ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). There are 2 minutes remaining in this vote.

□ 1409

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated for:

Ms. MOORE of Wisconsin: Madam Speaker, on rollcall No. 785, had I been present, I would have voted "aye."

Stated against:

Mr. JORDAN of Ohio. Madam Speaker, I was absent from the House Floor during today's rollcall vote on ordering the previous question on House Resolution 594.

Had I been present, I would have voted "no."

FURTHER MESSAGE FROM THE SENATE

A message from the Senate by Ms. Curtis, one of its clerks, announced that the Senate has passed with an amendment in which the concurrence of the House is requested, a bill of the House of the following title:

H.R. 2638. An act making appropriations for the Department of Homeland Security for the fiscal year ending September 30, 2008, and for other purposes.

The message also announced that the Senate insists upon its amendment to the bill (H.R. 2638) ''An Act making appropriations for the Department of Homeland Security for the fiscal year ending September 30, 2008, and for other purposes,'' requests a conference with the House on the disagreeing votes of the two Houses thereon, and appoints Mr. BYRD, Mr. INOUYE, Mr. LEAHY, Ms. MIKULSKI, Mr. KOHL, Mrs. MURRAY, Ms. LANDRIEU, Mr. LAUTENBERG, Mr. NELSON (NE), Mr. COCHRAN, Mr. GREGG, Mr. STEVENS, Mr. SPECTER, Mr. DOMENICI, Mr. SHELBY, Mr. CRAIG, and Mr. ALEXANDER, to be the conferees on the part of the Senate.

CHILDREN'S HEALTH AND MEDICARE PROTECTION ACT OF 2007

Mr. DINGELL. Mr. Speaker, pursuant to House Resolution 594, I call up the bill (H.R. 3162) to amend titles XVIII, XIX, and XXI of the Social Security Act to extend and improve the children's health insurance program, to improve beneficiary protections under the Medicare, Medicaid, and the CHIP program, and for other purposes, and ask for its immediate consideration.

The Clerk read the title of the bill.

The text of the bill is as follows:

H.R. 3162

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 ''Children's Health and Medicare Protection Act of 2007''.

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

TITLE I—CHILDREN'S HEALTH INSURANCE PROGRAM

SEC. 100. PURPOSE.

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

Subtitle A—Funding

SEC. 101. ESTABLISHMENT OF NEW BASE CHIP ALLOTMENTS.

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

(1) in subsection (a)—

(A) in paragraph (9), by striking ''and'' at the end;

(B) in paragraph (10), by striking the period at the end and inserting ''; and''; and

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

''(11) for fiscal year 2008 and each succeeding fiscal year, the sum of the State allotments provided under subsection (i) for such fiscal year.''; and

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

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

''(i) ALLOTMENTS FOR STATES AND TERRITORIES BEGINNING WITH FISCAL YEAR 2008.—

''(1) GENERAL ALLOTMENT COMPUTATION.—Subject to the succeeding provisions of this subsection, the Secretary shall compute a State allotment for each State for each fiscal year as follows:

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

''(i) the State projection (in its submission on forms CMS–21B and CMS–37 for May 2007) of Federal payments to the State under this title for such fiscal year, except that, in the case of a State that has enacted legislation

to modify its State child health plan during 2007, the State may substitute its projection in its submission on forms CMS–21B and CMS–37 for August 2007, instead of such forms for May 2007; or

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

''(B) INFLATION UPDATE FOR FISCAL YEAR 2009 AND EACH SECOND SUCCEEDING FISCAL YEAR.—For fiscal year 2009 and each second succeeding fiscal year, the allotment of a State is equal to the amount of the State allotment under this paragraph for the previous fiscal year multiplied by the allotment increase factor under paragraph (2) for the fiscal year involved.

''(C) REBASING IN FISCAL YEAR 2010 AND EACH SECOND SUCCEEDING FISCAL YEAR.—For fiscal year 2010 and each second succeeding fiscal year, the allotment of a State is equal to the Federal payments to the State that are attributable to (and countable towards) the total amount of allotments available under this section to the State (including allotments made available under paragraph (3) as well as amounts redistributed to the State) in the previous fiscal year multiplied by the allotment increase factor under paragraph (2) for the fiscal year involved.

''(D) SPECIAL RULES FOR TERRITORIES.—Notwithstanding the previous subparagraphs, the allotment for a State that is not one of the 50 States or the District of Columbia for fiscal year 2008 and for a succeeding fiscal year is equal to the Federal payments provided to the State under this title for the previous fiscal year multiplied by the allotment increase factor under paragraph (2) for the fiscal year involved (but determined by applying under paragraph (2)(B) as if the reference to 'in the State' were a reference to 'in the United States').

''(2) ALLOTMENT INCREASE FACTOR.—The allotment increase factor under this paragraph for a fiscal year is equal to the product of the following:

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

''(B) CHILD POPULATION GROWTH FACTOR.—1 plus the percentage increase (if any) in the population of children under 19 years of age in the State from July 1 in the previous fiscal year to July 1 in the fiscal year involved, as determined by the Secretary based on the most recent published estimates of the Bureau of the Census before the beginning of the fiscal year involved, plus 1 percentage point.

''(3) PERFORMANCE-BASED SHORTFALL ADJUSTMENT.—

''(A) IN GENERAL.—If a State's expenditures under this title in a fiscal year (beginning with fiscal year 2008) exceed the total amount of allotments available under this section to the State in the fiscal year (determined without regard to any redistribution it receives under subsection (f) that is available for expenditure during such fiscal year, but including any carryover from a previous fiscal year) and if the average monthly unduplicated number of children enrolled under the State plan under this title (including children receiving health care coverage through funds under this title pursuant to a waiver under section 1115) during such fiscal year exceeds its target average number of such enrollees (as determined under subparagraph (B)) for that fiscal year, the allotment under this section for the State for the subsequent fiscal year (or, pursuant to subparagraph (F), for the fiscal year involved) shall be increased by the product of—

''(i) the amount by which such average monthly caseload exceeds such target number of enrollees; and

''(ii) the projected per capita expenditures under the State child health plan (as determined under subparagraph (C) for the original fiscal year involved), multiplied by the enhanced FMAP (as defined in section 2105(b)) for the State and fiscal year involved

''(B) TARGET AVERAGE NUMBER OF CHILD ENROLLEES.—In this subsection, the target average number of child enrollees for a State—

''(i) for fiscal year 2008 is equal to the monthly average unduplicated number of children enrolled in the State child health plan under this title (including such children receiving health care coverage through funds under this title pursuant to a waiver under section 1115) during fiscal year 2007 increased by the population growth for children in that State for the year ending on June 30, 2006 (as estimated by the Bureau of the Census) plus 1 percentage point; or

''(ii) for a subsequent fiscal year is equal to the target average number of child enrollees for the State for the previous fiscal year increased by the population growth for children in that State for the year ending on June 30 before the beginning of the fiscal year (as estimated by the Bureau of the Census) plus 1 percentage point.

''(C) PROJECTED PER CAPITA EXPENDITURES.—For purposes of subparagraph (A)(ii), the projected per capita expenditures under a State child health plan—

''(i) for fiscal year 2008 is equal to the average per capita expenditures (including both State and Federal financial participation) under such plan for the targeted low-income children counted in the average monthly caseload for purposes of this paragraph during fiscal year 2007, increased by the annual percentage increase in the per capita amount of National Health Expenditures (as estimated by the Secretary) for 2008; or

''(ii) for a subsequent fiscal year is equal to the projected per capita expenditures under such plan for the previous fiscal year (as determined under clause (i) or this clause) increased by the annual percentage increase in the per capita amount of National Health Expenditures (as estimated by the Secretary) for the year in which such subsequent fiscal year ends.

''(D) AVAILABILITY.—Notwithstanding subsection (e), an increase in allotment under this paragraph shall only be available for expenditure during the fiscal year in which it is provided.

''(E) NO REDISTRIBUTION OF PERFORMANCE-BASED SHORTFALL ADJUSTMENT.—In no case shall any increase in allotment under this paragraph for a State be subject to redistribution to other States.

''(F) INTERIM ALLOTMENT ADJUSTMENT.—The Secretary shall develop a process to administer the performance-based shortfall adjustment in a manner so it is applied to (and before the end of) the fiscal year (rather than the subsequent fiscal year) involved for a State that the Secretary estimates will be in shortfall and will exceed its enrollment target for that fiscal year.

''(G) PERIODIC AUDITING.—The Comptroller General of the United States shall periodically audit the accuracy of data used in the computation of allotment adjustments under this paragraph. Based on such audits, the Comptroller General shall make such recommendations to the Congress and the Secretary as the Comptroller General deems appropriate.

''(4) CONTINUED REPORTING.—For purposes of paragraph (3) and subsection (f), the State shall submit to the Secretary the State's projected Federal expenditures, even if the amount of such expenditures exceeds the total amount of allotments available to the State in such fiscal year.''.

SEC. 102. 2-YEAR INITIAL AVAILABILITY OF CHIP ALLOTMENTS.

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

''(e) AVAILABILITY OF AMOUNTS ALLOTTED.—

''(1) IN GENERAL.—Except as provided in paragraph (2) and subsection (i)(3)(D), amounts allotted to a State pursuant to this section—

''(A) for each of fiscal years 1998 through 2007, shall remain available for expenditure by the State through the end of the second succeeding fiscal year; and

''(B) for fiscal year 2008 and each fiscal year thereafter, shall remain available for expenditure by the State through the end of the succeeding fiscal year.

''(2) AVAILABILITY OF AMOUNTS REDISTRIBUTED.—Amounts redistributed to a State under subsection (f) shall be available for expenditure by the State through the end of the fiscal year in which they are redistributed, except that funds so redistributed to a State that are not expended by the end of such fiscal year shall remain available after the end of such fiscal year and shall be available in the following fiscal year for subsequent redistribution under such subsection.''.

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

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

(1) by striking ''The Secretary'' and inserting the following:

''(1) IN GENERAL.—The Secretary'';

(2) by striking ''States that have fully expended the amount of their allotments under this section.'' and inserting ''States that the Secretary determines with respect to the fiscal year for which unused allotments are available for redistribution under this subsection, are shortfall States described in paragraph (2) for such fiscal year, but not to exceed the amount of the shortfall described in paragraph (2)(A) for each such State (as may be adjusted under paragraph (2)(C)). The amount of allotments not expended or redistributed under the previous sentence shall remain available for redistribution in the succeeding fiscal year.''; and

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

''(2) SHORTFALL STATES DESCRIBED.—

''(A) IN GENERAL.—For purposes of paragraph (1), with respect to a fiscal year, a shortfall State described in this subparagraph is a State with a State child health plan approved under this title for which the Secretary estimates on the basis of the most recent data available to the Secretary, that the projected expenditures under such plan for the State for the fiscal year will exceed the sum of—

''(i) the amount of the State's allotments for any preceding fiscal years that remains available for expenditure and that will not be expended by the end of the immediately preceding fiscal year;

''(ii) the amount (if any) of the performance based adjustment under subsection (i)(3)(A); and

''(iii) the amount of the State's allotment for the fiscal year.

''(B) PRORATION RULE.—If the amounts available for redistribution under paragraph (1) for a fiscal year are less than the total amounts of the estimated shortfalls determined for the year under subparagraph (A), the amount to be redistributed under such

paragraph for each shortfall State shall be reduced proportionally.

''(C) RETROSPECTIVE ADJUSTMENT.—The Secretary may adjust the estimates and determinations made under paragraph (1) and this paragraph with respect to a fiscal year as necessary on the basis of the amounts reported by States not later than November 30 of the succeeding fiscal year, as approved by the Secretary.''.

SEC. 104. EXTENSION OF OPTION FOR QUALIFYING STATES.

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

Subtitle B—Improving Enrollment and Retention of Eligible Children

SEC. 111. CHIP PERFORMANCE BONUS PAYMENT TO OFFSET ADDITIONAL ENROLLMENT COSTS RESULTING FROM ENROLLMENT AND RETENTION EFFORTS.

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

''(3) PERFORMANCE BONUS PAYMENT TO OFFSET ADDITIONAL MEDICAID AND CHIP CHILD ENROLLMENT COSTS RESULTING FROM ENROLLMENT AND RETENTION EFFORTS.—

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

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

''(i) FOR ABOVE BASELINE MEDICAID CHILD ENROLLMENT COSTS.—

''(I) FIRST TIER ABOVE BASELINE MEDICAID ENROLLEES.—An amount equal to the number of first tier above baseline child enrollees (as determined under subparagraph (C)(i)) under title XIX for the State and fiscal year multiplied by 35 percent of the projected per capita State Medicaid expenditures (as determined under subparagraph (D)(i)) for the State and fiscal year under title XIX.

''(II) SECOND TIER ABOVE BASELINE MEDICAID ENROLLEES.—An amount equal to the number of second tier above baseline child enrollees (as determined under subparagraph (C)(ii)) under title XIX for the State and fiscal year multiplied by 90 percent of the projected per capita State Medicaid expenditures (as determined under subparagraph (D)(i)) for the State and fiscal year under title XIX.

''(ii) FOR ABOVE BASELINE CHIP ENROLLMENT COSTS.—

''(I) FIRST TIER ABOVE BASELINE CHIP ENROLLEES.—An amount equal to the number of first tier above baseline child enrollees under this title (as determined under subparagraph (C)(i)) for the State and fiscal year multiplied by 5 percent of the projected per capita State CHIP expenditures (as determined under subparagraph (D)(ii)) for the State and fiscal year under this title.

''(II) SECOND TIER ABOVE BASELINE CHIP ENROLLEES.—An amount equal to the number of second tier above baseline child enrollees under this title (as determined under subparagraph (C)(ii)) for the State and fiscal year multiplied by 75 percent of the projected per capita State CHIP expenditures (as determined under subparagraph (D)(ii)) for the State and fiscal year under this title.

''(C) NUMBER OF FIRST AND SECOND TIER ABOVE BASELINE CHILD ENROLLEES; BASELINE NUMBER OF CHILD ENROLLEES.—For purposes of this paragraph:

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

''(I) the monthly average unduplicated number of qualifying children (as defined in subparagraph (E)) enrolled during the fiscal year under the State child health plan under this title or under the State plan under title XIX, respectively; exceeds

''(II) the baseline number of enrollees described in clause (iii) for the State and fiscal year under this title or title XIX, respectively;

but not to exceed 3 percent (in the case of title XIX) or 7.5 percent (in the case of this title) of the baseline number of enrollees described in subclause (II).

''(ii) SECOND TIER ABOVE BASELINE CHILD ENROLLEES.—The number of second tier above baseline child enrollees for a State for a fiscal year under this title or title XIX is equal to the number (if any, as determined by the Secretary) by which—

''(I) the monthly average unduplicated number of qualifying children (as defined in subparagraph (E)) enrolled during the fiscal year under this title or under title XIX, respectively, as described in clause (i)(I); exceeds

''(II) the sum of the baseline number of child enrollees described in clause (iii) for the State and fiscal year under this title or title XIX, respectively, as described in clause (i)(II), and the maximum number of first tier above baseline child enrollees for the State and fiscal year under this title or title XIX, respectively, as determined under clause (i).

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

''(I) for fiscal year 2008 is equal to the monthly average unduplicated number of qualifying children enrolled in the State child health plan under this title or in the State plan under title XIX, respectively, during fiscal year 2007 increased by the population growth for children in that State for the year ending on June 30, 2006 (as estimated by the Bureau of the Census) plus 1 percentage point; or

''(II) for a subsequent fiscal year is equal to the baseline number of child enrollees for the State for the previous fiscal year under this title or title XIX, respectively, increased by the population growth for children in that State for the year ending on June 30 before the beginning of the fiscal year (as estimated by the Bureau of the Census) plus 1 percentage point.

''(D) PROJECTED PER CAPITA STATE EXPENDITURES.—For purposes of subparagraph (B)—

''(i) PROJECTED PER CAPITA STATE MEDICAID EXPENDITURES.—The projected per capita State Medicaid expenditures for a State and fiscal year under title XIX is equal to the average per capita expenditures (including both State and Federal financial participation) for children under the State plan under such title, including under waivers but not including such children eligible for assistance by virtue of the receipt of benefits under title XVI, for the most recent fiscal year for which actual data are available (as determined by the Secretary), increased (for each subsequent fiscal year up to and including the fiscal year involved) by the annual percentage increase in per capita amount of National Health Expenditures (as estimated by the Secretary) for the calendar year in which the respective subsequent fiscal year ends and multiplied by a State matching percentage equal to 100 percent minus the Federal medical assistance percentage (as defined in section 1905(b)) for the fiscal year involved.

''(ii) PROJECTED PER CAPITA STATE CHIP EXPENDITURES.—The projected per capita State CHIP expenditures for a State and fiscal year under this title is equal to the average per capita expenditures (including both State and Federal financial participation) for children under the State child health plan under this title, including under waivers, for the most recent fiscal year for which actual data are available (as determined by the Secretary), increased (for each subsequent fiscal year up to and including the fiscal year involved) by the annual percentage increase in per capita amount of National Health Expenditures (as estimated by the Secretary) for the calendar year in which the respective subsequent fiscal year ends and multiplied by a State matching percentage equal to 100 percent minus the enhanced FMAP (as defined in section 2105(b)) for the fiscal year involved.

''(E) QUALIFYING CHILDREN DEFINED.—For purposes of this subsection, the term 'qualifying children' means, with respect to this title or title XIX, children who meet the eligibility criteria (including income, categorical eligibility, age, and immigration status criteria) in effect as of July 1, 2007, for enrollment under this title or title XIX, respectively, taking into account crtieria applied as of such date under this title or title XIX, respectively, pursuant to a waiver under section 1115.

''(4) ENROLLMENT AND RETENTION PROVISIONS FOR CHILDREN.— For purposes of paragraph (3)(A), a State meets the condition of this paragraph for a fiscal year if it is implementing at least 4 of the following enrollment and retention provisions (treating each subparagraph as a separate enrollment and retention provision) throughout the entire fiscal year:

''(A) CONTINUOUS ELIGIBILITY.—The State has elected the option of continuous eligibility for a full 12 months for all children described in section 1902(e)(12) under title XIX under 19 years of age, as well as applying such policy under its State child health plan under this title.

''(B) LIBERALIZATION OF ASSET REQUIREMENTS.—The State meets the requirement specified in either of the following clauses:

''(i) ELIMINATION OF ASSET TEST.—The State does not apply any asset or resource test for eligibility for children under title XIX or this title.

''(ii) ADMINISTRATIVE VERIFICATION OF ASSETS.—The State—

''(I) permits a parent or caretaker relative who is applying on behalf of a child for medical assistance under title XIX or child health assistance under this title to declare and certify by signature under penalty of perjury information relating to family assets for purposes of determining and redetermining financial eligibility; and

''(II) takes steps to verify assets through means other than by requiring documentation from parents and applicants except in individual cases of discrepancies or where otherwise justified.

''(C) ELIMINATION OF IN-PERSON INTERVIEW REQUIREMENT.—The State does not require an application of a child for medical assistance under title XIX (or for child health assistance under this title), including an application for renewal of such assistance, to be made in person nor does the State require a face-to-face interview, unless there are discrepancies or individual circumstances justifying an in-person application or face-to-face interview.

''(D) USE OF JOINT APPLICATION FOR MEDICAID AND CHIP.—The application form and supplemental forms (if any) and information verification process is the same for purposes of establishing and renewing eligibility for children for medical assistance under title XIX and child health assistance under this title.

''(E) AUTOMATIC RENEWAL (USE OF ADMINISTRATIVE RENEWAL).—

''(i) IN GENERAL.—The State provides, in the case of renewal of a child's eligibility for medical assistance under title XIX or child health assistance under this title, a preprinted form completed by the State based on the information available to the State and notice to the parent or caretaker relative of the child that eligibility of the child will be renewed and continued based on such information unless the State is provided other information. Nothing in this clause shall be construed as preventing a State from verifying, through electronic and other means, the information so provided.

''(ii) SATISFACTION THROUGH DEMONSTRATED USE OF EX PARTE PROCESS.—A State shall be treated as satisfying the requirement of clause (i) if renewal of eligibility of children under title XIX or this title is determined without any requirement for an in-person interview, unless sufficient information is not in the State's possession and cannot be acquired from other sources (including other State agencies) without the participation of the applicant or the applicant's parent or caretaker relative.

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

''(G) EXPRESS LANE.—The State is implementing the option described in section 1902(e)(13) under title XIX as well as, pursuant to section 2107(e)(1), under this title.''.

SEC. 112. STATE OPTION TO RELY ON FINDINGS FROM AN EXPRESS LANE AGENCY TO CONDUCT SIMPLIFIED ELIGIBILITY DETERMINATIONS.

(a) MEDICAID.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) is amended by adding at the end the following:

''(13) EXPRESS LANE OPTION.—

''(A) IN GENERAL.—

''(i) OPTION TO USE A FINDING FROM AN EXPRESS LANE AGENCY.—At the option of the State, the State plan may provide that in determining eligibility under this title for a child (as defined in subparagraph (F)), the State may rely on a finding made within a reasonable period (as determined by the State) from an Express Lane agency (as defined in subparagraph (E)) when it determines whether a child satisfies one or more components of eligibility for medical assistance under this title. The State may rely on a finding from an Express Lane agency notwithstanding sections 1902(a)(46)(B), 1903(x), and 1137(d) and any differences in budget unit, disregard, deeming or other methodology, if the following requirements are met:

''(I) PROHIBITION ON DETERMINING CHILDREN INELIGIBLE FOR COVERAGE.— If a finding from an Express Lane agency would result in a determination that a child does not satisfy an eligibility requirement for medical assistance under this title and for child health assistance under title XXI, the State shall determine eligibility for assistance using its regular procedures.

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

''(III) COMPLIANCE WITH SCREEN AND ENROLL REQUIREMENT.—The State shall satisfy the requirements under (A) and (B) of section 2102(b)(3) (relating to screen and enroll) before enrolling a child in child health assistance under title XXI. At its option, the State may fulfill such requirements in accordance with either option provided under subparagraph (C) of this paragraph.

''(ii) OPTION TO APPLY TO RENEWALS AND REDETERMINATIONS.—The State may apply the provisions of this paragraph when conducting initial determinations of eligibility, redeterminations of eligibility, or both, as described in the State plan.

''(B) RULES OF CONSTRUCTION.—Nothing in this paragraph shall be construed—

''(i) to limit or prohibit a State from taking any actions otherwise permitted under this title or title XXI in determining eligibility for or enrolling children into medical assistance under this title or child health assistance under title XXI; or

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

''(C) OPTIONS FOR SATISFYING THE SCREEN AND ENROLL REQUIREMENT.—

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

''(ii) ESTABLISHING A SCREENING THRESHOLD.—

''(I) IN GENERAL.—Under this clause, the State establishes a screening threshold set as a percentage of the Federal poverty level that exceeds the highest income threshold applicable under this title to the child by a minimum of 30 percentage points or, at State option, a higher number of percentage points that reflects the value (as determined by the State and described in the State plan) of any differences between income methodologies used by the program administered by the Express Lane agency and the methodologies used by the State in determining eligibility for medical assistance under this title.

''(II) CHILDREN WITH INCOME NOT ABOVE THRESHOLD.—If the income of a child does not exceed the screening threshold, the child is deemed to satisfy the income eligibility criteria for medical assistance under this title regardless of whether such child would otherwise satisfy such criteria.

''(III) CHILDREN WITH INCOME ABOVE THRESHOLD.—If the income of a child exceeds the screening threshold, the child shall be considered to have an income above the Medicaid applicable income level described in section 2110(b)(4) and to satisfy the requirement under section 2110(b)(1)(C) (relating to the requirement that CHIP matching funds be used only for children not eligible for Medicaid). If such a child is enrolled in child health assistance under title XXI, the State shall provide the parent, guardian, or custodial relative with the following:

''(aa) Notice that the child may be eligible to receive medical assistance under the State plan under this title if evaluated for such assistance under the State's regular procedures and notice of the process through which a parent, guardian, or custodial relative can request that the State evaluate the child's eligibility for medical assistance under this title using such regular procedures.

''(bb) A description of differences between the medical assistance provided under this title and child health assistance under title XXI, including differences in cost-sharing requirements and covered benefits.

''(iii) TEMPORARY ENROLLMENT IN CHIP PENDING SCREEN AND ENROLL.—

''(I) IN GENERAL.—Under this clause, a State enrolls a child in child health assistance under title XXI for a temporary period if the child appears eligible for such assistance based on an income finding by an Express Lane agency.

''(II) DETERMINATION OF ELIGIBILITY.—During such temporary enrollment period, the State shall determine the child's eligibility for child health assistance under title XXI or for medical assistance under this title in accordance with this clause.

''(III) PROMPT FOLLOW UP.—In making such a determination, the State shall take prompt action to determine whether the child should be enrolled in medical assistance under this title or child health assistance under title XXI pursuant to subparagraphs (A) and (B) of section 2102(b)(3) (relating to screen and enroll).

''(IV) REQUIREMENT FOR SIMPLIFIED DETERMINATION.—In making such a determination, the State shall use procedures that, to the maximum feasible extent, reduce the burden imposed on the individual of such determination. Such procedures may not require the child's parent, guardian, or custodial relative to provide or verify information that already has been provided to the State agency by an Express Lane agency or another source of information unless the State agency has reason to believe the information is erroneous.

''(V) AVAILABILITY OF CHIP MATCHING FUNDS DURING TEMPORARY ENROLLMENT PERIOD.—Medical assistance for items and services that are provided to a child enrolled in title XXI during a temporary enrollment period under this clause shall be treated as child health assistance under such title.

''(D) OPTION FOR AUTOMATIC ENROLLMENT.—

''(i) IN GENERAL.—At its option, a State may initiate an evaluation of an individual's eligibility for medical assistance under this title without an application and determine the individual's eligibility for such assistance using findings from one or more Express Lane agencies and information from sources other than a child, if the requirements of clauses (ii) and (iii) are met.

''(ii) INDIVIDUAL CHOICE REQUIREMENT.—The requirement of this clause is that the child is enrolled in medical assistance under this title or child health assistance under title XXI only if the child (or a parent, caretaker relative, or guardian on the behalf of the child) has affirmatively assented to such enrollment.

''(iii) INFORMATION REQUIREMENT.—The requirement of this clause is that the State informs the parent, guardian, or custodial relative of the child of the services that will be covered, appropriate methods for using such services, premium or other cost sharing charges (if any) that apply, medical support obligations (under section 1912(a)) created by enrollment (if applicable), and the actions the parent, guardian, or relative must take to maintain enrollment and renew coverage.

''(E) EXPRESS LANE AGENCY DEFINED.—In this paragraph, the term 'express lane agency' means an agency that meets the following requirements:

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

''(ii) The agency notifies the child (or a parent, caretaker relative, or guardian on the behalf of the child)—

''(I) of the information which shall be disclosed;

''(II) that the information will be used by the State solely for purposes of determining eligibility for and for providing medical assistance under this title or child health assistance under title XXI; and

''(III) that the child, or parent, caretaker relative, or guardian, may elect to not have the information disclosed for such purposes.

''(iii) The agency and the State agency are subject to an interagency agreement limiting the disclosure and use of such information to such purposes.

''(iv) The agency is determined by the State agency to be capable of making the determinations described in this paragraph and is identified in the State plan under this title or title XXI.

For purposes of this subparagraph, the term 'State agency' refers to the agency determining eligibility for medical assistance under this title or child health assistance under title XXI.

''(F) CHILD DEFINED.—For purposes of this paragraph, the term 'child' means an individual under 19 years of age, or, at the option of a State, such higher age, not to exceed 21 years of age, as the State may elect.''.

(b) CHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)) is amended by redesignating subparagraph (B) and succeeding subparagraphs as subparagraph (C) and succeeding subparagraphs and by inserting after subparagraph (A) the following new subparagraph:

''(B) Section 1902(e)(13) (relating to the State option to rely on findings from an Express Lane agency to help evaluate a child's eligibility for medical assistance).''.

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

''(dd) ELECTRONIC TRANSMISSION OF INFORMATION.—If the State agency determining eligibility for medical assistance under this title or child health assistance under title XXI verifies an element of eligibility based on information from an Express Lane Agency (as defined in subsection (e)(13)(F)), or from another public agency, then the applicant's signature under penalty of perjury shall not be required as to such element. Any signature requirement for an application for medical assistance may be satisfied through an electronic signature, as defined in section 1710(1) of the Government Paperwork Elimination Act (44 U.S.C. 3504 note). The requirements of subparagraphs (A) and (B) of section 1137(d)(2) may be met through evidence in digital or electronic form.''.

