets the requirements de-  
7                   scribed in paragraph (5).

8                   “(3) ADDITIONAL REQUIREMENTS FOR DUAL  
9                   SNPS.—In the case of a specialized MA plan for spe-  
10                  cial needs individuals described in subsection  
11                  (b)(6)(B)(ii), the applicable requirements described  
12                  in this paragraph are as follows:

13                  “(A) Each individual that enrolls in the  
14                  plan on or after January 1, 2010, is a special  
15                  needs individuals described in subsection  
16                  (b)(6)(B)(ii).

17                  “(B) The plan meets the requirements de-  
18                  scribed in paragraph (5).

19                  “(C) The plan provides each prospective  
20                  enrollee, prior to enrollment, with a comprehen-  
21                  sive written statement (using standardized con-  
22                  tent and format established by the Secretary)  
23                  that describes—

24                         “(i) the benefits and cost-sharing pro-  
25                         tections that the individual is entitled to



1 under the State Medicaid program under  
2 title XIX; and

3 “(ii) which of such benefits and cost-  
4 sharing protections are covered under the  
5 plan.

6 Such statement shall be included with any de-  
7 scription of benefits offered by the plan.

8 “(D) The plan has a contract with the  
9 State Medicaid agency to provide benefits, or  
10 arrange for benefits to be provided, for which  
11 such individual is entitled to receive as medical  
12 assistance under title XIX. Such benefits may  
13 include long-term care services consistent with  
14 State policy.

15 “(4) ADDITIONAL REQUIREMENTS FOR SEVERE  
16 OR DISABLING CHRONIC CONDITION SNPS.—In the  
17 case of a specialized MA plan for special needs indi-  
18 viduals described in subsection (b)(6)(B)(iii), the ap-  
19 plicable requirements described in this paragraph  
20 are as follows:

21 “(A) Each individual that enrolls in the  
22 plan on or after January 1, 2010, is a special  
23 needs individual described in subsection  
24 (b)(6)(B)(iii).

1           “(B) The plan meets the requirements de-  
2           scribed in paragraph (5).”.

3           (2) AUTHORITY TO OPERATE BUT NO SERVICE  
4           AREA EXPANSION FOR DUAL SNPS THAT DO NOT  
5           MEET CERTAIN REQUIREMENTS.—Notwithstanding  
6           subsection (f) of section 1859 of the Social Security  
7           Act (42 U.S.C. 1395w-28), during the period begin-  
8           ning on January 1, 2010, and ending on December  
9           31, 2010, in the case of a specialized Medicare Ad-  
10          vantage plan for special needs individuals described  
11          in subsection (b)(6)(B)(ii) of such section, as  
12          amended by this section, that does not meet the re-  
13          quirement described in subsection (f)(3)(D) of such  
14          section, the Secretary of Health and Human Serv-  
15          ices—

16                   (A) shall permit such plan to be offered  
17                   under part C of title XVIII of such Act; and

18                   (B) shall not permit an expansion of the  
19                   service area of the plan under such part C.

20           (3) RESOURCES FOR STATE MEDICAID AGEN-  
21          CIES.—The Secretary of Health and Human Serv-  
22          ices shall provide for the designation of appropriate  
23          staff and resources that can address State inquiries  
24          with respect to the coordination of State and Fed-  
25          eral policies for specialized MA plans for special

1 needs individuals described in section  
2 1859(b)(6)(B)(ii) of the Social Security Act (42  
3 U.S.C. 1395w-28(b)(6)(B)(ii)), as amended by this  
4 section.

5 (4) NO REQUIREMENT FOR CONTRACT.—Noth-  
6 ing in the provisions of, or amendments made by,  
7 this subsection shall require a State to enter into a  
8 contract with a Medicare Advantage organization  
9 with respect to a specialized MA plan for special  
10 needs individuals described in section  
11 1859(b)(6)(B)(ii) of the Social Security Act (42  
12 U.S.C. 1395w-28(b)(6)(B)(ii)), as amended by this  
13 section.

14 (d) CARE MANAGEMENT REQUIREMENTS FOR ALL  
15 SNPs.—

16 (1) REQUIREMENTS.—Section 1859(f) of the  
17 Social Security Act (42 U.S.C. 1395w-28(f)), as  
18 amended by subsection (c)(1), is amended by adding  
19 at the end the following new paragraph:

20 “(5) CARE MANAGEMENT REQUIREMENTS FOR  
21 ALL SNPs.—The requirements described in this  
22 paragraph are that the organization offering a spe-  
23 cialized MA plan for special needs individuals de-  
24 scribed in subsection (b)(6)(B)(i)—

1           “(A) have in place an evidenced-based  
2 model of care with appropriate networks of pro-  
3 viders and specialists; and

4           “(B) with respect to each individual en-  
5 rolled in the plan—

6           “(i) conduct an initial assessment and  
7 an annual reassessment of the individual’s  
8 physical, psychosocial, and functional  
9 needs;

10          “(ii) develop a plan, in consultation  
11 with the individual as feasible, that identi-  
12 fies goals and objectives, including measur-  
13 able outcomes as well as specific services  
14 and benefits to be provided; and

15          “(iii) use an interdisciplinary team in  
16 the management of care.”.

17           (2) REVIEW TO ENSURE COMPLIANCE WITH  
18 CARE MANAGEMENT REQUIREMENTS.—Section  
19 1857(d) of the Social Security Act (42 U.S.C.  
20 1395w–27(d)) is amended by adding at the end the  
21 following new paragraph:

22           “(6) REVIEW TO ENSURE COMPLIANCE WITH  
23 CARE MANAGEMENT REQUIREMENTS FOR SPECIAL-  
24 IZED MEDICARE ADVANTAGE PLANS FOR SPECIAL  
25 NEEDS INDIVIDUALS.—In conjunction with the peri-

1       odic audit of a specialized Medicare Advantage plan  
2       for special needs individuals under paragraph (1),  
3       the Secretary shall conduct a review to ensure that  
4       such organization offering the plan meets the re-  
5       quirements described in section 1859(f)(5).”.

6       (e) CLARIFICATION OF THE DEFINITION OF A SE-  
7       VERE OR DISABLING CHRONIC CONDITIONS SPECIALIZED  
8       NEEDS INDIVIDUAL.—

9               (1) IN GENERAL.—Section 1859(b)(6)(B)(iii) of  
10       the Social Security Act (42 U.S.C. 1395w-  
11       28(b)(6)(B)(iii)) is amended by inserting “who have  
12       one or more comorbid and medically complex chronic  
13       conditions that are substantially disabling or life  
14       threatening, have a high risk of hospitalization or  
15       other significant adverse health outcomes, and re-  
16       quire specialized delivery systems across domains of  
17       care” before the period at the end.

18              (2) PANEL.—The Secretary of Health and  
19       Human Services shall convene a panel of clinical ad-  
20       visors to determine the conditions that meet the def-  
21       inition of severe and disabling chronic conditions  
22       under section 1859(b)(6)(B)(iii) of the Social Secu-  
23       rity Act (42 U.S.C. 1395w-28(b)(6)(B)(iii)), as  
24       amended by paragraph (1). The panel shall include

1 the Director of the Agency for Healthcare Research  
2 and Quality (or the Director’s designee).

3 (f) SPECIAL REQUIREMENTS REGARDING QUALITY  
4 REPORTING FOR SPECIALIZED MA PLANS FOR SPECIAL  
5 NEEDS INDIVIDUALS.—

6 (1) IN GENERAL.—Section 1852(e)(3)(A) of the  
7 Social Security Act (42 U.S.C. 1395w–22(e)(3)(A)),  
8 as amended by section 163, is amended by inserting  
9 after clause (i) the following new clause:

10 “(ii) SPECIAL REQUIREMENTS FOR  
11 SPECIALIZED MA PLANS FOR SPECIAL  
12 NEEDS INDIVIDUALS.—In addition to the  
13 data required to be collected, analyzed, and  
14 reported under clause (i) and notwith-  
15 standing the limitations under subpara-  
16 graph (B), as part of the quality improve-  
17 ment program under paragraph (1), each  
18 MA organization offering a specialized  
19 Medicare Advantage plan for special needs  
20 individuals shall provide for the collection,  
21 analysis, and reporting of data that per-  
22 mits the measurement of health outcomes  
23 and other indices of quality with respect to  
24 the requirements described in paragraphs  
25 (2) through (5) of subsection (f). Such

1 data may be based on claims data and  
2 shall be at the plan level.”.

3 (2) EFFECTIVE DATE.—The amendment made  
4 by paragraph (1) shall take effect on a date specified  
5 by the Secretary of Health and Human Services (but  
6 in no case later than January 1, 2010), and shall  
7 apply to all specialized Medicare Advantage plans  
8 for special needs individuals regardless of when the  
9 plan first entered the Medicare Advantage program  
10 under part C of title XVIII of the Social Security  
11 Act.

