Calendar No. 776

110TH CONGRESS
2D SESSION

S. 3118

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

IN THE SENATE OF THE UNITED STATES

JUNE 11, 2008

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

JUNE 12, 2008

Read the second time and placed on the calendar

A BILL

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

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Preserving Access to Medicare Act of 2008''.

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

TITLE I—MEDICARE

Subtitle A—Rural Beneficiary Access Extensions and Improvements

SEC. 100. SHORT TITLE.

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

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

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

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

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

(3) in subparagraph (C)(i)—

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

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

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

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

1,500 discharges of such individuals in the fiscal year.''.

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

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

''(v) In the case of discharges occurring on or after October 1, 2008, and before October 1, 2009, in determining the amount under paragraph (1)(A)(iii) for purposes of clauses (i) and (ii)(II), such amount shall, if it results in greater payments to the hospital, be determined without regard to any adjustment for different area wage levels under paragraph (3)(E).''.

(b) TREATMENT OF CERTAIN HOSPITALS.—Notwithstanding any other provision of law, effective for discharges occurring on or after October 1, 2008, the provisions of paragraph (5)(G) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) shall apply for purposes of making payments under such section to Wesley Woods Geriatric Hospital (provider number 110203) in the same manner as such provisions apply for purposes

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

SEC. 103. AMBULANCE SERVICES IMPROVEMENTS.

(a) EXTENSION OF INCREASED MEDICARE PAYMENTS FOR GROUND AMBULANCE SERVICES.—Section 1834(l)(13) of the Social Security Act (42 U.S.C. 1395m(l)(13)) is amended—

(1) in subparagraph (A)—

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

(B) in clause (i), by inserting ''(or 3 percent if such service is furnished on or after July 1, 2008, and before January 1, 2010)'' after ''2 percent''; and

(C) in clause (ii), by inserting ''(or 2 percent if such service is furnished on or after July 1, 2008, and before January 1, 2010)'' after ''1 percent''; and

(2) in subparagraph (B)—

(A) in the heading, by striking ''2006'' and inserting ''APPLICABLE PERIOD''; and

(B) by inserting ''applicable'' before ''period''.

(b) AIR AMBULANCE PAYMENT IMPROVEMENTS.—

(1) TREATMENT OF CERTAIN AREAS FOR PAYMENT FOR AIR AMBULANCE SERVICES UNDER THE AMBULANCE FEE SCHEDULE.—Notwithstanding any other provision of law, for purposes of making payments under section 1834(l) of the Social Security Act (42 U.S.C. 1395m(l)) for air ambulance services furnished during the period beginning on July 1, 2008, and ending on December 31, 2009, any area that was designated as a rural area for purposes of making payments under such section for air ambulance services furnished on December 31, 2006, shall be treated as a rural area for purposes of making payments under such section for air ambulance services furnished during such period.

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

(A) IN GENERAL.—Section 1834(l)(14)(B)(i) of the Social Security Act (42 U.S.C. 1395m(l)(14)(B)(i)) is amended by striking ''reasonably determines or certifies'' and inserting ''certifies or reasonably determines''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply to services furnished on or after the date of the enactment of this Act.

SEC. 104. EXTENSION OF AUTHORIZATION FOR FLEX GRANTS.

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

(1) by striking ''and for'' and inserting ''for''; and

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

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

(1) in subparagraph (B), by striking ''and'' at the end;

(2) in subparagraph (C), by striking the period at the end and inserting ''; and''; and

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

''(D) providing support for critical access hospitals for quality improvement, quality re-

porting, performance improvements, and benchmarking.''.

SEC. 105. REBASING FOR SOLE COMMUNITY HOSPITALS.

(a) REBASING PERMITTED.—

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

''(L)(i) For cost reporting periods beginning on or after January 1, 2009, in the case of a sole community hospital there shall be substituted for the amount otherwise determined under subsection (d)(5)(D)(i) of this section, if such substitution results in a greater amount of payment under this section for the hospital, the subparagraph (L) rebased target amount.

''(ii) For purposes of this subparagraph, the term 'subparagraph (L) rebased target amount' has the meaning given the term 'target amount' in subparagraph (C), except that—

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

''(II) any reference in subparagraph (C)(i) to the 'first cost reporting period' described in such subparagraph is deemed a reference to the first cost

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

''(III) the applicable percentage increase shall only be applied under subparagraph (C)(iv) for discharges occurring on or after January 1, 2009.''.

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

(A) in subparagraph (C), in the matter preceding clause (i), by striking ''subparagraph (I)'' and inserting ''subparagraphs (I) and (L)''; and

(B) in subparagraph (I)(i), in the matter preceding subclause (I), by striking ''For'' and inserting ''Subject to subparagraph (L), for''.

(b) RURAL REFERRAL CENTER DESIGNATION.—Notwithstanding any other provision of law, for purposes of meeting the criteria for classification as a rural referral center under section 1886(d)(5)(C) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(C)) with respect to cost reporting periods beginning on or after October 1, 2008, the Halifax Regional Medical Center (provider number 340151) shall be deemed to satisfy the case mix requirement.

SEC. 106. EXTENSION AND EXPANSION OF THE MEDICARE HOLD HARMLESS PROVISION UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT (HOPD) SERVICES FOR CERTAIN HOSPITALS.

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

(1) in subclause (II)—

(A) in the first sentence, by striking ''2009'' and inserting ''2010''; and

(B) by striking the second sentence and inserting the following new sentence: ''For purposes of the preceding sentence, the applicable percentage shall be 95 percent with respect to covered OPD services furnished in 2006, 90 percent with respect to such services furnished in 2007, and 85 percent with respect to such services furnished in 2008 or 2009.''; and

(2) by adding at the end the following new subclause:

''(III) In the case of a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) that has not more than 100 beds, for covered OPD services furnished on or after January 1, 2009, and before January 1, 2010, for which the

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

SEC. 107. CLARIFICATION OF PAYMENT FOR CLINICAL LABORATORY TESTS FURNISHED BY CRITICAL ACCESS HOSPITALS.

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

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

(A) in the heading, by striking ''NO BENEFICIARY COST-SHARING FOR'' and inserting ''TREATMENT OF''; and

(B) by adding at the end the following new sentence: ''For purposes of the preceding sentence and section 1861(mm)(3), clinical diagnostic laboratory services furnished by a critical access hospital shall be treated as being furnished as part of outpatient critical access services without regard to whether the individual with respect to whom such services are furnished is physically present in the critical access

hospital at the time the specimen is collected as long as the individual is present within the same county as the hospital at the time the specimen is collected.''.

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

(b) MEDICARE CRITICAL ACCESS HOSPITAL DESIGNATIONS.—Section 405(h) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2269) is amended by adding at the end the following new paragraph:

''(3) EXCEPTION.—

''(A) IN GENERAL.—The amendment made by paragraph (1) shall not apply to the certification by the State of Alabama on or after January 1, 2006, under section 1820(c)(2)(B)(i)(II) of the Social Security Act (42 U.S.C. 1395i–4(c)(2)(B)(i)(II)) of one hospital that meets the criteria described in subparagraph (B) as a necessary provider of health care services to residents in the area of the hospital.

''(B) CRITERIA DESCRIBED.—A hospital meets the criteria described in this subparagraph if the hospital is located—

''(i) in the county seat of Butler, Alabama; and

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

SEC. 108. EXTENSION OF FLOOR ON MEDICARE WORK GEOGRAPHIC ADJUSTMENT UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

(a) IN GENERAL.—Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(E)), as amended by section 103 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended by striking ''before July 1, 2008'' and inserting ''before January 1, 2010''.

(b) TREATMENT OF PHYSICIANS' SERVICES FURNISHED IN CERTAIN AREAS.—Section 1848(e)(1)(G) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)(G)) is amended by adding at the end the following new sentence: ''For purposes of payment for services furnished in the State described in the preceding sentence on or after January 1, 2009, after calculating the work geographic index

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

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

''(1) in subparagraph (A), by striking 'subparagraphs (B), (C), and (E)' and inserting 'subparagraphs (B), (C), (E), and (G)'; and''.

SEC. 109. EXTENSION OF TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE.

Section 542(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554), as amended by section 732 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395w–4 note), section 104 of division B of the Tax Relief and Health Care Act of 2006 (42 U.S.C. 1395w–4 note), and section 104 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended by striking ''2007, and the first 6 months of 2008'' and inserting ''2007, 2008, and 2009''.

SEC. 110. ADDING HOSPITAL-BASED RENAL DIALYSIS CENTERS (INCLUDING SATELLITES) AS ORIGINATING SITES FOR PAYMENT OF TELEHEALTH SERVICES.

(a) IN GENERAL.—Section 1834(m)(4)(C)(ii) of the Social Security Act (42 U.S.C. 1395m(m)(4)(C)(ii)) is amended by adding at the end the following new subclause:

"(VI) A hospital-based or critical access hospital-based renal dialysis center (including satellites).".

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

SEC. 111. ADDING SKILLED NURSING FACILITIES AS ORIGINATING SITES FOR PAYMENT OF TELEHEALTH SERVICES.

(a) ADDITION.—

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

"(VII) A skilled nursing facility (as defined in section 1819(a)).".

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

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

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

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

(1) by striking '', and episodes'' and inserting '', episodes''; and

(2) by inserting ''and episodes and visits ending on or after January 1, 2009, and before January 1, 2010,'' after ''January 1, 2007,''.

Subtitle B—Other Provisions Relating to Part A

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

(a) EXTENSION.—

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

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

(b) FLOOR ON MEDICARE AREA WAGE INDEX.—

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

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

(2) AREA DESCRIBED.—An area described in this paragraph is a rural area (as defined in paragraph (2)(D) of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d))) where not less than 65 percent of the wages paid by all subsection (d) hospitals (as defined in paragraph (1)(B) of such section) that are located in such area on October 1, 2006, taking into account redesignations under section 601(g) of the Social Security Amendments of 1983 (Public Law 98–21) and not taking into account reclassifications or redesignations under paragraph (8) or (10) of such section 1886(d), are attributable to wages paid by one hospital. For purposes of making a determination under the preceding sentence, the wages to be used are the occupational mix adjusted inflated wages used to develop the wage index in effect during the period beginning on October 1, 2006 and ending on September 30, 2007 (as published in the Federal Register on October 11, 2006 (71 Fed. Reg. 59,886)).

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

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

(c) MEDICARE HOSPITAL GEOGRAPHIC RECLASSIFICATIONS.—

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

(2) RULES.—

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

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

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

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

(a) IN GENERAL.—

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

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

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

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

(iii) an integrated site-neutral payment methodology; and

(iv) an integrated quality assessment system; and

(B) actions necessary to establish the integrated continuum of care.

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

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

and administrative action as the Institute determines appropriate.

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

SEC. 123. REVOCATION OF UNIQUE DEEMING AUTHORITY OF THE JOINT COMMISSION.

(a) REVOCATION.—Section 1865 of the Social Security Act (42 U.S.C. 1395bb) is amended—

(1) by striking subsection (a); and

(2) by redesignating subsections (b), (c), (d), and (e) as subsections (a), (b), (c), and (d), respectively.

(b) CONFORMING AMENDMENTS.—(1) Section 1865 of the Social Security Act (42 U.S.C. 1395bb) is amended—

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

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

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

pitals,'' and inserting ''released to the Secretary by''; and

(ii) by striking the comma after ''Association'';

(C) in subsection (c), as so redesignated, by striking ''pursuant to subsection (a) or (b)(1)'' and inserting ''pursuant to subsection (a)(1)''; and

(D) in subsection (d), as so redesignated, by striking ''pursuant to subsection (a) or (b)(1)'' and inserting ''pursuant to subsection (a)(1)''.

(2) Section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)) is amended in the fourth sentence by striking ''and (ii) is accredited by the Joint Commission on Accreditation of Hospitals, or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be essentially equivalent to those of the Joint Commission on Accreditation of Hospitals'' and inserting ''and (ii) is accredited by a national accreditation body recognized by the Secretary under section 1865(a), or is accredited by or approved by a program of the country in which such institution is located if the Secretary finds the accreditation or comparable approval standards of such program to be

essentially equivalent to those of such a national accreditation body.''.

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

(4) Section 1875(b) of the Social Security Act (42 U.S.C. 1395ll(b)) is amended by striking ''the Joint Commission on Accreditation of Hospitals,'' and inserting ''national accreditation bodies under section 1865(a)''.

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

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

(c) AUTHORITY TO RECOGNIZE THE JOINT COMMISSION AS A NATIONAL ACCREDITATION BODY.—The Secretary of Health and Human Services may recognize the Joint Commission as a national accreditation body under section 1865 of the Social Security Act (42 U.S.C. 1395bb), as amended by this section, upon such terms and conditions, and upon submission of such information, as the Secretary may require.

(d) EFFECTIVE DATE; TRANSITION RULE.—(1) Subject to paragraph (2), the amendments made by this section shall apply with respect to accreditations of hospitals granted on or after the date that is 24 months after the date of enactment of this Act.

(2) For purposes of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.), the amendments made by this section shall not effect the accreditation of a hospital by the Joint Commission, or under accreditation or comparable approval standards found to be essentially equivalent to accreditation or approval standards of the Joint Commission, for the period of time applicable under such accreditation.

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

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study on payments for hospice care under the Medicare program under title XVIII of the Social Security Act. Such study shall include an analysis of potential changes in payment methodologies for hospice care under the Medicare program, including revisions to the cap amount under section 1814(i)(2) of the Social Security Act (42 U.S.C. 1395f(i)(2)), that may reflect—

(1) hospice patient characteristics;

(2) variation in hospice care utilization by patient characteristics;

(3) average lengths of stay in hospice care;

(4) disease category;

(5) geographic differences;

(6) specific types of hospice care services provided; and

(7) site of service.

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

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

SEC. 125. INTRODUCING THE PRINCIPALS OF VALUE-BASED HEALTH CARE INTO THE MEDICARE PROGRAM.

(a) INCENTIVES FOR PROVIDERS AND SUPPLIERS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall design and implement a budget-

neutral system for use in the Medicare program under title XVIII of the Social Security Act under which a portion of the payments that would otherwise be made under such program to some or all classes of individuals and entities furnishing items or services to beneficiaries of such program would be based on the quality of their performance.

(2) IMPLEMENTATION.—The Secretary shall first implement such system in hospitals. The initial focus of such efforts shall be on quality. The system shall also include incentives for reducing unwarranted geographic variations in quality.

(3) AUTHORITY.—The Secretary may implement the system described in this subsection without regard to any provision of title XVIII of the Social Security Act that would, in the absence of paragraphs (1) and (2), apply with respect to payment to an individual or entity furnishing items or services for which payment may be made under the Medicare program.

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

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

(2) health outcomes; and

(3) patient perceptions of their care.

Subtitle C—Other Provisions Relating to Part B

SEC. 131. PHYSICIAN PAYMENT, EFFICIENCY, AND QUALITY IMPROVEMENTS.

(a) IN GENERAL.—

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

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

(i) in the heading, by striking ''A PORTION OF'';

(ii) in subparagraph (A), by striking ''for the period beginning on January 1, 2008, and ending on June 30, 2008,''; and

(iii) in subparagraph (B)—

(I) in the heading, by striking ''THE REMAINING PORTION OF 2008 AND''; and

(II) by striking ''for the period beginning on July 1, 2008, and ending on December 31, 2008, and''.

(B) FOR 2009.—Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)), as amended by section 101 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended by adding at the end the following new paragraph:

''(9) UPDATE FOR 2009.—

''(A) IN GENERAL.—Subject to paragraphs (7)(B) and (8)(B), in lieu of the update to the single conversion factor established in paragraph (1)(C) that would otherwise apply for 2009, the update to the single conversion factor shall be 1.1 percent.

''(B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2010 AND SUBSEQUENT YEARS.—The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2010 and subsequent years as if subparagraph (A) had never applied.''.

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

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

(A) in subparagraph (A)—

(i) in clause (i)—

(I) in subclause (III), by striking ''$4,960,000,000'' and inserting ''$4,090,000,000'';

(II) by adding at the end the following new clause:

''(IV) For expenditures during 2014 through 2017, an amount equal to $30,660,000,000.''; and

(ii) in clause (ii), by adding at the end the following new subclause:

''(III) 2014 THROUGH 2017.—The amount available for expenditures during 2014 through 2017 shall only be available for an adjustment to the update of the conversion factor under subsection (d) for that year.''; and

(B) in subparagraph (B)—

(i) in clause (ii), by striking ''and'' at the end;

(ii) in clause (iii), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following new clause:

''(iv) 2014 through 2017 for payment with respect to physicians' services furnished during 2014 through 2017.''.

(b) EXTENSION AND IMPROVEMENT OF THE QUALITY REPORTING SYSTEM.—

(1) SYSTEM.—Section 1848(k)(2) of the Social Security Act (42 U.S.C. 1395w–4(k)(2)), as amended by section 101(b)(1) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended by adding at the end the following new subparagraphs:

''(C) FOR 2010 AND SUBSEQUENT YEARS.—

''(i) IN GENERAL.—Subject to clause (ii), for purposes of reporting data on quality measures for covered professional services furnished during 2010 and each subsequent year, subject to subsection (m)(3)(C), the quality measures (including electronic prescribing quality measures) specified under this paragraph shall be

such measures selected by the Secretary from measures that have been endorsed by the entity with a contract with the Secretary under section 1890(a).