(d) AUTHORIZATION OF INFORMATION DISCLOSURE.—

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

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

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

''SEC. 1939. AUTHORIZATION TO RECEIVE PERTINENT INFORMATION.

''(a) IN GENERAL.—Notwithstanding any other provision of law, a Federal or State agency or private entity in possession of the sources of data potentially pertinent to eligibility determinations under this title (including eligibility files maintained by Express Lane agencies described in section 1902(e)(13)(F), information described in paragraph (2) or (3) of section 1137(a), vital records information about births in any State, and information described in sections 453(i) and 1902(a)(25)(I)) is authorized to convey such data or information to the State agency administering the State plan under this title, to the extent such conveyance meets the requirements of subsection (b).

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

''(1) The individual whose circumstances are described in the data or information (or such individual's parent, guardian, caretaker relative, or authorized representative) has either provided advance consent to disclosure or has not objected to disclosure after receiving advance notice of disclosure and a reasonable opportunity to object.

''(2) Such data or information are used solely for the purposes of—

''(A) identifying individuals who are eligible or potentially eligible for medical assistance under this title and enrolling or attempting to enroll such individuals in the State plan; and

''(B) verifying the eligibility of individuals for medical assistance under the State plan.

''(3) An interagency or other agreement, consistent with standards developed by the Secretary—

''(A) prevents the unauthorized use, disclosure, or modification of such data and otherwise meets applicable Federal requirements safeguarding privacy and data security; and

''(B) requires the State agency administering the State plan to use the data and information obtained under this section to seek to enroll individuals in the plan.

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

''(d) RULE OF CONSTRUCTION.—The limitations and requirements that apply to disclosure pursuant to this section shall not be construed to prohibit the conveyance or disclosure of data or information otherwise permitted under Federal law (without regard to this section).''.

(2) CONFORMING AMENDMENT TO TITLE XXI.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)), as amended by subsection (b), is amended by adding at the end the following new subparagraph:

''(F) Section 1939 (relating to authorization to receive data potentially pertinent to eligibility determinations).''.

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

(A) by inserting ''(and, at State option, individuals who are potentially eligible or who apply)'' after ''with respect to individuals who are eligible''; and

(B) by inserting ''under this title (and, at State option, child health assistance under title XXI)'' after ''the State plan''.

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

SEC. 113. APPLICATION OF MEDICAID OUTREACH PROCEDURES TO ALL CHILDREN AND PREGNANT WOMEN.

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

(1) in the matter before subparagraph (A), by striking ''individuals for medical assistance under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX)'' and inserting ''children and pregnant women for medical assistance under any provision of this title''; and

(2) in subparagraph (B), by inserting before the semicolon at the end the following: '', which need not be the same application form for all such individuals''.

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

SEC. 114. ENCOURAGING CULTURALLY APPROPRIATE ENROLLMENT AND RETENTION PRACTICES.

(a) USE OF MEDICAID FUNDS.—Section 1903(a)(2) of the Social Security Act (42 U.S.C. 1396b(a)(2)) is amended by adding at the end the following new subparagraph:

''(E) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to translation or interpretation services in connection with the enrollment and retention under this title of children of families for whom English is not the primary language; plus''.

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

(1) IN GENERAL.—Section 2102(c)(1) of such Act (42 U.S.C. 1397bb(c)(1)) is amended by inserting ''(through community health workers and others)'' after ''Outreach''.

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

Subtitle C—Coverage

SEC. 121. ENSURING CHILD-CENTERED COVERAGE.

(a) ADDITIONAL REQUIRED SERVICES.—

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

(A) in subsection (a)—

(i) in the matter before paragraph (1), by striking ''subsection (c)(5)'' and inserting ''paragraphs (5) and (6) of subsection (c)''; and

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

(B) in subsection (c)—

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

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

''(5) DENTAL, FQHC, AND RHC SERVICES.—The child health assistance provided to a targeted low-income child (whether through benchmark coverage or benchmark-equivalent coverage or otherwise) shall include coverage of the following:

''(A) Dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

''(B) Federally-qualified health center services (as defined in section 1905(l)(2)) and rural health clinic services (as defined in section 1905(l)(1)).

Nothing in this section shall be construed as preventing a State child health plan from providing such services as part of benchmark coverage or in addition to the benefits provided through benchmark coverage.''.

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

''(C) Section 1902(bb) (relating to payment for services provided by Federally-qualified health centers and rural health clinics).''.

(3) MENTAL HEALTH PARITY.—Section 2103(a)(2)(C) of such Act (42 U.S.C. 1397aa(a)(2)(C)) is amended by inserting ''(or 100 percent in the case of the category of

services described in subparagraph (B) of such subsection)'' after ''75 percent''.

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

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

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

(A) in subparagraph (A)—

(i) in the matter before clause (i), by striking ''Notwithstanding any other provision of this title'' and inserting ''Subject to subparagraph (E)''; and

(ii) by striking ''enrollment in coverage that provides'' and all that follows and inserting ''benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2).'';

(B) by striking subparagraph (C) and inserting the following new subparagraph:

''(C) STATE OPTION TO PROVIDE ADDITIONAL BENEFITS.—A State, at its option, may provide such additional benefits to benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2) as the State may specify.''; and

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

''(E) REQUIRING COVERAGE OF EPSDT SERVICES.—Nothing in this paragraph shall be construed as affecting a child's entitlement to care and services described in subsections (a)(4)(B) and (r) of section 1905 and provided in accordance with section 1902(a)(43) whether provided through benchmark coverage, benchmark equivalent coverage, or otherwise.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall take effect as if included in the amendment made by section 6044(a) of the Deficit Reduction Act of 2005.

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

(1) IN GENERAL.—Section 2110(a)(5) of such Act (42 U.S.C. 1397jj(a)(5)) is amended by inserting after ''health center services'' the following: ''and school-based health center servicesservices for which coverage is otherwise provided under this title when furnished by a school-based health center that is authorized to furnish such services under State law''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to child health assistance furnished on or after the date of the enactment of this Act.

(d) ASSURING ACCESS TO CARE.—

(1) STATE CHILD HEALTH PLAN REQUIREMENT.—Section 2102(a)(7)(B) of such Act (42 U.S.C. 1397bb(c)(2)) is amended by inserting ''and services described in section 2103(c)(5)'' after ''emergency services''.

(2) REFERENCE TO EFFECTIVE DATE.—For the effective date for the amendments made by this subsection, see subsection (a)(5).

SEC. 122. IMPROVING BENCHMARK COVERAGE OPTIONS.

(a) LIMITATION ON SECRETARY-APPROVED COVERAGE.—

(1) UNDER CHIP.—Section 2103(a)(4) of the Social Security Act (42 U.S.C. 1397cc(a)(4)) is amended by inserting before the period at the end the following: ''if the health benefits coverage is at least equivalent to the benefits coverage in a benchmark benefit package described in subsection (b)''.

(2) UNDER MEDICAID.—Section 1937(b)(1)(D) of the Social Security Act (42 U.S.C. 1396u–7(b)(1)(D)) is amended by inserting before the period at the end the following: ''if the health benefits coverage is at least equivalent to the benefits coverage in benchmark coverage described in subparagraph (A), (B), or (C)''.

(b) REQUIREMENT FOR MOST POPULAR FAMILY COVERAGE FOR STATE EMPLOYEE COVERAGE BENCHMARK.—

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

(2) MEDICAID.—Section 1937(b)(1)(B) of such Act is amended by inserting ''and that has been selected most frequently, by employees seeking dependent coverage, among such plans that provide such dependent coverage, in either of the previous 2 plan years'' before the period at the end.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to health benefits coverage provided on or after October 1, 2008.

SEC. 123. PREMIUM GRACE PERIOD.

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

''(C) PREMIUM GRACE PERIOD.—The State child health plan—

''(i) shall afford individuals enrolled under the plan a grace period of at least 30 days from the beginning of a new coverage period to make premium payments before the individual's coverage under the plan may be terminated; and

''(ii) shall provide to such an individual, not later than 7 days after the first day of such grace period, notice—

''(I) that failure to make a premium payment within the grace period will result in termination of coverage under the State child health plan; and

''(II) of the individual's right to challenge the proposed termination pursuant to the applicable Federal regulations.

For purposes of clause (i), the term 'new coverage period' means the month immediately following the last month for which the premium has been paid.''.

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

Subtitle D—Populations

SEC. 131. OPTIONAL COVERAGE OF OLDER CHILDREN UNDER MEDICAID AND CHIP.

(a) MEDICAID.—

(1) IN GENERAL.—Section 1902(l)(1)(D) of the Social Security Act (42 U.S.C. 1396a(l)(1)(D)) is amended by striking ''but have not attained 19 years of age'' and inserting ''but is under 19 years of age (or, at the option of a State and subject to section 131(d) of the Children's Health and Medicare Protection Act of 2007, under such higher age, not to exceed 25 years of age, as the State may elect)''.

(2) CONFORMING AMENDMENTS.—

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

(B) Section 1902(e)(12) of such Act (42 U.S.C. 1396a(e)(12)) is amended by inserting ''or such higher age as the State has elected under subsection (l)(1)(D)'' after ''19 years of age''.

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

(D) Section 1920A(b)(1) of such Act (42 U.S.C. 1396r–1a(b)(1)) is amended by inserting ''or under such higher age as the State has elected under section 1902(l)(1)(D)'' after ''19 years of age''.

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

(F) Section 1932(a)(2)(A) of such Act (42 U.S.C. 1396u–2(a)(2)(A)) is amended by inserting ''(or under such higher age as the State has elected under section 1902(l)(1)(D))'' after ''19 years of age''.

(b) TITLE XXI.—Section 2110(c)(1) of such Act (42 U.S.C. 1397jj(c)(1)) is amended by inserting ''(or, at the option of the State and subject to section 131(d) of the Children's Health and Medicare Protection Act of 2007, under such higher age as the State has elected under section 1902(l)(1)(D))''.

(c) EFFECTIVE DATE.—Subject to subsection (d), the amendments made by this section take effect on January 1, 2010.

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

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

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

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

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

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

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

(1) in paragraph (1), by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (4)''; and

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

''(4)(A) A State may elect (in a plan amendment under this title) to provide medical assistance under this title, notwithstanding sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, for aliens who are lawfully residing in the United States (including battered aliens described in section 431(c) of such Act) and who are otherwise eligible for such assistance, within either or both of the following eligibility categories:

''(i) PREGNANT WOMEN.—Women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

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

''(B) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of medical assistance to such category and the cost of such assistance shall not be considered as an unreimbursed cost.''.

(b) CHIP.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)), as amended by section 112(b), 112(d)(2),and 121(a)(2), is amended by redesignating subparagraphs (E) through (G)

as subparagraphs (G) through (I), respectively, and by inserting after subparagraph (D) the following new subparagraphs:

''(E) Section 1903(v)(4)(A) (relating to optional coverage of certain categories of lawfully residing immigrants), insofar as it relates to the category of pregnant women described in clause (i) of such section, but only if the State has elected to apply such section with respect to such women under title XIX and the State has elected the option under section 2111 to provide assistance for pregnant women under this title.

''(F) Section 1903(v)(4)(A) (relating to optional coverage of categories of lawfully residing immigrants), insofar as it relates to the category of children described in clause (ii) of such section, but only if the State has elected to apply such section with respect to such children under title XIX.''.

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

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

(a) CHIP.—

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

''SEC. 2111. OPTIONAL COVERAGE OF TARGETED LOW-INCOME PREGNANT WOMEN.

''(a) OPTIONAL COVERAGE.—Notwithstanding any other provision of this title, a State may provide for coverage, through an amendment to its State child health plan under section 2102, of assistance for pregnant women for targeted low-income pregnant women in accordance with this section, but only if—

''(1) the State has established an income eligibility level—

''(A) for pregnant women, under any of clauses (i)(III), (i)(IV), or (ii)(IX) of section 1902(a)(10)(A), that is at least 185 percent (or such higher percent as the State has in effect for pregnant women under this title) of the poverty line applicable to a family of the size involved, but in no case a percent lower than the percent in effect under any such clause as of July 1, 2007; and

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

''(2) the State does not impose, with respect to the enrollment under the State child health plan of targeted low-income children during the quarter, any enrollment cap or other numerical limitation on enrollment, any waiting list, any procedures designed to delay the consideration of applications for enrollment, or similar limitation with respect to enrollment.

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

''(1) ASSISTANCE FOR PREGNANT WOMEN.—The term 'assistance for pregnant women' has the meaning given the term child health assistance in section 2110(a) as if any reference to targeted low-income children were a reference to targeted low-income pregnant women.

''(2) TARGETED LOW-INCOME PREGNANT WOMAN.—The term 'targeted low-income pregnant woman' means a woman—

''(A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends;

''(B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (a)(1)(A)) of the poverty level applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and

''(C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of section 2110(b), applied as if any reference to a child was a reference to a pregnant woman.

''(c) REFERENCES TO TERMS AND SPECIAL RULES.—In the case of, and with respect to, a State providing for coverage of assistance for pregnant women to targeted low-income pregnant women under subsection (a), the following special rules apply:

''(1) Any reference in this title (other than in subsection (b)) to a targeted low-income child is deemed to include a reference to a targeted low-income pregnant woman.

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

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

''(4) In applying section 2102(b)(3)(B), any reference to children found through screening to be eligible for medical assistance under the State medicaid plan under title XIX is deemed a reference to pregnant women.

''(5) There shall be no exclusion of benefits for services described in subsection (b)(1) based on any preexisting condition and no waiting period (including any waiting period imposed to carry out section 2102(b)(3)(C)) shall apply.

''(6) In applying section 2103(e)(3)(B) in the case of a pregnant woman provided coverage under this section, the limitation on total annual aggregate cost-sharing shall be applied to such pregnant woman.

''(7) In applying section 2104(i)—

''(A) in the case of a State which did not provide for coverage for pregnant women under this title (under a waiver or otherwise) during fiscal year 2007, the allotment amount otherwise computed for the first fiscal year in which the State elects to provide coverage under this section shall be increased by an amount (determined by the Secretary) equal to the enhanced FMAP of the expenditures under this title for such coverage, based upon projected enrollment and per capita costs of such enrollment; and

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

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

''(ii) in applying paragraph (3), pregnant women (and per capita expenditures for such women) shall be accounted for separately from children, but shall be included in the total amount of any allotment adjustment under such paragraph.

''(d) AUTOMATIC ENROLLMENT FOR CHILDREN BORN TO WOMEN RECEIVING ASSISTANCE FOR PREGNANT WOMEN.—If a child is born to a targeted low-income pregnant woman who was receiving assistance for pregnant women under this section on the date of the child's birth, the child shall be deemed to have applied for child health assistance under the State child health plan and to have been found eligible for such assistance under such plan or to have applied for medical assistance under title XIX and to have been found eligible for such assistance under such title on the date of such birth, based on the mother's reported income as of the time of her enrollment under this section and applicable income eligibility levels under this title and title XIX, and to remain eligible for such assistance until the child attains 1 year of age. During the period in which a child is deemed under the preceding sentence to be eligible for child health or medical assistance, the assistance for pregnant women or medical assistance eligibility identification number of the mother shall also serve as the identification number of the child, and all claims shall be submitted and paid under such number (unless the State issues a separate identification number for the child before such period expires).''.

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

''(H) Sections 1920 and 1920A (relating to presumptive eligibility for pregnant women and children).''.

(b) AMENDMENTS TO MEDICAID.—

(1) ELIGIBILITY OF A NEWBORN.—Section 1902(e)(4) of the Social Security Act (42 U.S.C. 1396a(e)(4)) is amended in the first sentence by striking ''so long as the child is a member of the woman's household and the woman remains (or would remain if pregnant) eligible for such assistance''.

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

''The term 'qualified provider' also includes a qualified entity, as defined in section 1920A(b)(3).''.

SEC. 134. LIMITATION ON WAIVER AUTHORITY TO COVER ADULTS.

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

''(d) LIMITATION ON COVERAGE OF ADULTS.—Notwithstanding any other provision of this title, the Secretary may not, through the exercise of any waiver authority on or after January 1, 2008, provide for Federal financial participation to a State under this title for health care services for individuals who are not targeted low-income children or pregnant women unless the Secretary determines that no eligible targeted low-income child in the State would be denied coverage under this title for health care services because of such eligibility. In making such determination, the Secretary must receive assurances that—

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

''(2) the State has in place an outreach program to reach all targeted low-income children in families with incomes less than 200 percent of the poverty line.''.

Subtitle E—Access

SEC. 141. CHILDREN'S ACCESS, PAYMENT, AND EQUALITY COMMISSION.

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

''CHILDREN'S ACCESS, PAYMENT, AND EQUALITY COMMISSION

''SEC. 1900. (a) ESTABLISHMENT.—There is hereby established as an agency of Congress the Children's Access, Payment, and Equality Commission (in this section referred to as the 'Commission').

''(b) DUTIES.—

''(1) REVIEW OF PAYMENT POLICIES AND ANNUAL REPORTS.—The Commission shall—

''(A) review Federal and State payment policies of the Medicaid program established under this title (in this section referred to as 'Medicaid') and the State Children's Health Insurance Program established under title XXI (in this section referred to as 'CHIP'), including topics described in paragraph (2);

''(B) review access to, and affordability of, coverage and services for enrollees under Medicaid and CHIP;

''(C) make recommendations to Congress concerning such policies;

''(D) by not later than March 1 of each year, submit to Congress a report containing the results of such reviews and its recommendations concerning such policies; and

''(E) by not later than June 1 of each year, submit to Congress a report containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

''(2) SPECIFIC TOPICS TO BE REVIEWED.—Specifically, the Commission shall review the following:

''(A) The factors affecting expenditures for services in different sectors (such as physician, hospital and other sectors), payment methodologies, and their relationship to access and quality of care for Medicaid and CHIP beneficiaries.

''(B) The impact of Federal and State Medicaid and CHIP payment policies on access to services (including dental services) for children (including children with disabilities) and other Medicaid and CHIP populations.

''(C) The impact of Federal and State Medicaid and CHIP policies on reducing health disparities, including geographic disparities and disparities among minority populations.

''(D) The overall financial stability of the health care safety net, including Federally-qualified health centers, rural health centers, school-based clinics, disproportionate share hospitals, public hospitals, providers and grantees under section 2612(a)(5) of the Public Health Service Act (popularly known as the Ryan White CARE Act), and other providers that have a patient base which includes a disproportionate number of uninsured or low-income individuals and the impact of CHIP and Medicaid policies on such stability.

''(E) The relation (if any) between payment rates for providers and improvement in care for children as measured under the children's health quality measurement program established under section 151 of the Children's Health and Medicare Protection Act of 2007.

''(F) The affordability, cost effectiveness, and accessibility of services needed by special populations under Medicaid and CHIP as compared with private-sector coverage.

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

''(H) The effect of demonstrations under section 1115, benchmark coverage under section 1937, and other coverage under section 1938, on access to care, affordability of coverage, provider ability to achieve children's health quality performance measures, and access to safety net services.

''(3) COMMENTS ON CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to payment policies under Medicaid or CHIP, the Secretary shall transmit a copy of the report to the Commission. The Commission shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as the Commission deems appropriate.

''(4) AGENDA AND ADDITIONAL REVIEWS.—The Commission shall consult periodically with the Chairmen and Ranking Minority Members of the appropriate committees of Congress regarding the Commission's agenda and progress towards achieving the agenda. The Commission may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title or title XXI as may be requested by such Chairmen and Members and as the Commission deems appropriate.

''(5) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

''(6) APPROPRIATE COMMITTEE OF CONGRESS.—For purposes of this section, the term 'appropriate committees of Congress' means the Committees on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

''(7) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each member of the Commission shall vote on the recommendation, and the Commission shall include, by member, the results of that vote in the report containing the recommendation.

''(8) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, the Commission shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.

''(c) APPLICATION OF PROVISIONS.—The following provisions of section 1805 shall apply to the Commission in the same manner as they apply to the Medicare Payment Advisory Commission:

''(1) Subsection (c) (relating to membership), except that the membership of the Commission shall also include representatives of children, pregnant women, individuals with disabilities, seniors, low-income families, and other groups of CHIP and Medicaid beneficiaries.

''(2) Subsection (d) (relating to staff and consultants).

''(3) Subsection (e) (relating to powers).

''(d) AUTHORIZATION OF APPROPRIATIONS.—

''(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

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

SEC. 142. MODEL OF INTERSTATE COORDINATED ENROLLMENT AND COVERAGE PROCESS.

(a) IN GENERAL.—In order to assure continuity of coverage of low-income children under the Medicaid program and the State Children's Health Insurance Program (CHIP), not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States, in consultation with State Medicaid and CHIP directors and organizations representing program beneficiaries, shall develop a model process for the coordination of the enrollment, retention, and coverage under such programs of children who, because of migration of families, emergency evacuations, educational needs, or otherwise, frequently change their State of residency or otherwise are temporarily located outside of the State of their residency.

(b) REPORT TO CONGRESS.—After development of such model process, the Comptroller General shall submit to Congress a report describing additional steps or authority needed to make further improvements to coordinate the enrollment, retention, and coverage under CHIP and Medicaid of children described in subsection (a).

SEC. 143. MEDICAID CITIZENSHIP DOCUMENTATION REQUIREMENTS.

(a) STATE OPTION TO REQUIRE CHILDREN TO PRESENT SATISFACTORY DOCUMENTARY EVIDENCE OF PROOF OF CITIZENSHIP OR NATIONALITY FOR PURPOSES OF ELIGIBILITY FOR MEDICAID; REQUIREMENT FOR AUDITING.—

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

(A) in subsection (a)(46)—

(i) by inserting ''(A)'' after ''(46)''; and

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

''(B) at the option of the State, require that, with respect to a child under 21 years of age (other than an individual described in section 1903(x)(2)) who declares to be a citizen or national of the United States for purposes of establishing initial eligibility for medical assistance under this title (or, at State option, for purposes of renewing or redetermining such eligibility to the extent that such satisfactory documentary evidence of citizenship or nationality has not yet been presented), there is presented satisfactory documentary evidence of citizenship or nationality of the individual (using criteria determined by the State, which shall be no more restrictive than the documentation specified in section 1903(x)(3)); and

''(C) comply with the auditing requirements of section 1903(x)(4);''; and

(C) in subsection (b)(3), by inserting ''or any citizenship documentation requirement for a child under 21 years of age that is more restrictive than what a State may provide under section 1903(x)'' before the period at the end.

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

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

''(B) In conducting audits under subparagraph (A), payments for non-emergency benefits shall be treated as erroneous if the audit could not confirm the citizenship of the individual based either on documentation in the case file or on documentation obtained independently during the audit.

''(C) If the erroneous error rate described in subparagraph (A)—

''(i) exceeds 3 percent, the State shall—

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

''(II) shall develop a corrective action plan; and

''(III) shall conduct another audit the following fiscal year, after the corrective action plan is implemented; or

''(ii) does not exceed 3 percent, the State is not required to conduct another audit under subparagraph (A) until the third fiscal year succeeding the fiscal year for which the audit was conducted.'';

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

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

(1) in subparagraph (C), by striking ''or'' at the end;

(2) by redesignating subparagraph (D) as subparagraph (E); and

(3) by inserting after subparagraph (C) the following new subparagraph:

''(D) pursuant to the application of section 1902(e)(4) (and, in the case of an individual who is eligible for medical assistance on such basis, the individual shall be deemed to have provided satisfactory documentary evidence of citizenship or nationality and shall not be required to provide further documentary evidence on any date that occurs during or after the period in which the individual is eligible for medical assistance on such basis; or''.

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

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

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

''(v) For an individual who is a member of, or enrolled in or affiliated with, a federally-recognized Indian tribe, a document issued by such tribe evidencing such membership, enrollment, or affiliation with the tribe (such as a tribal enrollment card or certificate of degree of Indian blood), and, only with respect to those federally-recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, such other forms of documentation (including tribal documentation, if appropriate) as the Secretary, after consulting with such tribes, determines to be satisfactory documentary evidence of citizenship or nationality for purposes of satisfying the requirement of this subparagraph.''.

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

''(5) In the case of an individual declaring to be a citizen or national of the United States with respect to whom a State requires the presentation of satisfactory documentary evidence of citizenship or nationality under section 1902(a)(46)(B), the individual shall be provided at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality under this subsection as is provided under clauses (i) and (ii) of section 1137(d)(4)(A) to an individual for the submittal to the State of evidence indicating a satisfactory immigration status and shall not be denied medical assistance on the basis of failure to provide such documentation until the individual has had such an opportunity.''.

(e) EFFECTIVE DATE.—

(1) RETROACTIVE APPLICATION.—The amendments made by this section shall take effect as if included in the enactment of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 4).

(2) RESTORATION OF ELIGIBILITY.—In the case of an individual who, during the period that began on July 1, 2006, and ends on the date of the enactment of this Act, was determined to be ineligible for medical assistance under a State Medicaid program solely as a result of the application of subsections (i)(22) and (x) of section 1903 of the Social Security Act (as in effect during such period), but who would have been determined eligible for such assistance if such subsections, as amended by this section, had applied to the individual, a State may deem the individual to be eligible for such assistance as of the date that the individual was determined to be ineligible for such medical assistance on such basis.

SEC. 144. ACCESS TO DENTAL CARE FOR CHILDREN.

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

(b) PROVISION OF DENTAL SERVICES THROUGH FQHCS.—

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

(A) by striking ''and'' at the end of paragraph (69);

(B) by striking the period at the end of paragraph (70) and inserting ''; and''; and

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

''(71) provide that the State will not prevent a Federally-qualified health center from entering into contractual relationships with private practice dental providers in the provision of Federally-qualified health center services.''.

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

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

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

''(B) Section 1902(a)(71) (relating to limiting FQHC contracting for provision of dental services).''.

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

(c) REPORTING INFORMATION ON DENTAL HEALTH.——

(1) MEDICAID.—Section 1902(a)(43)(D)(iii) of such Act (42 U.S.C. 1396a(a)(43)(D)(iii)) is amended by inserting ''and other information relating to the provision of dental services to such children described in section 2108(e)'' after ''receiving dental services,''.

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

''(e) INFORMATION ON DENTAL CARE FOR CHILDREN.—

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

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

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

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

''(2) INCLUSION OF INFORMATION ON ENROLLEES IN MANAGED CARE PLANS.—The information under paragraph (1) shall include information on children who are enrolled in managed care plans and other private health plans and contracts with such plans under this title shall provide for the reporting of such information by such plans to the State.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall be effective for annual reports submitted for years beginning after date of enactment.

(d) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States shall provide for a study that examines—

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

(B) the feasibility and appropriateness of using qualified mid-level dental health providers, in coordination with dentists, to improve access for children to oral health services and public health overall.

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

SEC. 145. PROHIBITING INITIATION OF NEW HEALTH OPPORTUNITY ACCOUNT DEMONSTRATION PROGRAMS.

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

Subtitle F—Quality and Program Integrity

SEC. 151. PEDIATRIC HEALTH QUALITY MEASUREMENT PROGRAM.

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

(1) ESTABLISHMENT OF PROGRAM TO DEVELOP QUALITY MEASURES FOR CHILDREN'S HEALTH.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a child health care quality measurement program (in this subsection referred to as the ''children's health quality measurement program'') to develop and implement—

(A) pediatric quality measures on children's health care that may be used by public and private health care purchasers (and a system for reporting such measures); and

(B) measures of overall program performance that may be used by public and private health care purchasers.

The Secretary shall publish, not later than September 30, 2009, the recommended measures under the program for application under the amendments made by subsection (b) for years beginning with 2010.

(2) MEASURES.—

(A) SCOPE.—The measures developed under the children's health quality measurement program shall—

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

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

(iii) be designed to ensure that the data required for such measures is collected and reported in a standard format that permits comparison at a State, plan, and provider level, and between insured and uninsured children;

(iv) take into account existing measures of child health quality and be periodically updated;

(v) include measures of clinical health care quality which meet the requirements for pediatric quality measures in paragraph (1);

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

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

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

(i) The proportion of insured (and uninsured) children who receive age-appropriate preventive health and dental care (including age appropriate immunizations) at each stage of child health development.

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

(iii) The effectiveness of early health care interventions for children whose assessments indicate the presence or risk of physical or mental conditions that could adversely affect growth and development.

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

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

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

In carrying out clause (vi), the Secretary shall develop quality measures and best practices relating to cystic fibrosis.

(C) REPORTING METHODOLOGY FOR ANALYSIS BY PEDIATRIC CHARACTERISTICS.—The children's health quality measurement program shall describe with specificity such measures and the process by which such measures will be reported in a manner that permits analysis based on each of the following pediatric characteristics:

(i) Age.