12 (g) EFFECTIVE DATE AND APPLICATION.—The  
13 amendments made by subsections (c)(1), (d), and (e)(1)  
14 shall apply to plan years beginning on or after January  
15 1, 2010, and shall apply to all specialized Medicare Advan-  
16 tage plans for special needs individuals regardless of when  
17 the plan first entered the Medicare Advantage program  
18 under part C of title XVIII of the Social Security Act.

19 (h) NO AFFECT ON MEDICAID BENEFITS FOR  
20 DUALS.—Nothing in the provisions of, or amendments  
21 made by, this section shall affect the benefits available  
22 under the Medicaid program under title XIX of the Social  
23 Security Act for special needs individuals described in sec-  
24 tion 1859(b)(6)(B)(ii) of such Act (42 U.S.C. 1395w-  
25 28(b)(6)(B)(ii)).

1 **SEC. 165. LIMITATION ON OUT-OF-POCKET COSTS FOR**  
2 **DUAL ELIGIBLES AND QUALIFIED MEDICARE**  
3 **BENEFICIARIES ENROLLED IN A SPECIAL-**  
4 **IZED MEDICARE ADVANTAGE PLAN FOR SPE-**  
5 **CIAL NEEDS INDIVIDUALS.**

6 (a) IN GENERAL.—Section 1852(a) of the Social Se-  
7 curity Act (42 U.S.C. 1395w–22(a)) is amended by adding  
8 at the end the following new paragraph:

9 “(7) LIMITATION ON COST-SHARING FOR DUAL  
10 ELIGIBLES AND QUALIFIED MEDICARE BENE-  
11 FICIARIES.—In the case of an individual who is a  
12 full-benefit dual eligible individual (as defined in sec-  
13 tion 1935(c)(6)) or a qualified Medicare beneficiary  
14 (as defined in section 1905(p)(1)) and who is en-  
15 rolled in a specialized Medicare Advantage plan for  
16 special needs individuals described in section  
17 1859(b)(6)(B)(ii), the plan may not impose cost-  
18 sharing that exceeds the amount of cost-sharing that  
19 would be permitted with respect to the individual  
20 under title XIX if the individual were not enrolled  
21 in such plan.”.

22 (b) EFFECTIVE DATE.—The amendment made by  
23 subsection (a) shall apply to plan years beginning on or  
24 after January 1, 2010.



1 **SEC. 166. ADJUSTMENT TO THE MEDICARE ADVANTAGE**  
2 **STABILIZATION FUND.**

3 Section 1858(e)(2)(A)(i) of the Social Security Act  
4 (42 U.S.C. 1395w-27a(e)(2)(A)(i)), as amended by sec-  
5 tion 110 of the Medicare, Medicaid, and SCHIP Extension  
6 Act of 2007 (Public Law 110-173), is amended—

7 (1) by striking “2013” and inserting “2014”;

8 and

9 (2) by striking “\$1,790,000,000” and inserting  
10 “\$1”.

11 **SEC. 167. ACCESS TO MEDICARE REASONABLE COST CON-**  
12 **TRACT PLANS.**

13 (a) EXTENSION OF REASONABLE COST CON-  
14 TRACTS.—Section 1876(h)(5)(C)(ii) of the Social Security  
15 Act (42 U.S.C. 1395mm(h)(5)(C)(ii)), as amended by sec-  
16 tion 109 of the Medicare, Medicaid, and SCHIP Extension  
17 Act of 2007 (Public Law 110-173), is amended by strik-  
18 ing “January 1, 2009” and inserting “January 1, 2010”  
19 in the matter preceding subclause (I).

20 (b) REQUIREMENT FOR AT LEAST TWO MEDICARE  
21 ADVANTAGE ORGANIZATIONS TO BE OFFERING A PLAN  
22 IN AN AREA FOR THE PROHIBITION TO BE APPLICA-  
23 BLE.—Subclauses (I) and (II) of section 1876(h)(5)(C)(ii)  
24 of the Social Security Act (42 U.S.C.  
25 1395mm(h)(5)(C)(ii)) are each amended by inserting “,

1 provided that all such plans are not offered by the same  
2 Medicare Advantage organization” after “clause (iii)”.

3 (c) REVISION OF REQUIREMENTS FOR A PLAN THAT  
4 ARE USED TO DETERMINE IF PROHIBITION IS APPLICA-  
5 BLE.—

6 (1) IN GENERAL.—Section 1876(h)(5)(C)(iii)(I)  
7 of the Social Security Act (42 U.S.C.  
8 1395mm(h)(5)(C)(iii)(I)) is amended by inserting  
9 “that are not in another Metropolitan Statistical  
10 Area with a population of more than 250,000” after  
11 “such Metropolitan Statistical Area”.

12 (2) CLARIFICATION.—Section  
13 1876(h)(5)(C)(iii)(I) of the Social Security Act (42  
14 U.S.C. 1395mm(h)(5)(C)(iii)(I)) is amended by add-  
15 ing at the end the following new sentence: “If the  
16 service area includes a portion in more than 1 Met-  
17 ropolitan Statistical Area with a population of more  
18 than 250,000, the minimum enrollment determina-  
19 tion under the preceding sentence shall be made  
20 with respect to each such Metropolitan Statistical  
21 Area (and such applicable contiguous counties to  
22 such Metropolitan Statistical Area).”.

23 (d) GAO STUDY AND REPORT.—

24 (1) STUDY.—The Comptroller General of the  
25 United States shall conduct a study of the reasons

1 (if any) why reasonable cost contracts under section  
2 1876(h) of the Social Security Act (42 U.S.C.  
3 1395mm(h)) are unable to become Medicare Advan-  
4 tage plans under part C of title XVIII of such Act.

5 (2) REPORT.—Not later than December 31,  
6 2009, the Comptroller General of the United States  
7 shall submit to Congress a report containing the re-  
8 sults of the study conducted under paragraph (1),  
9 together with recommendations for such legislation  
10 and administrative action as the Comptroller Gen-  
11 eral determines appropriate.

12 **SEC. 168. MEDPAC STUDY AND REPORT ON QUALITY MEAS-**  
13 **URES.**

14 (a) STUDY.—The Medicare Payment Advisory Com-  
15 mission shall conduct a study on how comparable meas-  
16 ures of performance and patient experience can be col-  
17 lected and reported by 2011 for the Medicare Advantage  
18 program under part C of title XVIII of the Social Security  
19 Act and the original Medicare fee-for-service program  
20 under parts A and B of such title. Such study shall ad-  
21 dress technical issues, such as data requirements, in addi-  
22 tion to issues relating to appropriate quality benchmarks  
23 that—



1 parts A and B of title XVIII of the Social Secu-  
2 rity Act, as reflected in plan bids; and

3 (B) county-level spending under such origi-  
4 nal Medicare fee-for-service program on a per  
5 capita basis, as calculated by the Chief Actuary  
6 of the Centers for Medicare & Medicaid Serv-  
7 ices.

8 The study with respect to the issue described in the  
9 preceding sentence shall include differences in cor-  
10 relation statistics by plan type and geographic area.

11 (2) Based on these results of the study with re-  
12 spect to the issue described in paragraph (1), and  
13 other data the Commission determines appro-  
14 priate—

15 (A) alternate approaches to payment with  
16 respect to a Medicare beneficiary enrolled in a  
17 Medicare Advantage plan other than through  
18 county-level payment area equivalents.

19 (B) the accuracy and completeness of  
20 county-level estimates of per capita spending  
21 under such original Medicare fee-for-service  
22 program (including counties in Puerto Rico), as  
23 used to determine the annual Medicare Advan-  
24 tage capitation rate under section 1853 of the

1 Social Security Act (42 U.S.C. 1395w–23), and  
2 whether such estimates include—

3 (i) expenditures with respect to Medi-  
4 care beneficiaries at facilities of the De-  
5 partment of Veterans Affairs; and

6 (ii) all appropriate administrative ex-  
7 penses, including claims processing.

8 (3) Ways to improve the accuracy and com-  
9 pleteness of county-level estimates of per capita  
10 spending described in paragraph (2)(B).

11 (b) REPORT.—Not later than March 31, 2010, the  
12 Commission shall submit to Congress a report containing  
13 the results of the study conducted under subsection (a),  
14 together with recommendations for such legislation and  
15 administrative action as the Commission determines ap-  
16 propriate.

17 **Subtitle E—Provisions Relating to**  
18 **Part D**

19 **PART I—IMPROVING PHARMACY ACCESS**

20 **SEC. 171. PROMPT PAYMENT BY PRESCRIPTION DRUG**  
21 **PLANS AND MA-PD PLANS UNDER PART D.**

22 (a) PROMPT PAYMENT BY PRESCRIPTION DRUG  
23 PLANS.—Section 1860D–12(b) of the Social Security Act  
24 (42 U.S.C. 1395w–112(b)) is amended by adding at the  
25 end the following new paragraph:

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

2                   “(A) PROMPT PAYMENT.—

3                           “(i) IN GENERAL.—Each contract en-  
4                           tered into with a PDP sponsor under this  
5                           part with respect to a prescription drug  
6                           plan offered by such sponsor shall provide  
7                           that payment shall be issued, mailed, or  
8                           otherwise transmitted with respect to all  
9                           clean claims submitted by pharmacies  
10                           (other than pharmacies that dispense  
11                           drugs by mail order only or are located in,  
12                           or contract with, a long-term care facility)  
13                           under this part within the applicable num-  
14                           ber of calendar days after the date on  
15                           which the claim is received.