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

''(D) OPPORTUNITY TO PROVIDE INPUT ON MEASURES FOR 2009 AND SUBSEQUENT YEARS.—For each quality measure (including an electronic prescribing quality measure) adopted by the Secretary under subparagraph (B) (with respect to 2009) or subparagraph (C), the Secretary shall ensure that eligible professionals have the opportunity to provide input during the development, endorsement, or selec-

tion of measures applicable to services they furnish.''.

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

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

(A) by amending the heading to read as follows: ''INCENTIVE PAYMENTS FOR QUALITY REPORTING'';

(B) by striking paragraph (1) and inserting the following:

''(1) INCENTIVE PAYMENTS.—

''(A) IN GENERAL.—For 2007 through 2010, with respect to covered professional services furnished during a reporting period by an eligible professional, if—

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

cian reporting system that are applicable to any such services furnished by such professional for such reporting period; and

''(ii) the eligible professional satisfactorily submits (as determined under this subsection) to the Secretary data on such quality measures in accordance with such reporting system for such reporting period,

in addition to the amount otherwise paid under this part, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)) or, in the case of a group practice under paragraph (3)(C), to the group practice, from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 an amount equal to the applicable quality percent of the Secretary's estimate (based on claims submitted not later than 2 months after the end of the reporting period) of the allowed charges under this part for all such covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (3)(C), by the group practice) during the reporting period.

''(B) APPLICABLE QUALITY PERCENT.—For purposes of subparagraph (A), the term 'applicable quality percent' means—

''(i) for 2007 and 2008, 1.5 percent; and

''(ii) for 2009 and 2010, 2.0 percent.'';

(C) by striking paragraph (3) and redesignating paragraph (2) as paragraph (3);

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

(i) in the matter preceding subparagraph (A), by striking ''For purposes'' and inserting the following:

''(A) IN GENERAL.—For purposes'';

(ii) by redesignating subparagraphs (A) and (B) as clauses (i) and (ii), respectively, and moving the indentation of such clauses 2 ems to the right;

(iii) in subparagraph (A), as added by clause (i), by adding at the end the following flush sentence:

''For years after 2008, quality measures for purposes of this subparagraph shall not include electronic prescribing quality measures.''; and

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

''(C) SATISFACTORY REPORTING MEASURES FOR GROUP PRACTICES.—

''(i) IN GENERAL.—By January 1, 2010, the Secretary shall establish and have in place a process under which eligible professionals in a group practice (as defined by the Secretary) shall be treated as satisfactorily submitting data on quality measures under subparagraph (A) and as meeting the requirement described in subparagraph (B)(ii)) for covered professional services for a reporting period (or, for purposes of subsection (a)(5), for a reporting period for a year) if, in lieu of reporting measures under subsection (k)(2)(C), the group practice reports measures determined appropriate by the Secretary, such as measures that target high-cost chronic conditions and preventive care, in a form and manner, and at a time, specified by the Secretary.

''(ii) STATISTICAL SAMPLING MODEL.—The process under clause (i)

shall provide for the use of a statistical sampling model to submit data on measures, such as the model used under the Physician Group Practice demonstration project under section 1866A.

''(iii) NO DOUBLE PAYMENTS.—Payments to a group practice under this subsection by reason of the process under clause (i) shall be in lieu of the payments that would otherwise be made under this subsection to eligible professionals in the group practice for satisfactorily submitting data on quality measures.

''(D) AUTHORITY TO REVISE SATISFACTORILY REPORTING DATA.—For years after 2009, the Secretary, in consultation with stakeholders and experts, may revise the criteria under this subsection for satisfactorily submitting data on quality measures under subparagraph (A) and the criteria for submitting data on electronic prescribing quality measures under subparagraph (B)(ii).'';

(E) in paragraph (5)—

(i) in subparagraph (C), by inserting ''for 2007, 2008, and 2009,'' after ''provision of law,'';

(ii) in subparagraph (D)—

(I) in clause (i)—

(aa) by inserting ''for 2007 and 2008'' after ''under this subsection''; and

(bb) by striking ''paragraph (2)'' and inserting ''this subsection'';

(II) in clause (ii), by striking ''shall'' and inserting ''may establish procedures to''; and

(III) in clause (iii)—

(aa) by inserting ''(or, in the case of a group practice under paragraph (3)(C), the group practice)'' after ''an eligible professional'';

(bb) by striking ''bonus incentive payment'' and inserting ''incentive payment under this subsection''; and

(cc) by adding at the end the following new sentence: ''If such payments for such period have already been made, the Secretary shall recoup such payments from the eligible professional (or the group practice).'';

(iii) in subparagraph (E)(i)—

(I) in subclause (II), by striking ''paragraph (2)'' and inserting ''this subsection''; and

(II) in subclause (IV)—

(aa) by striking ''the bonus'' and inserting ''any''; and

(bb) by inserting ''and the payment adjustment under subsection (a)(5)(A)'' before the period at the end;

(iv) in subparagraph (F)—

(I) by striking ''2009, paragraph (3) shall not apply, and'' and inserting ''subsequent years,''; and

(II) by striking ''paragraph (2)'' and inserting ''this subsection''; and

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

''(G) POSTING ON WEBSITE.—The Secretary shall post on the Internet website of the Centers for Medicare & Medicaid Services, in an easily understandable format, a list of the names of the following:

''(i) The eligible professionals (or, in the case of reporting under paragraph (3)(C), the group practices) who satisfactorily submitted data on quality measures under this subsection.

''(ii) The eligible professionals (or, in the case of reporting under paragraph (3)(C), the group practices) who are successful electronic prescribers.''; and

(F) in paragraph (6), by striking subparagraph (C) and inserting the following:

''(C) REPORTING PERIOD.—

''(i) IN GENERAL.—Subject to clauses (ii) and (iii), the term 'reporting period' means—

''(I) for 2007, the period beginning on July 1, 2007, and ending on December 31, 2007; and

"(II) for 2008, 2009, 2010, and 2011, the entire year.

"(ii) AUTHORITY TO REVISE REPORTING PERIOD.—For years after 2009, the Secretary may revise the reporting period under clause (i) if the Secretary determines such revision is appropriate, produces valid results on measures reported, and is consistent with the goals of maximizing scientific validity and reducing administrative burden. If the Secretary revises such period pursuant to the preceding sentence, the term 'reporting period' shall mean such revised period.

"(iii) REFERENCE.—Any reference in this subsection to a reporting period with respect to the application of subsection (a)(5) shall be deemed a reference to the reporting period under subparagraph (D)(iii) of such subsection.".

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

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

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

"(iv) Beginning with 2009, a qualified audiologist (as defined in section 1861(ll)(3)(B))."

(B) NO CHANGE IN BILLING.—Nothing in the amendment made by subparagraph (A) shall be construed to change the way in which billing for audiology services (as defined in section 1861(ll)(2) of the Social Security Act (42 U.S.C. 1395x(ll)(2))) occurs under title XVIII of such Act as of July 1, 2008.

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

(A) in paragraph (5)—

(i) in subparagraph (A)—

(I) by striking "section 1848(k) of the Social Security Act, as added by subsection (b)," and inserting "subsection (k)"; and

(II) by striking "such section" and inserting "such subsection";

(ii) in subparagraph (B), by striking ''of the Social Security Act (42 U.S.C. 1395l)'';

(iii) in subparagraph (E)—

(I) in clause (i), in the matter preceding subclause (I), by striking ''1869 or 1878 of the Social Security Act or otherwise'' and inserting ''1869, section 1878, or otherwise''; and

(II) in clause (ii), by striking ''of the Social Security Act''; and

(iv) in subparagraph (F)—

(I) by striking ''paragraph (2)(B) of section 1848(k) of the Social Security Act (42 U.S.C. 1395w–4(k))'' and inserting ''subsection (k)(2)(B)''; and

(II) by striking ''paragraph (4) of such section'' and inserting ''subsection (k)(4)'';

(B) in paragraph (6)—

(i) in subparagraph (A), by striking ''section 1848(k)(3) of the Social Security Act, as added by subsection (b)'' and inserting ''subsection (k)(3)''; and

(ii) in subparagraph (B), by striking ''section 1848(k) of the Social Security Act, as added by subsection (b)'' and inserting ''subsection (k)''; and

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

(6) NO AFFECT ON INCENTIVE PAYMENTS FOR 2007 OR 2008.—Nothing in the amendments made by this subsection or section 132 shall affect the operation of the provisions of section 1848(m) of the Social Security Act, as redesignated and amended by such subsection and section, with respect to 2007 or 2008.

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

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

''(n) PHYSICIAN FEEDBACK PROGRAM.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—The Secretary shall establish a Physician Feedback Program (in this subsection referred to as the 'Program') under which the Secretary shall use claims data under this title (and may use other data) to

provide confidential reports to physicians (and, as determined appropriate by the Secretary, to groups of physicians) that measure the resources involved in furnishing care to individuals under this title. If determined appropriate by the Secretary, the Secretary may include information on the quality of care furnished to individuals under this title by the physician (or group of physicians) in such reports.

''(B) RESOURCE USE.—The resources described in subparagraph (A) may be measured—

''(i) on an episode basis;

''(ii) on a per capita basis; or

''(iii) on both an episode and a per capita basis.

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

''(3) DATA FOR REPORTS.—To the extent practicable, reports under the Program shall be based on the most recent data available.

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

''(A) physician specialties that account for a certain percentage of all spending for physicians' services under this title;

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

''(C) physicians who use a high amount of resources compared to other physicians;

''(D) physicians practicing in certain geographic areas; or

''(E) physicians who treat a minimum number of individuals under this title.

''(5) AUTHORITY TO EXCLUDE CERTAIN INFORMATION IF INSUFFICIENT INFORMATION.—The Secretary may exclude certain information regarding a service from a report under the Program with respect to a physician (or group of physicians) if the Secretary determines that there is insufficient information relating to that service to provide a valid report on that service.

''(6) ADJUSTMENT OF DATA.—To the extent practicable, the Secretary shall make appropriate adjustments to the data used in preparing reports under the Program, such as adjustments to take

into account variations in health status and other patient characteristics.

''(7) EDUCATION AND OUTREACH.—The Secretary shall provide for education and outreach activities to physicians on the operation of, and methodologies employed under, the Program.

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

(2) GAO STUDY AND REPORT ON THE PHYSICIAN FEEDBACK PROGRAM.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study of the Physician Feedback Program conducted under section 1848(n) of the Social Security Act, as added by paragraph (1), including the implementation of the Program.

(B) REPORT.—Not later than March 1, 2011, the Comptroller General of the United States shall submit a report to Congress containing the results of the study conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

(d) PLAN FOR TRANSITION TO VALUE-BASED PURCHASING PROGRAM FOR PHYSICIANS AND OTHER PRACTITIONERS.—

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

(2) REPORT.—Not later than May 1, 2010, the Secretary of Health and Human Services shall submit a report to Congress containing the plan developed under paragraph (1), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(e) IMPLEMENTATION.—For purposes of carrying out the provisions of, and amendments made by, this title, in addition to any amounts otherwise provided in such provisions and amendments, there are appropriated to the Centers for Medicare & Medicaid Services Program Management Account, out of any money in the Treasury not otherwise appropriated, $140,000,000 for the period of fiscal years 2009 through 2013.

SEC. 132. INCENTIVES FOR ELECTRONIC PRESCRIBING.

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

(1) by inserting after paragraph (1), the following new paragraph:

"(2) INCENTIVE PAYMENTS FOR ELECTRONIC PRESCRIBING.—

"(A) IN GENERAL.—For 2009 through 2013, with respect to covered professional services furnished during a reporting period by an eligible professional, if the eligible professional is a successful electronic prescriber for such reporting period, in addition to the amount otherwise paid under this part, there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6)) or, in the case of a group practice under paragraph (3)(C), to the group practice, from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 an amount equal to the applicable electronic prescribing percent of the Secretary's estimate (based on claims submitted not later than 2 months after the end of the reporting period) of the allowed charges

under this part for all such covered professional services furnished by the eligible professional (or, in the case of a group practice under paragraph (3)(C), by the group practice) during the reporting period.

''(B) LIMITATION WITH RESPECT TO ELECTRONIC PRESCRIBING QUALITY MEASURES.—The provisions of this paragraph and subsection (a)(5) shall not apply to an eligible professional (or, in the case of a group practice under paragraph (3)(C), to the group practice) if, for the reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year)—

''(i) the allowed charges under this part for all covered professional services furnished by the eligible professional (or group, as applicable) for the codes to which the electronic prescribing quality measure applies (as identified by the Secretary and published on the Internet website of the Centers for Medicare & Medicaid Services as of January 1, 2008, and as subsequently modified by the Secretary) are less than 10 percent of the total of the allowed charges under this part

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

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

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

''(C) APPLICABLE ELECTRONIC PRESCRIBING PERCENT.—For purposes of subparagraph (A), the term 'applicable electronic prescribing percent' means—

''(i) for 2009 and 2010, 2.0 percent;

''(ii) for 2011 and 2012, 1.0 percent; and

''(iii) for 2013, 0.5 percent.'';

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

(A) in the heading, by inserting ''AND SUCCESSFUL ELECTRONIC PRESCRIBER'' after ''REPORTING''; and

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

''(B) SUCCESSFUL ELECTRONIC PRESCRIBER.—

''(i) IN GENERAL.—For purposes of paragraph (2) and subsection (a)(5), an eligible professional shall be treated as a successful electronic prescriber for a reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year) if the eligible professional meets the requirement described in clause (ii), or, if the Secretary determines appropriate, the requirement described in clause (iii). If the Secretary makes the determination under the preceding sentence to apply the requirement described in clause (ii) for a period, then the requirement described in clause (i) shall not apply for such period.

''(ii) REQUIREMENT FOR SUBMITTING DATA ON ELECTRONIC PRESCRIBING QUALITY MEASURES.—The requirement described in this clause is that, with respect to covered professional services furnished by an eligible professional during a report-

ing period (or, for purposes of subsection (a)(5), for the reporting period for a year), if there are any electronic prescribing quality measures that have been established under the physician reporting system and are applicable to any such services furnished by such professional for the period, such professional reported each such measure under such system in at least 50 percent of the cases in which such measure is reportable by such professional under such system.

''(iii) REQUIREMENT FOR ELECTRONICALLY PRESCRIBING UNDER PART D.—The requirement described in this clause is that the eligible professional electronically submitted a sufficient number (as determined by the Secretary) of prescriptions under part D during the reporting period (or, for purposes of subsection (a)(5), for the reporting period for a year).

''(iv) USE OF PART D DATA.—Notwithstanding sections 1858(c)(3)(B), 1860D–15(d)(2)(B), and 1860D–15(f)(2), the Secretary may use data submitted for

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

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

(3) in paragraph (5)(E)—

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

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

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

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

''(5) INCENTIVES FOR ELECTRONIC PRESCRIBING.—

''(A) ADJUSTMENT.—

''(i) IN GENERAL.—Subject to subparagraph (B) and subsection (m)(2)(B), with respect to covered professional services furnished by an eligible professional during 2011 or any subsequent year, if the eligible professional is not a successful electronic prescriber for the reporting period for the year (as determined under subsection (m)(3)(B)), the fee schedule amount for such services furnished by such professional during the year (including the fee schedule amount for purposes of determining a payment based on such amount) shall be equal to the applicable percent of the fee schedule amount that would otherwise apply to such services under this subsection (determined after application of

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

''(ii) APPLICABLE PERCENT.—For purposes of clause (i), the term 'applicable percent' means—

''(I) for 2011, 99 percent;

''(II) for 2012, 98.5 percent; and

''(III) for 2013 and each subsequent year, 98 percent.

''(B) SIGNIFICANT HARDSHIP EXCEPTION.—The Secretary may exempt an eligible professional from the application of the payment adjustment under subparagraph (A) if the Secretary determines that compliance with the requirement for being a successful electronic prescriber would be a significant hardship, such as an eligible professional who practices in a rural area without sufficient Internet access and an eligible professional who frequently sends prescriptions to pharmacies that are not capable of receiving prescriptions electronically.

''(C) APPLICATION.—

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

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

''(ii) INCENTIVE PAYMENT VALIDATION RULES.—Clauses (ii) and (iii) of subsection (m)(5)(D) shall apply for purposes of this paragraph in a similar manner as they apply for purposes of such subsection.

''(D) DEFINITIONS.—For purposes of this paragraph:

''(i) ELIGIBLE PROFESSIONAL; COVERED PROFESSIONAL SERVICES.—The terms 'eligible professional' and 'covered professional services' have the meanings given such terms in subsection (k)(3).

''(ii) PHYSICIAN REPORTING SYSTEM.—The term 'physician reporting system' means the system established under subsection (k).

''(iii) REPORTING PERIOD.—The term 'reporting period' means, with respect to a year, a period specified by the Secretary.''.

SEC. 133. INCREASING THE NUMBER OF SITES FOR THE ELECTRONIC HEALTH RECORDS DEMONSTRATION.