(ii) Gender.

(iii) Race.

(iv) Ethnicity.

(v) Primary language of the child's parents (or caretaker relative).

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

(vii) Geographic location.

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

(D) PEDIATRIC QUALITY MEASURE.—In this subsection, the term ''pediatric quality measure'' means a measurement of clinical care that assesses one or more aspects of pediatric health care quality (in various settings) including the structure of the clinical care system, the process and outcome of care, or patient experience in such care.

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

(A) States;

(B) pediatric hospitals, pediatricians, and other primary and specialized pediatric health care professionals (including members of the allied health professions) who specialize in the care and treatment of children, particularly children with special physical, mental, and developmental health care needs;

(C) dental professionals;

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

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

(F) national organizations and individuals with expertise in pediatric health quality performance measurement; and

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

(4) USE OF GRANTS AND CONTRACTS.—In carrying out the children's health quality measurement program, the Secretary may award grants and contracts to develop, test, validate, update, and disseminate quality measures under the program.

(5) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to States to establish for the reporting of quality measures under titles XIX and XXI of the Social Security Act in accordance with the children's health quality measurement program.

(b) DISSEMINATION OF INFORMATION ON THE QUALITY OF PROGRAM PERFORMANCE.—Not later than January 1, 2009, and annually thereafter, the Secretary shall collect, analyze, and make publicly available on a public website of the Department of Health and Human Services in an online format—

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

(2) information on health care quality for children contained in external quality review reports required under section 1932(c)(2) of such Act (42 U.S.C. 1396u–2) or produced by States that administer separate plans under title XXI of such Act.

(c) REPORTS TO CONGRESS ON PROGRAM PERFORMANCE.—Not later than January 1, 2010, and every 2 years thereafter, the Secretary shall report to Congress on—

(1) the quality of health care for children enrolled under title XIX and XXI of the Social Security Act under the children's health quality measurement program; and

(2) patterns of health care utilization with respect to the measures specified in subsection (a)(2)(B) among children by the pediatric characteristics listed in subsection (a)(2)(C).

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

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

''(3) COMPLIANCE WITH MANAGED CARE REQUIREMENTS.—The State child health plan shall provide for the application of subsections (a)(4), (a)(5), (b), (c), (d), and (e) of section 1932 (relating to requirements for managed care) to coverage, State agencies, enrollment brokers, managed care entities, and managed care organizations under this title in the same manner as such subsections apply to coverage and such entities and organizations under title XIX.''.

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

SEC. 153. UPDATED FEDERAL EVALUATION OF CHIP.

Section 2108(c) of the Social Security Act (42 U.S.C. 1397hh(c)) is amended by striking paragraph (5) and inserting the following:

''(5) SUBSEQUENT EVALUATION USING UPDATED INFORMATION.—

''(A) IN GENERAL.—The Secretary, directly or through contracts or interagency agreements, shall conduct an independent subsequent evaluation of 10 States with approved child health plans.

''(B) SELECTION OF STATES AND MATTERS INCLUDED.—Paragraphs (2) and (3) shall apply to such subsequent evaluation in the same manner as such provisions apply to the evaluation conducted under paragraph (1).

''(C) SUBMISSION TO CONGRESS.—Not later than December 31, 2010, the Secretary shall submit to Congress the results of the evaluation conducted under this paragraph.

''(D) FUNDING.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $10,000,000 for fiscal year 2009 for the purpose of conducting the evaluation authorized under this paragraph. Amounts appropriated under this subparagraph shall remain available for expenditure through fiscal year 2011.''.

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

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

''(d) ACCESS TO RECORDS FOR IG AND GAO AUDITS AND EVALUATIONS.—For the purpose of evaluating and auditing the program established under this title, the Secretary, the Office of Inspector General, and the Comptroller General shall have access to any books, accounts, records, correspondence, and other documents that are related to the expenditure of Federal funds under this title and that are in the possession, custody, or control of States receiving Federal funds under this title or political subdivisions thereof, or any grantee or contractor of such States or political subdivisions.''.

SEC. 155. REFERENCES TO TITLE XXI.

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

SEC. 156. RELIANCE ON LAW; EXCEPTION FOR STATE LEGISLATION.

(a) RELIANCE ON LAW.— With respect to amendments made by this title or title VIII that become effective as of a date—

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

(2) Federal financial participation for medical assistance or child health assistance furnished under title XIX or XXI, respectively, of the Social Security Act on or after such date by a State in good faith reliance on such amendments before the date of promulgation of final regulations, if any, to carry out such amendments (or before the date of guidance, if any, regarding the implementation of such amendments) shall not be denied on the basis of the State's failure to comply with such regulations or guidance.

(b) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX or State child health plan under XXI of the Social Security Act, which the Secretary of Health and Human Services determines requires State legislation in order for respective plan to meet one or more additional requirements imposed by amendments made by this title or title VIII, the respective 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 such an additional requirement 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 shall be considered to be a separate regular session of the State legislature.

TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS

Subtitle A—Improvements in Benefits

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

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

(1) in subsection (s)(2)—

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

(B) in subparagraph (AA), by adding ''and'' after the semicolon at the end; and

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

''(BB) additional preventive services (described in subsection (ccc)(1)(M));''; and

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

''Preventive Services

''(ccc)(1) The term 'preventive services' means the following:

''(A) Prostate cancer screening tests (as defined in subsection (oo)).

''(B) Colorectal cancer screening tests (as defined in subsection (pp)).

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

''(D) Screening for glaucoma for certain individuals (as described in subsection (s)(2)(U)).

''(E) Medical nutrition therapy services for certain individuals (as described in subsection (s)(2)(V)).

''(F) An initial preventive physical examination (as defined in subsection (ww)).

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

''(H) Diabetes screening tests (as defined in subsection described in subsection (s)(2)(Y)).

''(I) Ultrasound screening for abdominal aortic aneurysm for certain individuals (as described in described in subsection (s)(2)(AA)).

''(J) Pneumococcal and influenza vaccine and their administration (as described in subsection (s)(10)(A)).

''(K) Hepatitis B vaccine and its administration for certain individuals (as described in subsection (s)(10)(B)).

''(L) Screening mammography (as defined in subsection (jj)).

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

''(N) Bone mass measurement (as defined in subsection (rr)).

''(O) Additional preventive services (as determined under paragraph (2)).

''(2)(A) The term `additional preventive services' means items and services, including mental health services, not described in subparagraphs (A) through (N) of paragraph (1) that the Secretary determines to be reasonable and necessary for the prevention or early detection of an illness or disability.

''(B) In making determinations under subparagraph (1), the Secretary shall—

''(C) take into account evidence-based recommendations by the United States Preventive Services Task Force and other appropriate organizations; and

''(D) use the process for making national coverage determinations (as defined in section 1869(f)(1)(B)) under this title.''.

(b) PAYMENT AND ELIMINATION OF COST-SHARING.—

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

(A) in clause (T), by striking ''80 percent'' and inserting ''100 percent''; and

(B) by striking ''and'' before ''(V)''; and

(C) by inserting before the semicolon at the end the following: '', and (W) with respect to additional preventive services (as defined in section 1861(ccc)(2)) and other preventive services for which a payment rate is not otherwise established under this section, the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under a fee schedule established by the Secretary for purposes of this clause''.

(2) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 13951(t)(1)(B)(iv)) is amended by striking ''screening mammography (as defined in section 1861(jj)) and diagnostic mammography'' and inserting ''diagnostic mammography and preventive services (as defined in section 1861(ccc)(1))''.

(B) CONFORMING AMENDMENTS.—Section 1833(a)(2) of the Social Security Act (42 U.S.C. 13951(a)(2)) is amended—

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

(ii) in subparagraph (G)(ii), by adding ''and''at the end; and

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

''(H) with respect to additional preventive services (as defined in section 1861(ccc)(2)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(W);''.

(3) WAIVER OF APPLICATION OF DEDUCTIBLE FOR ALL PREVENTIVE SERVICES.—The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 13951(b)) is amended —

(A) in clause (1), by striking ''items and services described in section 1861(s)(10)(A)'' and inserting ''preventive services (as defined in section 1861(ccc)(1))'';

(B) by inserting ''and'' before ''(4)''; and

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

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

''(M) Additional preventive services (as defined in subsection (ccc)(2)).''.

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

SEC. 202. WAIVER OF DEDUCTIBLE FOR COLORECTAL CANCER SCREENING TESTS REGARDLESS OF CODING, SUBSEQUENT DIAGNOSIS, OR ANCILLARY TISSUE REMOVAL.

(a) IN GENERAL.—Section 1833(b)(8) of the Social Security Act (42 U.S.C. 13951(b)(8)) is amended by inserting '', regardless of the code applied, of the establishment of a diagnosis as a result of the test, or of the removal of tissue or other matter or other procedure that is performed in connection with and as a result of the screening test'' after ''1861(pp)(1))''.

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

SEC. 203. PARITY FOR MENTAL HEALTH COINSURANCE.

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

(1) in the first sentence, by striking ''62–1/2 percent'' and inserting ''the incurred expense percentage (as specified in the last sentence)''; and

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

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

SEC. 211. IMPROVING ASSETS TESTS FOR MEDICARE SAVINGS PROGRAM AND LOW-INCOME SUBSIDY PROGRAM.

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

(1) TO FULL-PREMIUM SUBSIDY ELIGIBLE INDIVIDUALS.—Section 1860D–14(a) of the Social Security Act (42 U.S.C. 1395w–114(a)) is amended—

(A) in paragraph (1), in the matter before subparagraph (A), by inserting ''(or, beginning with 2009, paragraph (3)(E))'' after ''paragraph (3)(D)''; and

(B) in paragraph (3)(A)(iii), by striking ''(D) or''.

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

(A) by striking ''and'' at the end of subclause (I);

(B) in subclause (II), by inserting ''(before 2009)'' after ''subsequent year'';

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

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

''(III) for 2009, $17,000 (or $34,000 in the case of the combined value of the individual's assets or resources and the assets or resources of the individual's spouse); and

''(IV) for a subsequent year, the dollar amounts specified in this subclause (or subclause (III)) for the previous year increased by $1,000 (or $2,000 in the case of the combined value referred to in subclause (III)).''.

(3) APPLICATION OF LIS TEST UNDER MEDICARE SAVINGS PROGRAM.—Section 1905(p)(1)(C) of such Act (42 U.S.C. 1396d(p)(1)(C)) is amended by inserting before the period at the end the following: ''or, effective beginning with January 1, 2009, whose resources (as so determined) do not exceed the maximum resource level applied for the year under section 1860D–14(a)(3)(E) applicable to an individual or to the individual and the individual's spouse (as the case may be)''.

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

SEC. 212. MAKING QI PROGRAM PERMANENT AND EXPANDING ELIGIBILITY.

(a) MAKING PROGRAM PERMANENT.—

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

(A) by striking ''sections 1933 and'' and by inserting ''section''; and

(B) by striking ''(but only with'' and all that follows through ''September 2007)''.

(2) ELIMINATION OF FUNDING LIMITATION.—

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

(i) in subsection (a), by striking ''who are selected to receive such assistance under subsection (b)''

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

(iii) in subsection (d), by striking ''furnished in a State'' and all that follows and inserting ''the Federal medical assistance percentage shall be equal to 100 percent.''; and

(iv) by redesignating subsections (d) and (f) as subsections (b) and (c), respectively.

(B) CONFORMING AMENDMENT.—Section 1905(b) of such Act (42 U.S.C. 1396d(b)) is amended by striking ''1933(d)'' and inserting ''1933(b)''.

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

(b) INCREASE IN ELIGIBILITY TO 150 PERCENT OF THE FEDERAL POVERTY LEVEL.—Section 1902(a)(10)(E)(iv) of such Act is further amended by inserting ''(or, effective January 1, 2008, 150 percent)'' after ''135 percent''.

SEC. 213. ELIMINATING BARRIERS TO ENROLLMENT.

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

''(G) SELF-CERTIFICATION OF INCOME AND RESOURCES.—For purposes of applying this section, an individual shall be permitted to qualify on the basis of self-certification of income and resources without the need to provide additional documentation.''.

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

''(H) AUTOMATIC REENROLLMENT.—For purposes of applying this section, in the case of an individual who has been determined to be a subsidy eligible individual (and within a particular class of such individuals, such as a full-subsidy eligible individual or a partial subsidy eligible individual), the individual shall be deemed to continue to be so determined without the need for any annual or periodic application unless and until the individual notifies a Federal or State official responsible for such determinations that the individual's eligibility conditions have changed so that the individual is no longer a subsidy eligible individual (or is no longer within such class of such individuals).''.

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

''(7) The Secretary shall take all reasonable steps to encourage States to provide for administrative verification of income and automatic reenrollment (as provided under clauses (iii) and (iv) of section 1860D–14(a)(3)(C) in the case of the low-income subsidy program).''.

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

''(c) ASSISTANCE WITH MEDICARE SAVINGS PROGRAM AND LOW-INCOME SUBSIDY PROGRAM APPLICATIONS.—

''(1) DISTRIBUTION OF APPLICATIONS TO APPLICANTS FOR MEDICARE.—In the case of each individual applying for hospital insurance benefits under section 226 or 226A, the Commissioner shall provide the following:

''(A) Information describing the low-income subsidy program under section 1860D–14 and the medicare savings program under title XIX.

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

''(C) Information on how the individual may obtain assistance in completing such applications, including information on how the individual may contact the State health insurance assistance program (SHIP) for the State in which the individual is located.

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

''(2) TRAINING PERSONNEL IN ASSISTING IN COMPLETING APPLICATIONS.—The Commissioner shall provide training to those employees of the Social Security Administration who are involved in receiving applications for benefits described in paragraph (1) in assisting applicants in completing a medicare savings program application described in paragraph (1). Such employees who are so trained shall provide such assistance upon request.

''(3) TRANSMITTAL OF COMPLETED APPLICATION.—If such an employee assists in completing such an application, the employee, with the consent of the applicant, shall transmit the completed application to the appropriate State medicaid agency for processing.

''(4) COORDINATION WITH OUTREACH.—The Commissioner shall coordinate outreach activities under this subsection with outreach activities conducted by States in connection with the low-income subsidy program and the medicare savings program.''.

(e) MEDICAID AGENCY CONSIDERATION OF APPLICATIONS.—Section 1935(a) of such Act (42 U.S.C. 1396u–5(a)) is amended by adding at the end the following new paragraph:

''(4) CONSIDERATION OF MSP APPLICATIONS.—The State shall accept medicare savings program applications transmitted under section 1144(c)(3) and act on such applications in the same manner and deadlines as if they had been submitted directly by the applicant.''.

(f) TRANSLATION OF MODEL FORM.—Section 1905(p)(5)(A) of the Social Security Act (42 U.S.C. 1396d(p)(5)(A)) is amended by adding at the end the following: ''The Secretary shall provide for the translation of such application form into at least the 10 languages (other than English) that are most often used by individuals applying for hospital insurance benefits under section 226 or 226A and shall make the translated forms available to the States and to the Commissioner of Social Security.''.

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

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

''(21) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF PROVIDING LOW-INCOME SUBSIDIES UNDER MEDICARE.—

''(A) RETURN INFORMATION FROM INTERNAL REVENUE SERVICE TO SOCIAL SECURITY ADMINISTRATION.—The Secretary, upon written request from the Commissioner of Social Security, shall disclose to the officers and employees of the Social Security Administration with respect to any individual identified by the Commissioner as potentially eligible (based on information other than return information) for low-income subsidies under section 1860D–14 of the Social Security Act—

''(i) whether the adjusted gross income for the applicable year is less than 135 percent of the poverty line (as specified by the Commissioner in such request),

''(ii) whether such adjusted gross income is between 135 percent and 150 percent of the poverty line (as so specified),

''(iii) whether any designated distributions (as defined in section 3405(e)(1)) were reported with respect to such individual under section 6047(d) for the applicable year, and the amount (if any) of the distributions so reported,

''(iv) whether the return was a joint return for the applicable year, and

''(v) the applicable year.

''(B) APPLICABLE YEAR.—

''(i) IN GENERAL.—For the purposes of this paragraph, the term 'applicable year' means the most recent taxable year for which information is available in the Internal Revenue Service's taxpayer data information systems, or, if there is no return filed for the individual for such year, the prior taxable year.

''(ii) NO RETURN.—If no return is filed for such individual for both taxable years referred to in clause (i), the Secretary shall disclose the fact that there is no return filed for such individual for the applicable year in lieu of the information described in subparagraph (A).

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

''(D) TERMINATION.—No disclosure shall be made under this paragraph after the 2-year period beginning on the date of the enactment of this paragraph.''.

(2) PROCEDURES AND RECORDKEEPING RELATED TO DISCLOSURES.—Paragraph (4) of section 6103(p) of such Code is amended by striking ''or (17)'' each place it appears and inserting ''(17), or (21)''.

(3) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Secretary of the Treasury, after consultation with the Commissioner of Social Security, shall submit a written report to Congress regarding the use of disclosures made under section 6103(l)(21) of the Internal Revenue Code of 1986, as added by this subsection, in identifying individuals eligible for the low-income subsidies under section 1860D–14 of the Social Security Act.

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

(h) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall take effect on January 1, 2009.

SEC. 214. ELIMINATING APPLICATION OF ESTATE RECOVERY.

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

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

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

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

(1) in the heading, by striking ''INSTITUTIONALIZED INDIVIDUALS.—In'' and inserting ''ELIMINATION OF COST-SHARING FOR CERTAIN FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

''(I) INSTITUTIONALIZED INDIVIDUALS.—In''; and

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

''(II) CERTAIN OTHER INDIVIDUALS.—In the case of an individual who is a full-benefit dual eligible individual and with respect to whom there has been a determination that but for the provision of home and community based care (whether under section 1915 or under a waiver under section 1115) the individual would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan under title XIX, the elimination of any beneficiary coinsurance described in section 1860D–2(b)(2) (for all

amounts through the total amount of expenditures at which benefits are available under section 1860D–2(b)(4)).''.

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

SEC. 216. EXEMPTIONS FROM INCOME AND RESOURCES FOR DETERMINATION OF ELIGIBILITY FOR LOW-INCOME SUBSIDY.

(a) IN GENERAL.—Section 1860D–14(a)(3) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)), as amended by subsections (a) and (b) of section 213, is further amended—

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

(2) in subparagraph (D), in the matter before clause (i), by inserting ''subject to the additional exclusions provided under subparagraph (G)'' before '')'';

(3) in subparagraph (E)(i), in the matter before subclause (I), by inserting ''subject to the additional exclusions provided under subparagraph (G)'' before '')''; and

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

''(I) ADDITIONAL EXCLUSIONS.—In determining the resources of an individual (and the eligible spouse of the individual, if any) under section 1613 for purposes of subparagraphs (D) and (E) the following additional exclusions shall apply:

''(i) LIFE INSURANCE POLICY.—No part of the value of any life insurance policy shall be taken into account.

''(ii) PENSION OR RETIREMENT PLAN.—No balance in any pension or retirement plan shall be taken into account.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2009, and shall apply to determinations of eligibility for months beginning with January 2009.

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

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

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

''(iv) OVERALL LIMITATION ON COST-SHARING.—In the case of all such individuals, a limitation on aggregate cost-sharing under this part for a year not to exceed 2.5 percent of income.''; and

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

''(F) OVERALL LIMITATION ON COST-SHARING.—A limitation on aggregate cost-sharing under this part for a year not to exceed 2.5 percent of income.''.

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

SEC. 218. INTELLIGENT ASSIGNMENT IN ENROLLMENT.

(a) IN GENERAL.—Section 1860D–1(b)(1) of the Social Security Act (42 U.S.C. 1395w–101(b)(1) is amended—

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

(2) by adding at the end the following new subparagraph:''.

''(D) INTELLIGENT ASSIGNMENT.—In the case of any auto-enrollment under subparagraph (C), no part D eligible individual described in such subparagraph shall be enrolled in a prescription drug plan which does not meet the following requirements:

''(i) FORMULARY.—The plan has a formulary that covers at least—

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

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

''(ii) PHARMACY NETWORK.—The plan has a network of pharmacies that substantially exceeds the minimum requirements for prescription drug plans in the State and that provides access in areas where lower income individuals reside.

''(iii) QUALITY.—

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

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

''(iv) LOW COST.—The total cost under this title of providing prescription drug coverage under the plan consistent with the previous clauses of this subparagraph is among the lowest 25th percentile of prescription drug plans under this part in the State.

In the case that no plan meets the requirements under clauses (i) through (iv), the Secretary shall implement this subparagraph to the greatest extent possible with the goal of protecting beneficiary access to drugs without increasing the cost relative to the enrollment process under subparagraph (C) as in existence before the date of the enactment of this subparagraph.''.

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

Subtitle C—Part D Beneficiary Improvements

SEC. 221. INCLUDING COSTS INCURRED BY AIDS DRUG ASSISTANCE PROGRAMS AND INDIAN HEALTH SERVICE IN PROVIDING PRESCRIPTION DRUGS TOWARD THE ANNUAL OUT OF POCKET THRESHOLD UNDER PART D.

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

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

(2) in clause (ii)—

(A) by striking ''such costs shall be treated as incurred only if'' and inserting ''subject to clause (iii), such costs shall be treated as incurred only if'';

(B) by striking '', under section 1860D–14, or under a State Pharmaceutical Assistance Program''; and

(C) by striking the period at the end and inserting ''; and''; and

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

''(iii) such costs shall be treated as incurred and shall not be considered to be reimbursed under clause (ii) if such costs are borne or paid—

''(I) under section 1860D–14;

''(II) under a State Pharmaceutical Assistance Program;

''(III) by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act); or

''(IV) under an AIDS Drug Assistance Program under part B of title XXVI of the Public Health Service Act.''.

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

SEC. 222. PERMITTING MID-YEAR CHANGES IN ENROLLMENT FOR FORMULARY CHANGES ADVERSELY IMPACT AN ENROLLEE.

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

''(F) CHANGE IN FORMULARY RESULTING IN INCREASE IN COST-SHARING.—

''(i) IN GENERAL.—Except as provided in clause (ii), in the case of an individual enrolled in a prescription drug plan (or MA–PD plan) who has been prescribed a covered part D drug while so enrolled, if the formulary of the plan is materially changed (other than at the end of a contract year) so to reduce the coverage (or increase the cost-sharing) of the drug under the plan.

''(ii) EXCEPTION.—Clause (i) shall not apply in the case that a drug is removed from the formulary of a plan because of a recall or withdrawal of the drug issued by the Food and Drug Administration.''.

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

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

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

(1) by striking ''subparagraph (E)'' and inserting ''subparagraphs (E) and (J)''; and

(2) by inserting ''and benzodiazepines, respectively'' after ''smoking cessation agents''.

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

SEC. 224. PERMITTING UPDATING DRUG COMPENDIA UNDER PART D USING PART B UPDATE PROCESS.

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

''(iv) UPDATING DRUG COMPENDIA USING PART B PROCESS.—The Secretary may apply under this subparagraph the same process for updating drug compendia that is used for purposes of section 1861(t)(2)(B)(ii).''.

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

(a) IN GENERAL.—Section 1860D–4(b)(3) of the Social Security Act (42 U.S.C. 1395w–104(b)(3)) is amended—

(1) in subparagraph (C)(i), by inserting '', except as provided in subparagraph (G),'' after ''although''; and

(2) by inserting after subparagraph (F) the following new subparagraph:

''(G) REQUIRED INCLUSION OF DRUGS IN CERTAIN THERAPEUTIC CLASSES.—

''(i) IN GENERAL.—The formulary must include all or substantially all covered part D drugs in each of the following therapeutic classes of covered part D drugs:

''(I) Anticonvulsants.

''(II) Antineoplastics.

''(III) Antiretrovirals.

''(IV) Antidepressants.

''(V) Antipsychotics.

''(VI) Immunosuppresessants.

''(ii) USE OF UTILIZATION MANAGEMENT TOOLS.—A PDP sponsor of a prescription drug plan may use prior authorization or step therapy for the initiation of medications within one of the classifications specified in clause (i) but only when approved by the Secretary, except that such prior authorization or step therapy may not be used in the case of antiretrovirals and in the case of individuals who already are stabilized on a drug treatment regimen.''.

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

SEC. 226. ELIMINATION OF MEDICARE PART D LATE ENROLLMENT PENALTIES PAID BY LOW-INCOME SUBSIDY-ELIGIBLE INDIVIDUALS.

(a) INDIVIDUALS WITH INCOME BELOW 135 PERCENT OF POVERTY LINE.—Paragraph (1)(A)(ii) of section 1860D–14(a) of the Social Security Act (42 U.S.C. 1395w–114(a)) is amended to read as follows:

''(ii) 100 percent of any late enrollment penalties imposed under section 1860D–13(b) for such individual.''.

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

(1) by inserting ''equal to (i) an amount'' after ''premium subsidy'';

(2) by striking ''paragraph (1)(A)'' and inserting ''clause (i) of paragraph (1)(A)''; and

(3) by adding at the end before the period the following: '', plus (ii) 100 percent of the amount described in clause (ii) of such paragraph for such individual''.

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

SEC. 227. SPECIAL ENROLLMENT PERIOD FOR SUBSIDY ELIGIBLE INDIVIDUALS.

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

''(G) ELIGIBILITY FOR LOW-INCOME SUBSIDY.—

''(i) IN GENERAL.—In the case of an applicable subsidy eligible individual (as defined in clause (ii)), the special enrollment period described in clause (iii).

''(ii) APPLICABLE SUBSIDY ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this subparagraph, the term 'applicable subsidy eligible individual' means a part D eligible individual who is determined under subparagraph (B) of section 1860D–14(a)(3) to be a subsidy eligible individual (as defined in subparagraph (A) of such section), and includes such an individual who was enrolled in a prescription drug plan or an MA–PD plan on the date of such determination.

''(iii) SPECIAL ENROLLMENT PERIOD DESCRIBED.—The special enrollment period described in this clause, with respect to an applicable subsidy eligible individual, is the 90-day period beginning on the date the individual receives notification that such individual has been determined under section 1860D–14(a)(3)(B) to be a subsidy eligible individual (as so defined).''.

(b) AUTOMATIC ENROLLMENT PROCESS FOR CERTAIN SUBSIDY ELIGIBLE INDIVIDUALS.—Section 1860D–1(b)(1) of the Social Security Act (42 U.S.C. 1395w–101(b)(1)), as amended by section 218(a)(2), is further amended by adding at the end the following new subparagraph:

''(E) SPECIAL RULE FOR SUBSIDY ELIGIBLE INDIVIDUALS.—The process established under subparagraph (A) shall include, in the case of an applicable subsidy eligible individual (as defined in clause (ii) of paragraph (3)(F)) who fails to enroll in a prescription drug plan or an MA–PD plan during the special enrollment period described in clause (iii) of such paragraph applicable to such individual, a process for the facilitated enrollment of the individual in the prescription drug plan or MA–PD plan that is most appropriate for such individual (as determined by the Secretary). Nothing in the previous sentence shall prevent an individual described in such sentence from declining enrollment in a plan determined appropriate by the Secretary (or in the program under this part) or from changing such enrollment.''.

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

Subtitle D—Reducing Health Disparities

SEC. 231. MEDICARE DATA ON RACE, ETHNICITY, AND PRIMARY LANGUAGE.

(a) REQUIREMENTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary'') shall—

(A) collect data on the race, ethnicity, and primary language of each applicant for and recipient of benefits under title XVIII of the Social Security Act—

(i) using, at a minimum, the categories for race and ethnicity described in the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity;

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

(iii) where practicable, collecting data for additional population groups if such groups can be aggregated into the minimum race and ethnicity categories; and

(iv) where practicable, through self-reporting;

(B) with respect to the collection of the data described in subparagraph (A) for applicants and recipients who are minors or otherwise legally incapacitated, require that—

(i) such data be collected from the parent or legal guardian of such an applicant or recipient; and

(ii) the preferred language of the parent or legal guardian of such an applicant or recipient be collected;

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

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

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

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

(A) to permit the use of information collected under this subsection in a manner that would adversely affect any individual providing any such information; and

(B) to require health care providers to collect data.

(b) PROTECTION OF DATA.—The Secretary shall ensure (through the promulgation of regulations or otherwise) that all data collected pursuant to subsection (a) is protected—

(1) under the same privacy protections as the Secretary applies to other health data under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033) relating to the privacy of individually identifiable health information and other protections; and

(2) from all inappropriate internal use by any entity that collects, stores, or receives the data, including use of such data in determinations of eligibility (or continued eligibility) in health plans, and from other inappropriate uses, as defined by the Secretary.