16                           “(ii) CLEAN CLAIM DEFINED.—In this  
17                           paragraph, the term ‘clean claim’ means a  
18                           claim that has no defect or impropriety  
19                           (including any lack of any required sub-  
20                           stantiating documentation) or particular  
21                           circumstance requiring special treatment  
22                           that prevents timely payment from being  
23                           made on the claim under this part.

1                   “(iii) DATE OF RECEIPT OF CLAIM.—

2                   In this paragraph, a claim is considered to  
3                   have been received—

4                   “(I) with respect to claims sub-  
5                   mitted electronically, on the date on  
6                   which the claim is transferred; and

7                   “(II) with respect to claims sub-  
8                   mitted otherwise, on the 5th day after  
9                   the postmark date of the claim or the  
10                  date specified in the time stamp of the  
11                  transmission.

12                  “(B) APPLICABLE NUMBER OF CALENDAR  
13                  DAYS DEFINED.—In this paragraph, the term  
14                  ‘applicable number of calendar days’ means—

15                  “(i) with respect to claims submitted  
16                  electronically, 14 days; and

17                  “(ii) with respect to claims submitted  
18                  otherwise, 30 days.

19                  “(C) INTEREST PAYMENT.—

20                  “(i) IN GENERAL.—Subject to clause  
21                  (ii), if payment is not issued, mailed, or  
22                  otherwise transmitted within the applicable  
23                  number of calendar days (as defined in  
24                  subparagraph (B)) after a clean claim is  
25                  received, the PDP sponsor shall pay inter-



1 est to the pharmacy that submitted the  
2 claim at a rate equal to the weighted aver-  
3 age of interest on 3-month marketable  
4 Treasury securities determined for such  
5 period, increased by 0.1 percentage point  
6 for the period beginning on the day after  
7 the required payment date and ending on  
8 the date on which payment is made (as de-  
9 termined under subparagraph (D)(iv)). In-  
10 terest amounts paid under this subpara-  
11 graph shall not be counted against the ad-  
12 ministrative costs of a prescription drug  
13 plan or treated as allowable risk corridor  
14 costs under section 1860D–15(e).

15 “(ii) AUTHORITY NOT TO CHARGE IN-  
16 TEREST.—The Secretary may provide that  
17 a PDP sponsor is not charged interest  
18 under clause (i) in the case where there  
19 are exigent circumstances, including nat-  
20 ural disasters and other unique and unex-  
21 pected events, that prevent the timely proc-  
22 essing of claims.

23 “(D) PROCEDURES INVOLVING CLAIMS.—

24 “(i) CLAIM DEEMED TO BE CLEAN.—  
25 A claim is deemed to be a clean claim if

1 the PDP sponsor involved does not provide  
2 notice to the claimant of any deficiency in  
3 the claim—

4 “(I) with respect to claims sub-  
5 mitted electronically, within 10 days  
6 after the date on which the claim is  
7 received; and

8 “(II) with respect to claims sub-  
9 mitted otherwise, within 15 days after  
10 the date on which the claim is re-  
11 ceived.

12 “(ii) CLAIM DETERMINED TO NOT BE  
13 A CLEAN CLAIM.—

14 “(I) IN GENERAL.—If a PDP  
15 sponsor determines that a submitted  
16 claim is not a clean claim, the PDP  
17 sponsor shall, not later than the end  
18 of the period described in clause (i),  
19 notify the claimant of such determina-  
20 tion. Such notification shall specify all  
21 defects or improprieties in the claim  
22 and shall list all additional informa-  
23 tion or documents necessary for the  
24 proper processing and payment of the  
25 claim.

1                   “(II) DETERMINATION AFTER  
2                   SUBMISSION OF ADDITIONAL INFOR-  
3                   MATION.—A claim is deemed to be a  
4                   clean claim under this paragraph if  
5                   the PDP sponsor involved does not  
6                   provide notice to the claimant of any  
7                   defect or impropriety in the claim  
8                   within 10 days of the date on which  
9                   additional information is received  
10                  under subclause (I).

11                  “(iii) OBLIGATION TO PAY.—A claim  
12                  submitted to a PDP sponsor that is not  
13                  paid or contested by the sponsor within the  
14                  applicable number of days (as defined in  
15                  subparagraph (B)) after the date on which  
16                  the claim is received shall be deemed to be  
17                  a clean claim and shall be paid by the  
18                  PDP sponsor in accordance with subpara-  
19                  graph (A).

20                  “(iv) DATE OF PAYMENT OF CLAIM.—  
21                  Payment of a clean claim under such sub-  
22                  paragraph is considered to have been made  
23                  on the date on which—

1                   “(I) with respect to claims paid  
2                   electronically, the payment is trans-  
3                   ferred; and

4                   “(II) with respect to claims paid  
5                   otherwise, the payment is submitted  
6                   to the United States Postal Service or  
7                   common carrier for delivery.

8                   “(E)     ELECTRONIC     TRANSFER     OF  
9                   FUNDS.—A PDP sponsor shall pay all clean  
10                  claims submitted electronically by electronic  
11                  transfer of funds if the pharmacy so requests or  
12                  has so requested previously. In the case where  
13                  such payment is made electronically, remittance  
14                  may be made by the PDP sponsor electronically  
15                  as well.

16                  “(F) PROTECTING THE RIGHTS OF CLAIM-  
17                  ANTS.—

18                  “(i) IN GENERAL.—Nothing in this  
19                  paragraph shall be construed to prohibit or  
20                  limit a claim or action not covered by the  
21                  subject matter of this section that any in-  
22                  dividual or organization has against a pro-  
23                  vider or a PDP sponsor.

24                  “(ii) ANTI-RETALIATION.—Consistent  
25                  with applicable Federal or State law, a

1 PDP sponsor shall not retaliate against an  
2 individual or provider for exercising a right  
3 of action under this subparagraph.

4 “(G) RULE OF CONSTRUCTION.—A deter-  
5 mination under this paragraph that a claim  
6 submitted by a pharmacy is a clean claim shall  
7 not be construed as a positive determination re-  
8 garding eligibility for payment under this title,  
9 nor is it an indication of government approval  
10 of, or acquiescence regarding, the claim sub-  
11 mitted. The determination shall not relieve any  
12 party of civil or criminal liability with respect to  
13 the claim, nor does it offer a defense to any ad-  
14 ministrative, civil, or criminal action with re-  
15 spect to the claim.”.

16 (b) PROMPT PAYMENT BY MA–PD PLANS.—Section  
17 1857(f) of the Social Security Act (42 U.S.C. 1395w–27)  
18 is amended by adding at the end the following new para-  
19 graph:

20 “(3) INCORPORATION OF CERTAIN PRESCRIP-  
21 TION DRUG PLAN CONTRACT REQUIREMENTS.—The  
22 following provisions shall apply to contracts with a  
23 Medicare Advantage organization offering an MA–  
24 PD plan in the same manner as they apply to con-

1       tracts with a PDP sponsor offering a prescription  
2       drug plan under part D:

3               “(A) PROMPT PAYMENT.—Section 1860D–  
4               12(b)(4).”.

5       (c) EFFECTIVE DATE.—The amendments made by  
6 this section shall apply to plan years beginning on or after  
7 January 1, 2010.

8 **SEC. 172. REGULAR UPDATE OF PRESCRIPTION DRUG**  
9               **PRICING STANDARD.**

10       (a) REQUIREMENT FOR PRESCRIPTION DRUG  
11 PLANS.—Section 1860D–12(b) of the Social Security Act  
12 (42 U.S.C. 1395w–112(b)), as amended by section  
13 171(a)(1), is amended by adding at the end the following  
14 new paragraph:

15               “(5) REGULAR UPDATE OF PRESCRIPTION  
16 DRUG PRICING STANDARD.—If the PDP sponsor of  
17 a prescription drug plan uses a standard for reim-  
18 bursement of pharmacies based on the cost of a  
19 drug, each contract entered into with such sponsor  
20 under this part with respect to the plan shall provide  
21 that the sponsor shall update such standard not less  
22 frequently than once every 7 days, beginning with an  
23 initial update on January 1 of each year, to accu-  
24 rately reflect the market price of acquiring the  
25 drug.”.

1 (b) REQUIREMENT FOR MA-PD PLANS.—Section  
2 1857(f)(3) of the Social Security Act, as amended by sec-  
3 tion 171(a)(2), is amended by adding at the end the fol-  
4 lowing new subparagraph:

5 “(B) REGULAR UPDATE OF PRESCRIPTION  
6 DRUG PRICING STANDARD.—Section 1860D-  
7 12(b)(6).”.

8 (c) EFFECTIVE DATE.—The amendments made by  
9 this section shall apply to plan years beginning on or after  
10 January 1, 2009.