Out of funds in the Treasury not otherwise appropriated, there are appropriated for the period of fiscal years 2009 through 2014, $45,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for administrative costs to increase the number of sites, up to 40, in which the Electronic Health Records Demonstration is being conducted.

SEC. 134. PRIMARY CARE IMPROVEMENTS.

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

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

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

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

terly basis) an amount equal to 5 percent of the payment amount for the service under this part.

''(2) DEFINITIONS.—In this subsection:

''(A) PRIMARY CARE PHYSICIAN.—The term 'primary care physician' means a physician (as described in section 1861(r)(1)) for whom primary care services accounted for at least a specified percent (as determined by the Secretary) of the allowed charges under this part for such physician in a prior period as determined appropriate by the Secretary.

''(B) PRIMARY CARE SCARCITY COUNTY.—The term 'primary care scarcity county' means the primary care scarcity counties that the Secretary was using under subsection (u) with respect to physicians' services furnished on December 31, 2007.

''(C) PRIMARY CARE SERVICES.—The term 'primary care services' means procedure codes for services in the category of the Healthcare Common Procedure Coding System, as established by the Secretary under section 1848(c)(5) (as of December 31, 2008 and as subsequently modified by the Secretary) consisting of evaluation and management services,

but limited to such procedure codes in the category of office or other outpatient services, and consisting of subcategories of such procedure codes for services for both new and established patients.

''(3) JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting the identification of primary care physicians, primary care specialty areas, or primary care services under this subsection.''.

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

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

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

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

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

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

''(A) The expansion of the project is expected to improve the quality of patient care without increasing spending under the Medicare program (not taking into account amounts available under subsection (g)).

''(B) The expansion of the project is expected to reduce spending under the Medicare program (not taking into account amounts available under subsection (g)) without reducing the quality of patient care.''.

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

''(g) FUNDING FROM SMI TRUST FUND.—There shall be available, from the Federal Supplementary Medical Insurance Trust Fund (under section 1841 of the Social Security Act (42 U.S.C. 1395t)), the amount of $100,000,000 to carry out the project.

''(h) APPLICATION.—Chapter 35 of title 44, United States Code, shall not apply to the conduct of the project.''.

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

''(vi) ALTERNATIVE APPLICATION OF BUDGET-NEUTRALITY ADJUSTMENT.—Notwithstanding subsection (d)(9)(A), effective for fee schedules established beginning with 2009, with respect to the 5-year review of work relative value units used in fee schedules for 2007 and 2008, in lieu of continuing to apply budget-neutrality adjustments required under clause (ii) for 2007 and 2008 to work relative value units, the Secretary shall apply such budget-neutrality adjustments to the conversion

factor otherwise determined for years beginning with 2009.''.

SEC. 135. MEDICARE ANESTHESIA TEACHING PROGRAM IMPROVEMENTS.

(a) SPECIAL PAYMENT RULE FOR TEACHING ANESTHESIOLOGISTS.—Section 1848(a) of the Social Security Act (42 U.S.C. 1395w–4(a)), as amended by section 132(b), is amended—

(1) in paragraph (4)(A), by inserting ''except as provided in paragraph (5),'' after ''anesthesia cases,''; and

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

''(6) SPECIAL RULE FOR TEACHING ANESTHESIOLOGISTS.—With respect to physicians' services furnished on or after January 1, 2010, in the case of teaching anesthesiologists involved in the training of physician residents in a single anesthesia case or two concurrent anesthesia cases, the fee schedule amount to be applied shall be 100 percent of the fee schedule amount otherwise applicable under this section if the anesthesia services were personally performed by the teaching anesthesiologist alone and paragraph (4) shall not apply if—

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

''(B) the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist has entered into an arrangement) is immediately available to furnish anesthesia services during the entire procedure.''.

(b) TREATMENT OF CERTIFIED REGISTERED NURSE ANESTHETISTS.—With respect to items and services furnished on or after January 1, 2010, the Secretary of Health and Human Services shall make appropriate adjustments to payments under the Medicare program under title XVIII of the Social Security Act for teaching certified registered nurse anesthetists to implement a policy with respect to teaching certified registered nurse anesthetists that—

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

(2) maintains the existing payment differences between teaching anesthesiologists and teaching certified registered nurse anesthetists.

SEC. 136. MEDICARE COORDINATED CARE PRACTICE RESEARCH NETWORK DEMONSTRATION.

(a) DEMONSTRATION PROGRAM.—

(1) IN GENERAL.—Not later than October 1, 2009, the Secretary shall establish a demonstration program to test best practices and new and innovative coordinated care projects for Medicare beneficiaries with multiple chronic conditions.

(2) DEMONSTRATION PROGRAM DESIGN.—

(A) INITIAL SITES.—The Secretary shall select not less than 8 organizations to participate in the demonstration program under this section initially. The organizations selected under this subparagraph shall meet the following requirements:

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

(ii) The organizations were participants in the Medicare Coordinated Care Demonstration under section 4016 of the Balanced Budget Act of 1997 (42 U.S.C. 1395b–1 note) as of October 1, 2007.

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

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

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

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

(3) DURATION.—

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

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

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

(I) reduces expenditures under the Medicare program; or

(II) does not increase expenditures under the Medicare program and increases the quality of health care services provided to Medicare beneficiaries with multiple chronic conditions and satisfaction of beneficiaries and health care providers;

the Secretary shall continue the existing demonstration program and may expand the demonstration program.

(ii) IMPLEMENTATION OF DEMONSTRATION PROGRAM RESULTS.—If the report under paragraph (5) contains an evaluation described in clause (i), the Secretary may issue regulations to implement, on a permanent basis, the components of the demonstration program that are beneficial to the Medicare program.

(4) USE OF CONTRACTOR TO FACILITATE COMMUNICATION AND INFORMATION SHARING.—

(A) IN GENERAL.—Under the demonstration program under this section, the Secretary shall enter into a contract with a contractor to

facilitate communications and data analysis among sites participating in the demonstration program and to share information on best practices with such sites.

(B) DUTIES.—The contractor shall have such duties and responsibilities as are specified by the Secretary, including ensuring, to the extent feasible, that each site participating in the demonstration program under this section receives timely and regular access to data from the other sites participating in the demonstration program to enable each site to modify, refine, and evaluate current and proposed chronic care interventions and new models of care.

(b) EVALUATION AND REPORT.—Not later than 4 years after the establishment of the demonstration program under this section, the Secretary shall submit a report to Congress on the Medicare chronic care practice research network based on an evaluation of the demonstration program. Such report shall include an evaluation of the effectiveness of each site participating in the demonstration program, including the following:

(1) An analysis of progress made under the demonstration program toward developing an efficient and effective research infrastructure capable of

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

(2) An evaluation of the impacts of the care coordination models used by each site participating in the demonstration program, including the overall quality of care provided, patient satisfaction, and cost-effectiveness of the interventions tested under the demonstration program at each site.

(3) An evaluation of the capability of the demonstration program to define and test specifications needed to deploy successful interventions on a large geographic or nationwide scale without loss of effectiveness.

(4) A description of any benefits to the Medicare program under title XVIII of the Social Security Act resulting from increased collaboration and partnership between participating sites under the demonstration program.

(5) Any other information regarding the demonstration program that the Secretary determines appropriate.

(6) Recommendations for practices and guidelines for chronic care, including a summary of the care models found to be most effective in managing

Medicare beneficiaries with multiple chronic conditions under the demonstration program under this subsection.

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

(c) FUNDING.—

(1) IMPLEMENTATION FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines to be appropriate, of $15,000,000 to the Centers for Medicare & Medicaid Services Program Management Account to implement the demonstration program under this section.

(2) ADDITIONAL FUNDING.—

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

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

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

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

SEC. 137. IMAGING PROVISIONS.

(a) ACCREDITATION REQUIREMENT.—

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

is amended by inserting after subsection (d) the following new subsection:

''(e) ACCREDITATION REQUIREMENT FOR ADVANCED DIAGNOSTIC IMAGING SERVICES.—

''(1) IN GENERAL.—

''(A) IN GENERAL.—Beginning with January 1, 2012, with respect to the technical component of advanced diagnostic imaging services for which payment is made under the fee schedule established under section 1848(b) and that are furnished by a supplier, payment may only be made if such supplier is accredited by an accreditation organization designated by the Secretary under paragraph (2)(B)(i).

''(B) ADVANCED DIAGNOSTIC IMAGING SERVICES DEFINED.—In this subsection, the term 'advanced diagnostic imaging services' includes diagnostic magnetic resonance imaging, computed tomography, nuclear medicine (including positron emission tomography), and such other diagnostic imaging services described in section 1848(b)(4)(B) (excluding X-ray, ultrasound, and fluoroscopy) as specified by the Secretary, in consultation with physician specialty organizations and other stakeholders.

''(C) SUPPLIER DEFINED.—In this subsection, the term 'supplier' has the meaning given such term in section 1861(d).

''(2) ACCREDITATION ORGANIZATIONS.—

''(A) FACTORS FOR DESIGNATION OF ACCREDITATION ORGANIZATIONS.—The Secretary shall consider the following factors in designating accreditation organizations under subparagraph (B)(i) and in reviewing and modifying the list of accreditation organizations designated pursuant to subparagraph (C):

''(i) The ability of the organization to conduct timely reviews of accreditation applications.

''(ii) Whether the organization has established a process for the timely integration of new advanced diagnostic imaging services into the organization's accreditation program.

''(iii) Whether the organization uses random site visits, site audits, or other strategies for ensuring accredited suppliers maintain adherence to the criteria described in paragraph (3).

''(iv) The ability of the organization to take into account the capacities of suppliers located in a rural area (as defined in section 1886(d)(2)(D)).

''(v) Whether the organization has established reasonable fees to be charged to suppliers applying for accreditation.

''(vi) Such other factors as the Secretary determines appropriate.

''(B) DESIGNATION.—Not later than January 1, 2010, the Secretary shall designate organizations to accredit suppliers furnishing the technical component of advanced diagnostic imaging services. The list of accreditation organizations so designated may be modified pursuant to subparagraph (C).

''(C) REVIEW AND MODIFICATION OF LIST OF ACCREDITATION ORGANIZATIONS.—

''(i) IN GENERAL.—The Secretary shall review the list of accreditation organizations designated under subparagraph (B) taking into account the factors under subparagraph (A). Taking into account the results of such review, the Secretary may, by regulation, modify the list of accreditation

organizations designated under subparagraph (B).

''(ii) SPECIAL RULE FOR ACCREDITATIONS DONE PRIOR TO REMOVAL FROM LIST OF DESIGNATED ACCREDITATION ORGANIZATIONS.—In the case where the Secretary removes an organization from the list of accreditation organizations designated under subparagraph (B), any supplier that is accredited by the organization during the period beginning on the date on which the organization is designated as an accreditation organization under subparagraph (B) and ending on the date on which the organization is removed from such list shall be considered to have been accredited by an organization designated by the Secretary under subparagraph (B) for the remaining period such accreditation is in effect.

''(3) CRITERIA FOR ACCREDITATION.—The Secretary shall establish procedures to ensure that the criteria used by an accreditation organization designated under paragraph (2)(B) to evaluate a supplier that furnishes the technical component of ad-

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

"(A) standards for qualifications of medical personnel who are not physicians and who furnish the technical component of advanced diagnostic imaging services;

"(B) standards for qualifications and responsibilities of medical directors and supervising physicians, including standards that recognize the considerations described in paragraph (4);

"(C) procedures to ensure that equipment used in furnishing the technical component of advanced diagnostic imaging services meets performance specifications;

"(D) standards that require the supplier have procedures in place to ensure the safety of persons who furnish the technical component of advanced diagnostic imaging services and individuals to whom such services are furnished;

"(E) standards that require the establishment and maintenance of a quality assurance and quality control program by the supplier that is adequate and appropriate to ensure the

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

''(F) any other standards or procedures the Secretary determines appropriate.

''(4) RECOGNITION IN STANDARDS FOR THE EVALUATION OF MEDICAL DIRECTORS AND SUPERVISING PHYSICIANS.—The standards described in paragraph (3)(B) shall recognize whether a medical director or supervising physician—

''(A) in a particular specialty receives training in advanced diagnostic imaging services in a residency program;

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

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

''(D) has met such other standards as the Secretary determines appropriate.

''(5) RULE FOR ACCREDITATIONS MADE PRIOR TO DESIGNATION.—In the case of a supplier that is accredited before January 1, 2010, by an accreditation organization designated by the Secretary under paragraph (2)(B) as of January 1, 2010, such sup-

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

(2) CONFORMING AMENDMENTS.—

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

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

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

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

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

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

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

(b) DEMONSTRATION PROJECT TO ASSESS THE APPROPRIATE USE OF IMAGING SERVICES.—

(1) CONDUCT OF DEMONSTRATION PROJECT.—

(A) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall conduct a demonstration project using the models described in paragraph (2)(E) to collect data regarding physician compliance with appropriateness criteria selected under paragraph (2)(D) in order to determine the appropriateness of advanced diagnostic imaging services furnished to Medicare beneficiaries.

(B) ADVANCED DIAGNOSTIC IMAGING SERVICES.—In this subsection, the term ''advanced diagnostic imaging services'' has the meaning given such term in section 1834(e)(1)(B) of the Social Security Act, as added by subsection (a).

(C) AUTHORITY TO FOCUS DEMONSTRATION PROJECT.—The Secretary may focus the demonstration project with respect to certain advanced diagnostic imaging services, such as

services that account for a large amount of expenditures under the Medicare program, services that have recently experienced a high rate of growth, or services for which appropriateness criteria exists.

(2) IMPLEMENTATION AND DESIGN OF DEMONSTRATION PROJECT.—

(A) IMPLEMENTATION AND DURATION.—

(i) IMPLEMENTATION.—The Secretary shall implement the demonstration project under this subsection not later than January 1, 2010.

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

(B) APPLICATION AND SELECTION OF PARTICIPATING PHYSICIANS.—

(i) APPLICATION.—Each physician that desires to participate in the demonstration project under this subsection shall submit an application to the Secretary at such time, in such manner, and containing such information as the Secretary may require.

(ii) SELECTION.—The Secretary shall select physicians to participate in the demonstration project under this subsection from among physicians submitting applications under clause (i). The Secretary shall ensure that the physicians selected—

(I) represent a wide range of geographic areas, demographic characteristics (such as urban, rural, and suburban), and practice settings (such as private and academic practices); and

(II) have the capability to submit data to the Secretary (or an entity under a subcontract with the Secretary) in an electronic format in accordance with standards established by the Secretary.

(C) ADMINISTRATIVE COSTS AND INCENTIVES.—The Secretary shall—

(i) reimburse physicians for reasonable administrative costs incurred in participating in the demonstration project under this subsection; and

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

the demonstration project under this subsection.

(D) USE OF APPROPRIATENESS CRITERIA.—

(i) IN GENERAL.—The Secretary, in consultation with medical specialty societies and other stakeholders, shall select criteria with respect to the clinical appropriateness of advanced diagnostic imaging services for use in the demonstration project under this subsection.

(ii) CRITERIA SELECTED.—Any criteria selected under clause (i) shall—

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

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

(E) MODELS FOR COLLECTING DATA REGARDING PHYSICIAN COMPLIANCE WITH SELECTED CRITERIA.—Subject to subparagraph (H), in carrying out the demonstration project under this subsection, the Secretary shall use each of the following models for collecting data

regarding physician compliance with appropriateness criteria selected under subparagraph (D):

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

(ii) A model described in subparagraph (G).

(iii) Any other model that the Secretary determines to be useful in evaluating the use of appropriateness criteria for advanced diagnostic imaging services.

(F) POINT OF SERVICE MODEL DESCRIBED.—A model described in this subparagraph is a model that—

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

(I) contains a certification by the physician furnishing the imaging service that the data on the intake form was confirmed with the Medicare beneficiary before the service was furnished;

(II) contains standardized data elements for diagnosis, service ordered, service furnished, and such

other information determined by the Secretary, in consultation with medical specialty societies and other stakeholders, to be germane to evaluating the effectiveness of the use of appropriateness criteria selected under subparagraph (D); and

(III) is accessible to physicians participating in the demonstration project under this subsection in a format that allows for the electronic submission of such form; and

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

(G) POINT OF ORDER MODEL DESCRIBED.—A model described in this subparagraph is a model that—

(i) uses a computerized order-entry system that requires the transmittal of relevant supporting information at the time of referral for advanced diagnostic imaging services and provides automated decision-support feedback to the referring physician regarding the appropriateness of furnishing such imaging services; and

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

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

(i) as a model for collecting data regarding physician compliance with appropriateness criteria selected under subparagraph (D) under the demonstration project under this subsection; or

(ii) under any model used for collecting such data under the demonstration project.