(c) COLLECTION PLAN.—In carrying out the duties specified in subsection (a), the Secretary shall develop and implement a plan to improve the collection, analysis, and reporting of racial, ethnic, and primary language data within the programs administered under title XVIII of the Social Security Act, and, in consultation with the National Committee on Vital Health Statistics, the Office of Minority Health, and other appropriate public and private entities, shall make recommendations on how to—

(1) implement subsection (a) while minimizing the cost and administrative burdens of data collection and reporting;

(2) expand awareness that data collection, analysis, and reporting by race, ethnicity, and primary language is legal and necessary to assure equity and non-discrimination in the quality of health care services;

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

(4) improve health and health care data collection and analysis for more population groups if such groups can be aggregated into the minimum race and ethnicity categories;

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

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

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

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

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

(1) IN GENERAL.—The Secretary may, either directly or through grant or contract, provide technical assistance to enable a health care provider or plan operating under the Medicare program to comply with the requirements of this section.

(2) TYPES OF ASSISTANCE.—Assistance provided under this subsection may include assistance to—

(A) enhance or upgrade computer technology that will facilitate racial, ethnic, and primary language data collection and analysis;

(B) improve methods for health data collection and analysis including additional population groups beyond the Office of Management and Budget categories if such groups can be aggregated into the minimum race and ethnicity categories;

(C) develop mechanisms for submitting collected data subject to existing privacy and confidentiality regulations; and

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

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

(1) identify appropriate quality assurance mechanisms to monitor for health disparities under the Medicare program;

(2) specify the clinical, diagnostic, or therapeutic measures which should be monitored;

(3) develop new quality measures relating to racial and ethnic disparities in health and health care;

(4) identify the level at which data analysis should be conducted; and

(5) share data with external organizations for research and quality improvement purposes, in compliance with applicable Federal privacy laws.

(h) REPORT.—Not later than 2 years after the date of enactment of this Act, and biennially thereafter, the Secretary shall submit to the appropriate committees of Congress a report on the effectiveness of data collection, analysis, and reporting on race, ethnicity, and primary language under the programs administered through title XVIII of the Social Security Act. The report shall evaluate the progress made with respect to the plan under subsection (c) or subsequent revisions thereto.

(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2008 through 2012.

SEC. 232. ENSURING EFFECTIVE COMMUNICATION IN MEDICARE.

(a) ENSURING EFFECTIVE COMMUNICATION BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(1) STUDY ON MEDICARE PAYMENTS FOR LANGUAGE SERVICES.—The Secretary of Health and Human Services shall conduct a study that examines ways that Medicare should develop payment systems for language services using the results of the demonstration program conducted under section 233.

(2) ANALYSES.— The study shall include an analysis of each of the following:

(A) How to develop and structure appropriate payment systems for language services for all Medicare service providers.

(B) The feasibility of adopting a payment methodology for on-site interpreters, including interpreters who work as independent contractors and interpreters who work for agencies that provide on-site interpretation, pursuant to which such interpreters could directly bill Medicare for services provided in support of physician office services for an LEP Medicare patient.

(C) The feasibility of Medicare contracting directly with agencies that provide off-site interpretation including telephonic and video interpretation pursuant to which such contractors could directly bill Medicare for the services provided in support of physician office services for an LEP Medicare patient.

(D) The feasibility of modifying the existing Medicare resource-based relative value scale (RBRVS) by using adjustments (such as multipliers or add-ons) when a patient is LEP.

(E) How each of options described in a previous paragraph would be funded and how such funding would affect physician payments, a physician's practice, and beneficiary cost-sharing.

(3) VARIATION IN PAYMENT SYSTEM DESCRIBED.—The payment systems described in subsection (b) may allow variations based upon types of service providers, available delivery methods, and costs for providing language services including such factors as—

(A) the type of language services provided (such as provision of health care or health care related services directly in a non-English language by a bilingual provider or use of an interpreter);

(B) type of interpretation services provided (such as in-person, telephonic, video interpretation);

(C) the methods and costs of providing language services (including the costs of providing language services with internal staff or through contract with external independent contractors and/or agencies);

(D) providing services for languages not frequently encountered in the United States; and

(E) providing services in rural areas.

(4) REPORT.—The Secretary shall submit a report on the study conducted under subsection (a) to appropriate committees of Congress not later than 1 year after the expiration of the demonstration program conducted under section 3.

(b) HEALTH PLANS.—Section 1857(g)(1) of the Social Security Act (42 U.S.C. 1395w–27(g)(1)) is amended—

(1) by striking ''or'' at the end of subparagraph (F);

(2) by adding ''and'' at the end of subparagraph (G); and

(3) by inserting after subparagraph (G) the following new subparagraph:

''(H) fails substantially to provide language services to limited English proficient beneficiaries enrolled in the plan that are required under law;''.

SEC. 233. DEMONSTRATION TO PROMOTE ACCESS FOR MEDICARE BENEFICIARIES WITH LIMITED ENGLISH PROFICIENCY BY PROVIDING REIMBURSEMENT FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES.

(a) IN GENERAL.—Within one year after the date of the enactment of this Act the Secretary, acting through the Centers for Medicare & Medicaid Services, shall award 24 3-year demonstration grants to eligible Medicare service providers to improve effective communication between such providers and Medicare beneficiaries who are limited English proficient. The Secretary shall not authorize a grant larger than $500,000 over three years for any grantee.

(b) ELIGIBILITY; PRIORITY.—

(1) ELIGIBILITY.—To be eligible to receive a grant under subsection (1) an entity shall—

(A) be—

(i) a provider of services under part A of title XVIII of the Social Security Act;

(ii) a service provider under part B of such title;

(iii) a part C organization offering a Medicare part C plan under part C of such title; or

(iv) a PDP sponsor of a prescription drug plan under part D of such title; and

(B) prepare and submit to the Secretary an application, at such time, in such manner, and accompanied by such additional information as the Secretary may require.

(2) PRIORITY.—

(A) DISTRIBUTION.—To the extent feasible, in awarding grants under this section, the Secretary shall award—

(i) 6 grants to providers of services described in paragraph (1)(A)(i);

(ii) 6 grants to service providers described in paragraph (1)(A)(ii);

(iii) 6 grants to organizations described in paragraph (1)(A)(iii); and

(iv) 6 grants to sponsors described in paragraph (1)(A)(iv).

(B) FOR COMMUNITY ORGANIZATIONS.—The Secretary shall give priority to applicants that have developed partnerships with community organizations or with agencies with experience in language access.

(C) VARIATION IN GRANTEES.—The Secretary shall also ensure that the grantees under this section represent, among other factors, variations in—

(i) different types of service providers and organizations under parts A through D of title XVIII of the Social Security Act;

(ii) languages needed and their frequency of use;

(iii) urban and rural settings;

(iv) at least two geographic regions; and

(v) at least two large metropolitan statistical areas with diverse populations.

(c) USE OF FUNDS.—

(1) IN GENERAL.—A grantee shall use grant funds received under this section to pay for the provision of competent language services to Medicare beneficiaries who are limited English proficient. Competent interpreter services may be provided through on-site interpretation, telephonic interpretation, or video interpretation or direct provision of health care or health care related services by a bilingual health care provider. A grantee may use bilingual providers, staff, or contract interpreters. A grantee may use grant funds to pay for competent translation services. A grantee may use up to 10 percent of the grant funds to pay for administrative costs associated with the provision of competent language services and for reporting required under subsection (E).

(2) ORGANIZATIONS.—Grantees that are part C organizations or PDP sponsors must ensure that their network providers receive at least 50 percent of the grant funds to pay for the provision of competent language services to Medicare beneficiaries who are limited English proficient, including physicians and pharmacies.

(3) DETERMINATION OF PAYMENTS FOR LANGUAGE SERVICES.—Payments to grantees shall be calculated based on the estimated numbers of LEP Medicare beneficiaries in a grantee's service area utilizing—

(A) data on the numbers of limited English proficient individuals who speak English less than ''very well'' from the most recently available data from the Bureau of the Census or other State-based study the Secretary determines likely to yield accurate data regarding the number of LEP individuals served by the grantee; or

(B) the grantee's own data if the grantee routinely collects data on Medicare beneficiaries' primary language in a manner determined by the Secretary to yield accurate data and such data shows greater numbers of LEP individuals than the data listed in subparagraph (A).

(4) LIMITATIONS.—

(A) REPORTING.—Payments shall only be provided under this section to grantees that report their costs of providing language services as required under subsection (e). If a grantee fails to provide the reports under such section for the first year of a grant, the Secretary may terminate the grant and solicit applications from new grantees to participate in the subsequent two years of the demonstration program.

(B) TYPE OF SERVICES.—

(i) IN GENERAL.—Subject to clause (ii), payments shall be provided under this section only to grantees that utilize competent bilingual staff or competent interpreter or translation services which—

(I) if the grantee operates in a State that has statewide health care interpreter standards, meet the State standards currently in effect; or

(II) if the grantee operates in a State that does not have statewide health care interpreter standards, utilizes competent interpreters who follow the National Council on Interpreting in Health Care's Code of Ethics and Standards of Practice.

(ii) EXEMPTIONS.—The requirements of clause (i) shall not apply—

(I) in the case of a Medicare beneficiary who is limited English proficient (who has been informed in the beneficiary's primary language of the availability of free interpreter and translation services) and who requests the use of family, friends, or other persons untrained in interpretation or translation and the grantee documents the request in the beneficiary's record; and

(II) in the case of a medical emergency where the delay directly associated with obtaining a competent interpreter or translation services would jeopardize the health of the patient.

Nothing in clause (ii)(II) shall be construed to exempt an emergency rooms or similar entities that regularly provide health care services in medical emergencies from having in place systems to provide competent interpreter and translation services without undue delay.

(d) ASSURANCES.—Grantees under this section shall—

(1) ensure that appropriate clinical and support staff receive ongoing education and training in linguistically appropriate service delivery; ensure the linguistic competence of bilingual providers;

(2) offer and provide appropriate language services at no additional charge to each patient with limited English proficiency at all points of contact, in a timely manner during all hours of operation;

(3) notify Medicare beneficiaries of their right to receive language services in their primary language;

(4) post signage in the languages of the commonly encountered group or groups present in the service area of the organization; and

(5) ensure that—

(A) primary language data are collected for recipients of language services; and

(B) consistent with the privacy protections provided under the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), if the recipient of language services is a minor or is incapacitated, the primary language of the parent or legal guardian is collected and utilized.

(e) REPORTING REQUIREMENTS.—Grantees under this section shall provide the Secretary with reports at the conclusion of the each year of a grant under this section. each report shall include at least the following information:

(1) The number of Medicare beneficiaries to whom language services are provided.

(2) The languages of those Medicare beneficiaries.

(3) The types of language services provided (such as provision of services directly in non-English language by a bilingual health care provider or use of an interpreter).

(4) Type of interpretation (such as in-person, telephonic, or video interpretation).

(5) The methods of providing language services (such as staff or contract with external independent contractors or agencies).

(6) The length of time for each interpretation encounter.

(7) The costs of providing language services (which may be actual or estimated, as determined by the Secretary).

(f) NO COST SHARING.—LEP Beneficiaries shall not have to pay cost-sharing or co-pays for language services provided through this demonstration program.

(g) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the demonstration program under this section and shall submit to the appropriate committees of Congress a report not later than 1 year after the completion of the program. The report shall include the following:

(1) An analysis of the patient outcomes and costs of furnishing care to the LEP Medicare beneficiaries participating in the project as compared to such outcomes and costs for limited English proficient Medicare beneficiaries not participating.

(2) The effect of delivering culturally and linguistically appropriate services on beneficiary access to care, utilization of services, efficiency and cost-effectiveness of health care delivery, patient satisfaction, and select health outcomes.

(3) Recommendations regarding the extension of such project to the entire Medicare program.

(h) GENERAL PROVISIONS.—Nothing in this section shall be construed to limit otherwise existing obligations of recipients of Federal financial assistance under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000(d) et seq.) or any other statute.

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $10,000,000 for each fiscal year of the demonstration.

SEC. 234. DEMONSTRATION TO IMPROVE CARE TO PREVIOUSLY UNINSURED.

(a) ESTABLISHMENT.—Within one year after the date of enactment of this Act, the Secretary shall establish a demonstration project to determine the greatest needs and most effective methods of outreach to medicare beneficiaries who were previously uninsured.

(b) SCOPE.—The demonstration shall be in no fewer than 10 sites, and shall include state health insurance assistance programs, community health centers, community-based organizations, community health workers, and other service providers under parts A, B, and C of title XVIII of the Social Security Act. Grantees that are plans operating under part C shall document that enrollees who were previously uninsured receive the ''Welcome to Medicare'' physical exam.

(c) DURATION.—The Secretary shall conduct the demonstration project for a period of 2 years.

(d) REPORT AND EVALUATION.—The Secretary shall conduct an evaluation of the demonstration and not later than 1 year after the completion of the project shall submit to Congress a report including the following:

(1) An analysis of the effectiveness of outreach activities targeting beneficiaries who were previously uninsured, such as revising outreach and enrollment materials (including the potential for use of video information), providing one-on-one counseling, working with community health workers, and amending the Medicare and You handbook.

(2) The effect of such outreach on beneficiary access to care, utilization of services, efficiency and cost-effectiveness of health care delivery, patient satisfaction, and select health outcomes.

SEC. 235. OFFICE OF THE INSPECTOR GENERAL REPORT ON COMPLIANCE WITH AND ENFORCEMENT OF NATIONAL STANDARDS ON CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) IN MEDICARE.

(a) REPORT.—Not later than two years after the date of the enactment of this Act, the Inspector General of the Department of Health and Human Services shall prepare and publish a report on—

(1) the extent to which Medicare providers and plans are complying with the Office for Civil Rights' Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons and the Office of Minority Health's Culturally and Linguistically Appropriate Services Standards in health care; and

(2) a description of the costs associated with or savings related to the provision of language services.

Such report shall include recommendations on improving compliance with CLAS Standards and recommendations on improving enforcement of CLAS Standards.

(b) IMPLEMENTATION.—Not later than one year after the date of publication of the report under subsection (a), the Department of Health and Human Services shall implement changes responsive to any deficiencies identified in the report.

SEC. 236. IOM REPORT ON IMPACT OF LANGUAGE ACCESS SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall seek to enter into an arrangement with the Institute of under which the Institute will prepare and publish, not later than 3 years after the date of the enactment of this Act, a report on the impact of language access services on the health and health care of limited English proficient populations.

(b) CONTENTS.—Such report shall include—

(1) recommendations on the development and implementation of policies and practices by health care organizations and providers for limited English proficient patient populations;

(2) a description of the effect of providing language access services on quality of health care and access to care and reduced medical error; and

(3) a description of the costs associated with or savings related to provision of language access services.

SEC. 237. DEFINITIONS.

In this subtitle:

(1) BILINGUAL.—The term ''bilingual'' with respect to an individual means a person who has sufficient degree of proficiency in two languages and can ensure effective communication can occur in both languages.

(2) COMPETENT INTERPRETER SERVICES.—The term ''competent interpreter services'' means a trans-language rendition of a spoken message in which the interpreter comprehends the source language and can speak comprehensively in the target language to convey the meaning intended in the source language. The interpreter knows health and health-related terminology and provides accurate interpretations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source message.

(3) COMPETENT TRANSLATION SERVICES.—The term ''competent translation services'' means a trans-language rendition of a written document in which the translator comprehends the source language and can write comprehensively in the target language to convey the meaning intended in the source language. The translator knows health and health-related terminology and provides accurate translations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source document.

(4) EFFECTIVE COMMUNICATION.—The term ''effective communication'' means an exchange of information between the provider of health care or health care-related services and the limited English proficient recipient of such services that enables limited English proficient individuals to access, understand, and benefit from health care or health care-related services.

(5) INTERPRETING/INTERPRETATION.—The terms ''interpreting'' and ''interpretation'' mean the transmission of a spoken message from one language into another, faithfully, accurately, and objectively.

(6) HEALTH CARE SERVICES.—The term ''health care services'' means services that address physical as well as mental health conditions in all care settings.

(7) HEALTH CARE-RELATED SERVICES.—The term ''health care-related services'' means human or social services programs or activities that provide access, referrals or links to health care.

(8) LANGUAGE ACCESS.—The term ''language access'' means the provision of language services to an LEP individual designed to enhance that individual's access to, understanding of or benefit from health care or health care-related services.

(9) LANGUAGE SERVICES.—The term ''language services'' means provision of health care services directly in a non-English language, interpretation, translation, and non-English signage.

(10) LIMITED ENGLISH PROFICIENT.—The term ''limited English proficient'' or ''LEP'' with respect to an individual means an individual who speaks a primary language other than English and who cannot speak, read, write or understand the English language at a level that permits the individual to effectively communicate with clinical or nonclinical staff at an entity providing health care or health care related services.

(11) MEDICARE PROGRAM.—The term ''Medicare program'' means the programs under parts A through D of title XVIII of the Social Security Act.

(12) SERVICE PROVIDER.—The term ''service provider'' includes all suppliers, providers of services, or entities under contract to provide coverage, items or services under any part of title XVIII of the Social Security Act.

TITLE III—PHYSICIANS' SERVICE PAYMENT REFORM

SEC. 301. ESTABLISHMENT OF SEPARATE TARGET GROWTH RATES FOR SERVICE CATEGORIES.

(a) ESTABLISHMENT OF SERVICE CATEGORIES.—Subsection (j) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new paragraph:

''(5) SERVICE CATEGORIES.—For services furnished on or after January 1, 2008, each of the following categories of physicians' services shall be treated as a separate 'service category':

''(A) Evaluation and management services for primary care (including new and established patient office visits delivered by physicians who the Secretary determines provide accessible, continuous, coordinated, and comprehensive care for Medicare beneficiaries, emergency department visits, and home visits), and for preventive services (including screening mammography, colorectal cancer screening, and other services as defined by the Secretary, limited to the recommendations of the United States Preventive Services Task Force).

''(B) Evaluation and management services not described in subparagraph (A).

''(C) Imaging services (as defined in subsection (b)(4)(B)) and diagnostic tests (other than clinical diagnostic laboratory tests) not described in subparagraph (A).

''(D) Procedures that are subject (under regulations promulgated to carry out this section) to a 10-day or 90-day global period (in this paragraph referred to as 'major procedures'), except that the Secretary may reclassify as minor procedures under subparagraph (F) any procedures that would otherwise be included in this category if the Secretary determines that such procedures are not major procedures.

''(E) Anesthesia services that are paid on the basis of the separate conversion factor for anesthesia services determined under subsection (d)(1)(D).

''(F) Minor procedures and any other physicians' services that are not described in a preceding subparagraph.''.

(b) ESTABLISHMENT OF SEPARATE CONVERSION FACTORS FOR EACH SERVICE CATEGORY.—Subsection (d)(1) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended—

(1) in subparagraph (A)—

(A) by designating the sentence beginning ''The conversion factor'' as clause (i) with the heading ''APPLICATION OF SINGLE CONVERSION FACTOR'' and with appropriate indentation;

(B) by striking ''The conversion factor'' and inserting ''Subject to clause (ii), the conversion factor''; and

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

''(ii) APPLICATION OF MULTIPLE CONVERSION FACTORS BEGINNING WITH 2008.—

''(I) IN GENERAL.—In applying clause (i) for years beginning with 2008, separate conversion factors shall be established for each service category of physicians' services (as defined in subsection (j)(5)) and any reference in this section to a conversion factor for such years shall be deemed to be a reference to the conversion factor for each of such categories.

''(II) INITIAL CONVERSION FACTORS; SPECIAL RULE FOR ANESTHESIA SERVICES.— Such factors for 2008 shall be based upon the single conversion factor for 2007 multiplied by the update established under paragraph (8) for such category for 2008. In the case of the service category described in subsection (j)(5)(F) (relating to anesthesia services), the conversion factor for 2008 shall be based on the separate conversion factor specified in subparagraph (D) for 2007 multiplied by the update established under paragraph (8) for such category for 2008.

''(III) UPDATING OF CONVERSION FACTORS.—Such factor for a service category for a subsequent year shall be based upon the conversion factor for such category for the previous year and adjusted by the update established for such category under paragraph (8) for the year involved.''; and

(2) in subparagraph (D), by inserting ''(before 2008)'' after ''for a year''.

(c) ESTABLISHING UPDATES FOR CONVERSION FACTORS FOR SERVICE CATEGORIES.—Section 1848(d) of the Social Security Act (42 U.S.C. 1395w–4(d)) is amended—

(1) in paragraph (4)(B), by striking ''and (6)'' and inserting '', (6), and (8)'';

(2) in paragraph (4)(C)(iii), by striking ''The allowed'' and inserting ''Subject to paragraph (8)(B), the allowed'';

(3) in paragraph (4)(D), by striking ''The update'' and inserting ''Subject to paragraph (8)(E), the update''; and

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

''(8) UPDATES FOR SERVICE CATEGORIES BEGINNING WITH 2008.—

''(A) IN GENERAL.—In applying paragraph (4) for a year beginning with 2008, the following rules apply:

''(i) APPLICATION OF SEPARATE UPDATE ADJUSTMENTS FOR EACH SERVICE CATEGORY.—Pursuant to paragraph (1)(A)(ii)(I), the update shall be made to the conversion factor for each service category (as defined in subsection (j)(5)) based upon an update adjustment factor for the respective category and year and the update adjustment factor shall be computed, for a year, separately for each service category.

''(ii) COMPUTATION OF ALLOWED AND ACTUAL EXPENDITURES BASED ON SERVICE CATEGORIES.—In computing the prior year adjustment component and the cumulative adjustment component under clauses (i) and (ii) of paragraph (4)(B), the following rules apply:

''(I) APPLICATION BASED ON SERVICE CATEGORIES.—The allowed expenditures and actual expenditures shall be the allowed and actual expenditures for the service category, as determined under subparagraph (B).

''(II) LIMITATION TO PHYSICIAN FEE-SCHEDULE SERVICES.—Actual expenditures shall only take into account expenditures for services furnished under the physician fee schedule.

''(III) APPLICATION OF CATEGORY SPECIFIC TARGET GROWTH RATE.—The growth rate applied under clause (ii)(II) of such paragraph shall be the target growth rate for the service category involved under subsection (f)(5).

''(IV) ALLOCATION OF CUMULATIVE OVERHANG.—There shall be substituted for the difference described in subparagraph (B)(ii)(I) of such paragraph the amount described in subparagraph (C)(i) for the service category involved.

''(B) DETERMINATION OF ALLOWED EXPENDITURES.—In applying paragraph (4) for a year beginning with 2008, notwithstanding subparagraph (C)(iii) of such paragraph, the allowed expenditures for a service category for a year is an amount computed by the Secretary as follows:

''(i) FOR 2008.—For 2008:

''(I) TOTAL 2007 ALLOWED EXPENDITURES.—Compute the total allowed expenditures for services furnished under the physician fee schedule under such paragraph for 2007.

''(II) INCREASE BY GROWTH RATE.—Increase the total under subclause (I) by the target growth rate for such category under subsection (f) for 2008.

''(III) ALLOCATION TO SERVICE CATEGORY.—Multiply the increased total under subclause (II) by the overhang allocation factor for the service category (as defined in subparagraph (C)(iii)).

''(ii) FOR SUBSEQUENT YEARS.—For a subsequent year, take the amount of allowed expenditures for such category for the preceding year (under clause (i) or this clause) and increase it by the target growth rate determined under subsection (f) for such category and year.

''(C) COMPUTATION AND APPLICATION OF CUMULATIVE OVERHANG AMONG CATEGORIES.—

''(i) IN GENERAL.—For purposes of applying paragraph (4)(B)(ii)(II) under clause (ii)(IV), the amount described in this clause for a year (beginning with 2008) is the sum of the following:

''(I) PRE-2008 CUMULATIVE OVERHANG.—The amount of the pre-2008 cumulative excess spending (as defined in clause (ii)) multiplied by the overhang allocation factor for the service category (under clause (iii)).

''(II) POST-2007 CUMULATIVE AMOUNTS.—For a year beginning with 2009, the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services (as determined under paragraph (4)(C)) in the service category from January 1, 2008, through the end of the prior year and the amount of the actual expenditures for such services in such category during that period.

''(ii) PRE-2008 CUMULATIVE EXCESS SPENDING DEFINED.—For purposes of clause (i)(I), the term 'pre-2008 cumulative excess spending' means the difference described in paragraph (4)(B)(ii)(I) as determined for the year 2008, taking into account expenditures through December 31, 2007. Such difference takes into account expenditures included in subsection (f)(4)(A).

''(iii) OVERHANG ALLOCATION FACTOR.—For purposes of this paragraph, the term 'overhang allocation factor' means, for a service category, the proportion, as determined by the Secretary of total actual expenditures under this part for items and services in such category during 2007 to the total of such actual expenditures for all the service categories. In calculating such proportion, the Secretary shall only take into account services furnished under the physician fee schedule.

''(D) FLOOR FOR UPDATES FOR 2008 AND 2009.—The update to the conversion factors for each service category for each of 2008 and 2009 shall be not less than 0.5 percent.

''(E) CHANGE IN RESTRICTION ON UPDATE ADJUSTMENT FACTOR FOR 2010 AND 2011.—The update adjustment factor determined under subparagraph (4)(B), as modified by this paragraph, for a service category for a year (beginning with 2010 and ending with 2011) may be less than –0.07, but may not be less than –0.14.''.

(d) APPLICATION OF SEPARATE TARGET GROWTH RATES FOR EACH CATEGORY.—

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

''(5) APPLICATION OF SEPARATE TARGET GROWTH RATES FOR EACH SERVICE CATEGORY BEGINNING WITH 2008.—The target growth rate for a year beginning with 2008 shall be computed and applied separately under this subsection for each service category (as defined in subsection (j)(5)) and shall be computed using the same method for computing the sustainable growth rate except for the following:

''(A) The reference in paragraphs (2)(A) and (2)(D) to 'all physicians' services' is deemed a reference to the physicians' services included in such category but shall not take into account items and services included in physicians' services through the operation of paragraph (4)(A).

''(B) The factor described in paragraph (2)(C) for the service category described in subsection (j)(5)(A) shall be increased by 0.03.

''(C) A national coverage determination (as defined in section 1869(f)(1)(B)) shall be treated as a change in regulation described in paragraph (2)(D).''.

(2) USE OF TARGET GROWTH RATES.—Section 1848 of such Act is further amended—

(A) in subsection (d)—

(i) in paragraph (1)(E)(ii), by inserting ''or target'' after ''sustainable''; and

(ii) in paragraph (4)(B)(ii)(II), by inserting ''or target'' after ''sustainable''; and

(B) in subsection (f)—

(i) in the heading by inserting ''; TARGET GROWTH RATE'' after ''SUSTAINABLE GROWTH RATE''

(ii) in paragraph (1)—

(I) by striking ''and'' at the end of subparagraph (A);

(II) in subparagraph (B), by inserting ''before 2008'' after ''each succeeding year'' and by striking the period at the end and inserting ''; and''; and

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

''(C) November 1 of each succeeding year the target growth rate for such succeeding year and each of the 2 preceding years.''; and

(iii) in paragraph (2), in the matter before subparagraph (A), by inserting after ''beginning with 2000'' the following: ''and ending with 2007'' .

(e) REPORTS ON EXPENDITURES FOR PART B DRUGS AND CLINICAL DIAGNOSTIC LABORATORY TESTS.—

(1) REPORTING REQUIREMENT.—The Secretary of Health and Human Services shall include information in the annual physician fee schedule proposed rule on the change in the annual rate of growth of actual expenditures for clinical diagnostic laboratory tests or drugs, biologicals, and radiopharmaceuticals for which payment is made under part B of title XVIII of the Social Security Act.

(2) RECOMMENDATIONS.—The report submitted under paragraph (1) shall include an analysis of the reasons for such excess expenditures and recommendations for addressing them in the future.

SEC. 302. IMPROVING ACCURACY OF RELATIVE VALUES UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

(a) USE OF EXPERT PANEL TO IDENTIFY MISVALUED PHYSICIANS' SERVICES.—Section 1848(c) of the Social Security Act (42 U.S.C. 1395w(c)) is amended by adding at the end the following new paragraph:

''(7) USE OF EXPERT PANEL TO IDENTIFY MISVALUED PHYSICIANS' SERVICES.—

''(A) IN GENERAL.—The Secretary shall establish an expert panel (in this paragraph referred to as the 'expert panel')—

''(i) to identify, through data analysis, physicians' services for which the relative value under this subsection is potentially misvalued, particularly those services for which such relative value may be overvalued;

''(ii) to assess whether those misvalued services warrant review using existing processes (referred to in paragraph (2)(J)(ii)) for the consideration of coding changes; and

''(iii) to advise the Secretary concerning the exercise of authority under clauses (ii)(III) and (vi) of paragraph (2)(B).