11 **PART II—OTHER PROVISIONS**

12 **SEC. 175. INCLUSION OF BARBITURATES AND**  
13 **BENZODIAZEPINES AS COVERED PART D**  
14 **DRUGS.**

15 (a) IN GENERAL.—Section 1860D-2(e)(2)(A) of the  
16 Social Security Act (42 U.S.C. 1395w-102(e)(2)(A)) is  
17 amended by inserting after “agents,” the following “other  
18 than subparagraph (I) of such section (relating to barbitu-  
19 rates) if the barbiturate is used in the treatment of epi-  
20 lepsy, cancer, or a chronic mental health disorder, and  
21 other than subparagraph (J) of such section (relating to  
22 benzodiazepines),”.

23 (b) EFFECTIVE DATE.—The amendments made by  
24 subsection (a) shall apply to prescriptions dispensed on or  
25 after January 1, 2013.

1 **SEC. 176. FORMULARY REQUIREMENTS WITH RESPECT TO**  
2 **CERTAIN CATEGORIES OR CLASSES OF**  
3 **DRUGS.**

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

6 (1) in subparagraph (C)(i), by striking “The  
7 formulary” and inserting “Subject to subparagraph  
8 (G), the formulary”; and

9 (2) by inserting after subparagraph (F) the fol-  
10 lowing new subparagraph:

11 “(G) REQUIRED INCLUSION OF DRUGS IN  
12 CERTAIN CATEGORIES AND CLASSES.—

13 “(i) IDENTIFICATION OF DRUGS IN  
14 CERTAIN CATEGORIES AND CLASSES.—Be-  
15 ginning with plan year 2010, the Secretary  
16 shall identify, as appropriate, categories  
17 and classes of drugs for which both of the  
18 following criteria are met:

19 “(I) Restricted access to drugs in  
20 the category or class would have  
21 major or life threatening clinical con-  
22 sequences for individuals who have a  
23 disease or disorder treated by the  
24 drugs in such category or class.

25 “(II) There is significant clinical  
26 need for such individuals to have ac-



1           cess to multiple drugs within a cat-  
2           egory or class due to unique chemical  
3           actions and pharmacological effects of  
4           the drugs within the category or class,  
5           such as drugs used in the treatment  
6           of cancer.

7           “(ii) FORMULARY REQUIREMENTS.—

8           Subject to clause (iii), PDP sponsors offer-  
9           ing prescription drug plans shall be re-  
10          quired to include all covered part D drugs  
11          in the categories and classes identified by  
12          the Secretary under clause (i).

13          “(iii) EXCEPTIONS.—The Secretary

14          may establish exceptions that permits a  
15          PDP sponsor of a prescription drug plan  
16          to exclude from its formulary a particular  
17          covered part D drug in a category or class  
18          that is otherwise required to be included in  
19          the formulary under clause (ii) (or to oth-  
20          erwise limit access to such a drug, includ-  
21          ing through prior authorization or utiliza-  
22          tion management). Any exceptions estab-  
23          lished under the preceding sentence shall  
24          be provided under a process that—

1           “(I) ensures that any exception  
2           to such requirement is based upon sci-  
3           entific evidence and medical standards  
4           of practice (and, in the case of  
5           antiretroviral medications, is con-  
6           sistent with the Department of Health  
7           and Human Services Guidelines for  
8           the Use of Antiretroviral Agents in  
9           HIV-1-Infected Adults and Adoles-  
10          cents); and

11                   “(II) includes a public notice and  
12                   comment period.”.

## 13           **Subtitle F—Other Provisions**

### 14   **SEC. 181. USE OF PART D DATA.**

15           Section 1860D–12(b)(3)(D) of the Social Security  
16   Act (42 U.S.C. 1395w–112(b)(3)(D)) is amended by add-  
17   ing at the end the following sentence: “Notwithstanding  
18   any other provision of law, information provided to the  
19   Secretary under the application of section 1857(e)(1) to  
20   contracts under this section under the preceding sen-  
21   tence—

22                   “(i) may be used for the purposes of  
23                   carrying out this part, improving public  
24                   health through research on the utilization,  
25                   safety, effectiveness, quality, and efficiency

1 of health care services (as the Secretary  
2 determines appropriate); and

3 “(ii) shall be made available to Con-  
4 gressional support agencies (in accordance  
5 with their obligations to support Congress  
6 as set out in their authorizing statutes) for  
7 the purposes of conducting Congressional  
8 oversight, monitoring, making rec-  
9 ommendations, and analysis of the pro-  
10 gram under this title.”.

11 **SEC. 182. REVISION OF DEFINITION OF MEDICALLY AC-**  
12 **CEPTED INDICATION FOR DRUGS.**

13 (a) REVISION OF DEFINITION FOR PART D  
14 DRUGS.—

15 (1) IN GENERAL.—Section 1860D–2(e)(1) of  
16 the Social Security Act (42 U.S.C. 1395w–  
17 102(e)(1)) is amended, in the matter following sub-  
18 paragraph (B)—

19 (A) by striking “(as defined in section  
20 1927(k)(6))” and inserting “(as defined in  
21 paragraph (4))”; and

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

24 “(4) MEDICALLY ACCEPTED INDICATION DE-  
25 FINED.—

1           “(A) IN GENERAL.—For purposes of para-  
2 graph (1), the term ‘medically accepted indica-  
3 tion’ has the meaning given that term—

4           “(i) in the case of a covered part D  
5 drug used in an anticancer  
6 chemotherapeutic regimen, in section  
7 1861(t)(2)(B), except that in applying  
8 such section—

9           “(I) ‘prescription drug plan or  
10 MA–PD plan’ shall be substituted for  
11 ‘carrier’ each place it appears; and

12           “(II) subject to subparagraph  
13 (B), the compendia described in sec-  
14 tion 1927(g)(1)(B)(i)(III) shall be in-  
15 cluded in the list of compendia de-  
16 scribed in clause (ii)(I) section  
17 1861(t)(2)(B); and

18           “(ii) in the case of any other covered  
19 part D drug, in section 1927(k)(6).

20           “(B) CONFLICT OF INTEREST.—On and  
21 after January 1, 2010, subparagraph (A)(i)(II)  
22 shall not apply unless the compendia described  
23 in section 1927(g)(1)(B)(i)(III) meets the re-  
24 quirement in the third sentence of section  
25 1861(t)(2)(B).



1 amended by inserting after section 1889 the fol-  
2 lowing new section:

3 “CONTRACT WITH A CONSENSUS-BASED ENTITY  
4 REGARDING PERFORMANCE MEASUREMENT

5 “SEC. 1890. (a) CONTRACT.—

6 “(1) IN GENERAL.—For purposes of activities  
7 conducted under this Act, the Secretary shall iden-  
8 tify and have in effect a contract with a consensus-  
9 based entity, such as the National Quality Forum,  
10 that meets the requirements described in subsection  
11 (c). Such contract shall provide that the entity will  
12 perform the duties described in subsection (b).

13 “(2) TIMING FOR FIRST CONTRACT.—As soon  
14 as practicable after the date of the enactment of this  
15 subsection, the Secretary shall enter into the first  
16 contract under paragraph (1).

17 “(3) PERIOD OF CONTRACT.—A contract under  
18 paragraph (1) shall be for a period of 4 years (ex-  
19 cept as may be renewed after a subsequent bidding  
20 process).

21 “(4) COMPETITIVE PROCEDURES.—Competitive  
22 procedures (as defined in section 4(5) of the Office  
23 of Federal Procurement Policy Act (41 U.S.C.  
24 403(5))) shall be used to enter into a contract under  
25 paragraph (1).

1       “(b) DUTIES.—The duties described in this sub-  
2 section are the following:

3           “(1) PRIORITY SETTING PROCESS.—The entity  
4 shall synthesize evidence and convene key stake-  
5 holders to make recommendations, with respect to  
6 activities conducted under this Act, on an integrated  
7 national strategy and priorities for health care per-  
8 formance measurement in all applicable settings. In  
9 making such recommendations, the entity shall—

10           “(A) ensure that priority is given to meas-  
11 ures—

12           “(i) that address the health care pro-  
13 vided to patients with prevalent, high-cost  
14 chronic diseases;

15           “(ii) with the greatest potential for  
16 improving the quality, efficiency, and pa-  
17 tient-centeredness of health care; and

18           “(iii) that may be implemented rap-  
19 idly due to existing evidence, standards of  
20 care, or other reasons; and

21           “(B) take into account measures that—

22           “(i) may assist consumers and pa-  
23 tients in making informed health care deci-  
24 sions;

1                   “(ii) address health disparities across  
2                   groups and areas; and

3                   “(iii) address the continuum of care a  
4                   patient receives, including services fur-  
5                   nished by multiple health care providers or  
6                   practitioners and across multiple settings.

7                   “(2) ENDORSEMENT OF MEASURES.—The enti-  
8                   ty shall provide for the endorsement of standardized  
9                   health care performance measures. The endorsement  
10                  process under the preceding sentence shall consider  
11                  whether a measure—

12                  “(A) is evidence-based, reliable, valid,  
13                  verifiable, relevant to enhanced health out-  
14                  comes, actionable at the caregiver level, feasible  
15                  to collect and report, and responsive to vari-  
16                  ations in patient characteristics, such as health  
17                  status, language capabilities, race or ethnicity,  
18                  and income level; and

19                  “(B) is consistent across types of health  
20                  care providers, including hospitals and physi-  
21                  cians.