(I) REQUIRED CONTRACTS AND PERFORMANCE STANDARDS FOR CERTAIN ENTITIES.—

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

(ii) PERFORMANCE STANDARDS.—The Secretary shall establish and enforce performance standards for such entities under the contracts entered into under clause (i), including performance standards with respect to—

(I) the satisfaction of Medicare beneficiaries who are furnished advanced diagnostic imaging services by a physician participating in the demonstration project;

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

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

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

(3) COMPARISON OF UTILIZATION OF ADVANCED DIAGNOSTIC IMAGING SERVICES AND FEEDBACK REPORTS.—

(A) COMPARISON OF UTILIZATION OF ADVANCED DIAGNOSTIC IMAGING SERVICES.—The Secretary shall consult with medical specialty societies and other stakeholders to develop mechanisms for comparing the utilization of advanced diagnostic imaging services by physicians participating in the demonstration project under this subsection against—

(i) the appropriateness criteria selected under paragraph (2)(D); and

(ii) to the extent feasible, the utilization of such services by physicians not participating in the demonstration project.

(B) FEEDBACK REPORTS.—The Secretary shall, in consultation with medical specialty societies and other stakeholders, develop mechanisms to provide feedback reports to physicians participating in the demonstration project under this subsection. Such feedback reports shall include—

(i) a profile of the rate of compliance by the physician with appropriateness criteria selected under paragraph (2)(D), including a comparison of—

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

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

(ii) to the extent feasible, a comparison of—

(I) the rate of utilization of advanced diagnostic imaging services by the physician; and

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

(4) CONDUCT OF DEMONSTRATION PROJECT AND WAIVER.—

(A) CONDUCT OF DEMONSTRATION PROJECT.—Chapter 35 of title 44, United States Code, shall not apply to the conduct of the demonstration project under this subsection.

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

(5) EVALUATION AND REPORT.—

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

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

(ii) assess the performance of entities under a contract entered into under paragraph (2)(I)(i);

(iii) analyze data—

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

(II) on patterns and trends in the appropriateness and inappropriateness of such services furnished by such physicians;

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

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

(iv) address—

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

ceptable and outlier levels of performance with respect to the appropriateness of advanced diagnostic imaging services furnished;

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

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

(IV) whether, under such an expansion, physicians who demonstrate consistent compliance with such appropriateness criteria should be exempted from certain requirements;

(V) the use of incident-specific versus practice-specific outlier information in formulating future recommendations with respect to the use of appropriateness criteria for such services under the Medicare program; and

(VI) the potential for using methods (including financial incentives), in addition to those used under the models under the demonstration project, to ensure compliance with such criteria.

(B) REPORT.—Not later than 1 year after the completion of the demonstration project under this subsection, the Secretary shall submit to Congress a report containing the results of the evaluation of the demonstration project conducted under subparagraph (A), together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

(6) FUNDING.—The Secretary shall provide for the transfer from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of $10,000,000, for carrying out the demonstration project under this subsection (including costs associated with administering the demonstration project, reimbursing physicians for administrative costs and providing incentives to encourage participation under paragraph (2)(C), entering into contracts under

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

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

(1) IN GENERAL.—Section 1877(b)(2) of the Social Security Act (42 U.S.C. 1395nn(b)(2)) is amended by adding at the end the following new sentence: ''Such requirements shall, with respect to magnetic resonance imaging, computed tomography, positron emission tomography, and any other designated health services specified under subsection (h)(6)(D) that the Secretary determines appropriate, include a requirement that the referring physician inform the individual in writing at the time of the referral that the individual may obtain the services for which the individual is being referred from a person other than a person described in subparagraph (A)(i) and provide such individual with a written list of suppliers (as defined in section 1861(d)) who furnish such services in the area in which such individual resides.''.

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

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

(1) STUDY.—

(A) IN GENERAL.—The Comptroller General of the United States (in this subsection referred to as the ''Comptroller General'') shall conduct a study, by imaging modality, on—

(i) the effect of the accreditation requirement under section 1834(e) of the Social Security Act, as added by subsection (a); and

(ii) any other relevant questions involving access to, and the value of, advanced diagnostic imaging services for Medicare beneficiaries.

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

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

(ii) The cost of such accreditation requirement, including costs to facilities of compliance with such requirement and

costs to the Secretary of administering such requirement.

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

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

(2) REPORTS.—

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

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

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

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

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

SEC. 139. EXTENSION OF EXCEPTIONS PROCESS FOR MEDICARE THERAPY CAPS.

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

SEC. 140. SPEECH-LANGUAGE PATHOLOGY SERVICES.

(a) IN GENERAL.—Section 1861(ll) of the Social Security Act (42 U.S.C. 1395x(ll)) is amended—

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

(2) by inserting after paragraph (1) the following new paragraph:

''(2) The term 'outpatient speech-language pathology services' has the meaning given the term 'outpatient physical therapy services' in subsection (p), except that in applying such subsection—

''(A) 'speech-language pathology' shall be substituted for 'physical therapy' each place it appears; and

''(B) 'speech-language pathologist' shall be substituted for 'physical therapist' each place it appears.''.

(b) CONFORMING AMENDMENTS.—

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

(A) by striking ''and outpatient'' and inserting '', outpatient''; and

(B) by inserting before the semicolon at the end the following: '', and outpatient speech-language pathology services (other than services to which the second sentence of section 1861(p) applies through the application of section 1861(ll)(2))''.

(2) Subparagraphs (A) and (B) of section 1833(a)(8) of such Act (42 U.S.C. 1395l(a)(8)) are each amended by striking ''(which includes outpatient speech-language pathology services)'' and inserting '', outpatient speech-language pathology services,''.

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

(A) by inserting ''and speech-language pathology services of the type described in such

section through the application of section 1861(ll)(2)'' after ''1861(p)''; and

(B) by inserting ''and speech-language pathology services'' after ''and physical therapy services''.

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

(A) by striking ''section 1861(g)'' and inserting ''subsection (g) or (ll)(2) of section 1861'' each place it appears; and

(B) by inserting ''or outpatient speech-language pathology services, respectively'' after ''occupational therapy services''.

(5) Section 1861(p) of such Act (42 U.S.C. 1395x(p)) is amended by striking the fourth sentence.

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

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

(A) by striking ''outpatient occupational therapy services or outpatient physical therapy services'' and inserting ''outpatient physical

therapy services, outpatient speech-language pathology services, or outpatient occupational therapy services''; and

(B) by striking ''section 1861(g)'' and inserting ''subsection (g) or (ll)(2) of section 1861''.

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

(A) by striking ''section 1861(g)'' and inserting ''subsection (g) or (ll)(2) of section 1861'' the first two places it appears;

(B) by striking ''defined) or'' and inserting ''defined),''; and

(C) by inserting before the semicolon at the end the following: '', or (through the operation of section 1861(ll)(2)) with respect to the furnishing of outpatient speech-language pathology''.

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

''(L) Outpatient speech-language pathology services.''.

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

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

SEC. 141. COVERAGE OF ITEMS AND SERVICES UNDER A CARDIAC REHABILITATION PROGRAM AND A PULMONARY REHABILITATION PROGRAM.

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

(1) in subsection (s)(2)—

(A) in subparagraph (Z), by striking ''and'' at the end;

(B) in subparagraph (AA), by striking the period at the end and inserting ''; and''; and

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

''(BB) items and services furnished under a cardiac rehabilitation program (as defined in

subsection (ddd)) or under a pulmonary rehabilitation program (as defined in subsection (eee)).''; and

(2) by adding at the end the following new subsections:

''Cardiac Rehabilitation Program

''(ddd)(1) The term 'cardiac rehabilitation program' means a physician-supervised program (as described in paragraph (2)) that furnishes the items and services described in paragraph (3).

''(2) A program described in this paragraph is a program under which—

''(A) items and services under the program are delivered—

''(i) in a physician's office;

''(ii) in a physician-directed clinic; or

''(iii) in a hospital on an outpatient basis;

''(B) a physician is immediately available and accessible for medical consultation and medical emergencies at all times items and services are being furnished under the program, except that, in the case of items and services furnished under such a program in a hospital, such availability shall be presumed; and

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

''(i) the individual's diagnosis;

''(ii) the type, amount, frequency, and duration of the items and services furnished under the plan; and

''(iii) the goals set for the individual under the plan.

''(3) The items and services described in this paragraph are—

''(A) physician-prescribed exercise;

''(B) cardiac risk factor modification, including education, counseling, and behavioral intervention (to the extent such education, counseling, and behavioral intervention is closely related to the individual's care and treatment and is tailored to the individual's needs);

''(C) psychosocial assessment;

''(D) outcomes assessment; and

''(E) such other items and services as the Secretary may determine, but only if such items and services are—

''(i) reasonable and necessary for the diagnosis or active treatment of the individual's condition;

''(ii) reasonably expected to improve or maintain the individual's condition and functional level; and

''(iii) furnished under such guidelines relating to the frequency and duration of such items and services as the Secretary shall establish, taking into account accepted norms of medical practice and the reasonable expectation of improvement of the individual.

''(4) The Secretary shall establish standards to ensure that a physician with expertise in the management of individuals with cardiac pathophysiology who is licensed to practice medicine in the State in which a cardiac rehabilitation program is offered—

''(A) is responsible for such program; and

''(B) in consultation with appropriate staff, is involved substantially in directing the progress of individual patients in the program.

''Pulmonary Rehabilitation Program

''(eee)(1) The term 'pulmonary rehabilitation program' means a physician-supervised program (as described in subsection (ddd)(2) with respect to a program

under this subsection) that furnishes the items and services described in paragraph (2).

''(2) The items and services described in this paragraph are—

''(A) physician-prescribed exercise;

''(B) education or training (to the extent the education or training is closely and clearly related to the individual's care and treatment and is tailored to such individual's needs);

''(C) psychosocial assessment;

''(D) outcomes assessment; and

''(E) such other items and services as the Secretary may determine, but only if such items and services are—

''(i) reasonable and necessary for the diagnosis or active treatment of the individual's condition;

''(ii) reasonably expected to improve or maintain the individual's condition and functional level; and

''(iii) furnished under such guidelines relating to the frequency and duration of such items and services as the Secretary shall establish, taking into account accepted norms of

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

''(3) The Secretary shall establish standards to ensure that a physician with expertise in the management of patients with respiratory pathophysiology who is licensed to practice medicine in the State in which a pulmonary rehabilitation program is offered—

''(A) is responsible for such program; and

''(B) in consultation with appropriate staff, is involved substantially in directing the progress of individual patients in the program.''.

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

SEC. 142. REPEAL OF TRANSFER OF OWNERSHIP OF OXYGEN EQUIPMENT.

(a) IN GENERAL.—Section 1834(a)(5)(F) of the Social Security Act (42 U.S.C. 1395m(a)(5)(F)) is amended—

(1) in the heading, by striking ''OWNERSHIP OF EQUIPMENT'' and inserting ''RENTAL CAP''; and

(2) by striking clause (ii) and inserting the following:

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

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

''(I) the supplier furnishing such equipment under this subsection shall continue to furnish the equipment during any period of medical need for the remainder of the reasonable useful lifetime of the equipment, as determined by the Secretary;

''(II) payments for oxygen shall continue to be made in the amount recognized for oxygen under paragraph (9) for the period of medical need; and

''(III) maintenance and servicing payments shall, if the Secretary determines such payments are reasonable and necessary, be made (for parts and labor not covered by the supplier's or manufacturer's warranty, as determined by the Secretary to be appropriate for the equipment), and such payments shall be in an amount determined to be appropriate by the Secretary.''.

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

SEC. 143. EXTENSION OF PAYMENT RULE FOR BRACHYTHERAPY AND THERAPEUTIC RADIOPHARMACEUTICALS.

Section 1833(t)(16)(C) of the Social Security Act (42 U.S.C. 1395l(t)(16)(C)), as amended by section 106 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended by striking ''July 1, 2008'' each place it appears and inserting ''January 1, 2010''.

SEC. 144. CLINICAL LABORATORY TESTS.

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

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

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

(A) by inserting ''or'' before ''(ii)''; and

(B) by striking ''or (iii) on the basis'' and all that follows before the comma at the end.

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

(b) CLINICAL LABORATORY TEST FEE SCHEDULE UPDATE ADJUSTMENT.—Section 1833(h)(2)(A)(i) of the Social Security Act (42 U.S.C. 1395l(h)(2)(A)(ii)) is amended by inserting ''minus, for each of the years 2009 through 2013, 0.5 percentage points'' after ''city average)''.

SEC. 145. SENSE OF THE SENATE ON DELAYED IMPLEMENTATION OF COMPETITIVE BIDDING FOR DURABLE MEDICAL EQUIPMENT, PROSTHETICS, ORTHOTICS, AND SUPPLIES (DMEPOS).

It is the Sense of the Senate that—

(1) the implementation of the durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) competitive bidding program under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) should be delayed by 18 months in order to review and address ongoing concerns about the bidding process and to ensure continued access to quality medical equipment and supplies for all Medicare beneficiaries; and

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

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

Subtitle D—End Stage Renal Disease Program Reforms

SEC. 151. KIDNEY DISEASE EDUCATION AND AWARENESS PROVISIONS.

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

"SEC. 399R. CHRONIC KIDNEY DISEASE INITIATIVES.

''(a) IN GENERAL.—The Secretary may establish pilot projects to—

''(1) increase awareness regarding chronic kidney disease, focusing on prevention;

''(2) increase screening for chronic kidney disease, focusing on Medicare beneficiaries at risk of chronic kidney disease; and

''(3) enhance surveillance systems to better assess the prevalence and incidence of chronic kidney disease.

''(b) SCOPE AND DURATION.—

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

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

''(c) EVALUATION AND REPORT.—The Comptroller General of the United States shall conduct an evaluation of the pilot projects conducted under this section. Not later than 12 months after the date on which the pilot projects are completed, the Comptroller General shall submit to Congress a report on the evaluation.''.

(b) MEDICARE COVERAGE OF KIDNEY DISEASE PATIENT EDUCATION SERVICES.—

(1) COVERAGE OF KIDNEY DISEASE EDUCATION SERVICES.—

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

(i) in subparagraph (AA), by striking ''and'' after the semicolon at the end;

(ii) in subparagraph (BB), by adding ''and'' after the semicolon at the end; and

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

''(CC) kidney disease education services (as defined in subsection (fff));''.

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

''Kidney Disease Education Services

''(fff)(1) The term 'kidney disease education services' means educational services that are—

''(A) furnished to an individual with stage IV chronic kidney disease who, according to accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant;

''(B) furnished, upon the referral of the physician managing the individual's kidney condition, by a qualified person (as defined in paragraph (2)); and

''(C) designed—

''(i) to provide comprehensive information (consistent with the standards set under paragraph (3)) regarding—

''(I) the management of comorbidities, including for purposes of delaying the need for dialysis;

''(II) the prevention of uremic complications; and

"(III) each option for renal replacement therapy (including hemodialysis and peritoneal dialysis at home and in-center as well as vascular access options and transplantation);

"(ii) to ensure that the individual has the opportunity to actively participate in the choice of therapy; and

"(iii) to be tailored to meet the needs of the individual involved.

"(2) The term 'qualified person' means—

"(A) a physician (as defined in section 1861(r)(1)) or a physician assistant, nurse practitioner, or clinical nurse specialist (as defined in section 1861(aa)(5)), who furnishes services for which payment may be made under the fee schedule established under section 1848; and

"(B) a renal dialysis facility subject to the requirements of section 1881(b)(1) with personnel who—

"(i) provide the services described in paragraph (1); and

"(ii) meet the requirements of subparagraph (A).

''(3) The Secretary shall set standards for the content of such information to be provided under paragraph (1)(C)(i) after consulting with physicians, other health professionals, health educators, professional organizations, accrediting organizations, kidney patient organizations, dialysis facilities, transplant centers, network organizations described in section 1881(c)(2), and other knowledgeable persons. To the extent possible the Secretary shall consult with persons or entities described in the previous sentence, other than a dialysis facility, that has not received industry funding from a drug or biological manufacturer or dialysis facility.

''(4) No individual shall be furnished more than 6 sessions of kidney disease education services under this title.''.

(C) PAYMENT UNDER THE PHYSICIAN FEE SCHEDULE.—Section 1848(j)(3) of the Social Security Act (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(2)(CC),'' after ''(2)(AA),''.

(D) LIMITATION ON NUMBER OF SESSIONS.—Section 1862(a)(1) of the Social Security Act (42 U.S.C. 1395y(a)(1)) is amended—

(i) in subparagraph (M), by striking ''and'' at the end;

(ii) in subparagraph (N), by striking the semicolon at the end and inserting ", and"; and

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

"(O) in the case of kidney disease education services (as defined in paragraph (1) of section 1861(fff)), which are furnished in excess of the number of sessions covered under paragraph (4) of such section;".

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

SEC. 152. RENAL DIALYSIS PROVISIONS.

(a) COMPOSITE RATE.—

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

(A) in clause (i), by striking "and" at the end;

(B) in clause (ii)—

(i) by inserting "and before January 1, 2009," after "April 1, 2007,"; and

(ii) by striking the period at the end and inserting "; and"; and

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

''(iii) furnished on or after January 1, 2009, and before January 1, 2010, by 1.0 percent above the amount of such composite rate component for such services furnished on December 31, 2008; and

''(iv) furnished on or after January 1, 2010, by 1.0 percent above the amount of such composite rate component for such services furnished on December 31, 2009.''.