''(B) COMPOSITION OF PANEL.—The expert panel shall be appointed by the Secretary and composed of—

''(i) members with expertise in medical economics and technology diffusion;

''(ii) members with clinical expertise;

''(iii) physicians, particularly physicians (such as a physician employed by the Veterans Administration or a physician who has a full time faculty appointment at a medical school) who are not directly affected by changes in the physician fee schedule under this section;

''(iv) carrier medical directors; and

''(v) representatives of private payor health plans.

''(C) APPOINTMENT CONSIDERATIONS.—In appointing members to the expert panel, the Secretary shall assure racial and ethnic diversity on the panel and may consider appointing a liaison from organizations with experience in the consideration of coding changes to the panel.''.

(b) EXAMINATION OF SERVICES WITH SUBSTANTIAL CHANGES.—Such section is further amended by adding at the end the following new paragraph:

''(8) EXAMINATION OF SERVICES WITH SUBSTANTIAL CHANGES.—The Secretary, in consultation with the expert panel under paragraph (7), shall—

''(A) conduct a five-year review of physicians' services in conjunction with the RUC 5-year review, particularly for services that have experienced substantial changes in length of stay, site of service, volume, practice expense, or other factors that may indicate changes in physician work;

''(B) identify new services to determine if they are likely to experience a reduction in relative value over time and forward a list of the services so identified for such five-year review; and

''(C) for physicians' services that are otherwise unreviewed under the process the Secretary has established, periodically review a sample of relative value units within different types of services to assess the accuracy of the relative values contained in the Medicare physician fee schedule.''.

(c) AUTHORITY TO REDUCE WORK COMPONENT FOR SERVICES WITH ACCELERATED VOLUME GROWTH.—

(1) IN GENERAL.—Paragraph (2)(B) of such section is amended—

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

''(III) REDUCTIONS IN WORK VALUE UNITS FOR SERVICES WITH ACCELERATED VOLUME GROWTH.—Effective January 1, 2009, reduced expenditures attributable to clause (vi).''; and

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

''(vi) AUTHORIZING REDUCTION IN WORK VALUE UNITS FOR SERVICES WITH ACCELERATED VOLUME GROWTH.—The Secretary may provide (without using existing processes the Secretary has established for review of relative value) for a reduction in the work value units for a particular physician's service if the annual rate of growth in the expenditures for such service for which payment is made under this part for individuals for 2006 or a subsequent year exceeds the average annual rate of growth in expenditures of all physicians' services for which payment is made under this part by more than 10 percentage points for such year.

''(vii) CONSULTATION WITH EXPERT PANEL AND BASED ON CLINICAL EVIDENCE.—The Secretary shall exercise authority under clauses (ii)(III) and (vi) in consultation with the expert panel established under paragraph (7) and shall take into account clinical evidence supporting or refuting the merits of such accelerated growth''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply with respect to payment for services furnished on or after January 1, 2009.

(d) ADJUSTMENT AUTHORITY FOR EFFICIENCY GAINS FOR NEW PROCEDURES.—Paragraph (2)(B)(ii) of such section is amended by adding at the end the following new subclause:

''(III) ADJUSTMENT AUTHORITY FOR EFFICIENCY GAINS FOR NEW PROCEDURES.—In carrying out subclauses (I) and (II), the Secretary may apply a methodology, based on supporting evidence, under which there is imposed a reduction over a period of years in specified relative value units in the case of a new (or newer) procedure to take into account inherent efficiencies that are typically or likely to be gained during the period of initial increased application of the procedure.''.

SEC. 303. PHYSICIAN FEEDBACK MECHANISM ON PRACTICE PATTERNS.

By not later than July 1, 2008, the Secretary of Health and Human Services shall develop and implement a mechanism to measure resource use on a per capita and an episode basis in order to provide confidential feedback to physicians in the Medicare program on how their practice patterns compare to physicians generally, both in the same locality as well as nationally. Such feedback shall not be subject to disclosure under section 552 of title 5, United States Code).

SEC. 304. PAYMENTS FOR EFFICIENT PHYSICIANS.

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 EFFICIENT PHYSICIANS.—

''(1) IN GENERAL.—In the case of physicians' services furnished on or after January 1, 2009, and before January 1, 2011, by a participating physician in an efficient area (as identified under paragraph (2)), in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid an amount equal to 5 percent of the payment amount for the services under this part.

''(2) IDENTIFICATION OF EFFICIENT AREAS.—

''(A) IN GENERAL.—Based upon available data, the Secretary shall identify those counties or equivalent areas in the United States in the lowest fifth percentile of utilization based on per capita spending for services provided in 2007 under this part and part A.

''(B) IDENTIFICATION OF COUNTIES WHERE SERVICE IS FURNISHED..—For purposes of paying the additional amount specified in paragraph (1), if the Secretary uses the 5-digit postal ZIP Code where the service is furnished, the dominant county of the postal ZIP Code (as determined by the United States Postal Service, or otherwise) shall be used to determine whether the postal ZIP

Code is in a county described in subparagraph (A).

''(C) JUDICIAL REVIEW.— There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting—

''(i) the identification of a county or other area under subparagraph (A); or

''(ii) the assignment of a postal ZIP Code to a county or other area under subparagraph (B).

''(D) PUBLICATION OF LIST OF COUNTIES; POSTING ON WEBSITE.—With respect to a year for which a county or area is identified under this paragraph, the Secretary shall identify such counties or areas as part of the proposed and final rule to implement the physician fee schedule under section 1848 for the applicable year. The Secretary shall post the list of counties identified under this paragraph on the Internet website of the Centers for Medicare & Medicaid Services.''.

SEC. 305. RECOMMENDATIONS ON REFINING THE PHYSICIAN FEE SCHEDULE.

(a) RECOMMENDATIONS ON CONSOLIDATED CODING FOR SERVICES COMMONLY PERFORMED TOGETHER.—Not later than December 31, 2008, the Comptroller General of the United States shall—

(1) complete an analysis of codes paid under the Medicare physician fee schedule to determine whether the codes for procedures that are commonly furnished together should be combined; and

(2) submit to Congress a report on such analysis and include in the report recommendations on whether an adjustment should be made to the relative value units for such combined code.

(b) RECOMMENDATIONS ON INCREASED USE OF BUNDLED PAYMENTS.—Not later than December 31, 2008, the Comptroller General of the United States shall—

(1) complete an analysis of those procedures under the Medicare physician fee schedule for which no global payment methodology is applied but for which a ''bundled'' payment methodology would be appropriate; and

(2) submit to Congress a report on such analysis and include in the report recommendations on increasing the use of ''bundled'' payment methodology under such schedule.

(c) MEDICARE PHYSICIAN FEE SCHEDULE.—In this section, the term ''Medicare physician fee schedule'' means the fee schedule established under section 1848 of the Social Security Act (42 U.S.C. 1395w–4).

SEC. 306. IMPROVED AND EXPANDED MEDICAL HOME DEMONSTRATION PROJECT.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish under title XVIII of the Social Security Act an expanded medical home demonstration project (in this section referred to as the ''expanded project'') under this section. The expanded project supersedes the project that was initiated under section 204 of the Medicare Improvement and Extension Act of 2006 (division B of Public Law 109–432). The purpose of the expanded project is—

(1) to guide the redesign of the health care delivery system to provide accessible, continuous, comprehensive, and coordinated, care to Medicare beneficiaries; and

(2) to provide care management fees to personal physicians delivering continuous and comprehensive care in qualified medical homes.

(b) NATURE AND SCOPE OF PROJECT.—

(1) DURATION; SCOPE.—The expanded project shall operate during a period of three years, beginning not later than October 1, 2009, and shall include a nationally representative sample of physicians serving urban, rural, and underserved areas throughout the United States.

(2) ENCOURAGING PARTICIPATION OF SMALL PHYSICIAN PRACTICES.—

(A) IN GENERAL.—The expanded project shall be designed to include the participation of physicians in practices with fewer than four full-time equivalent physicians, as well as physicians in larger practices particularly in rural and underserved areas.

(B) TECHNICAL ASSISTANCE.— In order to facilitate the participation under the expanded project of physicians in such practices, the Secretary shall make available additional technical assistance to such practices during the first year of the expanded project.

(3) SELECTION OF HOMES TO PARTICIPATE.— The Secretary shall select up to 500 medical homes to participate in the expanded project and shall give priority to—

(A) the selection of up to 100 HIT-enhanced medical homes; and

(B) the selection of other medical homes that serve communities whose populations are at higher risk for health disparities,

(4) BENEFICIARY PARTICIPATION.—The Secretary shall establish a process for any Medicare beneficiary who is served by a medical home participating in the expanded project to elect to participate in the project. Each beneficiary who elects to so participate shall be eligible—

(A) for enhanced medical home services under the project with no cost sharing for the additional services; and

(B) for a reduction of up to 50 percent in the coinsurance for services furnished under the physician fee schedule under section 1848 of the Social Security Act by the medical home.

The Secretary shall develop standard recruitment materials and election processes for Medicare beneficiaries who are electing to participate in the expanded project.

(c) STANDARDS FOR MEDICAL HOMES, HIT-ENHANCED MEDICAL HOMES.—

(1) STANDARD SETTING AND CERTIFICATION PROCESS.—The Secretary shall establish a process for selection of a qualified standard setting and certification organization—

(A) to establish standards, consistent with this section, for medical practices to qualify as medical homes or as HIT-enhanced medical homes; and

(B) to provide for the review and certification of medical practices as meeting such standards.

(2) BASIC STANDARDS FOR MEDICAL HOMES.— For purposes of this subsection, the term ''medical home'' means a physician-directed practice that has been certified, under paragraph (1), as meeting the following standards:

(A) ACCESS AND COMMUNICATION WITH PATIENTS.—The practice applies standards for access to care and communication with participating beneficiaries.

(B) MANAGING PATIENT INFORMATION AND USING INFORMATION IN MANAGEMENT TO SUPPORT PATIENT CARE.—The practice has readily accessible, clinically useful information on participating beneficiaries that enables the practice to treat such beneficiaries comprehensively and systematically.

(C) MANAGING AND COORDINATING CARE ACCORDING TO INDIVIDUAL NEEDS.—The practice maintains continuous relationships with participating beneficiaries by implementing evidence-based guidelines and applying them to the identified needs of individual beneficiaries over time and with the intensity needed by such beneficiaries.

(D) PROVIDING ONGOING ASSISTANCE AND ENCOURAGEMENT IN PATIENT SELF-MANAGEMENT.—The practice—

(i) collaborates with participating beneficiaries to pursue their goals for optimal achievable health; and

(ii) assesses patient-specific barriers to communication and conducts activities to support patient self-management.

(E) RESOURCES TO MANAGE CARE.—The practice has in place the resources and processes necessary to achieve improvements in the management and coordination of care for participating beneficiaries.

(F) MONITORING PERFORMANCE.—The practice monitors its clinical process and performance (including outcome measures) in meeting the applicable standards under this subsection and provides information in a form and manner specified by the Secretary with respect to such process and performance.

(3) ADDITIONAL STANDARDS FOR HIT-ENHANCED MEDICAL HOME.—For purposes of this subsection, the term ''HIT-enhanced medical home'' means a medical home that has been certified, under paragraph (1), as using a health information technology system that includes at least the following elements:

(A) ELECTRONIC HEALTH RECORD (EHR).—The system uses, for participating beneficiaries, an electronic health record that meets the following standards:

(i) IN GENERAL.—The record—

(I) has the capability of interoperability with secure data acquisition from health information technology systems of other health care providers in the area served by the home; or

(II) the capability to securely acquire clinical data delivered by such other health care providers to a secure common data source.

(ii) The record protects the privacy and security of health information.

(iii) The record has the capability to acquire, manage, and display all the types of clinical information commonly relevant to services furnished by the home, such as complete medical records, radiographic image retrieval, and clinical laboratory information.

(iv) The record is integrated with decision support capacities that facilitate the use of evidence-based medicine and clinical decision support tools to guide decision-making at the point-of-care based on patient-specific factors.

(B) E-PRESCRIBING.—The system supports e-prescribing and computerized physician order entry.

(C) OUTCOME MEASUREMENT.—The system supports the secure, confidential provision of clinical process and outcome measures approved by the National Quality Forum to the Secretary for use in confidential manner for provider feedback and peer review and for outcomes and clinical effectiveness research.

(D) PATIENT EDUCATION CAPABILITY.—The system actively facilitates participating beneficiaries engaging in the management of their own health through education and support systems and tools for shared decision-making.

(E) SUPPORT OF BASIC STANDARDS.— The elements of such system, such as the electronic health record, email communications, patient registries, and clinical-decision support tools, are integrated in a manner to better achieve the basic standards specified in paragraph (2) for a medical home.

(4) USE OF DATA.—The Secretary shall use the data submitted under paragraph (1)(F) in a confidential manner for feedback and peer review for medical homes and for outcomes and clinical effectiveness research. After the first two years of the expanded project, these data may be used for adjustment in the monthly medical home care management fee under subsection (d)(2)(E).

(d) MONTHLY MEDICAL HOME CARE MANAGEMENT FEE.—

(1) IN GENERAL.—Under the expanded project, the Secretary shall provide for payment to the personal physician of each participating beneficiary of a monthly medical home care management fee.

(2) AMOUNT OF PAYMENT.— In determining the amount of such fee, the Secretary shall consider the following:

(A) OPERATING EXPENSES.—The additional practice expenses for the delivery of services through a medical home, taking into account the additional expenses for an HIT-enhanced medical home. Such expenses include costs associated with—

(i) structural expenses, such as equipment, maintenance, and training costs;

(ii) enhanced access and communication functions;

(iii) population management and registry functions;

(iv) patient medical data and referral tracking functions;

(v) provision of evidence-based care;

(vi) implementation and maintenance of health information technology;

(vii) reporting on performance and improvement conditions; and

(viii) patient education and patient decision support, including print and electronic patient education materials.

(B) ADDED VALUE SERVICES.—The value of additional physician work, such as augmented care plan oversight, expanded e-mail and telephonic consultations, extended patient medical data review (including data stored and transmitted electronically), and physician supervision of enhanced self management education, and expanded follow-up accomplished by non-physician personnel, in a medical home that is not adequately taken into account in the establishment of the physician fee schedule under section 1848 of the Social Security Act.

(C) RISK ADJUSTMENT.—The development of an appropriate risk adjustment mechanism to account for the varying costs of medical homes based upon characteristics of participating beneficiaries.

(D) HIT ADJUSTMENT.—Variation of the fee based on the extensiveness of use of the health information technology in the medical home.

(E) PERFORMANCE-BASED.—After the first two years of the expanded project, an adjustment of the fee based on performance of the home in achieving quality or outcomes standards.

(3) PERSONAL PHYSICIAN DEFINED.—For purposes of this subsection, the term ''personal physician'' means, with respect to a participating Medicare beneficiary, a physician (as defined in section 1861(r)(1) of the Social Security Act (42 U.S.C. 1395x(r)(1)) who provides accessible, continuous, coordinated, and comprehensive care for the beneficiary as part of a medical practice that is a qualified medical home. Such a physician may be a specialist for a beneficiary requiring ongoing care for a chronic condition or multiple chronic conditions (such as severe asthma, complex diabetes, cardiovascular disease, rheumatologic disorder) or for a beneficiary with a prolonged illness.

(e) FUNDING.—

(1) USE OF CURRENT PROJECT FUNDING.—Funds otherwise applied to the demonstration under section 204 of the Medicare Improvement and Extension Act of 2006 (division B of Public Law 109–432) shall be available to carry out the expanded project

(2) ADDITIONAL FUNDING FROM SMI TRUST FUND.—

(A) IN GENERAL.—In addition to the funds provided under paragraph (1), there shall be available, from the Federal Supplementary Medical Insurance Trust Fund (under section 1841 of the Social Security Act), the amount of $500,000,000 to carry out the expanded project, including payments to of monthly medical home care management fees under subsection (d), reductions in coinsurance for participating beneficiaries under subsection (b)(4)(B), and funds for the design, implementation, and evaluation of the expanded project.

(B) MONITORING EXPENDITURES; EARLY TERMINATION.—The Secretary shall monitor the expenditures under the expanded project and may terminate the project early in order that expenditures not exceed the amount of funding provided for the project under subparagraph (A).

(f) EVALUATIONS AND REPORTS.—.

(1) ANNUAL INTERIM EVALUATIONS AND REPORTS.—For each year of the expanded project, the Secretary shall provide for an evaluation of the project and shall submit to Congress, by a date specified by the Secretary, a report on the project and on the evaluation of the project for each such year.

(2) FINAL EVALUATION AND REPORT.—The Secretary shall provide for an evaluation of the expanded project and shall submit to Congress, not later than 18 months after the date of completion of the project, a report on the project and on the evaluation of the project.

SEC. 307. REPEAL OF PHYSICIAN ASSISTANCE AND QUALITY INITIATIVE FUND.

Subsection (l) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is repealed.

SEC. 308. ADJUSTMENT TO MEDICARE PAYMENT LOCALITIES.

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

''(6) FEE SCHEDULE GEOGRAPHIC AREAS.—

''(A) IN GENERAL.—

''(i) REVISION.—Subject to clause (ii), for services furnished on or after January 1, 2009, the Secretary shall revise the fee schedule areas used for payment under this section applicable to the State of California using the county-based geographic adjustment factor as specified in option 3 (table 9) in the proposed rule for the 2008 physician fee schedule published at 72 Fed. Reg. 38,122 (July 12, 2007).

''(ii) TRANSITION.—For services furnished during the period beginning January 1, 2009, and ending December 31, 2010, after calculating the work, practice expense, and malpractice geographic indices described in clauses (i), (ii), and (iii) of paragraph (1)(A) that would otherwise apply, the Secretary shall increase any such geographic index for any county in California that is lower than the geographic index used for payment for services under this section as of December 31, 2008, in such county to such geographic index level.

''(iii) NON-APPLICATION OF PERIODIC REVISION.—If a periodic review of geographic indices, as required under paragraph (1)(B), results in a reduction in a work, practice expense and malpractice geographic index for any county in California that is below the geographic index level established pursuant to clause (ii) during a portion of the period described in such clause, the work, practice expense, or malpractice index established in such clause shall be applied to payment for services furnished in such county during such portion of such period.

''(B) SUBSEQUENT REVISIONS.—

''(i) TIMING.—Not later than January 1, 2014, the Secretary shall review and make revisions to fee schedule areas in all States for which more than one fee schedule area is used for payment of services under this section. The Secretary may revise fee schedule areas in States in which a single fee schedule area is used for payment for services under this section using the same methodology applied in the previous sentence.

''(ii) LINK WITH GEOGRAPHIC INDEX DATA REVISION.—The revision described in clause (i) shall be made effective concurrently with the application of the periodic review of geographic adjustment factors required under paragraph (1)(C) for 2014.''.

SEC. 309. PAYMENT FOR IMAGING SERVICES.

(a) PAYMENT UNDER PART B OF THE MEDICARE PROGRAM FOR DIAGNOSTIC IMAGING SERVICES FURNISHED IN FACILITIES CONDITIONED ON ACCREDITATION OF FACILITIES.—

(1) SPECIAL PAYMENT RULE.—

(A) IN GENERAL.—Section 1848(b)(4) of the Social Security Act (42 U.S.C. 1395w-4(b)(4)) is amended—

(i) in the heading, by striking ''RULE'' and inserting ''RULES'';

(ii) in subparagraph (A), by striking ''IN GENERAL'' and inserting ''LIMITATION''; and

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

''(C) PAYMENT ONLY FOR SERVICES PROVIDED IN ACCREDITED FACILITIES.—

''(i) IN GENERAL.—In the case of imaging services that are diagnostic imaging services described in clause (ii), the payment amount for the technical component and the professional component of the services established for a year under the fee schedule described in paragraph (1) shall each be zero, unless the services are furnished at a diagnostic imaging services facility that meets the certificate requirement described in section 354(b)(1) of the Public Health Service Act, as applied under subsection (m). The previous sentence shall not apply with respect to the professional component of a diagnostic imaging service that is furnished by a physician or that is an ultrasound furnished by nurse practitioner or or nurse-midwife.

''(ii) DIAGNOSTIC IMAGING SERVICES.—For purposes of clause (i) and subsection (m), the term 'diagnostic imaging services' means all imaging modalities, including diagnostic magnetic resonance imaging ('MRI'), computed tomography ('CT'), positron emission tomography ('PET'), nuclear medicine procedures, x-rays, sonograms, ultrasounds, echocardiograms, and such emerging diagnostic imaging technologies as specified by the Secretary. Such term does not include image guided procedures.''.

(B) EFFECTIVE DATE.—

(i) IN GENERAL.—Subject to clause (ii), the amendments made by subparagraph (A) shall apply to diagnostic imaging services furnished on or after January 1, 2010.

(ii) EXTENSION FOR ULTRASOUND SERVICES.—The amendments made by subparagraph (A) shall apply to diagnostic imaging services that are ultrasound services on or after January 1, 2012.

(2) CERTIFICATION OF FACILITIES THAT FURNISH DIAGNOSTIC IMAGING SERVICES.—Section 1848 of the Social Security Act (42 U.S.C. 1395w–4) is amended by adding at the end the following new subsection:

''(m) CERTIFICATION OF FACILITIES THAT FURNISH DIAGNOSTIC IMAGING SERVICES.—

''(1) IN GENERAL.—For purposes of subsection (b)(4)(C)(i), except as provided under paragraphs (2) through (8), the provisions of section 354 of the Public Health Service Act (as in effect as of June 1, 2007), relating to the certification of mammography facilities, shall apply, with respect to the provision of diagnostic imaging services (as defined in subsection (b)(4)(C)(ii)) and to a diagnostic imaging services facility defined in paragraph (8) (and to the process of accrediting such facilities) in the same manner that such provisions apply, with respect to the provision of mammograms and to a facility defined in paragraph (8) (and to the process of accrediting such facilities) in the same manner that such provisions apply, with respect

to the provision of mammograms and to a facility defined in subsection (a)(3) of such section (and to the process of accrediting such mammography facilities).

''(2) TERMINOLOGY AND REFERENCES.—For purposes of applying section 354 of the Public Health Service Act under paragraph (1)—

''(A) any reference to 'mammography', or 'breast imaging' is deemed a reference to 'diagnostic imaging services (as defined in section 1848(b)(4)(C)(ii) of the Social Security Act)';

''(B) any reference to a mammogram or film is deemed a reference to an image, as defined in paragraph (8);

''(C) any reference to 'mammography facility' or to a 'facility' under such section 354 is deemed a reference to a diagnostic imaging services facility, as defined in paragraph (8);

''(D) any reference to radiological equipment used to image the breast is deemed a reference to medical imaging equipment used to provide diagnostic imaging services;

''(E) any reference to radiological procedures or radiological is deemed a reference to medical imaging services, as defined in paragraph (8) or medical imaging, respectively;

''(F) any reference to an inspection (as defined in subsection (a)(4) of such section) or inspector is deemed a reference to an audit (as defined in paragraph (8)) or auditor, respectively;

''(G) any reference to a medical physicist (as described in subsection (f)(1)(E) of such section) is deemed to include a reference to a magnetic resonance scientist or the appropriate qualified expert as determined by the accrediting body;

''(H) in applying subsection (d)(1)(A)(i) of such section, the reference to 'type of each x-ray machine, image receptor, and processor' is deemed a reference to 'type of imaging equipment';

''(I) in applying subsection (d)(1)(B) of such section, the reference that 'the person or agent submits to the Secretary' is deemed a reference that 'the person or agent submits to the Secretary, through the appropriate accreditation body';

''(J) in applying subsection (d)(1)(B)(i) of such section, the reference to standards established by the Secretary is deemed a reference to standards established by an accreditation body and approved by the Secretary;

''(K) in applying subsection (e) of such section, relating to an accreditation body—

''(i) in paragraph (1)(A), the reference to 'may' is deemed a reference to 'shall';

''(ii) in paragraph (1)(B)(i)(II), the reference to 'a random sample of clinical images from such facilities' is deemed a reference to 'a statistically significant random sample of clinical images from a statistically significant random sample of facilities';

''(iii) in paragraph (3)(A) of such section—

''(I) the reference to 'paragraph (1)(B)' in such subsection is deemed to be a reference to 'paragraph (1)(B) and subsection (f)'; and

''(II) the reference to the 'Secretary' is deemed a reference to 'an accreditation body, with the approval of the Secretary'; and

''(iv) in paragraph (6)(B), the reference to the Committee on Labor and Human Resources of the Senate is deemed to be the Committee on Finance of the Senate and the reference to the Committee on Energy and Commerce of the House of Representatives is deemed to include a reference to the Committee on Ways and Means of the House of Representatives;

''(L) in applying subsection (f), relating to quality standards—

''(i) each reference to standards established by the Secretary is deemed a reference to standards established by an accreditation body involved and approved by the Secretary under subsection (d)(1)(B)(i) of such section

''(ii) in paragraph (1)(A), the reference to 'radiation dose' is deemed a reference to 'radiation dose, as appropriate';

''(iii) in paragraph (1)(B), the reference to 'radiological standards' is deemed a reference to 'medical imaging standards, as appropriate';

''(iv) in paragraphs (1)(D)(ii) and (1)(E)(iii), the reference to 'the Secretary' is deemed a reference to 'an accreditation body with the approval of the Secretary';

''(v) in each of subclauses (III) and (IV) of paragraph (1)(G)(ii), each reference to 'patient' is deemed a reference to 'patient, if requested by the patient'; and

''(M) in applying subsection (g), relating to inspections—

''(i) each reference to the 'Secretary or State or local agency acting on behalf of the Secretary' is deemed to include a reference to an accreditation body involved;

''(ii) in the first sentence of paragraph (1)(F), the reference to 'annual inspections required under this paragraph' is deemed a reference to 'the audits carried out in facilities at least every three years from the date of initial accreditation under this paragraph'; and

''(iii) in the second sentence of paragraph (1)(F), the reference to 'inspections carried out under this paragraph' is deemed a reference to 'audits conducted under this paragraph during the previous year'.

''(3) DATES AND PERIODS.—For purposes of paragraph (1), in applying section 354 of the Public Health Service Act, the following applies:

''(A) IN GENERAL.—Except as provided in subparagraph (B)—

''(i) any reference to 'October 1, 1994' shall be deemed a reference to 'January 1, 2010';

''(ii) the reference to 'the date of the enactment of this section' in each of subsections (e)(1)(D) and (f)(1)(E)(iii) is deemed to be a reference to 'the date of the enactment of the Children's Health and Medicare Protection Act of 2007';

''(iii) the reference to 'annually' in subsection (g)(1)(E) is deemed a reference to 'every three years';

''(iv) the reference to 'October 1, 1996' in subsection (l) is deemed to be a reference to 'January 1, 2011';

''(v) the reference to 'October 1, 1999' in subsection (n)(3)(H) is deemed to be a reference to 'January 1, 2012'; and

''(vi) the reference to 'October 1, 1993' in the matter following paragraph (3)(J) of subsection (n) is deemed to be a reference 'January 1, 2010'.

''(B) ULTRASOUND SERVICES.—With respect to diagnostic imaging services that are ultrasounds—

''(i) any reference to 'October 1, 1994' shall be deemed a reference to 'January 1, 2012';

''(ii) the reference to 'the date of the enactment of this section' in subsection (f)(1)(E)(iii) is deemed to be a reference to '7 years after the date of the enactment of the Children's Health and Medicare Protection Act of 2007';

''(iii) the reference to 'October 1, 1996' in subsection (l) is deemed to be a reference to 'January 1, 2013';

''(4) PROVISIONS NOT APPLICABLE.—For purposes of paragraph (1), in applying section 354 of the Public Health Service Act, the following provision shall not apply:

''(A) Subsections (e) and (f) of such section, in so far as the respective subsection imposes any requirement for a physician to be certified, accredited, or otherwise meet requirements, with respect to the provision of any diagnostic imaging services, as a condition of payment under subsection (b)(4)(C)(i), with respect to the professional or technical component, for such service.

''(B) Subsection (e)(1)(B)(iv) of such section, insofar as it applies to a facility with respect to the provision of ultrasounds.

''(C) Subsection (e)(1)(B)(v).