22                  “(3) MAINTENANCE OF MEASURES.—The entity  
23                  shall establish and implement a process to ensure  
24                  that measures endorsed under paragraph (2) are up-



1       dated (or retired if obsolete) as new evidence is de-  
2       veloped.

3               “(4) PROMOTION OF THE DEVELOPMENT OF  
4       ELECTRONIC HEALTH RECORDS.—The entity shall  
5       promote the development and use of electronic  
6       health records that contain the functionality for  
7       automated collection, aggregation, and transmission  
8       of performance measurement information.

9               “(5) ANNUAL REPORT TO CONGRESS AND THE  
10       SECRETARY; SECRETARIAL PUBLICATION AND COM-  
11       MENT.—

12               “(A) ANNUAL REPORT.—By not later than  
13       March 1 of each year (beginning with 2009),  
14       the entity shall submit to Congress and the Sec-  
15       retary a report containing a description of—

16                       “(i) the implementation of quality  
17                       measurement initiatives under this Act and  
18                       the coordination of such initiatives with  
19                       quality initiatives implemented by other  
20                       payers;

21                       “(ii) the recommendations made  
22                       under paragraph (1); and

23                       “(iii) the performance by the entity of  
24                       the duties required under the contract en-

1           tered into with the Secretary under sub-  
2           section (a).

3           “(B) SECRETARIAL REVIEW AND PUBLICA-  
4           TION OF ANNUAL REPORT.—Not later than 6  
5           months after receiving a report under subpara-  
6           graph (A) for a year, the Secretary shall—

7                   “(i) review such report; and

8                   “(ii) publish such report in the Fed-  
9                   eral Register, together with any comments  
10                  of the Secretary on such report.

11          “(c) REQUIREMENTS DESCRIBED.—The require-  
12          ments described in this subsection are the following:

13                  “(1) PRIVATE NONPROFIT.—The entity is a pri-  
14                  vate nonprofit entity governed by a board.

15                  “(2) BOARD MEMBERSHIP.—The members of  
16                  the board of the entity include—

17                          “(A) representatives of health plans and  
18                          health care providers and practitioners or rep-  
19                          resentatives of groups representing such health  
20                          plans and health care providers and practi-  
21                          tioners;

22                          “(B) health care consumers or representa-  
23                          tives of groups representing health care con-  
24                          sumers; and

1           “(C) representatives of purchasers and em-  
2           ployers or representatives of groups rep-  
3           resenting purchasers or employers.

4           “(3) ENTITY MEMBERSHIP.—The membership  
5           of the entity includes persons who have experience  
6           with—

7                   “(A) urban health care issues;

8                   “(B) safety net health care issues;

9                   “(C) rural and frontier health care issues;

10           and

11                   “(D) health care quality and safety issues.

12           “(4) OPEN AND TRANSPARENT.—With respect  
13           to matters related to the contract with the Secretary  
14           under subsection (a), the entity conducts its business  
15           in an open and transparent manner and provides the  
16           opportunity for public comment on its activities.

17           “(5) VOLUNTARY CONSENSUS STANDARDS SET-  
18           TING ORGANIZATION.—The entity operates as a vol-  
19           untary consensus standards setting organization as  
20           defined for purposes of section 12(d) of the National  
21           Technology Transfer and Advancement Act of 1995  
22           (Public Law 104–113) and Office of Management  
23           and Budget Revised Circular A–119 (published in  
24           the Federal Register on February 10, 1998).

1           “(6) EXPERIENCE.—The entity has at least 4  
2           years of experience in establishing national con-  
3           sensus standards.

4           “(7) MEMBERSHIP FEES.—If the entity re-  
5           quires a membership fee for participation in the  
6           functions of the entity, such fees shall be reasonable  
7           and adjusted based on the capacity of the potential  
8           member to pay the fee. In no case shall membership  
9           fees pose a barrier to the participation of individuals  
10          or groups with low or nominal resources to partici-  
11          pate in the functions of the entity.

12          “(d) FUNDING.—For purposes of carrying out this  
13          section, the Secretary shall provide for the transfer, from  
14          the Federal Hospital Insurance Trust Fund under section  
15          1817 and the Federal Supplementary Medical Insurance  
16          Trust Fund under section 1841 (in such proportion as the  
17          Secretary determines appropriate), of \$10,000,000 to the  
18          Centers for Medicare & Medicaid Services Program Man-  
19          agement Account for each of fiscal years 2009 through  
20          2012.”.

21          “(2) SENSE OF THE SENATE.—It is the Sense of  
22          the Senate that the selection by the Secretary of  
23          Health and Human Services of an entity to contract  
24          with under section 1890(a) of the Social Security  
25          Act, as added by paragraph (1), should not be con-

1       strued as diminishing the significant contributions of  
2       the Boards of Medicine, the quality alliances, and  
3       other clinical and technical experts to efforts to  
4       measure and improve the quality of health care serv-  
5       ices.

6       (b) GAO STUDY AND REPORTS ON THE PERFORM-  
7       ANCE AND COSTS OF THE CONSENSUS-BASED ENTITY  
8       UNDER THE CONTRACT.—

9               (1) IN GENERAL.—The Comptroller General of  
10       the United States shall conduct a study on—

11               (A) the performance of the entity with a  
12       contract with the Secretary of Health and  
13       Human Services under section 1890(a) of the  
14       Social Security Act, as added by subsection (a),  
15       of its duties under such contract; and

16               (B) the costs incurred by such entity in  
17       performing such duties.

18       (2) REPORTS.—Not later than 18 months and  
19       36 months after the effective date of the first con-  
20       tract entered into under such section 1890(a), the  
21       Comptroller General of the United States shall sub-  
22       mit to Congress a report containing the results of  
23       the study conducted under paragraph (1), together  
24       with recommendations for such legislation and ad-

1       ministrative action as the Comptroller General deter-  
2       mines appropriate.

3       **SEC. 184. COST-SHARING FOR CLINICAL TRIALS.**

4       Section 1833 of the Social Security Act (42 U.S.C.  
5       13951), as amended by section 151(a), is amended by add-  
6       ing at the end the following new subsection:

7       “(w) METHODS OF PAYMENT.—The Secretary may  
8       develop alternative methods of payment for items and  
9       services provided under clinical trials and comparative ef-  
10      fectiveness studies sponsored or supported by an agency  
11      of the Department of Health and Human Services, as de-  
12      termined by the Secretary, to those that would otherwise  
13      apply under this section, to the extent such alternative  
14      methods are necessary to preserve the scientific validity  
15      of such trials or studies, such as in the case where mask-  
16      ing the identity of interventions from patients and inves-  
17      tigators is necessary to comply with the particular trial  
18      or study design.”.

19      **SEC. 185. ADDRESSING HEALTH CARE DISPARITIES.**

20      Title XVIII of the Social Security Act (42 U.S.C.  
21      1395 et seq.) is amended by inserting after section 1808  
22      the following new section:

23             “ADDRESSING HEALTH CARE DISPARITIES

24             “SEC. 1809. (a) EVALUATING DATA COLLECTION  
25      APPROACHES.—The Secretary shall evaluate approaches  
26      for the collection of data under this title, to be performed

1 in conjunction with existing quality reporting require-  
2 ments and programs under this title, that allow for the  
3 ongoing, accurate, and timely collection and evaluation of  
4 data on disparities in health care services and performance  
5 on the basis of race, ethnicity, and gender. In conducting  
6 such evaluation, the Secretary shall consider the following  
7 objectives:

8           “(1) Protecting patient privacy.

9           “(2) Minimizing the administrative burdens of  
10 data collection and reporting on providers and health  
11 plans participating under this title.

12           “(3) Improving Medicare program data on race,  
13 ethnicity, and gender.

14           “(b) REPORTS TO CONGRESS.—

15           “(1) REPORT ON EVALUATION.—Not later than  
16 18 months after the date of the enactment of this  
17 section, the Secretary shall submit to Congress a re-  
18 port on the evaluation conducted under subsection  
19 (a). Such report shall, taking into consideration the  
20 results of such evaluation—

21           “(A) identify approaches (including defin-  
22 ing methodologies) for identifying and collecting  
23 and evaluating data on health care disparities  
24 on the basis of race, ethnicity, and gender for  
25 the original Medicare fee-for-service program

1 under parts A and B, the Medicare Advantage  
2 program under part C, and the Medicare pre-  
3 scription drug program under part D; and

4 “(B) include recommendations on the most  
5 effective strategies and approaches to reporting  
6 HEDIS quality measures as required under sec-  
7 tion 1852(e)(3) and other nationally recognized  
8 quality performance measures, as appropriate,  
9 on the basis of race, ethnicity, and gender.