(2) SITE NEUTRAL COMPOSITE RATE.—Section 1881(b)(12)(A) of the Social Security Act (42 U.S.C. 1395rr(b)(12)(A)) is amended by adding at the end the following new sentence: ''Under such system, the payment rate for dialysis services furnished on or after January 1, 2009, by providers of services shall be the same as the payment rate (computed without regard to this sentence) for such services furnished by renal dialysis facilities, and in applying the geographic index under subparagraph (D) to providers of services, the labor share shall be based on the labor share otherwise applied for renal dialysis facilities.''.

(b) DEVELOPMENT OF ESRD BUNDLED PAYMENT SYSTEM.—

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

''(14)(A)(i) Subject to subparagraph (E), for services furnished on or after January 1, 2011, the Secretary shall implement a payment system under which a single payment is made under this title to a provider of services or a renal dialysis facility for renal dialysis services (as defined in subparagraph (B)) in lieu of any other payment (including a payment adjustment under paragraph (12)(B)(ii)) and for such services and items furnished pursuant to paragraph (4).

''(ii) In implementing the system under this paragraph the Secretary shall ensure that the estimated total amount of payments under this title for 2011 for renal dialysis services shall equal 98 percent of the estimated total amount of payments for renal dialysis services, including payments under paragraph (12)(B)(ii), that would have been made under this title with respect to services furnished in 2011 if such system had not been implemented. In making such estimation, the Secretary shall use per patient utilization data from 2007, 2008, or 2009, whichever has the lowest per patient utilization.

''(B) For purposes of this paragraph, the term 'renal dialysis services' includes—

''(i) items and services included in the composite rate for renal dialysis services as of December 31, 2010;

''(ii) erythropoiesis stimulating agents and any oral form of such agents that are furnished to individuals for the treatment of end stage renal disease;

''(iii) other drugs and biologicals that are furnished to individuals for the treatment of end stage renal disease and for which payment was (before the application of this paragraph) made separately under this title, and any oral equivalent form of such drug or biological; and

''(iv) diagnostic laboratory tests and other items and services not described in clause (i) that are furnished to individuals for the treatment of end stage renal disease.

Such term does not include vaccines.

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

''(D) Such system—

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

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

''(ii) shall include a payment adjustment for high cost outliers due to unusual variations in the type or amount of medically necessary care, including variations in the amount of erythropoiesis stimulating agents necessary for anemia management;

''(iii) shall include a payment adjustment that reflects the extent to which costs incurred by rural, low-volume providers and facilities (as defined by the Secretary) in furnishing renal dialysis services exceed the costs incurred by other providers and facilities in furnishing such services, and for payment for renal dialysis services furnished on or after January 1, 2011, and before January 1, 2014, such payment adjustment shall not be less than 10 percent; and

''(iv) may include such other payment adjustments as the Secretary determines appropriate, such as a payment adjustment—

''(I) for pediatric providers of services and renal dialysis facilities; and

''(II) for providers of services or renal dialysis facilities located in rural areas.

The Secretary shall take into consideration the unique treatment needs of children and young adults in establishing such system.

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

''(ii) A provider of services or renal dialysis facility may make a one-time election to be excluded from the phase-in under clause (i) and be paid entirely based on the payment amount under the payment system under this paragraph. Such an election shall be made prior to January 1, 2011, in a form and manner specified by the Secretary, and is final and may not be rescinded.

''(iii) The Secretary shall make an adjustment to the payments under this paragraph for years during which the phase-in under clause (i) is applicable so that the estimated total amount of payments under this paragraph, including payments under this subparagraph, shall equal the estimated total amount of payments that would otherwise occur under this paragraph without such phase-in.

''(F)(i) Subject to clause (ii), beginning in 2012, the Secretary shall annually increase payment amounts established under this paragraph by an ESRD market basket

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

''(ii) For years during which a phase-in of the payment system pursuant to subparagraph (E) is applicable, the following rules shall apply to the portion of the payment under the system that is based on the payment of the composite rate that would otherwise apply if the system under this paragraph had not been enacted:

''(I) The update under clause (i) shall not apply.

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

''(G) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise of the determination of payment amounts under subparagraph (A), the establishment of an appropriate unit of payment under subparagraph (C), the identification of renal dialysis services included in the bundled payment, the adjustments under subparagraph (D), the application of the

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

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

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

''(ii) included in subparagraph (B) for purposes of payment under this paragraph.''.

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

(A) in paragraph (22), by striking ''or'' at the end;

(B) in paragraph (23), by striking the period at the end and inserting ''; or''; and

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

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

tion to a provider of services or a renal dialysis facility for such services.''.

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

(i) in paragraph (12)(A), by striking ''In lieu of payment'' and inserting ''Subject to paragraph (14), in lieu of payment'';

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

(I) by inserting ''or paragraph (14)'' after ''this paragraph''; and

(II) by inserting ''or under the system under paragraph (14)'' after ''subparagraph (B)''; and

(iii) in paragraph (13)—

(I) in subparagraph (A), in the matter preceding clause (i), by striking ''The payment amounts'' and inserting ''Subject to paragraph (14), the payment amounts''; and

(II) in subparagraph (B)—

(aa) in clause (i), by striking ''(i)'' after ''(B)'' and by inserting '',

subject to paragraph (14)'' before the period at the end; and

(bb) by striking clause (ii).

(B) Section 1861(s)(2)(F) of the Social Security Act (42 U.S.C. 1395x(s)(2)(F)) is amended by inserting '', and, for items and services furnished on or after January 1, 2011, renal dialysis services (as defined in section 1881(b)(14)(B))'' before the semicolon at the end.

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

(4) RULE OF CONSTRUCTION.—Nothing in this subsection or the amendments made by this subsection shall be construed as authorizing or requiring the Secretary of Health and Human Services to make payments under the payment system implemented under paragraph (14)(A)(i) of section 1881(b) of the Social Security Act (42 U.S.C. 1395rr(b)), as added by paragraph (1), for any unrecovered amount for any bad debt attributable to deductible and coinsurance on items and services not included in the basic case-mix adjusted composite rate under paragraph (12) of such section as in effect before the date of the enactment of this Act.

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

''(h) QUALITY INCENTIVES IN THE END-STAGE RENAL DISEASE PROGRAM.—

''(1) QUALITY INCENTIVES.—

''(A) IN GENERAL.—With respect to renal dialysis services (as defined in subsection (b)(14)(B)) furnished on or after January 1, 2012, in the case of a provider of services or a renal dialysis facility that does not meet the requirement described in subparagraph (B) with respect to the year, payments otherwise made to such provider or facility under the system under subsection (b)(14) for such services shall be reduced by up to 2.0 percent, as determined appropriate by the Secretary.

''(B) REQUIREMENT.—The requirement described in this subparagraph is that the provider or facility meets (or exceeds) the total performance score under paragraph (3) with respect to performance standards established by the Secretary with respect to measures specified in paragraph (2).

''(C) NO EFFECT IN SUBSEQUENT YEARS.—The reduction under subparagraph (A) shall apply only with respect to the year involved, and the Secretary shall not take into account such reduction in computing the single payment amount under the system under paragraph (14) in a subsequent year.

''(2) MEASURES.—

''(A) IN GENERAL.—The measures specified under this paragraph with respect to the year involved shall include—

''(i) measures on anemia management that reflect the labeling approved by the Food and Drug Administration for such management and measures on dialysis adequacy;

''(ii) to the extent feasible, such measure (or measures) of patient satisfaction as the Secretary shall specify; and

''(iii) such other measures as the Secretary specifies, including, to the extent feasible, measures on—

''(I) iron management; and

"(II) vascular access, including for maximizing the placement of arterial venous fistula.

"(B) USE OF ENDORSED MEASURES.—

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

"(ii) EXCEPTION.—In the case of a specified area or medical topic determined appropriate by the Secretary for which a feasible and practical measure has not been endorsed by the entity with a contract under section 1890(a), the Secretary may specify a measure that is not so endorsed as long as due consideration is given to measures that have been endorsed or adopted by a consensus organization identified by the Secretary.

"(C) UPDATING MEASURES.—The Secretary shall establish a process for updating the measures specified under subparagraph (A) in consultation with interested parties.

''(D) CONSIDERATION.—In specifying measures under subparagraph (A), the Secretary shall consider the availability of measures that address the unique treatment needs of children and young adults with kidney failure.

''(3) PERFORMANCE SCORES.—

''(A) TOTAL PERFORMANCE SCORE.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary shall develop a methodology for assessing the total performance of each provider of services and renal dialysis facility based on performance standards with respect to the measures selected under paragraph (2) for a performance period established under paragraph (4)(D) (in this subsection referred to as the 'total performance score').

''(ii) APPLICATION.—For providers of services and renal dialysis facilities that do not meet (or exceed) the total performance score established by the Secretary, the Secretary shall ensure that the application of the methodology developed under clause (i) results in an appropriate distribution of reductions in payment under paragraph (1)

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

''(B) PERFORMANCE SCORE WITH RESPECT TO INDIVIDUAL MEASURES.—The Secretary shall also calculate separate performance scores for each measure, including for dialysis adequacy and anemia management.

''(4) PERFORMANCE STANDARDS.—

''(A) ESTABLISHMENT.—Subject to subparagraph (E), the Secretary shall establish performance standards with respect to measures selected under paragraph (2) for a performance period with respect to a year (as established under subparagraph (D)).

''(B) ACHIEVEMENT AND IMPROVEMENT.—The performance standards established under subparagraph (A) shall include levels of achievement and improvement, as determined appropriate by the Secretary.

''(C) TIMING.—The Secretary shall establish the performance standards under subpara-

graph (A) prior to the beginning of the performance period for the year involved.

''(D) PERFORMANCE PERIOD.—The Secretary shall establish the performance period with respect to a year. Such performance period shall occur prior to the beginning of such year.

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

''(A) The determination of the amount of the payment reduction under paragraph (1).

''(B) The establishment of the performance standards and the performance period under paragraph (4).

''(C) The specification of measures under paragraph (2).

''(D) The methodology developed under paragraph (3) that is used to calculate total performance scores and performance scores for individual measures.

''(6) PUBLIC REPORTING.—

''(A) IN GENERAL.—The Secretary shall establish procedures for making information regarding performance under this subsection available to the public, including—

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

''(ii) the performance score achieved by the provider or facility with respect to individual measures.

''(B) OPPORTUNITY TO REVIEW.—The procedures established under subparagraph (A) shall ensure that a provider of services and a renal dialysis facility has the opportunity to review the information that is to be made public with respect to the provider or facility prior to such data being made public.

''(C) CERTIFICATES.—

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

ance score achieved by the provider or facility under paragraph (3).

''(ii) DISPLAY.—Each facility or provider receiving a certificate under clause (i) shall prominently display the certificate at the provider or facility.

''(D) WEB-BASED LIST.—The Secretary shall establish a list of providers of services and renal dialysis facilities who furnish renal dialysis services under this section that indicates the total performance score and the performance score for individual measures achieved by the provider and facility under paragraph (3). Such information shall be posted on the Internet website of the Centers for Medicare & Medicaid Services in an easily understandable format.''.

(d) GAO REPORT ON ESRD BUNDLING SYSTEM AND QUALITY INITIATIVE.—Not later than April 1, 2012, the Comptroller General of the United States shall submit to Congress a report on the implementation of the payment system under subsection (b)(14) of section 1881 of the Social Security Act (as added by subsection (b)) for renal dialysis services and related services (defined in subparagraph (B) of such subsection (b)(14)) and the quality initiative under subsection (h) of such section 1881 (as

added by subsection (b)). Such report shall include the following information:

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

(2) The mode of administering such agents, including information on the proportion of individuals receiving such agents intravenously as compared to subcutaneously.

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

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

Subtitle E—Provisions Relating to Part C

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

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

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (4)''; and

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

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

''(A) IN GENERAL.—After determining the applicable amount for an area for a year under paragraph (1) (beginning with 2010), the Secretary shall adjust such applicable amount to exclude from such applicable amount the phase-in percentage (as defined in subparagraph (B)(i)) for the year of the Secretary's estimate of the standardized costs for payments under section 1886(d)(5)(B) in the area for the year. Any adjustment under the preceding sentence shall be made prior to the application of paragraph (2).

''(B) PERCENTAGES DEFINED.—For purposes of this paragraph:

''(i) PHASE-IN PERCENTAGE.—The term 'phase-in percentage' means, for an area for a year, the ratio (expressed as a percentage, but in no case greater than 100 percent) of—

''(I) the maximum cumulative adjustment percentage for the year (as defined in clause (ii)); to

''(II) the standardized IME cost percentage (as defined in clause (iii)) for the area and year.

''(ii) MAXIMUM CUMULATIVE ADJUSTMENT PERCENTAGE.—The term 'maximum cumulative adjustment percentage' means, for—

''(I) 2010, 0.6 percent; and

''(II) a subsequent year, the maximum cumulative adjustment percentage for the previous year increased by 0.6 percentage points.

''(iii) STANDARDIZED IME COST PERCENTAGE.—The term 'standardized IME cost percentage' means, for an area for a

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

''(C) FEE-FOR-SERVICE AMOUNT.—The fee-for-service amount specified in this subparagraph for an area for a year is the amount specified under subsection (c)(1)(D) for the area and the year.''.

(b) EXCLUDING ADJUSTMENT FROM THE UPDATE.—Section 1853(k)(1)(B)(i) of the Social Security Act (42 U.S.C. 1395w–23(k)(1)(B)(i)) is amended by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (4)''.

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

''(3) CAPITATION RATES DETERMINED WITHOUT REGARD TO THE PHASE-OUT OF THE INDIRECT COSTS OF MEDICAL EDUCATION FROM THE ANNUAL MEDICARE ADVANTAGE CAPITATION RATE.—Capitation amounts under this subsection shall be deter-

mined without regard to the application of section 1853(k)(4).''.

SEC. 162. REVISIONS TO QUALITY IMPROVEMENT PROGRAMS.

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

(b) DATA COLLECTION REQUIREMENTS FOR MA REGIONAL PLANS, MA PRIVATE FEE-FOR-SERVICE PLANS, AND MSA PLANS.—

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

(A) in clause (i)—

(i) by striking ''clauses (ii) and (iii)'' and inserting ''clause (ii)''; and

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

plans that are preferred provider organization plans, except that the limitation under clause (ii) shall not apply and such requirements shall apply regardless of whether or not the services are furnished by providers of services, physicians, or other health care practitioners and suppliers that have contracts with the organization offering the MA private fee-for-service plan or the MSA plan.''

(B) by striking clause (ii);

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

(D) in clause (ii), as redesignated by subparagraph (C)—

(i) in the heading—

(I) by inserting ''LOCAL'' after ''TO''; and

(II) by inserting ''AND MA REGIONAL PLANS'' after ''ORGANIZATIONS''; and

(ii) by inserting ''and to MA regional plans'' after ''organization plans''.

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

(A) in clause (ii), by striking ''subclause (iii)'' and inserting ''clauses (iii) and (iv)''; and

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

''(iv) LIMITATION.—Notwithstanding clause (ii), with respect to MA private fee-for-service plans and MSA plans, to the extent that services are not services furnished by providers of services, physicians, or other health care practitioners and suppliers that have contracts with the organization offering the plan, the data required to be collected, analyzed, and reported under subparagraph (A)(i) shall only include administrative and beneficiary survey data.''.

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

SEC. 163. REVISIONS RELATING TO SPECIALIZED MEDICARE ADVANTAGE PLANS FOR SPECIAL NEEDS INDIVIDUALS.

(a) EXTENSION OF AUTHORITY TO RESTRICT ENROLLMENT.—Section 1859(f) of the Social Security Act (42 U.S.C. 1395w–28(f)), as amended by section 108(a) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended by striking ''2010'' and inserting ''2011''.

(b) MORATORIUM ON AUTHORITY TO DESIGNATE OTHER PLANS AS SPECIALIZED MA PLANS.—During the period beginning on January 1, 2010, and ending on December 31, 2010, the Secretary of Health and Human Services may not exercise the authority provided under section 231(d) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395w–21 note) to designate other plans as specialized MA plans for special needs individuals.

(c) REQUIREMENTS FOR ENROLLMENT.—

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

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

(B) in subsection (f)—

(i) by amending the heading to read as follows: ''PROVISIONS REGARDING SPECIALIZED MA PLANS FOR SPECIAL NEEDS INDIVIDUALS'';

(ii) by designating the sentence beginning ''In the case of'' as paragraph (1) with the heading ''RESTRICTIONS ON ENROLLMENT.—'' and with appropriate indentation; and

(iii) by adding at the end the following new paragraphs:

''(2) ADDITIONAL REQUIREMENTS FOR INSTITUTIONAL SNPS.—In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(i), the applicable requirements described in this paragraph are as follows:

''(A) Enrollment under the plan is restricted so, of the individuals who are enrolling in the plan on or after January 1, 2009, at least 90 percent of such individuals are individuals who are special needs individuals described in subsection (b)(6)(B)(i). In applying this subparagraph, in order for an individual residing in a community setting but requiring an institu-

tional level of care to be treated as an individual described in such subsection, the individual must be assessed and certified, using a State assessment tool of the State in which the individual resides, as requiring an institutional level of care.