''(D) Subsection (f)(1)(H) of such section, relating to standards for special techniques for mammograms of patients with breast implants.

''(E) Subsection (g)(6) of such section, relating to an inspection demonstration program.

''(F) Subsection (n)(3)(G) of such section, relating to the national advisory committee.

''(G) Subsection (p) of such section, relating to breast cancer screening surveillance research grants.

''(H) Paragraphs (1)(B) and (2) of subsection (r) of such section, related to funding.

''(5) ACCREDITATION BODIES.—For purposes of paragraph (1), in applying section 354(e)(1) of the Public Health Service, the following shall apply:

''(A) APPROVAL OF TWO ACCREDITATION BODIES FOR EACH TREATMENT MODALITY.—In the case that there is more than one accreditation body for a treatment modality that qualifies for approval under this subsection, the Secretary shall approve at least two accreditation bodies for such treatment modality.

''(B) ADDITIONAL ACCREDITATION BODY STANDARDS.—In addition to the standards described in subparagraph (B) of such section for accreditation bodies, the Secretary shall establish standards that require—

''(i) the timely integration of new technology by accreditation bodies for purposes of accrediting facilities under this subsection; and

''(ii) the accreditation body involved to evaluate the annual medical physicist survey (or annual medical survey of another appropriate qualified expert chosen by the accreditation body) of a facility upon onsite review of such facility.

''(6) ADDITIONAL QUALITY STANDARDS.—For purposes of paragraph (1), in applying subsection (f)(1) of section 354 of the Public Health Service—

''(A) the quality standards under such subsection shall, with respect to a facility include—

''(i) standards for qualifications of medical personnel who are not physicians and who perform diagnostic imaging services at the facility that require such personnel to ensure that individuals, prior to performing medical imaging, demonstrate compliance with the standards established under subsection (a) through successful completion of certification by a nationally recognized professional organization, licensure, completion of an examination, pertinent coursework or degree program, verified pertinent experience, or through other ways determined appropriate by an accreditation body (with the approval of the Secretary, or through some combination thereof);

''(ii) standards requiring the facility to maintain records of the credentials of physicians and other medical personnel described in clause (i);

''(iii) standards for qualifications and responsibilities of medical directors and other personnel with supervising roles at the facility;

''(iv) standards that require the facility has procedures to ensure the safety of patients of the facility; and

''(v) standards for the establishment of a quality control program at the facility to be implemented as described in subparagraph (E) of such subsection;

''(B) the quality standards described in subparagraph (B) of such subsection shall be deemed to include standards that require the

establishment and maintenance of a quality assurance and quality control program at each facility that is adequate and appropriate to ensure the reliability, clarity, and accuracy of the technical quality of diagnostic images produced at such facilities; and

''(C) the quality standard described in subparagraph (C) of such subsection, relating to a requirement for personnel who perform specified services, shall include in such requirement that such personnel must meet continuing medical education standards as specified by an accreditation body (with the approval of the Secretary) and update such standards at least once every three years.

''(7) ADDITIONAL REQUIREMENTS.—Notwithstanding any provision of section 354 of the Public Health Service Act, the following shall apply to the accreditation process under this subsection for purposes of subsection (b)(4)(C)(i):

''(A) Any diagnostic imaging services facility accredited before January 1, 2010 (or January 1, 2012 in the case of ultrasounds), by an accrediting body approved by the Secretary shall be deemed a facility accredited by an approved accreditation body for purposes of such subsection as of such date if the facility submits to the Secretary proof of such accreditation by transmittal of the certificate of accreditation, including by electronic means.

''(B) The Secretary may require the accreditation under this subsection of an emerging technology used in the provision of a diagnostic imaging service as a condition of payment under subsection (b)(4)(C)(i) for such service at such time as the Secretary determines there is sufficient empirical and scientific information to properly carry out the accreditation process for such technology.

''(8) DEFINITIONS.—For purposes of this subsection:

''(A) AUDIT.—The term 'audit' means an onsite evaluation, with respect to a diagnostic imaging services facility, by the Secretary, State or local agency on behalf of the Secretary, or accreditation body approved under this subsection that includes the following:

''(i) Equipment verification.

''(ii) Evaluation of policies and procedures for compliance with accreditation requirements.

''(iii) Evaluation of personnel qualifications and credentialing.

''(iv) Evaluation of the technical quality of images.

''(v) Evaluation of patient reports.

''(vi) Evaluation of peer-review mechanisms and other quality assurance activities.

''(vii) Evaluation of quality control procedures, results, and follow-up actions.

''(viii) Evaluation of medical physicists (or other appropriate professionals chosen by the accreditation body) and magnetic resonance scientist surveys.

''(ix) Evaluation of consumer complaint mechanisms.

''(x) Provision of recommendations for improvement based on findings with respect to clauses (i) through (ix).

''(B) DIAGNOSTIC IMAGING SERVICES FACILITY.—The term 'diagnostic imaging services facility' has the meaning given the term 'facility' in section 354(a)(3) of the Public Health Service Act (42 U.S.C. 263b(a)(3)) subject to the reference changes specified in paragraph (2), but does not include any facility that does not furnish diagnostic imaging services for which payment may be made under this section.

''(C) IMAGE.—The term 'image' means the portrayal of internal structures of the human body for the purpose of detecting and determining the presence or extent of disease or injury and may be produced through various techniques or modalities, including radiant energy or ionizing radiation and ultrasound and magnetic resonance. Such term does not include image guided procedures.

''(D) MEDICAL IMAGING SERVICE.—The term 'medical imaging service' means a service that involves the science of an image. Such term does not include image guided procedures.''.

(b) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—Section 1848 of the Social Security Act (42 U.S.C. 1395w(b)(4)) is amended—

(1) in subsection (b)(4)—

(A) in the heading, by striking ''RULE'' and inserting ''RULES'';

(B) in subparagraph (B), by striking ''subparagraph (A)'' and inserting ''this paragraph''; and

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

''(C) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—In computing the number of practice expense relative value units under subsection (c)(2)(C)(ii) with respect to imaging services described in subparagraph (B), the Secretary shall adjust such number of units so it reflects a 75 percent (rather than 50 percent) presumed rate of utilization of imaging equipment.''; and

(2) in subsection (c)(2)(B)(v)(II), by inserting ''AND OTHER PROVISIONS'' after ''OPD PAYMENT CAP''

(c) ADJUSTMENT IN TECHNICAL COMPONENT ''DISCOUNT'' ON SINGLE-SESSION IMAGING TO CONSECUTIVE BODY PARTS.—Section 1848(b)(4) of such Act is further amended by adding at the end the following new subparagraph:

''(D) ADJUSTMENT IN TECHNICAL COMPONENT DISCOUNT ON SINGLE-SESSION IMAGING INVOLVING CONSECUTIVE BODY PARTS.—The Secretary shall increase the reduction in expenditures attributable to the multiple procedure payment reduction applicable to the technical component for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (42 C.F.R. 405, et al.) from 25 percent to 50 percent.''.

(d) ADJUSTMENT IN ASSUMED INTEREST RATE FOR CAPITAL PURCHASES.—Section 1848(b)(4) of such Act is further amended by adding at the end the following new subparagraph:

''(E) ADJUSTMENT IN ASSUMED INTEREST RATE FOR CAPITAL PURCHASES.—In computing the practice expense component for imaging services under this section, the Secretary shall change the interest rate assumption for capital purchases of imaging devices to reflect the prevailing rate in the market, but in no case higher than 11 percent.''.

(e) DISALLOWANCE OF GLOBAL BILLING.—Effective for claims filed for imaging services (as defined in subsection (b)(4)(B) of section 1848 of the Social Security Act) furnished on or after the first day of the first month that begins more than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall not accept (or pay) a claim under such section unless the claim is made separately for each component of such services.

(f) EFFECTIVE DATE.—Except as otherwise provided, this section, and the amendments made by this section, shall apply to services furnished on or after January 1, 2008.

SEC. 310. REPEAL OF PHYSICIANS ADVISORY COUNCIL.

Section 1868(a) of the Social Security Act (42 U.S.C. 1395ee(a)), relating to the Practicing Physicians Advisory Council, is repealed.

TITLE IV—MEDICARE ADVANTAGE REFORMS

Subtitle A—Payment Reform

SEC. 401. EQUALIZING PAYMENTS BETWEEN MEDICARE ADVANTAGE PLANS AND FEE-FOR-SERVICE MEDICARE.

(a) PHASE IN OF PAYMENT BASED ON FEE-FOR-SERVICE COSTS.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended—

(1) in subsection (j)(1)(A)—

(A) by striking ''beginning with 2007'' and inserting ''for 2007 and 2008''; and

(B) by inserting after ''(k)(1)'' the following: '', or, beginning with 2009, 1/12 of the blended benchmark amount determined under subsection (l)(1)''; and

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

''(l) DETERMINATION OF BLENDED BENCHMARK AMOUNT.—

''(1) IN GENERAL.—For purposes of subsection (j), subject to paragraphs (2) and (3), the term 'blended benchmark amount' means for an area—

''(A) for 2009 the sum of—

''(i) 2/3 of the applicable amount (as defined in subsection (k)(1)) for the area and year; and

''(ii) 1/3 of the amount specified in subsection (c)(1)(D)(i) for the area and year;

''(B) for 2010 the sum of—

''(i) 1/3 of the applicable amount for the area and year; and

''(ii) 2/3 of the amount specified in subsection (c)(1)(D)(i) for the area and year; and

''(C) for a subsequent year the amount specified in subsection (c)(1)(D)(i) for the area and year.

''(2) FEE-FOR-SERVICE PAYMENT FLOOR.—In no case shall the blended benchmark amount for an area and year be less than the amount specified in subsection (c)(1)(D)(i) for the area and year.

''(3) EXCEPTION FOR PACE PLANS.—This subsection shall not apply to payments to a PACE program under section 1894.''.

(b) PHASE IN OF PAYMENT BASED ON IME COSTS.—

(1) IN GENERAL.—Section 1853(c)(1)(D)(i) of such Act (42 U.S.C. 1395w–23(c)(1)(D)(i)) is amended by inserting ''and costs attributable to payments under section 1886(d)(5)(B)'' after ''1886(h)''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to the capitation rate for years beginning with 2009.

(c) LIMITATION ON PLAN ENROLLMENT IN CASES OF EXCESS BIDS FOR 2009 AND 2010.—

(1) IN GENERAL.—In the case of a Medicare Part C organization that offers a Medicare Part C plan in the 50 States or the District of Columbia for which—

(A) bid amount described in paragraph (2) for a Medicare Part C plan for 2009 or 2010, exceeds

(B) the percent specified in paragraph (4) of the fee-for-service amount described in paragraph (3),

the Medicare Part C plan may not enroll any new enrollees in the plan during the annual, coordinated election period (under section 1851(e)(3)(B) of such Act (42 U.S.C. 1395w–21(e)(3)(B)) for the year or during the year (if the enrollment becomes effective during the year).

(2) BID AMOUNT FOR PART A AND B SERVICES.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the bid amount described in this paragraph is the unadjusted Medicare Part C statutory non-drug monthly bid amount (as defined in section 1854(b)(2)(E) of the Social Security Act (42 U.S.C. 1395w–24(b)(2)(E)).

(B) TREATMENT OF MSA PLANS.—In the case of an MSA plan (as defined in section

1859(b)(3) of the Social Security Act, 42 U.S.C. 1935w–28(b)(3)), the bid amount described in this paragraph is the amount described in section 1854(a)(3)(A) of such Act (42 U.S.C. 1395w–24(a)(3)(A)).

(3) FEE-FOR-SERVICE AMOUNT DESCRIBED.—

(A) IN GENERAL.—Subject to subparagraph (B), the fee-for-service amount described in this paragraph for an Medicare Part C local area is the amount described in section 1853(c)(1)(D)(i) of the Social Security Act (42 U.S.C. 1395w–23) for such area.

(B) TREATMENT OF MULTI-COUNTY PLANS.—In the case of an MA plan the service area for which covers more than one Medicare Part C local area, the fee-for-service amount described in this paragraph is the amount described in section 1853(c)(1)(D)(i) of the Social Security Act for each such area served, weighted for each such area by the proportion of the enrollment of the plan that resides in the county (as determined based on amounts posted by the Administrator of the Centers for Medicare & Medicaid Services in the April bid notice for the year involved).

(4) PERCENTAGE PHASE DOWN.—For purposes of paragraph (1), the percentage specified in this paragraph—

(A) for 2009 is 106 percent; and

(B) for 2010 is 103 percent.

(5) EXEMPTION OF AGE-INS.—For purposes of paragraph (1), the term ''new enrollee'' with respect to a Medicare Part C plan offered by a Medicare Part C organization, does not include an individual who was enrolled in a plan offered by the organization in the month immediately before the month in which the individual was eligible to enroll in such a Medicare Part C plan offered by the organization.

(d) ANNUAL REBASING OF FEE-FOR-SERVICE RATES.—Section 1853(c)(1)(D)(ii) of the Social Security Act (42 U.S.C. 1395w–23(c)(1)(D)(ii)) is amended—

(1) by inserting ''(before 2009)'' after ''for subsequent years''; and

(2) by inserting before the period at the end the following: ''and for each year beginning with 2009''.

(e) REPEAL OF PPO STABILIZATION FUND.—Section 1858 of the Social Security Act (42 U.S.C. 1395) is amended—

(1) by striking subsection (e); and

(2) in subsection (f)(1), by striking ''subject to subsection (e),''.

Subtitle B—Beneficiary Protections

SEC. 411. NAIC DEVELOPMENT OF MARKETING, ADVERTISING, AND RELATED PROTECTIONS.

(a) IN GENERAL.—Section 1852 of the Social Security Act (42 U.S.C. 1395w–22) is amended by adding at the end the following new subsection:

''(m) APPLICATION OF MODEL MARKETING AND ENROLLMENT STANDARDS.—

''(1) IN GENERAL.—The National Association of Insurance Commissioners (in this subsection referred to as the 'NAIC') is requested to develop, and to submit to the Secretary of Health and Human Services not later than 12 months after the date of the enactment of this Act, model regulations (in this section referred to as 'model regulations') regarding Medicare plan marketing, enrollment, broker and agent training and certification, agent and broker commissions, and market conduct by plans, agents and brokers for implementation (under paragraph (7)) under this part and part D, including for enforcement by States under section 1856(b)(3).

''(2) MARKETING GUIDELINES.—

''(A) IN GENERAL.—The model regulations shall address the sales and advertising techniques used by Medicare private plans, agents and brokers in selling plans, including defining and prohibiting cold calls, unsolicited door-to-door sales, cross-selling, and co-branding.

''(B) SPECIAL CONSIDERATIONS.—The model regulations shall specifically address the marketing—

''(i) of plans to full benefit dual-eligible individuals and qualified medicare beneficiaries;

''(ii) of plans to populations with limited English proficiency;

''(iii) of plans to beneficiaries in senior living facilities; and

''(iv) of plans at educational events.

''(3) ENROLLMENT GUIDELINES.—

''(A) IN GENERAL.—The model regulations shall address the disclosures Medicare private plans, agents, and brokers must make when enrolling beneficiaries, and a process—

''(i) for affirmative beneficiary sign off before enrollment in a plan; and

''(ii) in the case of Medicare Part C plans, for plans to conduct a beneficiary call-back to confirm beneficiary sign off and enrollment.

''(B) SPECIFIC CONSIDERATIONS.—The model regulations shall specially address beneficiary understanding of the Medicare plan through required disclosure (or beneficiary verification) of each of the following:

''(i) The type of Medicare private plan involved.

''(ii) Attributes of the plan, including premiums, cost sharing, formularies (if applicable), benefits, and provider access limitations in the plan.

''(iii) Comparative quality of the plan.

''(iv) The fact that plan attributes may change annually.

''(4) APPOINTMENT, CERTIFICATION AND TRAINING OF AGENTS AND BROKERS.—The model regulations shall establish procedures and requirements for appointment, certification (and periodic recertification), and training of agents and brokers that market or sell Medicare private plans consistent with existing State appointment and certification procedures and with this paragraph.

''(5) AGENT AND BROKER COMMISSIONS.—

''(A) IN GENERAL.—The model regulations shall establish standards for fair and appropriate commissions for agents and brokers consistent with this paragraph.

''(B) LIMITATION ON TYPES OF COMMISSION.—The model regulations shall specifically prohibit the following:

''(i) Differential commissions—

''(I) for Medicare Part C plans based on the type of Medicare private plan; or

''(II) prescription drug plans under part D based on the type of prescription drug plan.

''(ii) Commissions in the first year that are more than 200 percent of subsequent year commissions.

''(iii) The payment of extra bonuses or incentives (such as trips, gifts, and other non-commission cash payments).

''(C) AGENT DISCLOSURE.—In developing the model regulations, the NAIC shall consider requiring agents and brokers to disclose commissions to a beneficiary upon request of the beneficiary before enrollment.

''(D) PREVENTION OF FRAUD.—The model regulations shall consider the opportunity for fraud and abuse and beneficiary steering in setting standards under this paragraph and shall provide for the ability of State commissioners to investigate commission structures.

''(6) MARKET CONDUCT.—

''(A) IN GENERAL.—The model regulations shall establish standards for the market conduct of organizations offering Medicare private plans, and of agents and brokers selling such plans, and for State review of plan market conduct.

''(B) MATTERS TO BE INCLUDED.—Such standards shall include standards for—

''(i) timely payment of claims;

''(ii) beneficiary complaint reporting and disclosure; and

''(iii) State reporting of market conduct violations and sanctions.

''(7) IMPLEMENTATION.—

''(A) PUBLICATION OF NAIC MODEL REGULATIONS.—If the model regulations are submitted on a timely basis under paragraph (1)—

''(i) the Secretary shall publish them in the Federal Register upon receipt and request public comment on the issue of whether such regulations are consistent with the requirements established in this subsection for such regulations;

''(ii) not later than 6 months after the date of such publication, the Secretary shall determine whether such regulations are so consistent with such requirements and shall publish notice of such determination in the Federal Register; and

''(iii) if the Secretary makes the determination under clause (ii) that such regulations are consistent with such requirements, in the notice published under clause (ii) the Secretary shall publish notice of adoption of such model regulations as constituting the marketing and enrollment standards adopted under this subsection to be applied under this title; and

''(iv) if the Secretary makes the determination under such clause that such regulations are not consistent with such requirements, the procedures of clauses (ii) and (iii) of subparagraph (B) shall apply (in relation to the notice published under clause (ii)), in the same manner as such clauses would apply in the case of publication of a notice under subparagraph (B)(i).

''(B) NO MODEL REGULATIONS.—If the model regulations are not submitted on a timely basis under paragraph (1)—

''(i) the Secretary shall publish notice of such fact in the Federal Register;

''(ii) not later than 6 months after the date of publication of such notice, the Secretary shall propose regulations that provide for marketing and enrollment standards that incorporate the requirements of this subsection for the model regulations and request public comments on such proposed regulations; and

''(iii) not later than 6 months after the date of publication of such proposed regulations, the Secretary shall publish final regulations that shall constitute the marketing and enrollment standards adopted under this subsection to be applied under this title.

''(C) REFERENCES TO MARKETING AND ENROLLMENT STANDARDS.—In this title, a reference to marketing and enrollment standards adopted under this subsection is deemed a reference to the regulations constituting such standards adopted under subparagraph (A) or (B), as the case may be.

''(D) EFFECTIVE DATE OF STANDARDS.—In order to provide for the orderly and timely implementation of marketing and enrollment standards adopted under this subsection, the Secretary, in consultation with the NAIC, shall specify (by program instruction or otherwise) effective dates with respect to all components of such standards consistent with the following:

''(i) In the case of components that relate predominantly to operations in relation to Medicare private plans, the effective date shall be for plan years beginning on or after such date (not later than 1 year after the date of promulgation of the standards) as the Secretary specifies.

''(ii) In the case of other components, the effective date shall be such date, not later than 1 year after the date of promulgation of the standards, as the Secretary specifies.

''(E) CONSULTATION.— In promulgating marketing and enrollment standards under this paragraph, the NAIC or Secretary shall

consult with a working group composed of representatives of issuers of Medicare private plans, consumer groups, medicare beneficiaries, State Health Insurance Assistance Programs, and other qualified individuals. Such representatives shall be selected in a manner so as to assure balanced representation among the interested groups.

''(8) ENFORCEMENT.—

''(A) IN GENERAL.—Any Medicare private plan that violates marketing and enrollment standards is subject to sanctions under section 1857(g).

''(B) STATE RESPONSIBILITIES.—Nothing in this subsection or section 1857(g) shall prohibit States from imposing sanctions against Medicare private plans, agents, or brokers for violations of the marketing and enrollment standards adopted under section 1852(m). States shall have the sole authority to regulate agents and brokers.

''(9) MEDICARE PRIVATE PLAN DEFINED.—In this subsection, the term 'Medicare private plan' means a Medicare Part C plan and a prescription drug plan under part D.''.

(b) EXPANSION OF EXCEPTION TO PREEMPTION OF STATE ROLE.—

(1) IN GENERAL.—Section 1856(b)(3) of the Social Security Act (42 U.S.C. 1395w–26(b)(3)) is amended by striking ''(other than State licensing laws or State laws relating to plan solvency)'' and inserting ''(other than State laws relating to licensing or plan solvency and State laws or regulations adopting the marketing and enrollment standards adopted under section 1852(m)).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to plans offered on or after July 1, 2008.

(c) APPLICATION TO PRESCRIPTION DRUG PLANS.—

(1) IN GENERAL.—Section 1860D–1 of such Act is amended by adding at the end the following new subsection:

''(d) APPLICATION OF MARKETING AND ENROLLMENT STANDARDS.—The marketing and enrollment standards adopted under section 1852(m) shall apply to prescription drug plans (and sponsors of such plans) in the same manner as they apply to Medicare Part C plans and organizations offering such plans.''.

(2) REFERENCE TO CURRENT LAW PROVISIONS.—The amendment made by subsection (a) and (b) apply, pursuant to section 1860D–1(b)(1)(B)(ii) of the Social Security Act (42 U.S.C. 1395w–101(b)(1)(B)(ii)), to prescription drug plans under part D of title XVIII of such Act.

(d) CONTRACT REQUIREMENT TO MEET MARKETING AND ADVERTISING STANDARDS.—

(1) IN GENERAL.—Section 1857(d) of the Social Security Act (42 U.S.C. 1395w–27(d)), as amended by subsection (b)(1), is further amended by adding at the end the following new paragraph:

''(7) MARKETING AND ADVERTISING STANDARDS.—The contract shall require the organization to meet all standards adopted under section 1852(m) (including those enforced by the State involved pursuant to section 1856(b)(3)) relating to marketing and advertising conduct''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to contracts for plan years beginning on or after January 1, 2011.

(e) APPLICATION OF SANCTIONS.—

(1) APPLICATION TO VIOLATION OF MARKETING AND ENROLLMENT STANDARDS.—Section 1857(g) of such Act (42 U.S.C. 1395w–27(g)) is amended—

(A) by striking ''or'' at the end of subparagraph (F);

(B) by adding ''or'' at the end of subparagraph (G); and

(C) by inserting after subparagraph (G) the following new subparagraph:

''(H) violates marketing and enrollment standards adopted under section 1852(m);''.

(2) ENHANCED CIVIL MONEY SANCTIONS.—Such section is further amended—

(A) in paragraph (2)(A), by striking ''$25,000'', ''$100,000'', and ''$15,000'' and inserting ''$50,000'', ''$200,000'', and ''$30,000'', respectively; and

(B) in subparagraphs (A), (B), and (D) of paragraph (3), by striking ''$25,000'', ''$10,000'', and ''$100,000'', respectively, and inserting ''$50,000'', ''$20,000'', and ''$200,000'', respectively.

(3) EFFECTIVE DATE.—The amendments made by paragraph (2) shall apply to violations occurring on or after the date of the enactment of this Act.

(f) DISCLOSURE OF MARKET AND ADVERTISING CONTRACT VIOLATIONS AND IMPOSED SANCTIONS.—Section 1857 of such Act is amended by adding at the end the following new subsection

''(j) DISCLOSURE OF MARKET AND ADVERTISING CONTRACT VIOLATIONS AND IMPOSED SANCTIONS.—For years beginning with 2009, the Secretary shall post on its public website for the Medicare program an annual report that—

''(1) lists each MA organization for which the Secretary made during the year a determination under subsection (c)(2) the basis of which is described in paragraph (1)(E); and

''(2) that describes any applicable sanctions under subsection (g) applied to such organization pursuant to such determination.''.

(g) STANDARD DEFINITIONS OF BENEFITS AND FORMATS FOR USE IN MARKETING MATERIALS.—Section 1851(h) of such Act (42 U.S.C. 1395w–21(h)) is amended by adding at the end the following new paragraph:

''(6) STANDARD DEFINITIONS OF BENEFITS AND FORMATS FOR USE IN MARKETING MATERIALS.—

''(A) IN GENERAL.—Not later than January 1, 2010, the Secretary, in consultation with the National Association of Insurance Commissioners and a working group of the type described in section 1852(m)(7)(E), shall develop standard descriptions and definitions for benefits under this title for use in marketing material distributed by Medicare Part C organizations and formats for including such descriptions in such marketing material.

''(B) REQUIRED USE OF STANDARD DEFINITIONS.— For plan years beginning on or after January 1, 2011, the Secretary shall disapprove the distribution of marketing material under paragraph (1)(B) if such marketing material does not use, without modification, the applicable descriptions and formats specified under subparagraph (A).''.

(h) SUPPORT FOR STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPS).—Section 1857(e)(2) of the Social Security Act (42 U.S.C. 1395w–27(e)(2)) is amended—

(1) in subparagraph (B), by adding at the end the following: ''Of the amounts so collected, no less than $55,000,000 for fiscal year 2009, $65,000,000 for fiscal year 2010, $75,000,000 for fiscal year 2011, and $85,000,000 for fiscal year 2012 shall be used to support Medicare Part C and Part D counseling and assistance provided by State Health Insurance Assistance Programs.'';

(2) in subparagraph (C)—

(A) by striking ''and'' after ''$100,000,000''; and

(B) by striking ''an amount equal to $200,000,000'' and inserting ''and ending with fiscal year 2008 an amount equal to $200,000,000, for fiscal year 2009 an amount equal to $255,000,000, for fiscal year 2010 an amount equal to $265,000,000, for fiscal year 2011 an amount equal to $275,000,000, and for fiscal year 2012 an amount equal to $285,000,000''; and

(3) in subparagraph (D)(ii)—

(A) by striking ''and'' at the end of subclause (IV);

(B) in subclause (V), by striking the period at the end and inserting ''before fiscal year 2009; and''; and

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

''(VI) for fiscal year 2009 and each succeeding fiscal year the applicable portion (as so defined) of the amount specified in subparagraph (C) for that fiscal year.''.

SEC. 412. LIMITATION ON OUT-OF-POCKET COSTS FOR INDIVIDUAL HEALTH SERVICES.

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

(1) in subparagraph (A), by inserting before the period at the end the following: ''with cost-sharing that is no greater (and may be less) than the cost-sharing that would otherwise be imposed under such program option'';

(2) in subparagraph (B)(i), by striking '' or an actuarially equivalent level of cost-sharing as determined in this part''; and

(3) by amending clause (ii) of subparagraph (B) to read as follows:

''(ii) PERMITTING USE OF FLAT COPAYMENT OR PER DIEM RATE.—Nothing in clause (i) shall be construed as prohibiting a Medicare part C plan from using a flat copayment or per diem rate, in lieu of the cost-sharing that would be imposed under part A or B, so long as the amount of the cost-sharing imposed does not exceed the amount of the cost-sharing that would be imposed under the respective part if the individual were not enrolled in a plan under this part.''.

(b) LIMITATION FOR DUAL ELIGIBLES AND QUALIFIED MEDICARE BENEFICIARIES.—Section 1852(a) of such Act is amended by adding at the end the following new paragraph:

''(7) LIMITATION ON COST-SHARING FOR DUAL ELIGIBLES AND QUALIFIED MEDICARE BENEFICIARIES.—In the case of a individual who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)) or a qualified medicare beneficiary (as defined in section 1905(p)(1)) who is enrolled in a Medicare Part C plan, the plan may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under this title and title XIX if the individual were not enrolled with such plan.''.

(c) EFFECTIVE DATES.—

(1) The amendments made by subsection (a) shall apply to plan years beginning on or after January 1, 2009.

(2) The amendments made by subsection (b) shall apply to plan years beginning on or after January 1, 2008.

SEC. 413. MA PLAN ENROLLMENT MODIFICATIONS.