10 “(2) REPORTS ON DATA ANALYSES.—Not later  
11 than 4 years after the date of the enactment of this  
12 section, and 4 years thereafter, the Secretary shall  
13 submit to Congress a report that includes rec-  
14 ommendations for improving the identification of  
15 health care disparities for Medicare beneficiaries  
16 based on analyses of the data collected under sub-  
17 section (c).

18 “(c) IMPLEMENTING EFFECTIVE APPROACHES.—Not  
19 later than 24 months after the date of the enactment of  
20 this section, the Secretary shall implement the approaches  
21 identified in the report submitted under subsection (b)(1)  
22 for the ongoing, accurate, and timely collection and eval-  
23 uation of data on health care disparities on the basis of  
24 race, ethnicity, and gender.”.



1 **SEC. 186. DEMONSTRATION TO IMPROVE CARE TO PRE-**  
2 **VIOUSLY UNINSURED.**

3 (a) **ESTABLISHMENT.**—Within one year after the  
4 date of the enactment of this Act, the Secretary (in this  
5 section referred to as the “Secretary”) shall establish a  
6 demonstration project to determine the greatest needs and  
7 most effective methods of outreach to Medicare bene-  
8 ficiaries who were previously uninsured.

9 (b) **SCOPE.**—The demonstration shall be in no fewer  
10 than 10 sites, and shall include state health insurance as-  
11 sistance programs, community health centers, community-  
12 based organizations, community health workers, and other  
13 service providers under parts A, B, and C of title XVIII  
14 of the Social Security Act. Grantees that are plans oper-  
15 ating under part C shall document that enrollees who were  
16 previously uninsured receive the “Welcome to Medicare”  
17 physical exam.

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

20 (d) **REPORT AND EVALUATION.**—The Secretary shall  
21 conduct an evaluation of the demonstration and not later  
22 than 1 year after the completion of the project shall sub-  
23 mit to Congress a report including the following:

24 (1) An analysis of the effectiveness of outreach  
25 activities targeting beneficiaries who were previously  
26 uninsured, such as revising outreach and enrollment

1 materials (including the potential for use of video in-  
2 formation), providing one-on-one counseling, working  
3 with community health workers, and amending the  
4 Medicare and You handbook.

5 (2) The effect of such outreach on beneficiary  
6 access to care, utilization of services, efficiency and  
7 cost-effectiveness of health care delivery, patient sat-  
8 isfaction, and select health outcomes.

9 **SEC. 187. OFFICE OF THE INSPECTOR GENERAL REPORT**  
10 **ON COMPLIANCE WITH AND ENFORCEMENT**  
11 **OF NATIONAL STANDARDS ON CULTURALLY**  
12 **AND LINGUISTICALLY APPROPRIATE SERV-**  
13 **ICES (CLAS) IN MEDICARE.**

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

18 (1) the extent to which Medicare providers and  
19 plans are complying with the Office for Civil Rights’  
20 Guidance to Federal Financial Assistance Recipients  
21 Regarding Title VI Prohibition Against National Or-  
22 igin Discrimination Affecting Limited English Pro-  
23 ficient Persons and the Office of Minority Health’s  
24 Culturally and Linguistically Appropriate Services  
25 Standards in health care; and

1           (2) a description of the costs associated with or  
2           savings related to the provision of language services.  
3 Such report shall include recommendations on improving  
4 compliance with CLAS Standards and recommendations  
5 on improving enforcement of CLAS Standards.

6           (b) IMPLEMENTATION.—Not later than one year  
7 after the date of publication of the report under subsection  
8 (a), the Department of Health and Human Services shall  
9 implement changes responsive to any deficiencies identi-  
10 fied in the report.

11 **SEC. 188. MEDICARE IMPROVEMENT FUNDING.**

12           (a) MEDICARE IMPROVEMENT FUND.—

13           (1) IN GENERAL.—Subject to paragraph (2),  
14 title XVIII of the Social Security Act (42 U.S.C.  
15 1395 et seq.) is amended by adding at the end the  
16 following new section:

17                   “MEDICARE IMPROVEMENT FUND

18                   “SEC. 1898. (a) ESTABLISHMENT.—

19                   “The Secretary shall establish under this title a  
20 Medicare Improvement Fund (in this section re-  
21 ferred to as the ‘Fund’) which shall be available to  
22 the Secretary to make improvements under the origi-  
23 nal fee-for-service program under parts A and B for  
24 individuals entitled to, or enrolled for, benefits under  
25 part A or enrolled under part B.

26                   “(b) FUNDING.—

1           “(1) IN GENERAL.—There shall be available to  
2           the Fund, for expenditures from the Fund for serv-  
3           ices furnished during fiscal years 2014 through  
4           2017, \$19,900,000,000.

5           “(2) PAYMENT FROM TRUST FUNDS.—The  
6           amount specified under paragraph (1) shall be avail-  
7           able to the Fund, as expenditures are made from the  
8           Fund, from the Federal Hospital Insurance Trust  
9           Fund and the Federal Supplementary Medical In-  
10          surance Trust Fund in such proportion as the Sec-  
11          retary determines appropriate.

12          “(3) FUNDING LIMITATION.—Amounts in the  
13          Fund shall be available in advance of appropriations  
14          but only if the total amount obligated from the  
15          Fund does not exceed the amount available to the  
16          Fund under paragraph (1). The Secretary may obli-  
17          gate funds from the Fund only if the Secretary de-  
18          termines (and the Chief Actuary of the Centers for  
19          Medicare & Medicaid Services and the appropriate  
20          budget officer certify) that there are available in the  
21          Fund sufficient amounts to cover all such obligations  
22          incurred consistent with the previous sentence.”.

23          (2) CONTINGENCY.—

24                 (A) IN GENERAL.—If there is enacted, be-  
25                 fore, on, or after the date of the enactment of

1 this Act, a Supplemental Appropriations Act,  
2 2008 that includes a provision providing for a  
3 Medicare Improvement Fund under a section  
4 1898 of the Social Security Act, the alternative  
5 amendment described in subparagraph (B)—

6 (i) shall apply instead of the amend-  
7 ment made by paragraph (1); and

8 (ii) shall be executed after such provi-  
9 sion in such Supplemental Appropriations  
10 Act.

11 (B) ALTERNATIVE AMENDMENT DE-  
12 SCRIBED.—The alternative amendment de-  
13 scribed in this subparagraph is as follows: Sec-  
14 tion 1898(b)(1) of the Social Security Act, as  
15 added by the Supplemental Appropriations Act,  
16 2008, is amended by inserting before the period  
17 at the end the following: “ and, in addition for  
18 services furnished during fiscal years 2014  
19 through 2017, \$19,900,000,000”.

20 (b) IMPLEMENTATION.—For purposes of carrying out  
21 the provisions of, and amendments made by, this title, in  
22 addition to any other amounts provided in such provisions  
23 and amendments, the Secretary of Health and Human  
24 Services shall provide for the transfer, from the Federal  
25 Hospital Insurance Trust Fund under section 1817 of the

1 Social Security Act (42 U.S.C. 1395i) and the Federal  
2 Supplementary Medical Insurance Trust Fund under sec-  
3 tion 1841 of such Act (42 U.S.C. 1395t), in the same pro-  
4 portion as the Secretary determines under section 1853(f)  
5 of such Act (42 U.S.C. 1395w-23(f)), of \$140,000,000  
6 to the Centers for Medicare & Medicaid Services Program  
7 Management Account for the period of fiscal years 2009  
8 through 2013.

9 **SEC. 189. INCLUSION OF MEDICARE PROVIDERS AND SUP-**  
10 **PLIERS IN FEDERAL PAYMENT LEVY AND AD-**  
11 **MINISTRATIVE OFFSET PROGRAM.**

12 (a) IN GENERAL.—Section 1874 of the Social Secu-  
13 rity Act (42 U.S.C. 1395kk) is amended by adding at the  
14 end the following new subsection:

15 “(d) INCLUSION OF MEDICARE PROVIDER AND SUP-  
16 PLIER PAYMENTS IN FEDERAL PAYMENT LEVY PRO-  
17 GRAM.—

18 “(1) IN GENERAL.—The Centers for Medicare  
19 & Medicaid Services shall take all necessary steps to  
20 participate in the Federal Payment Levy Program  
21 under section 6331(h) of the Internal Revenue Code  
22 of 1986 as soon as possible and shall ensure that—

23 “(A) at least 50 percent of all payments  
24 under parts A and B are processed through

1 such program beginning within 1 year after the  
2 date of the enactment of this section;

3 “(B) at least 75 percent of all payments  
4 under parts A and B are processed through  
5 such program beginning within 2 years after  
6 such date; and

7 “(C) all payments under parts A and B  
8 are processed through such program beginning  
9 not later than September 30, 2011.

10 “(2) ASSISTANCE.—The Financial Management  
11 Service and the Internal Revenue Service shall pro-  
12 vide assistance to the Centers for Medicare & Med-  
13 icaid Services to ensure that all payments described  
14 in paragraph (1) are included in the Federal Pay-  
15 ment Levy Program by the deadlines specified in  
16 that subsection.”.