''(B) Effective for plan years beginning on or after January 1, 2010, the plan has in place a model of care plan described in paragraph (5).

''(3) ADDITIONAL REQUIREMENTS FOR DUAL SNPS.—In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(ii), the applicable requirements described in this paragraph are as follows:

''(A) Enrollment under the plan is restricted so, of the individuals who are enrolling in the plan on or after January 1, 2009, at least 90 percent of such individuals are individuals who are special needs individuals described in subsection (b)(6)(B)(ii).

''(B) Effective for plan years beginning on or after January 1, 2010, the plan has in place a model of care plan described in paragraph (5).

''(C) Effective for plan years beginning on or after January 1, 2012, the plan has documented arrangements with the State Medicaid agency that address cooperation on coordination of the operation of the plan and the State Medicaid plan under title XIX for such special needs individuals and that include at least the following:

''(i) A means for the agency to verify an enrollee's eligibility for medical assistance under such title.

''(ii) A means to identify and share information on provider participation under such title.

''(iii) A means to supply the specialized MA plan with information on the benefits to which an individual enrolled under the State Medicaid plan and eligible for medical assistance under title XIX is entitled.

''(D) Effective for plan years beginning on or after January 1, 2010, the plan has necessary arrangements, including arrangements with providers, in order to assure that enrollees who are special needs individuals described in

subsection (b)(6)(B)(ii) are not charged or liable for cost-sharing for items and services furnished through the plan and for which they are entitled to benefits under title XIX in excess of the cost-sharing that the individuals would be charged if the individuals were enrolled under the original Medicare fee-for-service program and not under the plan.

''(E) Effective for enrollments made during or after the annual open enrollment period for the plan year beginning on the earlier of January 1, 2012 or the first plan year for which the plan reaches an agreement with the state, the plan provides each prospective enrollee described in subsection (b)(6)(B)(ii), prior to enrollment, with an accurate and easily understandable summary comparison (using a standardized format established by the Secretary) that compares—

''(i) the benefits and cost-sharing that apply to individuals entitled to benefits under a State Medicaid program under title XIX if such individuals enroll in the original Medicare fee-for-service program under Parts A and B; and

"(ii) the benefits and cost-sharing that apply to individuals entitled to benefits under a State Medicaid program under title XIX if such individuals enroll in the plan.

Such summary comparison shall be included with any description of benefits offered by the plan.

"(4) ADDITIONAL REQUIREMENTS FOR SEVERE OR DISABLING CHRONIC CONDITION SNPS.—In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(B)(iii), the applicable requirements described in this paragraph are as follows:

"(A) Enrollment under the plan is restricted so, of the individuals who are enrolling in the plan on or after January 1, 2009, at least 90 percent of such individuals are individuals who are special needs individuals described in subsection (b)(6)(B)(iii).

"(B) Effective for plan years beginning on or after January 1, 2010, the plan has in place a model of care plan described in paragraph (5).".

(2) RESOURCES FOR STATE MEDICAID AGENCIES.—The Secretary of Health and Human Services shall provide for the designation of appropriate staff and resources that can address State inquiries with respect to the coordination of State and Federal policies for specialized MA plans for special needs individuals described in subsection (b)(6)(B)(ii) of section 1859 of the Social Security Act (42 U.S.C. 1395w–28) as described in subsection (f)(3) of such section, as added by this subsection.

(3) RULE OF CONSTRUCTION.—Nothing in the provisions of, or amendments made by, this subsection shall be construed to require a State to enter into a contract or agreement with a Medicare Advantage organization with respect to such plans.

(d) MODEL OF CARE PLAN REQUIREMENT FOR ALL SNPS.—

(1) IN GENERAL.—Section 1859(f) of the Social Security Act (42 U.S.C. 1395w–28(f)), as amended by subsection (c)(1), is amended by adding at the end the following new paragraph:

''(5) MODEL OF CARE PLAN REQUIREMENT FOR ALL SNPS.—A model of care plan described in this paragraph for a specialized MA plan is a model of

care plan that specifies how the plan will coordinate and deliver care designed for the plan's enrollees. Such model shall include at least the following:

"(A) Targeting a population of special needs enrollees for whom the plan is designed.

"(B) Coordination of care for enrollees.

"(C) Inclusion of a network of providers and services with clinical expertise relevant to the targeted enrollee population.

"(D) Delivery of care based on appropriate protocols for the targeted enrollee population.

"(E) Application of performance measures to evaluate processes and outcomes of the model.

"(F) At least annually, or more often as each enrollee's situation may require, contacting each enrollee (or the enrollee's representative) and evaluating the enrollee in order to ensure that the model of care is being appropriately applied to such enrollee.".

(2) REVIEW TO ENSURE COMPLIANCE WITH MODEL OF CARE PLAN REQUIREMENTS.—Section 1857(d) of the Social Security Act (42 U.S.C. 1395w–27(d)) is amended by adding at the end the following new paragraph:

''(6) REVIEW TO ENSURE COMPLIANCE WITH MODEL OF CARE PLAN REQUIREMENTS FOR SPECIALIZED MEDICARE ADVANTAGE PLANS FOR SPECIAL NEEDS INDIVIDUALS.—In conjunction with a general compliance audit of a specialized Medicare Advantage plan for special needs individuals under paragraph (2), the Secretary shall conduct a review to ensure that such plan is in compliance with the model of care plan requirements under section 1859(f)(5).''.

(e) 1-YEAR EXTENSION OF MORATORIUM FOR CHRONIC CARE SNPS.—Section 108(b)(2) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) is amended by inserting after ''December 31, 2009'' the following: ''(or December 31, 2010, in the case of a specialized MA plan for special needs individuals described in section 1859(b)(6)(B)(iii) of the Social Security Act)''.

SEC. 164. ADJUSTMENT TO THE MEDICARE ADVANTAGE STABILIZATION FUND.

Section 1858(e)(2)(A)(i) of the Social Security Act (42 U.S.C. 1395w–27a(e)(2)(A)(i)), as amended by section 110 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended—

(1) by striking ''2013'' and inserting ''2014''; and

(2) by striking ''$1,790,000,000'' and inserting ''$1''.

SEC. 165. ACCESS TO MEDICARE REASONABLE COST CONTRACT PLANS.

(a) EXTENSION OF REASONABLE COST CONTRACTS.—Section 1876(h)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)(ii)), as amended by section 109 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173), is amended by striking ''January 1, 2009'' and inserting ''January 1, 2010'' in the matter preceding subclause (I).

(b) REVISIONS TO LIMITATION ON EXTENSION OR RENEWAL.—

(1) CLARIFICATION REGARDING USE OF COUNTIES RATHER THAN SERVICE AREAS IN APPLICATION OF PROHIBITION.—Section 1876(h)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)(ii)), in the matter preceding subclause (I), is amended by striking ''for a service area'' and all that follows through ''previous year was'' and inserting ''for a county in the service area of such contract insofar as such county during the entire previous year was entirely''.

(2) REQUIREMENT FOR AT LEAST TWO MEDICARE ADVANTAGE ORGANIZATIONS TO BE OFFERING A PLAN IN AN AREA FOR THE PROHIBITION TO BE APPLICABLE.—Subclauses (I) and (II) of section 1876(h)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)(ii)) are each amended by inserting ", provided that all such plans are not offered by the same Medicare Advantage organization" after "clause (iii)".

(c) REVISION OF REQUIREMENTS FOR PLANS THAT ARE USED TO DETERMINE IF PROHIBITION IS APPLICABLE.—Section 1876(h)(5)(C)(iii) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)(iii)) is amended—

(1) in the matter preceding subclause (I)—

(A) by inserting "portion of the plan's" after "if the"; and

(B) by inserting "that is within the service area of a reasonable cost reimbursement contract" after "for the year"; and

(2) in subclause (I)—

(A) by inserting "that are not in another Metropolitan Statistical Area with a population of more than 250,000" after "such Metropolitan Statistical Area"; and

(B) by adding at the end the following new sentence: ''If the service area includes a portion in more than 1 Metropolitan Statistical Area with a population of more than 250,000, the minimum enrollment determination under the preceding sentence shall be made with respect to each such Metropolitan Statistical Area (and such applicable contiguous counties to such Metropolitan Statistical Area).''.

(d) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study of the reasons (if any) why reasonable cost contracts under section 1876(h) of the Social Security Act (42 U.S.C. 1395mm(h)) are unable to become Medicare Advantage plans under part C of title XVIII of such Act.

(2) REPORT.—Not later than July 1, 2009, the Comptroller General of the United States shall submit a report to Congress containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

SEC. 166. MEDPAC STUDY AND REPORT ON MEDICARE ADVANTAGE PAYMENTS.

(a) STUDY.—The Medicare Payment Advisory Commission (in this section referred to as the ''Commission'') shall conduct a study of the following:

(1) The correlation between—

(A) the costs that Medicare Advantage organizations with respect to Medicare Advantage plans incur in providing coverage under the plan for items and services covered under the original Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act, as reflected in plan bids; and

(B) county-level spending under such original Medicare fee-for-service program on a per capita basis, as calculated by the Chief Actuary of the Centers for Medicare & Medicaid Services.

The study with respect to the issue described in the preceding sentence shall include differences in correlation statistics by plan type and geographic area.

(2) Based on these results of the study with respect to the issue described in paragraph (1), and other data the Commission determines appropriate—

(A) alternate approaches to achieving payment neutrality under the Medicare program with respect to a Medicare beneficiary enrolled in a Medicare Advantage plan and a Medicare beneficiary enrolled in such original Medicare fee-for-service program other than through county-level payment area equivalents, such as—

(i) blends of national average per capita spending under such original Medicare fee-for-service program and local spending under such original Medicare fee-for-service program;

(ii) price adjusting national average per capita spending under such original Medicare fee-for-service program by geography and excluding utilization factors; and

(iii) blends of national average per capita spending under such original Medicare fee-for-service program with Medicare Advantage plan bids; and

(B) the accuracy and completeness of county-level estimates of per capita spending under such original Medicare fee-for-service

program (including counties in Puerto Rico), as used to determine the annual Medicare Advantage capitation rate under section 1853 of the Social Security Act (42 U.S.C. 1395w–23), and whether such estimates include—

(i) expenditures with respect to Medicare beneficiaries at facilities of the Department of Veterans Affairs; and

(ii) all appropriate administrative expenses, including claims processing.

(3) Ways to improve the accuracy and completeness of county-level estimates of per capita spending described in paragraph (2)(B).

(b) REPORT.—Not later than December 1, 2009, the Commission shall submit a report to Congress containing the results of the study conducted under subsection (a), together with recommendations for such legislation and administrative action as the Commission determines appropriate.

SEC. 167. MARKETING OF MEDICARE ADVANTAGE PLANS AND PRESCRIPTION DRUG PLANS.

(a) PROHIBITIONS.—

(1) MEDICARE ADVANTAGE PROGRAM.—

(A) IN GENERAL.—Section 1851(h)(4) of the Social Security Act (42 U.S.C. 1395w–

21(h)(4) is amended by striking subparagraph (A) and inserting the following:

"(A) shall not permit a Medicare Advantage organization (or the marketing representatives of such an organization) to—

"(i) provide cash or other remuneration as an inducement for enrollment or otherwise;

"(ii) offer gifts, except for gifts of nominal value (as determined by the Secretary), to potential enrollees;

"(iii) provide meals, regardless of value, to potential enrollees;

"(iv) solicit door-to-door or through other unsolicited means of direct contact, including the telephone and personally approaching the beneficiary, unless the beneficiary initiates the contact;

"(v) engage in activities that mislead beneficiaries about or misrepresent the Medicare Advantage organization or the Medicare Advantage plan offered by the organization, including any activities prohibited under cobranding standards estab-

lished by the Secretary to prevent beneficiaries from being misled;

''(vi) market non-health care related products to potential enrollees during any Medicare Advantage sales activity or presentation;

''(vii) conduct a marketing appointment with a beneficiary unless the organization has a documented agreement with the beneficiary in advance of the appointment as to what health care related products will be discussed;

''(viii) conduct sales presentations or distribute and accept Medicare Advantage plan enrollment forms in health care provider offices or, under rules provided by the Secretary, other places where health care is delivered; or

''(ix) engage in any other marketing activity prohibited by the Secretary; and''.

(2) MEDICARE PRESCRIPTION DRUG PROGRAM.—Section 1860D–4 of the Social Security Act (42 U.S.C. 1395w–104) is amended by adding at the end the following new subsection:

''(l) REQUIREMENTS WITH RESPECT TO MARKETING.—The following provisions shall apply to a PDP sponsor in the same manner as such provisions apply to a Medicare Advantage organization:

''(1) The prohibitions on the conduct of certain activities under section 1851(h)(4)(A).''.

(b) ADDITIONAL MARKETING PROTECTIONS.—

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

''(6) ADDITIONAL MARKETING PROTECTIONS.—

''(A) CONFIRMATION OF MARKETING RESOURCES.—Each Medicare Advantage organization shall establish and maintain a system for confirming that individuals who are enrolled in a Medicare Advantage plan offered by the organization—

''(i) have in fact enrolled in such plan; and

''(ii) understand the rules applicable under such plan.

''(B) LICENSING OF MARKETING REPRESENTATIVES.—

''(i) IN GENERAL.—Each Medicare Advantage organization shall—

''(I) only conduct marketing activities (as defined by the Secretary) in a State through marketing representatives who are licensed by the State; and

''(II) inform the State that it has appointed those individuals as marketing representatives of the organization, consistent with the State's appointment laws, except that no appointment fees shall apply to such appointment.

''(ii) MARKETING REPRESENTATIVE DEFINED.—In this subsection, the term 'marketing representative' means an employee, agent, broker, or other third party who conducts marketing activities (as so defined) for a Medicare Advantage organization.

''(C) COMPLIANCE WITH STATE REQUESTS FOR INFORMATION.—Each Medicare Advantage organization shall comply with State requests for information about the performance of a li-

censed agent or broker as part of a State investigation into the individual's conduct.''.

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

''(2) The additional marketing protections under section 1851(h)(6).''.

(c) COMMISSIONS AND TRAINING FOR MARKETING REPRESENTATIVES.—

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

''(7) COMMISSIONS AND TRAINING FOR MARKETING REPRESENTATIVES.—

''(A) COMMISSIONS.—Not later than January 1, 2009, the Secretary shall issue rules governing commissions and, as determined appropriate by the Secretary, other compensation offered by Medicare Advantage organizations. Such rules—

''(i) shall be intended to provide marketing representatives with incentives to

recommend appropriate plan options for individual beneficiaries; and

''(ii) shall take effect on a date specified by the Secretary.

''(B) TRAINING.—Each Medicare Advantage organization shall ensure that marketing representatives who sell Medicare products are trained and tested on—

''(i) rules and regulations under the program under this title; and

''(ii) other information specific to the Medicare Advantage plan products the organization intends to sell.''.

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

''(3) The requirements with respect to commissions and training for marketing representatives under section 1851(h)(7).''.

(d) EFFECTIVE DATE.—Except as provided in section 1851(h)(7)(A) of the Social Security Act, as added by subsection (c)(1), the amendments made by this section

shall apply with respect to marketing for plan years beginning on or after January 1, 2009.

Subtitle F—Other Provisions

SEC. 171. CONTRACT WITH A CONSENSUS-BASED ENTITY REGARDING PERFORMANCE MEASUREMENT.

(a) CONTRACT.—

(1) IN GENERAL.—Part E of title XVIII of the Social Security Act (42 U.S.C. 1395x et seq.) is amended by inserting after section 1889 the following new section:

''CONTRACT WITH A CONSENSUS-BASED ENTITY REGARDING PERFORMANCE MEASUREMENT

''SEC. 1890. (a) CONTRACT.—

''(1) IN GENERAL.—For purposes of activities conducted under this Act, the Secretary shall identify and have in effect a contract with a consensus-based entity, such as the National Quality Forum, that meets the requirements described in subsection (c). Such contract shall provide that the entity will perform the duties described in subsection (b).

''(2) TIMING FOR FIRST CONTRACT.—As soon as practicable after the date of the enactment of this subsection, the Secretary shall enter into the first contract under paragraph (1).

''(3) PERIOD OF CONTRACT.—A contract under paragraph (1) shall be for a period of 4 years (ex-

cept as may be renewed after a subsequent bidding process).

''(4) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5))) shall be used to enter into a contract under paragraph (1).

''(b) DUTIES.—The duties described in this subsection are the following:

''(1) PRIORITY SETTING PROCESS.—The entity shall synthesize evidence and convene key stakeholders to make recommendations, with respect to activities conducted under this Act, on an integrated national strategy and priorities for health care performance measurement in all applicable settings. In making such recommendations, the entity shall—

''(A) ensure that priority is given to measures—

''(i) that address the health care provided to patients with prevalent, high-cost chronic diseases;

''(ii) with the greatest potential for improving the quality, efficiency, and patient-centeredness of health care; and

''(iii) that may be implemented rapidly due to existing evidence, standards of care, or other reasons; and

''(B) take into account measures that—

''(i) may assist consumers and patients in making informed health care decisions;

''(ii) address health disparities across groups and areas; and

''(iii) address the continuum of care a patient receives, including services furnished by multiple health care providers or practitioners and across multiple settings.