(a) IMPROVED PLAN ENROLLMENT, DISENROLLMENT, AND CHANGE OF ENROLLMENT.—

(1) CONTINUOUS OPEN ENROLLMENT FOR FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS AND QUALIFIED MEDICARE BENEFICIARIES (QMB).—Section 1851(e)(2)(D) of the Social Security Act (42 U.S.C. 1395w–21(e)(2)(D)) is amended—

(A) in the heading, by inserting ;'', FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS, AND QUALIFIED MEDICARE BENEFICIARIES'' after ''INSTITUTIONALIZED INDIVIDUALS''; and

(B) in the matter before clause (i), by inserting '', a full-benefit dual eligible individual (as defined in section 1935(c)(6)), or a qualified medicare beneficiary (as defined in section 1905(p)(1))'' after ''institutionalized (as defined by the Secretary)''; and

(C) in clause (i), by inserting ''or disenroll'' after ''enroll''.

(2) SPECIAL ELECTION PERIODS FOR ADDITIONAL CATEGORIES OF INDIVIDUALS.—Section

1851(e)(4) of such Act (42 U.S.C. 1395w(e)(4)) is amended—

(A) in subparagraph (C), by striking at the end ''or'';

(B) in subparagraph (D), by inserting '', taking into account the health or well-being of the individual'' before the period and redesignating such subparagraph as subparagraph (G); and

(C) by inserting after subparagraph (C) the following new subparagraphs:

''(D) the individual is described in section 1902(a)(10)(E)(iii) (relating to specified low-income medicare beneficiaries); or

''(E) the individual is enrolled in an MA plan and enrollment in the plan is suspended under paragraph (2)(B) or (3)(C) of section 1857(g) because of a failure of the plan to meet applicable requirements.''.

(3) ELIMINATION OF CONTINUOUS OPEN ENROLLMENT OF ORIGINAL FEE-FOR-SERVICE ENROLLEES IN MEDICARE ADVANTAGE NON-PRESCRIPTION DRUG PLANS.—Subparagraph (E) of section 1851(e)(2) of the Social Security Act, as added by section 206 of division B of the Tax Relief and Health Care Act of 2006 (Public Law 109–432), is repealed.

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

(b) ACCESS TO MEDIGAP COVERAGE FOR INDIVIDUALS WHO LEAVE MA PLANS.—

(1) IN GENERAL.—Section 1882(s)(3) of the Social Security Act (42 U.S.C. 1395ss(s)(3)) is amended—

(A) in each of clauses (v)(III) and (vi) subparagraph (B), by striking ''12 months'' and inserting ''24 months''; and

(B) in each of subclauses (I) and (II) of subparagraph (F)(i), by striking ''12 months'' and inserting ''24 months''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to terminations of enrollments in MA plans occurring on or after the date of the enactment of this Act.

(c) IMPROVED ENROLLMENT POLICIES.—

(1) NO AUTO-ENROLLMENT OF MEDICAID BENEFICIARIES.—

(A) IN GENERAL.—Section 1851(e) of such Act (42 U.S.C. 1395w–21(e)) is amended by adding at the end the following new paragraph:

''(7) NO AUTO-ENROLLMENT OF MEDICAID BENEFICIARIES.—In no case may the Secretary provide for the enrollment in a MA plan of a Medicare Advantage eligible individual who is eligible to receive medical assistance under title XIX as a full-benefit dual eligible individual or a qualified medicare beneficiary, without the affirmative application of such individual (or authorized representative of the individual) to be enrolled in such plan.''.

(B) NO APPLICATION TO PRESCRIPTION DRUG PLANS.—Section 1860D–1(b)(1)(B)(iii) of such Act (42 U.S.C. 1395w–101(b)(1)(B)(iii)) is amended—

(i) by striking ''paragraph (2) and'' and by inserting ''paragraph (2),''; and

(ii) by inserting '', and paragraph (7),'' after ''paragraph (4)''.

(C) EFFECTIVE DATE.—The amendments made by this paragraph shall apply to enrollments that are effective on or after the date of the enactment of this Act.

SEC. 414. INFORMATION FOR BENEFICIARIES ON MA PLAN ADMINISTRATIVE COSTS.

(a) DISCLOSURE OF MEDICAL LOSS RATIOS AND OTHER EXPENSE DATA.—Section 1851 of the Social Security Act (42 U.S.C. 1395w–21) is amended by adding at the end the following new subsection:

''(j) PUBLICATION OF MEDICAL LOSS RATIOS AND OTHER COST-RELATED INFORMATION.—

''(1) IN GENERAL.—The Secretary shall publish, not later than October 1 of each year (beginning with 2009), for each Medicare Part C plan contract, the following:

''(A) The medical loss ratio of the plan in the previous year.

''(B) The per enrollee payment under this part to the plan, as adjusted to reflect a risk score (based on factors described in section 1853(a)(1)(C)(i)) of 1.0.

''(C) The average risk score (as so based).

''(2) SUBMISSION OF DATA.—

''(A) IN GENERAL.—Each Medicare Part C organization shall submit to the Secretary, in a form and manner specified by the Secretary, data necessary for the Secretary to publish the information described in paragraph (1) on a timely basis, including the information described in paragraph (3).

''(B) DATA FOR 2008 AND 2009.—The data submitted under subparagraph (A) for 2008 and for 2009 shall be consistent in content with the data reported as part of the Medicare Part C plan bid in June 2007 for 2008.

''(C) MEDICAL LOSS RATIO DATA.—The data to be submitted under subparagraph (A) relating to medical loss ratio for a year—

''(i) shall be submitted not later than June 1 of the following year; and

''(ii) beginning with 2010, shall be submitted based on the standardized elements and definitions developed under paragraph (4).

''(D) AUDITED DATA.—Data submitted under this paragraph shall be data that has been audited by an independent third party auditor.

''(3) MLR INFORMATION.—The information described in this paragraph with respect to a Medicare Part C plan for a year is as follows:

''(A) The costs for the plan in the previous year for each of the following:

''(i) Total medical expenses, separately indicated for benefits for the original medicare fee-for-service program option and for supplemental benefits.

''(ii) Non-medical expenses, shown separately for each of the following categories of expenses:

''(I) Marketing and sales.

''(II) Direct administration.

''(III) Indirect administration.

''(IV) Net cost of private reinsurance.

''(B) Gain or loss margin.

''(C) Total revenue requirement, computed as the total of medical and nonmedical expenses and gain or loss margin, multiplied by the gain or loss margin.

''(D) Percent of revenue ratio, computed as the total revenue requirement expressed as a percentage of revenue.

''(4) DEVELOPMENT OF DATA REPORTING STANDARDS.—

''(A) IN GENERAL.—The Secretary shall develop and implement standardized data elements and definitions for reporting under this subsection, for contract years beginning with 2010, of data necessary for the calculation of the medical loss ratio for Medicare Part C plans. Not later than December 31, 2008, the Secretary shall publish a report describing the elements and definitions so developed.

''(B) CONSULTATION.—The Secretary shall consult with representatives of Medicare Part C organizations, experts on health plan accounting systems, and representatives of the National Association of Insurance Commissioners, in the development of such data elements and definitions

''(5) MEDICAL LOSS RATIO DEFINED.—For purposes of this part, the term 'medical loss ratio' means, with respect to an MA plan for a year, the ratio of—

''(A) the aggregate benefits (excluding non-medical expenses described in paragraph (3)(A)(ii)) paid under the plan for the year, to

''(B) the aggregate amount of premiums (including basic and supplemental beneficiary premiums) and payments made under sections 1853 and 1860D–15) collected for the plan and year.

Such ratio shall be computed without regard to whether the benefits or premiums are for required or supplemental benefits under the plan.''.

(b) AUDIT OF ADMINISTRATIVE COSTS AND COMPLIANCE WITH THE FEDERAL ACQUISITION REGULATION.—

(1) IN GENERAL.—Section 1857(d)(2)(B) of such Act (42 U.S.C. 1395w–27(d)(2)(B)) is amended—

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

(B) by inserting before the period at the end the following: '', or (iii) to compliance with the requirements of subsection (e)(4) and the extent to which administrative costs comply with the applicable requirements for such costs under the Federal Acquisition Regulation''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply for contract years beginning after the date of the enactment of this Act.

(c) MINIMUM MEDICAL LOSS RATIO.—Section 1857(e) of the Social Security Act (42 U.S.C. 1395w–27(e)) is amended by adding at the end the following new paragraph:

''(4) REQUIREMENT FOR MINIMUM MEDICAL LOSS RATIO.—If the Secretary determines for a contract year (beginning with 2010) that an MA plan has failed to have a medical loss ratio (as defined in section 1851(j)(4)) of at least .85—

''(A) for that contract year, the Secretary shall reduce the blended benchmark amount under subsection (l) for the second succeeding contract year by the numer of percentage points by which such loss ratio was less than 85 percent;

''(B) for 3 consecutive contract years, the Secretary shall not permit the enrollment of new enrollees under the plan for coverage during the second succeeding contract year; and

''(C) the Secretary shall terminate the plan contract if the plan fails to have such a medical loss ratio for 5 consecutive contract years.''.

(d) INFORMATION ON MEDICARE PART C PLAN ENROLLMENT AND SERVICES.—Section 1851 of such Act, as amended by subsection (a), is further amended by adding at the end the following new subsection:

''(k) PUBLICATION OF ENROLLMENT AND OTHER INFORMATION.—

''(1) MONTHLY PUBLICATION OF PLAN-SPECIFIC ENROLLMENT DATA.—The Secretary shall publish (on the public website of the Centers for Medicare & Medicaid Services or otherwise) not later than 30 days after the end of each month (beginning with January 2008) on the actual enrollment in each Medicare Part C plan by contract and by county.

''(2) AVAILABILITY OF OTHER INFORMATION.—The Secretary shall make publicly available data and other information in a format that may be readily used for analysis of the Medicare Part C program under this part and will contribute to the understanding of the organization and operation of such program.''.

(e) MEDPAC REPORT ON VARYING MINIMUM MEDICAL LOSS RATIOS.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study of the need and feasibility ofproviding for different minimum medical loss ratios for different types of Medicare Part C plans, including coordinated care plans, group model plans, coordinated care independent practice association plans, preferred provider organization plans, and private fee-for-services plans.

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

Subtitle C—Quality and Other Provisions

SEC. 421. REQUIRING ALL MA PLANS TO MEET EQUAL STANDARDS.

(a) COLLECTION AND REPORTING OF INFORMATION.—

(1) IN GENERAL.—Section 1852(e)(1) of the Social Security Act (42 U.S.C. 1395w–112(e)(1)) is amended by striking ''(other than an MA private fee-for-service plan or an MSA plan)''.

(2) REPORTING FOR PRIVATE FEE-FOR-SERVICES AND MSA PLANS.—Section 1852(e)(3) of such Act is amended by adding at the end the following new subparagraph:

''(C) DATA COLLECTION REQUIREMENTS BY PRIVATE FEE-FOR-SERVICE PLANS AND MSA PLANS.—

''(i) USING MEASURES FOR PPOS FOR CONTRACT YEAR 2009.—For contract year 2009, the Medicare Part C organization offering a private fee-for-service plan or an MSA plan shall submit to the Secretary for such plan the same information on the same performance measures for which such information is required to be submitted for Medicare Part C plans that are preferred provider organization plans for that year.

''(ii) APPLICATION OF SAME MEASURES AS COORDINATED CARE PLANS BEGINNING IN CONTRACT YEAR 2010.—For a contract year beginning with 2010, a Medicare Part C organization offering a private fee-for-service plan or an MSA plan shall submit to the Secretary for such plan the same information on the same performance measures for which such information is required to be submitted for such contract year Medicare Part C plans described in section 1851(a)(2)(A)(i) for contract year such contract year.''.

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

(b) EMPLOYER PLANS.—

(1) IN GENERAL.—The first sentence of paragraph (2) of section 1857(i) of such Act (42 U.S.C. 1395w–27(i)) is amended by inserting before the period at the end the following: '', but only if 90 percent of the Medicare part C eligible individuals enrolled under such plan reside in a county in which the Medicare Part C organization offers a Medicare Part C local plan''.

(2) LIMITATION ON APPLICATION OF WAIVER AUTHORITY.—Paragraphs (1) and (2) of such section are each amended by inserting ''that were in effect before the date of the enactment of the Children's Health and Medicare Protection Act of 2007'' after ''waive or modify requirements''.

(3) EFFECTIVE DATES.—The amendment made by paragraph (1) shall apply for plan years beginning on or after January 1, 2009, and the amendments made by paragraph (2) shall take effect on the date of the enactment of this Act.

SEC. 422. DEVELOPMENT OF NEW QUALITY REPORTING MEASURES ON RACIAL DISPARITIES.

(a) NEW QUALITY REPORTING MEASURES.—

(1) IN GENERAL.—Section 1852(e)(3) of the Social Security Act (42 U.S.C. 1395w–22(e)(3)), as amended by section 421(a)(2), is amended—

(A) in subparagraph (B)—

(i) in clause (i), by striking ''The Secretary'' and inserting ''Subject to subparagraph (D), the Secretary''; and

(ii) in clause (ii), by inserting ''and subparagraph (C)'' after ''clause (iii)''; and

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

''(D) ADDITIONAL QUALITY REPORTING MEASURES.—

''(i) IN GENERAL.—The Secretary shall develop by October 1, 2009, quality measures for Medicare Part C plans that measure disparities in the amount and quality of health services provided to racial and ethnic minorities.

''(ii) DATA TO MEASURE RACIAL AND ETHNIC DISPARITIES IN THE AMOUNT AND QUALITY OF CARE PROVIDED TO ENROLLEES.—The Secretary shall provide for Medicare Part C organizations to submit data under this paragraph, including data similar to those submitted for other quality measures, that permits analysis of disparities among racial and ethnic minorities in health services, quality of care, and health status among Medicare Part C plan enrollees for use in submitting the reports under paragraph (5).''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to reporting of quality measures for plan years beginning on or after January 1, 2010.

(b) BIENNIAL REPORT ON RACIAL AND ETHNIC MINORITIES.—Section 1852(e) of such Act (42 U.S.C. 1395w–22(e)) is amended by adding at the end the following new paragraph:

''(5) REPORT TO CONGRESS.—

''(A) IN GENERAL.—Not later than 2 years after the date of the enactment of this paragraph, and biennially thereafter, the Secretary shall submit to Congress a report regarding how quality assurance programs conducted under this subsection measure and report on disparities in the amount and quality of health care services furnished to racial and ethnic minorities.

''(B) CONTENTS OF REPORT.—Each such report shall include the following:

''(i) A description of the means by which such programs focus on such racial and ethnic minorities.

''(ii) An evaluation of the impact of such programs on eliminating health disparities and on improving health outcomes, continuity and coordination of care, management of chronic conditions, and consumer satisfaction.

''(iii) Recommendations on ways to reduce clinical outcome disparities among racial and ethnic minorities.

''(iv) Data for each MA plan from HEDIS and other source reporting the disparities in the amount and quality of health services furnished to racial and ethnic minorities.''.

SEC. 423. STRENGTHENING AUDIT AUTHORITY.

(a) FOR PART C PAYMENTS RISK ADJUSTMENT.—Section 1857(d)(1) of the Social Security Act (42 U.S.C. 1395w–27(d)(1)) is amended by inserting after ''section 1858(c))'' the following: '', and data submitted with respect to risk adjustment under section 1853(a)(3).''.

(b) ENFORCEMENT OF AUDITS AND DEFICIENCIES.—

(1) IN GENERAL.—Section 1857(e) of such Act is amended by adding at the end the following new paragraph:

''(4) ENFORCEMENT OF AUDITS AND DEFICIENCIES.—

''(A) INFORMATION IN CONTRACT.—The Secretary shall require that each contract with a Medicare Part C organization under this section shall include terms that inform the organization of the provisions in subsection (d).

''(B) ENFORCEMENT AUTHORITY.—The Secretary is authorized, in connection with conducting audits and other activities under subsection (d), to take such actions, including pursuit of financial recoveries, necessary to address deficiencies identified in such audits or other activities.''.

(2) APPLICATION UNDER PART D.—For provision applying the amendment made by paragraph (1) to prescription drug plans under part D, see section 1860D–12(b)(3)(D) of the Social Security Act.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect the date of the enactment of this Act and shall apply to audits and activities conducted for contract years beginning on or after January 1, 2009.

SEC. 424. IMPROVING RISK ADJUSTMENT FOR MA PAYMENTS.

(a) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report that evaluates the adequacy of the Medicare Advantage risk adjustment system under section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395–23(a)(1)(C)).

(b) PARTICULARS.—The report under subsection (a) shall include an evaluation of at least the following:

(1) The need and feasibility of improving the adequacy of the risk adjustment system in predicting costs for beneficiaries with comorbid conditions and associated cognitive impairments.

(2) The need and feasibility of including further gradations of diseases and conditions (such as the degree of severity of congestive heart failure).

(3) The feasibility of measuring difference in coding over time between Medicare part C plans and the medicare traditional fee-for-service program and, to the extent this difference exists, the options for addressing it.

(4) The feasibility and value of including part D and other drug utilization data in the risk adjustment model.

SEC. 425. ELIMINATING SPECIAL TREATMENT OF PRIVATE FEE-FOR-SERVICE PLANS.

(a) ELIMINATION OF EXTRA BILLING PROVISION.—Section 1852(k)(2) of the Social Security Act (42 U.S.C. 1395w–22(k)(2)) is amended—

(1) in subparagraph (A)(i), by striking ''115 percent'' and inserting ''100 percent''; and

(2) in subparagraph (C)(i), by striking '' (including any liability for balance billing consistent with this subsection)''.

(b) REVIEW OF BID INFORMATION.—Section 1854(a)(6)(B) of such Act (42 U.S.C. 1395w–24(a)(6)(B)) is amended—

(1) in clause (i), by striking ''clauses (iii) and (iv)'' and inserting ''clause (iii)''; and

(2) by striking clause (iv).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to contract years beginning with 2009.

SEC. 426. RENAMING OF MEDICARE ADVANTAGE PROGRAM.

(a) IN GENERAL.—The program under part C of title XVIII of the Social Security Act is henceforth to be known as the ''Medicare Part C program''.

(b) CHANGE IN REFERENCES.—

(1) AMENDING SOCIAL SECURITY ACT.—The Social Security Act is amended by striking ''Medicare Advantage'', ''MA'', and ''Medicare+Choice'' and inserting ''Medicare Part C'' each place it appears, with the appropriate, respective typographic formatting, including typeface and capitalization.

(2) ADDITIONAL REFERENCES.—Notwithstanding section 201(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173), any reference to the program under part C of title XVIII of the Social Security Act shall be deemed a reference to the ''Medicare Part C'' program and, with respect to such part, any reference to ''Medicare+Choice''. ''Medicare Advantage'', or ''MA'' is deemed a reference to the program under such part.

Subtitle D—Extension of Authorities

SEC. 431. EXTENSION AND REVISION OF AUTHORITY FOR SPECIAL NEEDS PLANS (SNPS).

(a) EXTENDING RESTRICTION ON ENROLLMENT AUTHORITY FOR SNPS FOR 3 YEARS.—Subsection (f) of section 1859 of the Social Security Act (42 U.S.C. 1395w–28) is amended by striking ''2009'' and inserting ''2012''.

(b) STRUCTURE OF AUTHORITY FOR SNPS.—

(1) IN GENERAL.—Such section is further amended—

(A) in subsection (b)(6)(A), by striking all that follows ''means'' and inserting the following: ''an MA plan—

''(i) that serves special needs individuals (as defined in subparagraph (B));

''(ii) as of January 1, 2009, either—

''(I) at least 90 percent of the enrollees in which are described in subparagraph (B)(i), as determined under regulations in effect as of July 1, 2007; or

''(II) at least 90 percent of the enrollees in which are described in subparagraph (B)(ii) and are full-benefit dual eligible individuals (as defined in section 1935(c)(6)) or qualified medicare beneficiaries (as defined in section 1905(p)(1)); and

''(iii) as of January 1, 2009, meets the applicable requirements of paragraph (2) or (3) of subsection (f), as the case may be.'';

(B) in subsection (b)(6)(B)(iii), by inserting ''only for contract years beginning before January 1, 2009,'' after ''(iii)'';

(C) in subsection (f)—

(i) by amending the heading to read as follows: ''REQUIREMENTS FOR ENROLLMENT IN PART C PLANS FOR SPECIAL NEEDS BENEFICIARIES'';

(ii) by designating the sentence beginning ''In the case of'' as paragraph (1) with the heading ''REQUIREMENTS FOR 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)(A)(ii)(I), the applicable requirements of this subsection are as follows:

''(A) The plan has an agreement with the State that includes provisions regarding cooperation on the coordination of care for such individuals. Such agreement shall include a description of the manner that the State Medicaid program under title XIX will pay for the costs of services for individuals eligible under such title for medical assistance for acute care and long-term care services.

''(B) The plan has a contract with long-term care facilities and other providers in the area sufficient to provide care for enrollees described in subsection (b)(6)(B)(i).

''(C) The plan reports to the Secretary information on additional quality measures specified by the Secretary under section 1852(e)(3)(D)(iv)(I) for such plans.

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

''(A) The plan has an agreement with the State Medicaid agency that—

''(i) includes provisions regarding cooperation on the coordination of the financing of care for such individuals;

''(ii) includes a description of the manner that the State Medicaid program under title XIX will pay for the costs of cost-sharing and supplemental services for individuals enrolled in the plan eligible under such title for medical assistance for acute and long-term care services; and

''(iii) effective January 1, 2011, provides for capitation payments to cover costs of supplemental benefits for individuals described in subsection (b)(6)(A)(ii)(II).

''(B) The out-of-pocket costs for services under parts A and B that are charged to enrollees may not exceed the out-of-pocket costs for same services permitted for such individuals under title XIX.

''(C) The plan reports to the Secretary information on additional quality measures specified by the Secretary under section 1852(e)(3)(D)(iv)(II) for such plans.''.

(2) QUALITY STANDARDS AND QUALITY REPORTING.—Section 1852(e)(3) of such Act (42 U.S.C. 1395w–22(e)(3) is amended—

(A) in subparagraph (A)(i), by adding at the end the following: ''In the case of a specialized Medicare Part C plan for special needs individuals described in paragraph (2) or (3) of section 1859(f), the organization shall provide for the reporting on quality measures developed for the plan under subparagraph (D)(iii).''; and

(B) in subparagraph (D), as added by section 422(a)(1), by adding at the end the following new clause:

''(iii) SPECIFICATION OF ADDITIONAL QUALITY MEASUREMENTS FOR SPECIALIZED PART C PLANS.—For implementation for plan years beginning not later than January 1, 2010, the Secretary shall develop new quality measures appropriate to meeting the needs of—

''(I) beneficiaries enrolled in specialized Medicare Part C plans for special needs individuals (described in section 1859(b)(6)(A)(ii)(I)) that serve predominantly individuals who are dual-eligible individuals eligible for medical assistance under title XIX by measuring the special needs for care of individuals who are both Medicare and Medicaid beneficiaries; and

''(II) beneficiaries enrolled in specialized Medicare Part C plans for special needs individuals (described in section 1859(b)(6)(A)(ii)(II)) that serve predominantly institutionalized individuals by measuring the special needs for care of individuals who are a resident in long-term care institution.''.

(3) EFFECTIVE DATE; GRANDFATHER.—The amendments made by paragraph (1) shall take effect for enrollments occurring on or after January 1, 2009, and shall not apply—

(A) to plans with a contract with a State Medicaid agency to operate an integrated Medicaid-Medicare program, that had been approved by Centers for Medicare & Medicaid Services on January 1, 2004; and

(B) to plans that are operational as of the date of the enactment of this Act as approved Medicare demonstration projects and that provide services predominantly to individuals with end-stage renal disease.

(4) TRANSITION FOR NON-QUALIFYING SNPS.—

(A) RESTRICTIONS IN 2008 FOR CHRONIC CARE SNPS.—In the case of a specialized MA plan for special needs individuals (as defined in section 1859(b)(6)(A) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(A)) that, as of December 31, 2007, is not described in either subclause (I) or subclause (II) of clause (ii) of such section, as amended by paragraph (1), then as of January 1, 2008—

(i) the plan may not be offered unless it was offered before such date;

(ii) no new members may be enrolled with the plan; and

(iii) there may be no expansion of the service area of such plan.

(B) TRANSITION OF ENROLLEES.—The Secretary of Health and Human Services shall provide for an orderly transition of those specialized MA plans for special needs individuals (as defined in section 1859(b)(6)(A) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(A)), as of the date of the enactment of this Act), and their enrollees, that no longer qualify as such plans under such section, as amended by this subsection.

SEC. 432. EXTENSION AND REVISION OF AUTHORITY FOR MEDICARE REASONABLE COST CONTRACTS.

(a) EXTENSION FOR 3 YEARS OF PERIOD REASONABLE COST PLANS CAN REMAIN IN THE MARKET.—Section 1876(h)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)(ii)) is amended, in the matter preceding subclause (I), by striking ''January 1, 2008'' and inserting ''January 1, 2011''.

(b) APPLICATION OF CERTAIN MEDICARE ADVANTAGE REQUIREMENTS TO COST CONTRACTS EXTENDED OR RENEWED AFTER ENACTMENT.—Section 1876(h) of such Act (42 U.S.C. 1395mm(h)), as amended by subsection (a), is amended—

(1) by redesignating paragraph (5) as paragraph (6); and

(2) by inserting after paragraph (4) the following new paragraph:

''(5)(A) Any reasonable cost reimbursement contract with an eligible organization under this subsection that is extended or renewed on or after the date of enactment of the Children's Health and Medicare Protection Act of 2007 shall provide that the provisions of the Medicare Part C program described in subparagraph (B) shall apply to such organization and such contract in a substantially similar manner as such provisions apply to Medicare Part C organizations and Medicare Part C plans under part C.

''(B) The provisions described in this subparagraph are as follows:

''(i) Section 1851(h) (relating to the approval of marketing material and application forms).

''(ii) Section 1852(e) (relating to the requirement of having an ongoing quality improvement program and treatment of accreditation in the same manner as such provisions apply to Medicare Part C local plans that are preferred provider organization plans).

''(iii) Section 1852(f) (relating to grievance mechanisms).

''(iv) Section 1852(g) (relating to coverage determinations, reconsiderations, and appeals).

''(v) Section 1852(j)(4) (relating to limitations on physician incentive plans).

''(vi) Section 1854(c) (relating to the requirement of uniform premiums among individuals enrolled in the plan).

''(vii) Section 1854(g) (relating to restrictions on imposition of premium taxes with respect to payments to organizations).

''(viii) Section 1856(b)(3) (relating to relation to State laws).

''(ix) The provisions of part C relating to timelines for contract renewal and beneficiary notification.''.

TITLE V—PROVISIONS RELATING TO MEDICARE PART A

SEC. 501. INPATIENT HOSPITAL PAYMENT UPDATES.

(a) FOR ACUTE HOSPITALS.—Clause (i) of section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)) is amended—

(1) in subclause (XIX), by striking ''and'';

(2) by redesignating subclause (XX) as subclause (XXII); and

(3) by inserting after subclause (XIX) the following new subclauses:

''(XX) for fiscal year 2007, subject to clause (viii), the market basket percentage increase for hospitals in all areas,

''(XXI) for fiscal year 2008, subject to clause (viii), the market basket percentage increase minus 0.25 percentage point for hospitals in all areas, and''.

(b) FOR OTHER HOSPITALS.—Clause (ii) of such section is amended—

(1) in subclause (VII) by striking ''and'';

(2) by redesignating subclause (VIII) as subclause (X); and

(3) by inserting after subclause (VII) the following new subclauses:

''(VIII) fiscal years 2003 through 2007, is the market basket percentage increase,

''(IX) fiscal year 2008, is the market basket percentage increase minus 0.25 percentage point, and''.

(c) DELAYED EFFECTIVE DATE.—

(1) ACUTE CARE HOSPITALS.—The amendments made by subsection (a) shall not apply to discharges occurring before January 1, 2008.

(2) OTHER HOSPITALS.—The amendments made by subsection (b) shall be applied, only with respect to cost reporting periods beginning during fiscal year 2008 and not with respect to the computation for any succeeding cost reporting period, by substituting ''0.1875 percentage point'' for ''0.25 percentage point''.

SEC. 502. PAYMENT FOR INPATIENT REHABILITATION FACILITY (IRF) SERVICES.

(a) PAYMENT UPDATE.—

(1) IN GENERAL.—Section 1886(j)(3)(C) of the Social Security Act (42 U.S.C. 1395ww(j)(3)(C)) is amended by adding at the end the following: ''The increase factor to be applied under this subparagraph for fiscal year 2008 shall be 1 percent.''