17 (b) APPLICATION OF ADMINISTRATIVE OFFSET PRO-  
18 VISIONS TO MEDICARE PROVIDER OR SUPPLIER PAY-  
19 MENTS.—Section 3716 of title 31, United States Code, is  
20 amended—

21 (1) by inserting “the Department of Health and  
22 Human Services,” after “United States Postal Serv-  
23 ice,” in subsection (c)(1)(A); and

24 (2) by adding at the end of subsection (c)(3)  
25 the following new subparagraph:

1           “(D) This section shall apply to payments  
2           made after the date which is 90 days after the  
3           enactment of this subparagraph (or such earlier  
4           date as designated by the Secretary of Health  
5           and Human Services) with respect to claims or  
6           debts, and to amounts payable, under title  
7           XVIII of the Social Security Act.”.

8           (c) EFFECTIVE DATE.—The amendments made by  
9           this section shall take effect on the date of the enactment  
10          of this Act.

## 11                           **TITLE J—MEDICAID**

### 12   **SEC. 201. EXTENSION OF TRANSITIONAL MEDICAL ASSIST-** 13                           **ANCE (TMA) AND ABSTINENCE EDUCATION** 14                           **PROGRAM.**

15          Section 401 of division B of the Tax Relief and  
16          Health Care Act of 2006 (Public Law 109–432, 120 Stat.  
17          2994), as amended by section 1 of Public Law 110–48  
18          (121 Stat. 244), section 2 of the TMA, Abstinence, Edu-  
19          cation, and QI Programs Extension Act of 2007 (Public  
20          Law 110–90, 121 Stat. 984), and section 202 of the Medi-  
21          care, Medicaid, and SCHIP Extension Act of 2007 (Public  
22          Law 110–173) is amended—

23                   (1) by striking “June 30, 2008” and inserting  
24                   “June 30, 2009”;



1           (2) by striking “the third quarter of fiscal year  
2           2008” and inserting “the third quarter of fiscal year  
3           2009”; and

4           (3) by striking “the third quarter of fiscal year  
5           2007” and inserting “the third quarter of fiscal year  
6           2008”.

7   **SEC. 202. MEDICAID DSH EXTENSION.**

8           Section 1923(f)(6) of the Social Security Act (42  
9   U.S.C. 1396r-4(f)(6)) is amended—

10           (1) in the heading, by striking “FISCAL YEAR  
11           2007 AND PORTIONS OF FISCAL YEAR 2008” and in-  
12           serting “FISCAL YEARS 2007 THROUGH 2009 AND THE  
13           FIRST CALENDAR QUARTER OF FISCAL YEAR 2010”;  
14           and

15           (2) in subparagraph (A)—

16                   (A) in clause (i)—

17                           (i) in the second sentence—

18                                   (I) by striking “fiscal year 2008  
19                                   for the period ending on June 30,  
20                                   2008” and inserting “fiscal years  
21                                   2008 and 2009”; and

22                                   (II) by striking “ $\frac{3}{4}$  of”; and

23                                   (ii) by adding at the end the following  
24                                   new sentences: “Only with respect to fiscal  
25                                   year 2010 for the period ending on Decem-

1           ber 31, 2009, the DSH allotment for Ten-  
2           nessee for such portion of the fiscal year,  
3           notwithstanding such table or terms, shall  
4           be  $\frac{1}{4}$  of the amount specified in the first  
5           sentence for fiscal year 2007.”;

6           (B) in clause (ii), by striking “or for a pe-  
7           riod in fiscal year 2008” and inserting “, 2008,  
8           2009, or for a period in fiscal year 2010”;

9           (C) in clause (iv)—

10           (i) in the heading, by striking “FISCAL  
11           YEAR 2007 AND FISCAL YEAR 2008” and in-  
12           serting “FISCAL YEARS 2007 THROUGH 2009  
13           AND THE FIRST CALENDAR QUARTER OF  
14           FISCAL YEAR 2010”;

15           (ii) in subclause (I), by striking “or  
16           for a period in fiscal year 2008” and in-  
17           serting “, 2008, 2009, or for a period in  
18           fiscal year 2010”; and

19           (iii) in subclause (II), by striking “or  
20           for a period in fiscal year 2008” and in-  
21           serting “, 2008, 2009, or for a period in  
22           fiscal year 2010”; and

23           (3) in subparagraph (B)(i)—

1 (A) in the first sentence, by striking “fiscal  
2 year 2007” and inserting “each of fiscal years  
3 2007 through 2009”; and

4 (B) by striking the second sentence and in-  
5 serting the following: “Only with respect to fis-  
6 cal year 2010 for the period ending on Decem-  
7 ber 31, 2009, the DSH allotment for Hawaii  
8 for such portion of the fiscal year, notwith-  
9 standing the table set forth in paragraph (2),  
10 shall be \$2,500,000.”.

11 **SEC. 203. PHARMACY REIMBURSEMENT UNDER MEDICAID.**

12 (a) DELAY IN APPLICATION OF NEW PAYMENT  
13 LIMIT FOR MULTIPLE SOURCE DRUGS UNDER MED-  
14 ICAID.—Notwithstanding paragraphs (4) and (5) of sub-  
15 section (e) of section 1927 of the Social Security Act (42  
16 U.S.C. 1396r–8) or part 447 of title 42, Code of Federal  
17 Regulations, as published on July 17, 2007 (72 Federal  
18 Register 39142)—

19 (1) the specific upper limit under section  
20 447.332 of title 42, Code of Federal Regulations (as  
21 in effect on December 31, 2006) applicable to pay-  
22 ments made by a State for multiple source drugs  
23 under a State Medicaid plan shall continue to apply  
24 through September 30, 2009, for purposes of the

1 availability of Federal financial participation for  
2 such payments; and

3 (2) the Secretary of Health and Human Serv-  
4 ices shall not, prior to October 1, 2009, finalize, im-  
5 plement, enforce, or otherwise take any action  
6 (through promulgation of regulation, issuance of  
7 regulatory guidance, use of Federal payment audit  
8 procedures, or other administrative action, policy, or  
9 practice, including a Medical Assistance Manual  
10 transmittal or letter to State Medicaid directors) to  
11 impose the specific upper limit established under  
12 section 447.514(b) of title 42, Code of Federal Reg-  
13 ulations as published on July 17, 2007 (72 Federal  
14 Register 39142).

15 (b) TEMPORARY SUSPENSION OF UPDATED PUB-  
16 LICLY AVAILABLE AMP DATA.—Notwithstanding clause  
17 (v) of section 1927(b)(3)(D) of the Social Security Act (42  
18 U.S.C. 1396r–8(b)(3)(D)), the Secretary of Health and  
19 Human Services shall not, prior to October 1, 2009, make  
20 publicly available any AMP disclosed to the Secretary.

21 (c) DEFINITIONS.—In this subsection:

22 (1) The term “multiple source drug” has the  
23 meaning given that term in section 1927(k)(7)(A)(i)  
24 of the Social Security Act (42 U.S.C. 1396r–  
25 8(k)(7)(A)(i)).

1           (2) The term “AMP” has the meaning given  
2           “average manufacturer price” in section 1927(k)(1)  
3           of the Social Security Act (42 U.S.C. 1396r–  
4           8(k)(1)) and “AMP” in section 447.504(a) of title  
5           42, Code of Federal Regulations as published on  
6           July 17, 2007 (72 Federal Register 39142).

7   **SEC. 204. REVIEW OF ADMINISTRATIVE CLAIM DETERMINA-**  
8                                   **TIONS.**

9           (a) IN GENERAL.—Section 1116 of the Social Secu-  
10          rity Act (42 U.S.C. 1316) is amended by adding at the  
11          end the following new subsection:

12          “(e)(1) Whenever the Secretary determines that any  
13          item or class of items on account of which Federal finan-  
14          cial participation is claimed under title XIX shall be dis-  
15          allowed for such participation, the State shall be entitled  
16          to and upon request shall receive a reconsideration of the  
17          disallowance, provided that such request is made during  
18          the 60-day period that begins on the date the State re-  
19          ceives notice of the disallowance.

20          “(2)(A) A State may appeal a disallowance of a claim  
21          for federal financial participation under title XIX by the  
22          Secretary, or an unfavorable reconsideration of a disallow-  
23          ance, during the 60-day period that begins on the date  
24          the State receives notice of the disallowance or of the unfa-  
25          vorable reconsideration, in whole or in part, to the Depart-

1 mental Appeals Board, established in the Department of  
2 Health and Human Services (in this paragraph referred  
3 to as the ‘Board’), by filing a notice of appeal with the  
4 Board.

5       “(B) The Board shall consider a State’s appeal of  
6 a disallowance of such a claim (or of an unfavorable recon-  
7 sideration of a disallowance) on the basis of such docu-  
8 mentation as the State may submit and as the Board may  
9 require to support the final decision of the Board. In de-  
10 ciding whether to uphold a disallowance of such a claim  
11 or any portion thereof, the Board shall be bound by all  
12 applicable laws and regulations and shall conduct a thor-  
13 ough review of the issues, taking into account all relevant  
14 evidence. The Board’s decision of an appeal under sub-  
15 paragraph (A) shall be the final decision of the Secretary  
16 and shall be subject to reconsideration by the Board only  
17 upon motion of either party filed during the 60-day period  
18 that begins on the date of the Board’s decision or to judi-  
19 cial review in accordance with subparagraph (C).