''(2) ENDORSEMENT OF MEASURES.—The entity shall provide for the endorsement of standardized health care performance measures. The endorsement process under the preceding sentence shall consider whether a measure—

''(A) is evidence-based, reliable, valid, verifiable, relevant to enhanced health outcomes, actionable at the caregiver level, feasible to collect and report, and responsive to variations in patient characteristics, such as health status, language capabilities, race or ethnicity, and income level; and

''(B) is consistent across types of health care providers, including hospitals and physicians.

''(3) MAINTENANCE OF MEASURES.—The entity shall establish and implement a process to ensure that measures endorsed under paragraph (2) are updated (or retired if obsolete) as new evidence is developed.

''(4) PROMOTION OF THE DEVELOPMENT OF ELECTRONIC HEALTH RECORDS.—The entity shall promote the development and use of electronic health records that contain the functionality for automated collection, aggregation, and transmission of performance measurement information.

''(5) ANNUAL REPORT TO CONGRESS AND THE SECRETARY; SECRETARIAL PUBLICATION AND COMMENT.—

''(A) ANNUAL REPORT.—By not later than March 1 of each year (beginning with 2009), the entity shall submit to Congress and the Secretary a report containing a description of—

''(i) the implementation of quality measurement initiatives under this Act and the coordination of such initiatives with

quality initiatives implemented by other payers;

"(ii) the recommendations made under paragraph (1); and

"(iii) the performance by the entity of the duties required under the contract entered into with the Secretary under subsection (a).

"(B) SECRETARIAL REVIEW AND PUBLICATION OF ANNUAL REPORT.—Not later than 6 months after receiving a report under subparagraph (A) for a year, the Secretary shall—

"(i) review such report; and

"(ii) publish such report in the Federal Register, together with any comments of the Secretary on such report.

"(c) REQUIREMENTS DESCRIBED.—The requirements described in this subsection are the following:

"(1) PRIVATE NONPROFIT.—The entity is a private nonprofit entity governed by a board.

"(2) BOARD MEMBERSHIP.—The members of the board of the entity include—

"(A) representatives of health plans and health care providers and practitioners or representatives of groups representing such health

plans and health care providers and practitioners;

"(B) health care consumers or representatives of groups representing health care consumers; and

"(C) representatives of purchasers and employers or representatives of groups representing purchasers or employers.

"(3) ENTITY MEMBERSHIP.—The membership of the entity includes persons who have experience with—

"(A) urban health care issues;

"(B) safety net health care issues;

"(C) rural and frontier health care issues; and

"(D) health care quality and safety issues.

"(4) OPEN AND TRANSPARENT.—With respect to matters related to the contract with the Secretary under subsection (a), the entity conducts its business in an open and transparent manner and provides the opportunity for public comment on its activities.

"(5) VOLUNTARY CONSENSUS STANDARDS SETTING ORGANIZATION.—The entity operates as a voluntary consensus standards setting organization as defined for purposes of section 12(d) of the National

Technology Transfer and Advancement Act of 1995 (Public Law 104–113) and Office of Management and Budget Revised Circular A–119 (published in the Federal Register on February 10, 1998).

''(6) EXPERIENCE.—The entity has at least 4 years of experience in establishing national consensus standards.

''(7) MEMBERSHIP FEES.—If the entity requires a membership fee for participation in the functions of the entity, such fees shall be reasonable and adjusted based on the capacity of the potential member to pay the fee. In no case shall membership fees pose a barrier to the participation of individuals or groups with low or nominal resources to participate in the functions of the entity.

''(d) FUNDING.—For purposes of carrying out this subsection, the Secretary shall provide for the transfer, from the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 (in such proportion as the Secretary determines appropriate), of up to $40,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2009 through 2012.''.

(2) SENSE OF THE SENATE.—It is the Sense of the Senate that the selection by the Secretary of Health and Human Services of an entity to contract with under section 1890(a) of the Social Security Act, as added by subsection (a), should not be construed as diminishing the significant contributions of the Boards of Medicine, the quality alliances, and other clinical and technical experts to efforts to measure and improve the quality of health care services.

(b) GAO STUDY AND REPORTS ON THE PERFORMANCE AND COSTS OF THE CONSENSUS-BASED ENTITY UNDER THE CONTRACT.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study on—

(A) the performance of the entity with a contract with the Secretary of Health and Human Services under section 1890(a) of the Social Security Act, as added by subsection (a), of its duties under such contract; and

(B) the costs incurred by such entity in performing such duties.

(2) REPORTS.—Not later than 18 months and 36 months after the effective date of the first contract entered into under such section 1890(a), the

Comptroller General of the United States shall submit a report to Congress containing the results of the study conducted under paragraph (1), together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

SEC. 172. USE OF PART D DATA.

Section 1860D–12(b)(3)(D) of the Social Security Act (42 U.S.C. 1395w–112(b)(3)(D)) is amended by adding at the end the following sentence: ''Notwithstanding any other provision of law, information provided to the Secretary under the application of section 1857(e)(1) to contracts under this section under the preceding sentence may be used for the purposes of carrying out this part, improving public health through research on the utilization, safety, effectiveness, quality, and efficiency of health care services (as the Secretary determines appropriate), and conducting Congressional oversight, monitoring, and analysis of the program under this title.''.

SEC. 173. INCLUSION OF MEDICARE PROVIDERS AND SUPPLIERS IN FEDERAL PAYMENT LEVY AND ADMINISTRATIVE OFFSET PROGRAM.

(a) IN GENERAL.—Section 1874 of the Social Security Act (42 U.S.C. 1395kk) is amended by adding at the end the following new subsection:

"(d) INCLUSION OF MEDICARE PROVIDER AND SUPPLIER PAYMENTS IN FEDERAL PAYMENT LEVY PROGRAM.—

"(1) IN GENERAL.—The Centers for Medicare & Medicaid Services shall take all necessary steps to participate in the Federal Payment Levy Program under section 6331(h) of the Internal Revenue Code of 1986 as soon as possible and shall ensure that—

"(A) at least 50 percent of all payments under parts A and B are processed through such program beginning within 1 year after the date of the enactment of this section;

"(B) at least 75 percent of all payments under parts A and B are processed through such program beginning within 2 years after such date; and

"(C) all payments under parts A and B are processed through such program beginning not later than September 30, 2011.

"(2) ASSISTANCE.—The Financial Management Service and the Internal Revenue Service shall provide assistance to the Centers for Medicare & Medicaid Services to ensure that all payments described in paragraph (1) are included in the Federal Pay-

ment Levy Program by the deadlines specified in that subsection.''.

(b) APPLICATION OF ADMINISTRATIVE OFFSET PROVISIONS TO MEDICARE PROVIDER OR SUPPLIER PAYMENTS.—Section 3716 of title 31, United States Code, is amended—

(1) by inserting ''the Department of Health and Human Services,'' after ''United States Postal Service,'' in subsection (c)(1)(A); and

(2) by adding at the end of subsection (c)(3) the following new subparagraph:

''(D) This section shall apply to payments made after the date which is 90 days after the enactment of this subparagraph (or such earlier date as designated by the Secretary of Health and Human Services) with respect to claims or debts, and to amounts payable, under title XVIII of the Social Security Act.''.

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

TITLE II—MEDICAID

SEC. 201. EXTENSION OF TRANSITIONAL MEDICAL ASSISTANCE (TMA) AND ABSTINENCE EDUCATION PROGRAM THROUGH FISCAL YEAR 2009.

Section 401 of division B of the Tax Relief and Health Care Act of 2006 (Public Law 109–432, 120 Stat. 2994), as amended by section 1 of Public Law 110–48 (121 Stat. 244), section 2 of the TMA, Abstinence, Education, and QI Programs Extension Act of 2007 (Public Law 110–90, 121 Stat. 984), and section 202 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) is amended—

(1) by striking ''June 30, 2008'' and inserting ''September 30, 2009'';

(2) by striking ''the third quarter of fiscal year 2008'' and inserting ''the fourth quarter of fiscal year 2009''; and

(3) by striking ''the third quarter of fiscal year 2007'' and inserting ''the fourth quarter of fiscal year 2007''.

SEC. 202. EXTENSION OF QUALIFYING INDIVIDUAL (QI) PROGRAM THROUGH FISCAL YEAR 2009.

(a) EXTENSION.—Section 1902(a)(10)(E)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(10)(E)(iv)) is

amended by striking ''June 2008'' and inserting ''September 2009''.

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

(1) in paragraph (2)—

(A) by striking ''and'' at the end of subparagraph (H);

(B) in subparagraph (I)—

(i) by striking ''June 30'' and inserting ''September 30'';

(ii) by striking ''$200,000,000'' and inserting ''$375,000,000''; and

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

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

''(J) for the period that begins on October 1, 2008, and ends on December 31, 2008, the total allocation amount is $150,000,000; and

''(K) for the period that begins on January 1, 2009, and ends on September 30, 2009, the total allocation amount is $350,000,000.''; and

(2) in paragraph (3), in the matter preceding subparagraph (A), by striking ''or (H)'' and inserting ''(H), or (J)''.

SEC. 203. MEDICAID DSH EXTENSION THROUGH DECEMBER 31, 2009.

Section 1923(f)(6) of the Social Security Act (42 U.S.C. 1396r–4(f)(6)) is amended—

(1) in the heading, by striking ''FOR FISCAL YEAR 2007 AND PORTIONS OF FISCAL YEAR 2008'';

(2) in subparagraph (A)—

(A) in clause (i)—

(i) in the second sentence—

(I) by striking ''fiscal year 2008 for the period ending on June 30, 2008'' and inserting ''fiscal years 2008 and 2009''; and

(II) by striking ''¾ of''; and

(ii) by adding at the end the following new sentences: ''Only with respect to fiscal year 2010 for the period ending on December 31, 2009, the DSH allotment for Tennessee for such portion of the fiscal year, notwithstanding such table or terms, shall be ¼ of the amount specified in the first sentence for fiscal year 2007.'';

(B) in clause (ii), by striking ''or for a period in fiscal year 2008'' and inserting '', 2008, 2009, or for a period in fiscal year 2010''; and

(C) in clause (iv)—

(i) in the heading, by striking ''FISCAL YEAR 2007 AND FISCAL YEAR 2008'' and inserting ''FISCAL YEARS 2007 THROUGH 2009 AND THE FIRST CALENDAR QUARTER OF FISCAL YEAR 2010'';

(ii) in subclause (I), by striking ''or for a period in fiscal year 2008'' and inserting '', 2008, 2009, or for a period in fiscal year 2010''; and

(iii) in subclause (II), by striking ''or for a period in fiscal year 2008'' and inserting '', 2008, 2009, or for a period in fiscal year 2010''; and

(3) in subparagraph (B)(i)—

(A) in the first sentence, by striking ''fiscal year 2007'' and inserting ''each of fiscal years 2007 through 2009''; and

(B) by striking the second sentence and inserting the following: ''Only with respect to fiscal year 2010 for the period ending on December 31, 2009, the DSH allotment for Hawaii

for such portion of the fiscal year, notwithstanding the table set forth in paragraph (2), shall be $2,500,000.''.

SEC. 204. ASSET VERIFICATION THROUGH ACCESS TO INFORMATION HELD BY FINANCIAL INSTITUTIONS.

(a) ADDITION OF AUTHORITY.—Title XIX of the Social Security Act is amended by inserting after section 1939 the following new section:

''ASSET VERIFICATION THROUGH ACCESS TO INFORMATION HELD BY FINANCIAL INSTITUTIONS

''SEC. 1940. (a) IMPLEMENTATION.—

''(1) IN GENERAL.—Subject to the provisions of this section, each State shall implement an asset verification program described in subsection (b), for purposes of determining or redetermining the eligibility of an individual for medical assistance under the State plan under this title.

''(2) PLAN SUBMITTAL.—In order to meet the requirement of paragraph (1), each State shall—

''(A) submit not later than a deadline specified by the Secretary consistent with paragraph (3), a State plan amendment under this title that describes how the State intends to implement the asset verification program; and

''(B) provide for implementation of such program for eligibility determinations and redeterminations made on or after 6 months after the deadline established for submittal of such plan amendment.

''(3) PHASE-IN.—

''(A) IN GENERAL.—

''(i) IMPLEMENTATION IN CURRENT ASSET VERIFICATION DEMO STATES.—The Secretary shall require those States specified in subparagraph (C) (to which an asset verification program has been applied before the date of the enactment of this section) to implement an asset verification program under this subsection by the end of fiscal year 2009.

''(ii) IMPLEMENTATION IN OTHER STATES.—The Secretary shall require other States to submit and implement an asset verification program under this subsection in such manner as is designed to result in the application of such programs, in the aggregate for all such other States, to enrollment of approximately, but not less than, the following percentage of en-

rollees, in the aggregate for all such other States, by the end of the fiscal year involved:

"(I) 12.5 percent by the end of fiscal year 2009.

"(II) 25 percent by the end of fiscal year 2010.

"(III) 50 percent by the end of fiscal year 2011.

"(IV) 75 percent by the end of fiscal year 2012.

"(V) 100 percent by the end of fiscal year 2013.

"(B) CONSIDERATION.—In selecting States under subparagraph (A)(ii), the Secretary shall consult with the States involved and take into account the feasibility of implementing asset verification programs in each such State.

"(C) STATES SPECIFIED.—The States specified in this subparagraph are California, New York, and New Jersey.

"(D) CONSTRUCTION.—Nothing in subparagraph (A)(ii) shall be construed as preventing a State from requesting, and the Secretary approving, the implementation of an

asset verification program in advance of the deadline otherwise established under such subparagraph.

''(4) EXEMPTION OF TERRITORIES.—This section shall only apply to the 50 States and the District of Columbia.

''(b) ASSET VERIFICATION PROGRAM.—

''(1) IN GENERAL.—For purposes of this section, an asset verification program means a program described in paragraph (2) under which a State—

''(A) requires each applicant for, or recipient of, medical assistance under the State plan under this title on the basis of being aged, blind, or disabled to provide authorization by such applicant or recipient (and any other person whose resources are material to the determination of the eligibility of the applicant or recipient for such assistance) for the State to obtain (subject to the cost reimbursement requirements of section 1115(a) of the Right to Financial Privacy Act but at no cost to the applicant or recipient) from any financial institution (within the meaning of section 1101(1) of such Act) any financial record (within the meaning of section 1101(2) of such Act) held by the in-

stitution with respect to the applicant or recipient (and such other person, as applicable), whenever the State determines the record is needed in connection with a determination with respect to such eligibility for (or the amount or extent of) such medical assistance; and

''(B) uses the authorization provided under subparagraph (A) to verify the financial resources of such applicant or recipient (and such other person, as applicable), in order to determine or redetermine the eligibility of such applicant or recipient for medical assistance under the State plan.

''(2) PROGRAM DESCRIBED.—A program described in this paragraph is a program for verifying individual assets in a manner consistent with the approach used by the Commissioner of Social Security under section 1631(e)(1)(B)(ii).

''(c) DURATION OF AUTHORIZATION.—Notwithstanding section 1104(a)(1) of the Right to Financial Privacy Act, an authorization provided to a State under subsection (b)(1) shall remain effective until the earliest of—

''(1) the rendering of a final adverse decision on the applicant's application for medical assistance under the State's plan under this title;

''(2) the cessation of the recipient's eligibility for such medical assistance; or

''(3) the express revocation by the applicant or recipient (or such other person described in subsection (b)(1), as applicable) of the authorization, in a written notification to the State.

''(d) TREATMENT OF RIGHT TO FINANCIAL PRIVACY ACT REQUIREMENTS.—

''(1) An authorization obtained by the State under subsection (b)(1) shall be considered to meet the requirements of the Right to Financial Privacy Act for purposes of section 1103(a) of such Act, and need not be furnished to the financial institution, notwithstanding section 1104(a) of such Act.

''(2) The certification requirements of section 1103(b) of the Right to Financial Privacy Act shall not apply to requests by the State pursuant to an authorization provided under subsection (b)(1).

''(3) A request by the State pursuant to an authorization provided under subsection (b)(1) is deemed to meet the requirements of section 1104(a)(3) of the Right to Financial Privacy Act and of section 1102 of such Act, relating to a reasonable description of financial records.

''(e) REQUIRED DISCLOSURE.—The State shall inform any person who provides authorization pursuant to subsection (b)(1)(A) of the duration and scope of the authorization.

''(f) REFUSAL OR REVOCATION OF AUTHORIZATION.—If an applicant for, or recipient of, medical assistance under the State plan under this title (or such other person described in subsection (b)(1), as applicable) refuses to provide, or revokes, any authorization made by the applicant or recipient (or such other person, as applicable) under subsection (b)(1)(A) for the State to obtain from any financial institution any financial record, the State may, on that basis, determine that the applicant or recipient is ineligible for medical assistance.

''(g) USE OF CONTRACTOR.—For purposes of implementing an asset verification program under this section, a State may select and enter into a contract with a public or private entity meeting such criteria and qualifications as the State determines appropriate, consistent with requirements in regulations relating to general contracting provisions and with section 1903(i)(2). In carrying out activities under such contract, such an entity shall be subject to the same requirements and limitations on use and disclosure of information as would apply if the State were to carry out such activities directly.