20       “(C) A State may obtain judicial review of a decision  
21 of the Board by filing an action in any United States Dis-  
22 trict Court located within the appealing State (or, if sev-  
23 eral States jointly appeal the disallowance of claims for  
24 Federal financial participation under section 1903, in any  
25 United States District Court that is located within any

1 State that is a party to the appeal) or the United States  
2 District Court for the District of Columbia. Such an ac-  
3 tion may only be filed—

4 “(i) if no motion for reconsideration was filed  
5 within the 60-day period specified in subparagraph  
6 (B), during such 60-day period; or

7 “(ii) if such a motion was filed within such pe-  
8 riod, during the 60-day period that begins on the  
9 date of the Board’s decision on such motion.”.

10 (b) CONFORMING AMENDMENT.—Section 1116(d) of  
11 such Act (42 U.S.C. 1316(d)) is amended by striking “or  
12 XIX,”.

13 (c) EFFECTIVE DATE.—The amendments made by  
14 this section take effect on the date of the enactment of  
15 this Act and apply to any disallowance of a claim for Fed-  
16 eral financial participation under title XIX of the Social  
17 Security Act (42 U.S.C. 1396 et seq.) made on or after  
18 such date or during the 60-day period prior to such date.

19 **SEC. 205. COUNTY MEDICAID HEALTH INSURING ORGANI-**  
20 **ZATIONS.**

21 (a) IN GENERAL.—Section 9517(c)(3) of the Consoli-  
22 dated Omnibus Budget Reconciliation Act of 1985 (42  
23 U.S.C. 1396b note), as added by section 4734 of the Om-  
24 nibus Budget Reconciliation Act of 1990 and as amended  
25 by section 704 of the Medicare, Medicaid, and SCHIP

1 Benefits Improvement and Protection Act of 2000, is  
2 amended—

3 (1) in subparagraph (A), by inserting “, in the  
4 case of any health insuring organization described in  
5 such subparagraph that is operated by a public enti-  
6 ty established by Ventura County, and in the case  
7 of any health insuring organization described in such  
8 subparagraph that is operated by a public entity es-  
9 tablished by Merced County” after “described in  
10 subparagraph (B)”; and

11 (2) in subparagraph (C), by striking “14 per-  
12 cent” and inserting “16 percent”.

13 (b) EFFECTIVE DATE.—The amendments made by  
14 subsection (a) shall take effect on the date of the enact-  
15 ment of this Act.

## 16 **TITLE K—MISCELLANEOUS**

### 17 **SEC. 301. EXTENSION OF TANF SUPPLEMENTAL GRANTS.**

18 (a) EXTENSION THROUGH FISCAL YEAR 2009.—Sec-  
19 tion 7101(a) of the Deficit Reduction Act of 2005 (Public  
20 Law 109–171; 120 Stat. 135) is amended by striking “fis-  
21 cal year 2008” and inserting “fiscal year 2009”.

22 (b) CONFORMING AMENDMENT.—Section  
23 403(a)(3)(H)(ii) of the Social Security Act (42 U.S.C.  
24 603(a)(3)(H)(ii)) is amended to read as follows:



1                   “(ii) subparagraph (G) shall be ap-  
2                   plied as if ‘fiscal year 2009’ were sub-  
3                   stituted for ‘fiscal year 2001’; and”.

4 **SEC. 302. 70 PERCENT FEDERAL MATCHING FOR FOSTER**  
5 **CARE AND ADOPTION ASSISTANCE FOR THE**  
6 **DISTRICT OF COLUMBIA.**

7           (a) IN GENERAL.—Section 474(a) of the Social Secu-  
8 rity Act (42 U.S.C. 674(a)) is amended in each of para-  
9 graphs (1) and (2) by striking “(as defined in section  
10 1905(b) of this Act)” and inserting “(which shall be as  
11 defined in section 1905(b), in the case of a State other  
12 than the District of Columbia, or 70 percent, in the case  
13 of the District of Columbia)”.

14           (b) EFFECTIVE DATE.—The amendment made by  
15 subsection (a) shall take effect on October 1, 2008, and  
16 shall apply to calendar quarters beginning on or after that  
17 date.

18 **SEC. 303. EXTENSION OF SPECIAL DIABETES GRANT PRO-**  
19 **GRAMS.**

20           (a) SPECIAL DIABETES PROGRAMS FOR TYPE I DIA-  
21 BETES.—Section 330B(b)(2)(C) of the Public Health  
22 Service Act (42 U.S.C. 254c–2(b)(2)) is amended by strik-  
23 ing “2009” and inserting “2011”.

24           (b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—  
25 Section 330C(c)(2)(C) of the Public Health Service Act

1 (42 U.S.C. 254c-3(c)(2)(C)) is amended by striking  
2 “2009” and inserting “2011”.

3 (c) REPORT ON GRANT PROGRAMS.—Section 4923(b)  
4 of the Balanced Budget Act of 1997 (42 U.S.C. 1254c-  
5 2 note), as amended by section 931(c) of the Medicare,  
6 Medicaid, and SCHIP Benefits Improvement and Protec-  
7 tion Act of 2000, as enacted into law by section 1(a)(6)  
8 of Public Law 106-554, and section 1(c) of Public Law  
9 107-360, is amended—

10 (1) in paragraph (1), by striking “and” at the  
11 end;

12 (2) in paragraph (2)—

13 (A) by striking “a final report” and insert-  
14 ing “a second interim report”; and

15 (B) by striking the period at the end and  
16 inserting “; and”; and

17 (3) by adding at the end the following new  
18 paragraph:

19 “(3) a report on such evaluation not later than  
20 January 1, 2011.”.

1 **SEC. 304. IOM REPORTS ON BEST PRACTICES FOR CON-**  
2 **DUCTING SYSTEMATIC REVIEWS OF CLIN-**  
3 **ICAL EFFECTIVENESS RESEARCH AND FOR**  
4 **DEVELOPING CLINICAL PROTOCOLS.**

5 (a) SYSTEMATIC REVIEWS OF CLINICAL EFFECTIVE-  
6 NESS RESEARCH.—

7 (1) STUDY.—Not later than 60 days after the  
8 date of the enactment of this Act, the Secretary of  
9 Health and Human Services shall enter into a con-  
10 tract with the Institute of Medicine of the National  
11 Academies (in this section referred to as the “Insti-  
12 tute”) under which the Institute shall conduct a  
13 study to identify the methodological standards for  
14 conducting systematic reviews of clinical effective-  
15 ness research on health and health care in order to  
16 ensure that organizations conducting such reviews  
17 have information on methods that are objective, sci-  
18 entifically valid, and consistent.

19 (2) REPORT.—Not later than 18 months after  
20 the effective date of the contract under paragraph  
21 (1), the Institute, as part of such contract, shall  
22 submit to the Secretary of Health and Human Serv-  
23 ices and the appropriate committees of jurisdiction  
24 of Congress a report containing the results of the  
25 study conducted under paragraph (1), together with  
26 recommendations for such legislation and adminis-

1 trative action as the Institute determines appro-  
2 priate.

3 (3) PARTICIPATION.—The contract under para-  
4 graph (1) shall require that stakeholders with exper-  
5 tise in conducting clinical effectiveness research par-  
6 ticipate on the panel responsible for conducting the  
7 study under paragraph (1) and preparing the report  
8 under paragraph (2).

9 (b) CLINICAL PROTOCOLS.—

10 (1) STUDY.—Not later than 60 days after the  
11 date of the enactment of this Act, the Secretary of  
12 Health and Human Services shall enter into a con-  
13 tract with the Institute of Medicine of the National  
14 Academies (in this section referred to as the “Insti-  
15 tute”) under which the Institute shall conduct a  
16 study on the best methods used in developing clinical  
17 practice guidelines in order to ensure that organiza-  
18 tions developing such guidelines have information on  
19 approaches that are objective, scientifically valid,  
20 and consistent.

21 (2) REPORT.—Not later than 18 months after  
22 the effective date of the contract under paragraph  
23 (1), the Institute, as part of such contract, shall  
24 submit to the Secretary of Health and Human Serv-  
25 ices and the appropriate committees of jurisdiction

1 of Congress a report containing the results of the  
2 study conducted under paragraph (1), together with  
3 recommendations for such legislation and adminis-  
4 trative action as the Institute determines appro-  
5 priate.

6 (3) PARTICIPATION.—The contract under para-  
7 graph (1) shall require that stakeholders with exper-  
8 tise in making clinical recommendations participate  
9 on the panel responsible for conducting the study  
10 under paragraph (1) and preparing the report under  
11 paragraph (2).

12 (c) FUNDING.—Out of any funds in the Treasury not  
13 otherwise appropriated, there are appropriated for the pe-  
14 riod of fiscal years 2009 and 2010, \$3,000,000 to carry  
15 out this section.

○