''(h) TECHNICAL ASSISTANCE.—The Secretary shall provide States with technical assistance to aid in implementation of an asset verification program under this section.

''(i) REPORTS.—A State implementing an asset verification program under this section shall furnish to the Secretary such reports concerning the program, at such times, in such format, and containing such information as the Secretary determines appropriate.

''(j) TREATMENT OF PROGRAM EXPENSES.—Notwithstanding any other provision of law, reasonable expenses of States in carrying out the program under this section shall be treated, for purposes of section 1903(a), in the same manner as State expenditures specified in paragraph (7) of such section.''.

(b) STATE PLAN REQUIREMENTS.—Section 1902(a) of such Act (42 U.S.C. 1396a(a)) is amended—

(1) in paragraph (69) by striking ''and'' at the end;

(2) in paragraph (70) by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (70), as so amended, the following new paragraph:

''(71) provide that the State will implement an asset verification program as required under section 1940.''.

(c) WITHHOLDING OF FEDERAL MATCHING PAYMENTS FOR NONCOMPLIANT STATES.—Section 1903(i) of such Act (42 U.S.C. 1396b(i)) is amended—

(1) in paragraph (22) by striking ''or'' at the end;

(2) in paragraph (23) by striking the period at the end and inserting ''; or''; and

(3) by adding after paragraph (23) the following new paragraph:

''(24) if a State is required to implement an asset verification program under section 1940 and fails to implement such program in accordance with such section, with respect to amounts expended by such State for medical assistance for individuals subject to asset verification under such section, unless—

''(A) the State demonstrates to the Secretary's satisfaction that the State made a good faith effort to comply;

''(B) not later than 60 days after the date of a finding that the State is in noncompliance, the State submits to the Secretary (and the

Secretary approves) a corrective action plan to remedy such noncompliance; and

''(C) not later than 12 months after the date of such submission (and approval), the State fulfills the terms of such corrective action plan.''.

(d) REPEAL.—Section 4 of Public Law 110–90 is repealed.

SEC. 205. APPLICATION OF MEDICARE PAYMENT ADJUSTMENT FOR CERTAIN HOSPITAL-ACQUIRED CONDITIONS TO PAYMENTS FOR INPATIENT HOSPITAL SERVICES UNDER MEDICAID.

(a) STATE PLAN REQUIREMENT.—Section 1902(a)(13)(A)(iv) of the Social Security Act (42 U.S.C. 1396a(a)(13)(A)(iv)) is amended—

(1) by striking ''rates take'' and inserting ''rates—

''(I) take'';

(2) by striking the semicolon and inserting a comma; and

(3) by adding at the end the following:

''(II) ensure that higher payments are not made for services related to the presence of a condition that could be identified by a sec-

ondary diagnostic code described in section 1886(d)(4)(D);''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendments made by subsection (a) take effect on October 1, 2008.

(2) EXTENSION OF EFFECTIVE DATE FOR STATE LAW AMENDMENT.—In the case of a State plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

SEC. 206. REDUCTION IN PAYMENTS FOR MEDICAID ADMINISTRATIVE COSTS TO PREVENT DUPLICATION OF SUCH PAYMENTS UNDER TANF.

Section 1903 of the Social Security Act (42 U.S.C. 1396b) is amended—

(1) in subsection (a)(7), by striking ''section 1919(g)(3)(B)'' and inserting ''subsection (h)'';

(2) in subsection (a)(2)(D) by inserting '', subject to subsection (g)(3)(C) of such section'' after ''as are attributable to State activities under section 1919(g)''; and

(3) by adding after subsection (g) the following new subsection:

''(h) REDUCTION IN PAYMENTS FOR ADMINISTRATIVE COSTS TO PREVENT DUPLICATION OF PAYMENTS UNDER TITLE IV.—Beginning with the calendar quarter commencing October 1, 2008, the Secretary shall reduce the amount paid to each State under subsection (a)(7) for each quarter by an amount equal to ¼ of the annualized amount determined for the Medicaid program under section 16(k)(2)(B) of the Food Stamp Act of 1977 (7 U.S.C. 2025(k)(2)(B)).''.

SEC. 207. CLARIFICATION TREATMENT OF REGIONAL MEDICAL CENTER.

(a) IN GENERAL.—Nothing in section 1903(w) of the Social Security Act (42 U.S.C. 1396b(w)) shall be con-

strued by the Secretary of Health and Human Services as prohibiting a State's use of funds as the non-Federal share of expenditures under title XIX of such Act where such funds are transferred from or certified by a publicly-owned regional medical center located in another State and described in subsection (b), so long as the Secretary determines that such use of funds is proper and in the interest of the program under title XIX.

(b) CENTER DESCRIBED.—A center described in this subsection is a publicly-owned regional medical center that—

(1) provides level 1 trauma and burn care services;

(2) provides level 3 neonatal care services;

(3) is obligated to serve all patients, regardless of ability to pay;

(4) is located within a Standard Metropolitan Statistical Area (SMSA) that includes at least 3 States;

(5) provides services as a tertiary care provider for patients residing within a 125-mile radius; and

(6) meets the criteria for a disproportionate share hospital under section 1923 of such Act (42 U.S.C. 1396r–4) in at least one State other than the State in which the center is located.

SEC. 208. GRANTS TO IMPROVE OUTREACH AND ENROLLMENT UNDER MEDICAID.

(a) AUTHORITY TO AWARD GRANTS.—From the amounts appropriated for a fiscal year under subsection (g), the Secretary shall award grants to eligible entities to conduct outreach and enrollment efforts that are designed to increase the enrollment and participation of eligible individuals under Medicaid.

(b) PRIORITY FOR AWARD OF GRANTS.—

(1) IN GENERAL.—In awarding grants under subsection (a), the Secretary shall give priority to eligible entities that—

(A) propose to target geographic areas with high rates of—

(i) individuals who are eligible for, but unenrolled in, Medicaid, including such individuals who reside in rural areas; or

(ii) racial and ethnic minorities and health disparity populations, including those proposals that address cultural and linguistic barriers to enrollment; and

(B) submit the most demonstrable evidence required under paragraphs (1) and (2) of subsection (c).

(2) 10 PERCENT SET ASIDE FOR OUTREACH TO INDIANS.—An amount equal to 10 percent of the

funds appropriated under subsection (g) for a fiscal year shall be used by the Secretary to award grants to Indian Health Service providers and urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) for outreach to, and enrollment of, individuals who are Indians.

(c) APPLICATION.—An eligible entity that desires to receive a grant under subsection (a) shall submit an application to the Secretary in such form and manner, and containing such information, as the Secretary may decide. Such application shall include—

(1) evidence demonstrating that the entity includes members who have access to, and credibility with, ethnic or low-income populations in the communities in which activities funded under the grant are to be conducted;

(2) evidence demonstrating that the entity has the ability to address barriers to enrollment, such as lack of awareness of eligibility, stigma concerns and punitive fears associated with receipt of benefits, and other cultural barriers to applying for and receiving medical assistance;

(3) specific quality or outcomes performance measures to evaluate the effectiveness of activities funded by a grant awarded under this section; and

(4) an assurance that the eligible entity shall—

(A) conduct an assessment of the effectiveness of such activities against the performance measures;

(B) cooperate with the collection and reporting of enrollment data and other information in order for the Secretary to conduct such assessments; and

(C) in the case of an eligible entity that is not a State, provide each State in which the eligible entity conducts outreach activities with grant funds with enrollment data and other information as necessary for each such State to administer its State Medicaid program.

(d) DISSEMINATION OF ENROLLMENT DATA AND INFORMATION DETERMINED FROM EFFECTIVENESS ASSESSMENTS; ANNUAL REPORT.—The Secretary shall—

(1) make publicly available the enrollment data and information collected and reported in accordance with subsection (c)(4)(B); and

(2) not later than December 31, 2009, submit a report to Congress on the outreach and enrollment

activities conducted with funds appropriated under this section.

(e) SUPPLEMENT, NOT SUPPLANT.—Federal funds awarded under this section shall be used to supplement, not supplant, non-Federal funds that are otherwise available for activities funded under this section.

(f) DEFINITIONS.—In this section:

(1) ELIGIBLE ENTITY.—The term ''eligible entity'' means any of the following:

(A) A State.

(B) A local government.

(C) An Indian tribe or tribal consortium, a tribal organization, an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.), or an Indian Health Service provider.

(D) A Federal health safety net organization.

(E) A State, national, local, or community-based public or nonprofit private organization.

(F) A faith-based organization or consortia, to the extent that a grant awarded to such an entity is consistent with the requirements of section 1955 of the Public Health

Service Act (42 U.S.C. 300x–65) relating to a grant award to non-governmental entities.

(G) An elementary or secondary school.

(2) FEDERAL HEALTH SAFETY NET ORGANIZATION.—The term ''Federal health safety net organization'' means—

(A) a federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B));

(B) a hospital defined as a disproportionate share hospital for purposes of section 1923 of such Act (42 U.S.C. 1396r–4);

(C) a covered entity described in section 340B(a)(4) of the Public Health Service Act (42 U.S.C. 256b(a)(4)); and

(D) any other entity or consortium that serves children under a federally-funded program, including the special supplemental nutrition program for women, infants, and children (WIC) established under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786), the head start and early head start programs under the Head Start Act (42 U.S.C. 9801 et seq.), the school lunch program established under the

Richard B. Russell National School Lunch Act, and an elementary or secondary school.

(3) INDIANS; INDIAN TRIBE; TRIBAL ORGANIZATION; URBAN INDIAN ORGANIZATION.—The terms ''Indian'', ''Indian tribe'', ''tribal organization'', and ''urban Indian organization'' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(4) MEDICAID.—The term ''Medicaid'' means the program of medical assistance established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(g) APPROPRIATION.—There is appropriated, out of any money in the Treasury not otherwise appropriated, for the purpose of awarding grants under this section, $25,000,000 for fiscal year 2009, to remain available until expended. Amounts appropriated and paid under the authority of this section to an eligible entity that is a State shall be in addition to amounts paid to the State under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)).

TITLE III—MISCELLANEOUS

SEC. 301. EXTENSION OF TANF SUPPLEMENTAL GRANTS THROUGH FISCAL YEAR 2009.

(a) EXTENSION.—Section 7101(a) of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 135) is amended by striking ''fiscal year 2008'' and inserting ''fiscal year 2009''.

(b) CONFORMING AMENDMENT.—Section 403(a)(3)(H)(ii) of the Social Security Act (42 U.S.C. 603(a)(3)(H)(ii)) is amended to read as follows:

''(ii) subparagraph (G) shall be applied as if 'fiscal year 2009' were substituted for 'fiscal year 2001'; and''.

SEC. 302. SPECIAL DIABETES PROGRAMS FOR TYPE I DIABETES AND INDIANS.

(a) SPECIAL DIABETES PROGRAMS FOR TYPE I DIABETES.—Section 330B(b)(2)(C) of the Public Health Service Act (42 U.S.C. 254c–2(b)(2)(C)) is amended by striking ''2009'' and inserting ''2011''.

(b) SPECIAL DIABETES PROGRAMS FOR INDIANS.—Section 330C(c)(2)(C) of the Public Health Service Act (42 U.S.C. 254c–3(c)(2)(C)) is amended by striking ''2009'' and inserting ''2011''.

(c) REPORT ON GRANT PROGRAMS.—Section 4923(b) of the Balanced Budget Act of 1997 (42 U.S.C. 1254c–

2 note), as amended by section 931(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 1(a)(6) of Public Law 106–554, and section 1(c) of Public Law 107–360, is amended—

(1) in paragraph (1), by striking ''and'' at the end;

(2) in paragraph (2)—

(A) by striking ''a final report'' and inserting ''a second interim report''; and

(B) by striking the period at the end and inserting ''; and''; and

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

''(3) a final report on such evaluation not later than January 1, 2011.''.

SEC. 303. ADDITIONAL FUNDING FOR STATE HEALTH INSURANCE ASSISTANCE PROGRAMS, AREA AGENCIES ON AGING, AND AGING AND DISABILITY RESOURCE CENTERS.

(a) STATE HEATH INSURANCE PROGRAMS.—

(1) IN GENERAL.—Paragraph (2) of section 118(a) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) is amended by inserting ''and of $19,000,000 to such

account for fiscal year 2009'' before the period at the end.

(2) AMOUNT OF GRANTS.—The amount of a grant to a State under such section 118(a) from the total amount made available under that section for fiscal year 2009 shall be equal to the sum of the amount allocated to the State under paragraph (3)(A) and the amount allocated to the State under subparagraph (3)(B).

(3) ALLOCATION TO STATES.—

(A) ALLOCATION BASED ON PERCENTAGE OF LOW-INCOME BENEFICIARIES.—The amount allocated to a State under this subparagraph from ⅔ of the total amount made available under section 118(a) of such Act for fiscal year 2009 shall be based on the number of individuals who meet the requirement under subsection (a)(3)(A)(ii) of section 1860D–14 of the Social Security Act (42 U.S.C. 1395w–114) but who have not enrolled to receive a subsidy under such section 1860D–14 relative to the total number of individuals who meet the requirement under such subsection (a)(3)(A)(ii) in each State, as estimated by the Secretary.

(B) ALLOCATION BASED ON PERCENTAGE OF RURAL BENEFICIARIES.—The amount allocated to a State under this subparagraph from ⅓ of the total amount made available under section 118(a) of such Act for fiscal year 2009 shall be based on the number of part D eligible individuals (as defined in section 1860D–1(a)(3)(A) of such Act (42 U.S.C. 1395w–101(a)(3)(A))) residing in a rural area relative to the total number of such individuals in each State, as estimated by the Secretary.

(4) PORTION OF GRANT BASED ON PERCENTAGE OF LOW-INCOME BENEFICIARIES TO BE USED TO PROVIDE OUTREACH TO INDIVIDUALS WHO MAY BE SUBSIDY ELIGIBLE INDIVIDUALS OR ELIGIBLE FOR THE MEDICARE SAVINGS PROGRAM.—Each grant awarded under section 118(a) of such Act with respect to amounts allocated under paragraph (3)(A) shall be used to provide outreach to individuals who may be subsidy eligible individuals (as defined in section 1860D–14(a)(3)(A) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(A)) or eligible for the Medicare Savings Program (as defined in subsection (c)).

(b) AREA AGENCIES ON AGING AND DISABILITY RESOURCE CENTERS.—

(1) IN GENERAL.—Paragraph (2) of section 118(b) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) is amended by striking ''for the period of fiscal years 2008 through 2009'' and inserting ''for fiscal year 2008 and of $6,000,000 to such account for fiscal year 2009''.

(2) AMOUNT OF GRANT.—The amount of a grant to a State under such section 118(b) from the total amount made available under that section for fiscal year 2009 shall be determined in the same manner as the amount of a grant to a State under section 118(a) of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (Public Law 110–173) is determined for fiscal year 2009.

(3) ALLOCATION AND USE OF PORTION OF GRANT FUNDS TO PROVIDE OUTREACH TO INDIVIDUALS WHO MAY BE SUBSIDY ELIGIBLE INDIVIDUALS OR ELIGIBLE FOR THE MEDICARE SAVINGS PROGRAM.—

(A) ALLOCATION.—The total amount available under section 118(b) of the Medicare, Medicaid, and SCHIP Extension Act of 2007

(Public Law 110–173) for fiscal year 2009 shall be allocated to States in the same manner as the amount made available for such fiscal year under section 118(a) of such Act is allocated to States under subparagraphs (A) and (B) of subsection (a)(3) of this Act.

(B) USE OF PORTION OF GRANT FUNDS TO PROVIDE OUTREACH TO INDIVIDUALS WHO MAY BE SUBSIDY ELIGIBLE INDIVIDUALS OR ELIGIBLE FOR THE MEDICARE SAVINGS PROGRAM.—Paragraph (4) of subsection (a) of this Act shall apply to the amounts allocated under this paragraph in the same manner such paragraph applies to the amounts allocated under subsection (a)(3) of this Act.

(c) MEDICARE SAVINGS PROGRAM DEFINED.—For purposes of this section, the term ''Medicare Savings Program'' means the program of medical assistance for payment of the cost of Medicare cost-sharing under the Medicaid program pursuant to sections 1902(a)(10)(E) and 1933 of the Social Security Act (42 U.S.C. 1396a(a)(10)(E), 1396u–3).

SEC. 304. EXTENSION OF FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS.

Section 1011(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 13955dd note) is amended—

(1) in paragraph (1), by inserting ''and $200,000,000 for each of fiscal years 2009 and 2010,'' after ''2008'';

(2) by redesignating paragraph (2) as paragraph (3); and

(3) by inserting after paragraph (1) the following new paragraph:

''(2) ADMINISTRATIVE COSTS.—From the funds made available under paragraph (1) for fiscal year 2009, the Secretary may use not more than $8,000,000 of such funds for the administration of this section.''.

Calendar No. 776

110TH CONGRESS
2D SESSION

S. 3118

A BILL

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

JUNE 12, 2008

Read the second time and placed on the calendar