(2) DELAYED EFFECTIVE DATE.—The amendment made by paragraph (1) shall not apply to payment units occurring before January 1, 2008.

(b) INPATIENT REHABILITATION FACILITY CLASSIFICATION CRITERIA.—

(1) IN GENERAL.—Section 5005 of the Deficit Reduction Act of 2005 (Public Law 109–171) is amended—

(A) in subsection (a), by striking ''apply the applicable percent specified in subsection (b)'' and inserting ''require a compliance rate that is no greater than the 60 percent compliance rate that became effective for cost reporting periods beginning on or after July 1, 2006,''; and

(B) by amending subsection (b) to read as follows:

''(b) CONTINUED USE OF COMORBIDITIES.—For portions of cost reporting periods occurring on or after the date of the enactment of the Children's Health and Medicare Protection Act of 2007, the Secretary shall include patients with comorbidities as described in section 412.23(b)(2)(i) of title 42, Code of Federal Regulations (as in effect as of January 1, 2007), in the inpatient population that counts towards the percent specified in subsection (a).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1)(A) shall apply to portions of cost reporting periods beginning on or after the date of the enactment of this Act.

(c) PAYMENT FOR CERTAIN MEDICAL CONDITIONS TREATED IN INPATIENT REHABILITATION FACILITIES.—

(1) IN GENERAL.—Section 1886(j) of the Social Security Act (42 U.S.C. 1395ww(j)) is amended—

(A) by redesignating paragraph (7) as paragraph (8);

(B) by inserting after paragraph (6) the following new paragraph:

''(7) SPECIAL PAYMENT RULE FOR CERTAIN MEDICAL CONDITIONS.—

''(A) IN GENERAL.—Subject to subparagraph (H), in the case of discharges occurring on or after October 1, 2008, in lieu of the standardized payment amount (as determined pursuant to the preceding provisions of this subsection) that would otherwise be applicable under this subsection, the Secretary shall substitute, for payment units with respect to an applicable medical condition (as defined in subparagraph (G)(i)) that is treated in an inpatient rehabilitation facility, the modified standardized payment amount determined under subparagraph (B).

''(B) MODIFIED STANDARDIZED PAYMENT AMOUNT.—The modified standardized payment amount for an applicable medical condition shall be based on the amount determined under subparagraph (C) for such condition, as adjusted under subparagraphs (D), (E), and (F).

''(C) AMOUNT DETERMINED.—

''(i) IN GENERAL.—The amount determined under this subparagraph for an applicable medical condition shall be based on the sum of the following:

''(I) An amount equal to the average per stay skilled nursing facility payment rate for the applicable medical condition (as determined under clause (ii)).

''(II) An amount equal to 25 percent of the difference between the overhead costs (as defined in subparagraph (G)(ii)) component of the average inpatient rehabilitation facility per stay payment amount for the applicable medical condition (as determined under the preceding paragraphs of this subsection) and the overhead costs component of the average per stay skilled nursing facility payment rate for such condition (as determined under clause (ii)).

''(III) An amount equal to 33 percent of the difference between the patient care costs (as defined in subparagraph (G)(iii)) component of the average inpatient rehabilitation facility per stay payment amount for the applicable medical condition (as determined under the preceding paragraphs of this subsection) and the patient care costs component of the average per stay skilled nursing facility payment rate for such condition (as determined under clause (ii)).

''(ii) DETERMINATION OF AVERAGE PER STAY SKILLED NURSING FACILITY PAYMENT RATE.—For purposes of clause (i), the Secretary shall convert skilled nursing facility payment rates for applicable medical conditions, as determined under section 1888(e), to average per stay skilled nursing facility payment rates for each such condition.

''(D) ADJUSTMENTS.—The Secretary shall adjust the amount determined under subparagraph (C) for an applicable medical condition using the adjustments to the prospective payment rates for inpatient rehabilitation facilities described in paragraphs (2), (3), (4), and (6).

''(E) UPDATE FOR INFLATION.—Except in the case of a fiscal year for which the Secretary rebases the amounts determined under subparagraph (C) for applicable medical conditions pursuant to subparagraph (F), the Secretary shall annually update the amounts determined under subparagraph (C) for each applicable medical condition by the increase factor for inpatient rehabilitation facilities (as described in paragraph (3)(C)).

''(F) REBASING.—The Secretary shall periodically (but in no case less than once every 5 years) rebase the amounts determined under subparagraph (C) for applicable medical conditions using the methodology described in such subparagraph and the most recent and complete cost report and claims data available.

''(G) DEFINITIONS.—In this paragraph:

''(i) APPLICABLE MEDICAL CONDITION.—The term 'applicable medical condition' means—

''(I) unilateral knee replacement;

''(II) unilateral hip replacement; and

''(III) unilateral hip fracture.

''(ii) OVERHEAD COSTS.—The term 'overhead costs' means those Medicare-allowable costs that are contained in the General Service cost centers of the Medicare cost reports for inpatient rehabilitation facilities and for skilled nursing facilities, respectively, as determined by the Secretary.

''(iii) PATIENT CARE COSTS.—The term 'patient care costs' means total Medicare-allowable costs minus overhead costs.

''(H) SUNSET.—The provisions of this paragraph shall cease to apply as of the date the Secretary implements an integrated, site-neutral payment methodology under this title for post-acute care.''; and

(C) in paragraph (8), as redesignated by paragraph (1)—

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

(ii) in subparagraph (D), by striking the period at the end and inserting '', and''; and

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

''(E) modified standardized payment amounts under paragraph (7).''.

(2) SPECIAL RULE FOR DISCHARGES OCCURRING IN THE SECOND HALF OF FISCAL YEAR 2008.—

(A) IN GENERAL.—In the case of discharges from an inpatient rehabilitation facility occurring during the period beginning on April 1, 2008, and ending on September 30, 2008, for applicable medical conditions (as defined in paragraph (7)(G)(i) of section 1886(j) of the Social Security Act (42 U.S.C. 1395ww(j)), as inserted by paragraph (1)(B), in lieu of the standardized payment amount determined pursuant to such section, the standardized payment amount shall be $9,507 for unilateral knee replacement, $10,398 for unilateral hip replacement, and $10,958 for unilateral hip fracture. Such amounts are the amounts that are estimated would be determined under paragraph (7)(C) of such section 1886(j) for such conditions if such paragraph applied for such period. Such standardized payment amounts shall be multiplied by the relative weights for each case-mix group and tier, as published in the final rule of the Secretary of Health and Human Services for inpatient rehabilitation facility services prospective payment for fiscal year 2008, to obtain the applicable payment amounts for each such condition for each case-mix group and tier.

(B) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement this subsection by program instruction or otherwise. Paragraph (8)(E) of such section 1886(j) of the Social Security Act, as added by paragraph (1)(C), shall apply for purposes of this subsection in the same manner as such paragraph applies for purposes of paragraph (7) of such section 1886(j).

(d) RECOMMENDATIONS FOR CLASSIFYING INPATIENT REHABILITATION HOSPITALS AND UNITS.—

(1) REPORT TO CONGRESS.—Not later than 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with physicians (including geriatricians and physiatrists), administrators of inpatient rehabilitation, acute care hospitals, skilled nursing facilities, and other settings providing rehabilitation services, Medicare beneficiaries, trade organizations representing inpatient rehabilitation hospitals and units and skilled nursing facilities, and the Medicare Payment Advisory Commission, shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that includes—

(A) an examination of Medicare beneficiaries' access to medically necessary rehabilitation services;

(B) alternatives or refinements to the 75 percent rule policy for determining exclusion criteria for inpatient rehabilitation hospital and unit designation under the Medicare program, including determining clinical appropriateness of inpatient rehabilitation hospital and unit admissions and alternative criteria which would consider a patient's functional status, diagnosis, co-morbidities, and other relevant factors; and

(C) an examination that identifies any condition for which individuals are commonly admitted to inpatient rehabilitation hospitals that is not included as a condition described in section 412.23(b)(2)(iii) of title 42, Code of Federal Regulations, to determine the appropriate setting of care, and any variation in patient outcomes and costs, across settings of care, for treatment of such conditions.

For the purposes of this subsection, the term ''75 percent rule'' means the requirement of section 412.23(b)(2) of title 42, Code of Federal Regulations, that 75 percent of the patients

of a rehabilitation hospital or converted rehabilitation unit are in 1 or more of 13 listed treatment categories.

(2) CONSIDERATIONS.—In developing the report described in paragraph (1), the Secretary shall include the following:

(A) The potential effect of the 75 percent rule on access to rehabilitation care by Medicare beneficiaries for the treatment of a condition, whether or not such condition is described in section 412.23(b)(2)(iii) of title 42, Code of Federal Regulations.

(B) An analysis of the effectiveness of rehabilitation care for the treatment of conditions, whether or not such conditions are described in section 412.23(b)(2)(iii) of title 42, Code of Federal Regulations, available to Medicare beneficiaries in various health care settings, taking into account variation in patient outcomes and costs across different settings of care, and which may include whether the Medicare program and Medicare beneficiaries may incur higher costs of care for the entire episode of illness due to readmissions, extended lengths of stay, and other factors.

SEC. 503. LONG-TERM CARE HOSPITALS.

(a) LONG-TERM CARE HOSPITAL PAYMENT UPDATE.—

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

''(m) PROSPECTIVE PAYMENT FOR LONG-TERM CARE HOSPITALS.—

''(1) REFERENCE TO ESTABLISHMENT AND IMPLEMENTATION OF SYSTEM.—For provisions related to the establishment and implementation of a prospective payment system for payments under this title for inpatient hospital services furnished by a long-term care hospital described in subsection (d)(1)(B)(iv), see section 123 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 and section 307(b) of Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

''(2) UPDATE FOR RATE YEAR 2008.—In implementing the system described in paragraph (1) for discharges occurring during the rate year ending in 2008 for a hospital, the base rate for such discharges for the hospital shall be the same as the base rate for discharges for the hospital occurring during the previous rate year.''.

(2) DELAYED EFFECTIVE DATE.—Subsection (m)(2) of section 1886 of the Social Security Act, as added by paragraph (1), shall not apply to discharges occurring on or after July 1, 2007, and before January 1, 2008.

(b) PAYMENT FOR LONG-TERM CARE HOSPITAL SERVICES; PATIENT AND FACILITY CRITERIA.—

(1) DEFINITION OF LONG-TERM CARE HOSPITAL.—

(A) DEFINITION.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Long-Term Care Hospital

''(ccc) The term 'long-term care hospital' means an institution which—

''(1) is primarily engaged in providing inpatient services, by or under the supervision of a physician, to Medicare beneficiaries whose medically complex conditions require a long hospital stay and programs of care provided by a long-term care hospital;

''(2) has an average inpatient length of stay (as determined by the Secretary) for Medicare beneficiaries of greater than 25 days, or as otherwise defined in section 1886(d)(1)(B)(iv);

''(3) satisfies the requirements of subsection (e);

''(4) meets the following facility criteria:

''(A) the institution has a patient review process, documented in the patient medical record, that screens patients prior to admission for appropriateness of admission to a long-term care hospital, validates within 48 hours of admission that patients meet admission criteria for long-term care hospitals, regularly evaluates patients throughout their stay for continuation of care in a long-term care hospital, and assesses the available discharge options when patients no longer meet such continued stay criteria;

''(B) the institution has active physician involvement with patients during their treatment through an organized medical staff, physician-directed treatment with physician on-site availability on a daily basis to review patient progress, and consulting physicians on call and capable of being at the patient's side within a moderate period of time, as determined by the Secretary;

''(C) the institution has interdisciplinary team treatment for patients, requiring interdisciplinary teams of health care professionals, including physicians, to prepare and carry out an individualized treatment plan for each patient; and

''(5) meets patient criteria relating to patient mix and severity appropriate to the medically complex cases that long-term care hospitals are designed to treat, as measured under section 1886(m).''.

(B) NEW PATIENT CRITERIA FOR LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT.—Section 1886 of such Act (42 U.S.C. 1395ww), as amended by subsection (a), is further amended by adding at the end the following new subsection:

''(n) PATIENT CRITERIA FOR PROSPECTIVE PAYMENT TO LONG-TERM CARE HOSPITALS.—

''(1) IN GENERAL.—To be eligible for prospective payment under this section as a long-term care hospital, a long-term care hospital must admit not less than a majority of patients who have a high level of severity, as defined by the Secretary, and who are assigned to one or more of the following major diagnostic categories:

''(A) Circulatory diagnoses.

''(B) Digestive, endocrine, and metabolic diagnoses.

''(C) Infection disease diagnoses.

''(D) Neurological diagnoses.

''(E) Renal diagnoses.

''(F) Respiratory diagnoses.

''(G) Skin diagnoses.

''(H) Other major diagnostic categories as selected by the Secretary.

''(2) MAJOR DIAGNOSTIC CATEGORY DEFINED.—In paragraph (1), the term 'major diagnostic category' means the medical categories formed by dividing all possible principle diagnosis into mutually exclusive diagnosis areas which are referred to in 67 Federal Register 49985 (August 1, 2002).''.

(C) ESTABLISHMENT OF REHABILITATION UNITS WITHIN CERTAIN LONG-TERM CARE HOSPITALS.—If the Secretary of Health and Human Services does not include rehabilitation services within a major diagnostic category under section 1886(n)(2) of the Social Security Act, as added by subparagraph (B), the Secretary shall approve for purposes of title XVIII of such Act distinct part inpatient rehabilitation hospital units in long-term care hospitals consistent with the following:

(i) A hospital that, on or before October 1, 2004, was classified by the Secretary as a long-term care hospital, as described in section 1886(d)(1)(B)(iv)(I) of such Act (42 U.S.C. 1395ww(d)(1)(V)(iv)(I)), and was accredited by the Commission on Accreditation of Rehabilitation Facilities, may establish a hospital rehabilitation unit that is a distinct part of the long-term care hospital, if the distinct part meets the requirements (including conditions of participation) that would otherwise apply to a distinct-part rehabilitation unit if the distinct part were established by a subsection (d) hospital in accordance with the matter following clause (v) of section 1886(d)(1)(B) of such Act, including any regulations adopted by the Secretary in accordance with this section, except that the one-year waiting period described in section 412.30(c) of title 42, Code of Federal Regulations, applicable to the conversion of hospital beds into a distinct-part rehabilitation unit shall not apply to such units.

(ii) Services provided in inpatient rehabilitation units established under clause (i) shall not be reimbursed as long-term care hospital services under section 1886 of such Act and shall be subject to payment policies established by the Secretary to reimburse services provided by inpatient hospital rehabilitation units.

(D) EFFECTIVE DATE.—The amendments made by subparagraphs (A) and (B), and the provisions of subparagraph (C), shall apply to discharges occurring on or after January 1, 2008.

(2) IMPLEMENTATION OF FACILITY AND PATIENT CRITERIA.—

(A) REPORT.—No later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall submit to the appropriate committees of Congress a report containing recommendations regarding the promulgation of the national long-term care hospital facility and patient criteria for application under paragraphs (4) and (5) of section 1861(ccc) and section 1886(n) of the Social Security Act, as added by subparagraphs (A) and (B), respectively, of paragraph (1). In the report, the Secretary shall consider recommendations contained in a report to Congress by the Medicare Payment Advisory Commission in June 2004 for long-term care hospital-specific facility and patient criteria to ensure that patients admitted to long-term care hospitals are medically complex and appropriate to receive long-term care hospital services.

(B) IMPLEMENTATION.—No later than 1 year after the date of submittal of the report under subparagraph (A), the Secretary shall, after rulemaking, implement the national long-term care hospital facility and patient criteria referred to in such subparagraph. Such long-term care hospital facility and patient criteria shall be used to screen patients in determining the medical necessity and appropriateness of a Medicare beneficiary's admission to, continued stay at, and discharge from, long-term care hospitals under the Medicare program and shall take into account the medical judgment of the patient's physician, as provided for under sections 1814(a)(3) and 1835(a)(2)(B) of the Social Security Act (42 U.S.C. 1395f(a)(3), 1395n(a)(2)(B)).

(3) EXPANDED REVIEW OF MEDICAL NECESSITY.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall provide, under contracts with one or more appropriate fiscal intermediaries or medicare administrative contractors under section 1874A(a)(4)(G) of the Social Security Act (42 U.S.C. 1395kk(a)(4)(G)), for reviews of the medical necessity of admissions to long-term care hospitals (described in section 1886(d)(1)(B)(iv) of such Act) and continued stay at such hospitals, of individuals entitled to, or enrolled for, benefits under part A of title XVIII of such Act on a hospital-specific basis consistent with this paragraph. Such reviews shall be made for discharges occurring on or after October 1, 2007.

(B) REVIEW METHODOLOGY.—The medical necessity reviews under paragraph (A) shall be conducted for each such long-term care hospital on an annual basis in accordance with rules (including a sample methodology)

specified by the Secretary. Such sample methodology shall—

(i) provide for a statistically valid and representative sample of admissions of such individuals sufficient to provide results at a 95 percent confidence interval; and

(ii) guarantee that at least 75 percent of overpayments received by long-term care hospitals for medically unnecessary admissions and continued stays of individuals in long-term care hospitals will be identified and recovered and that related days of care will not be counted toward the length of stay requirement contained in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)).

(C) CONTINUATION OF REVIEWS.—Under contracts under this paragraph, the Secretary shall establish a denial rate with respect to such reviews that, if exceeded, could require further review of the medical necessity of admissions and continued stay in the hospital involved.

(D) TERMINATION OF REQUIRED REVIEWS.—

(i) IN GENERAL.—Subject to clause (iii), the previous provisions of this subsection shall cease to apply as of the date specified in clause (ii).

(ii) DATE SPECIFIED.—The date specified in this clause is the later of January 1, 2013, or the date of implementation of national long-term care hospital facility and patient criteria under section paragraph (2)(B).

(iii) CONTINUATION.—As of the date specified in clause (ii), the Secretary shall determine whether to continue to guarantee, through continued medical review and sampling under this paragraph, recovery of at least 75 percent of overpayments received by long-term care hospitals due to medically unnecessary admissions and continued stays.

(4) LIMITED, QUALIFIED MORATORIUM OF LONG-TERM CARE HOSPITALS.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall impose a temporary moratorium on the certification of new long-term care hospitals (and satellite facilities), and new long-term care hospital and satellite facility beds, for purposes of the Medicare program under title XVIII of the Social Security Act. The moratorium shall terminate at the end of the 4-year period beginning on the date of the enactment of this Act.

(B) EXCEPTIONS.—

(i) IN GENERAL.—The moratorium under subparagraph (A) shall not apply as follows:

(I) To a long-term care hospital, satellite facility, or additional beds under development as of the date of the enactment of this Act.

(II) To a new long-term care hospital in an area in which there is not a long-term care hospital, if the Secretary determines it to be in the best interest to provide access to long-term care hospital services to Medicare beneficiaries residing in such area. There shall be a presumption in favor of the moratorium, which may be rebutted by evidence the Secretary deems sufficient to show the need for long-term care hospital services in that area.

(III) To an existing long-term care hospital that requests to increase its number of long-term care hospital beds, if the Secretary determines there is a need at the long-term care hospital for additional beds to accommodate—

(aa) infectious disease issues for isolation of patients;

(bb) bedside dialysis services;

(cc) single-sex accommodation issues;

(dd) behavioral issues;

(ee) any requirements of State or local law; or

(ff) other clinical issues the Secretary determines warrant additional beds, in the best interest of Medicare beneficiaries.

(IV) To an existing long-term care hospital that requests an increase in beds because of the closure of a long-term care hospital or significant decrease in the number of long-term care hospital beds, in a State where there is only one other long-term care hospital.

There shall be no administrative or judicial review from a decision of the Secretary under this subparagraph.

(ii) ''UNDER DEVELOPMENT'' DEFINED.—For purposes of clause (i)(I), a long-term care hospital or satellite facility is considered to be ''under development'' as of a date if any of the following have occurred on or before such date:

(I) The hospital or a related party has a binding written agreement with an outside, unrelated party for the construction, reconstruction, lease, rental, or financing of the long-term care hospital.

(II) Actual construction, renovation or demolition for the long-term care hospital has begun.

(III) A certificate of need has been approved in a State where one is required or other necessary approvals from appropriate State agencies have been received for the operation of the hospital.

(IV) The hospital documents that it is within a 6-month long-term care hospital demonstration period required by section 412.23(e)(1)–(3) of title 42, Code of Federal Regulations, to demonstrate that it has a greater than 25 day average length of stay.

(V) There is other evidence presented that the Secretary determines would indicate that the hospital or satellite is under development.

(5) NO APPLICATION OF 25 PERCENT PATIENT THRESHOLD PAYMENT ADJUSTMENT TO FREESTANDING AND GRANDFATHERED LTCHS.—The Secretary shall not apply, during the 5-year period beginning on the date of the enactment of this Act, section 412.536 of title 42, Code of Federal Regulations, or any similar provision, to freestanding long-term care hospitals and the Secretary shall not apply such section or section 412.534 of title 42, Code of Federal Regulations, or any similar provisions, to a long-term care hospital identified by section 4417(a) of the Balanced Budget Act of 1997 (Public Law 105–33). A long-term care hospital identified by such section 4417(a) shall be deemed to be a freestanding long-term care hospital for the purpose of this section. Section 412.536 of title 42, Code of Federal Regulations, shall be void and of no effect.

(6) PAYMENT FOR HOSPITALS-WITHIN-HOSPITALS.—

(A) IN GENERAL.—Payments to an applicable long-term care hospital or satellite facility which is located in a rural area or which is co-located with an urban single or MSA dominant hospital under paragraphs (d)(1), (e)(1), and (e)(4) of section 412.534 of title 42, Code of Federal Regulations, shall not be subject to any payment adjustment under such section if no more than 75 percent of the hospital's Medicare discharges (other than discharges described in paragraphs (d)(2) or (e)(3) of such section) are admitted from a co-located hospital.

(B) CO-LOCATED LONG-TERM CARE HOSPITALS AND SATELLITE FACILITIES.—

(i) IN GENERAL.—Payment to an applicable long-term care hospital or satellite facility which is co-located with another hospital shall not be subject to any payment adjustment under section 412.534 of title 42, Code of Federal Regulations, if no more than 50 percent of the hospital's Medicare discharges (other than discharges described in section 412.534(c)(3) of such title) are admitted from a co-located hospital.

(ii) APPLICABLE LONG-TERM CARE HOSPITAL OR SATELLITE FACILITY DEFINED.—In this paragraph, the term ''applicable long-term care hospital or satellite facility'' means a hospital or satellite facility that is subject to the transition rules under section 412.534(g) of title 42, Code of Federal Regulations.

(C) EFFECTIVE DATE.—Subparagraphs (A) and (B) shall apply to discharges occurring on or after October 1, 2007, and before October 1, 2012.

(7) NO APPLICATION OF VERY SHORT-STAY OUTLIER POLICY.—The Secretary shall not apply, during the 5-year period beginning on the date of the enactment of this Act, the amendments finalized on May 11, 2007 (72 Federal Register 26904) made to the short-stay outlier payment provision for long-term care hospitals contained in section 412.529(c)(3)(i) of title 42, Code of Federal Regulations, or any similar provision.

(8) NO APPLICATION OF ONE TIME ADJUSTMENT TO STANDARD AMOUNT.—The Secretary shall not, during the 5-year period beginning on the date of the enactment of this Act, make the one-time prospective adjustment to long-term care hospital prospective payment rates provided for in section 412.523(d)(3) of title 42, Code of Federal Regulations, or any similar provision.

(c) SEPARATE CLASSIFICATION FOR CERTAIN LONG-STAY CANCER HOSPITALS.—

(1) IN GENERAL.—Subsection (d)(1)(B) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended—

(A) in clause (iv)—

(i) in subclause (I), by striking ''(iv)(I)'' and inserting ''(iv)'' and by striking ''or'' at the end; and

(ii) in subclause (II)—

(I) by striking '', or'' at the end and inserting a semicolon; and

(II) by redesignating such subclause as clause (vi) and by moving it to immediately follow clause (v); and

(B) in clause (v), by striking the semicolon at the end and inserting '', or''.

(2) CONFORMING PAYMENT REFERENCES.—Subsection (b) of such section is amended—

(A) in paragraph (2)(E)(ii), by adding at the end the following new subclause:

''(III) Hospitals described in clause (vi) of such subsection.'';

(B) in paragraph (3)(F)(iii), by adding at the end the following new subclause:

''(VI) Hospitals described in clause (vi) of such subsection.'';

(C) in paragraphs (3)(G)(ii), (3)(H)(i), and (3)(H)(ii)(I), by inserting ''or (vi)'' after ''clause (iv)'' each place it appears;

(D) in paragraph (3)(H)(iv), by adding at the end the following new subclause:

''(IV) Hospitals described in clause (vi) of such subsection.'';

(E) in paragraph (3)(J), by striking ''subsection (d)(1)(B)(iv)'' and inserting ''clause (iv) or (vi) of subsection (d)(1)(B)''; and

(F) in paragraph (7)(B), by adding at the end the following new clause:

''(iv) Hospitals described in clause (vi) of such subsection.''.

(3) ADDITIONAL CONFORMING AMENDMENTS.—The second sentence of subsection (d)(1)(B) of such section is amended—

(A) by inserting ''(as in effect as of such date)'' after ''clause (iv)''; and

(B) by inserting ''(or, in the case of a hospital classified under clause (iv)(II), as so in effect, shall be classified under clause (vi) on and after the effective date of such clause)'' after ''so classified''.

(4) TRANSITION RULE.—In the case of a hospital that is classified under clause (iv)(II) of section 1886(d)(1)(B) of the Social Security Act immediately before the date of the enactment of this Act and which is classified under clause (vi) of such section after such date of enactment, payments under section

1886 of such Act for cost reporting periods beginning after the date of the enactment of this Act shall be based upon payment rates in effect for the cost reporting period for such hospital beginning during fiscal year 2001, increased for each succeeding cost reporting period (beginning before the date of the enactment of this Act) by the applicable percentage increase under section 1886(b)(3)(B)(ii) of such Act.

(5) CLARIFICATION OF TREATMENT OF SATELLITE FACILITIES AND REMOTE LOCATIONS.—A long-stay cancer hospital described in section 1886(d)(1)(B)(vi) of the Social Security Act, as designated under paragraph (1), shall include satellites or remote site locations for such hospital established before or after the date of the enactment of this Act if the provider-based requirements under section 413.65 of title 42, Code of Federal Regulations, applicable certification requirements under title XVIII of the Social Security, and such other applicable State licensure and certificate of need requirements are met with respect to such satellites or remote site locations.

SEC. 504. INCREASING THE DSH ADJUSTMENT CAP.

Section 1886(d)(5)(F)(xiv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)(xiv)) is amended—

(1) subclause (II), by striking ''12 percent'' and inserting ''the percent specified in subclause (III)''; and

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

''(III) The percent specified in this subclause is, in the case of discharges occurring—

''(a) before October 1, 2007, 12 percent;

''(b) during fiscal year 2008, 16 percent;

''(c) during fiscal year 2009, 18 percent; and

''(d) on or after October 1, 2009, 12 percent.''.

SEC. 505. PPS-EXEMPT CANCER HOSPITALS.

(a) AUTHORIZING REBASING FOR PPS-EXEMPT CANCER HOSPITALS.—Section 1886(b)(3)(F) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(F)) is amended by adding at the end the following new clause:

''(iv) In the case of a hospital (or unit described in the matter following clause (v) of subsection (d)(1)(B)) that received payment under this subsection for inpatient hospital services furnished during cost reporting periods beginning before October 1, 1999, that is within a class of hospital described in clause (iii) (other than subclause (IV), relating to long-term care hospitals, and that requests the Secretary (in a form and manner specified by the Secretary) to effect a rebasing under this clause for the hospital, the Secretary may compute the target amount for the hospital's 12-month cost reporting period beginning during fiscal year 2008 as an amount equal to the average described in clause (ii) but determined as if any reference in such clause to 'the date of the enactment of this subparagraph' were a reference to 'the date of the enactment of this clause'.''.

(b) MEDPAC REPORT ON PPS-EXEMPT CANCER HOSPITALS.—Not later than March 1, 2009, the Medicare Payment Advisory Commission (established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6)) shall submit to the Secretary and Congress a report evaluating the following:

(1) Measures of payment adequacy and Medicare margins for PPS-exempt cancer hospitals, as established under section 1886(d)(1)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(v)).

(2) To the extent a PPS-exempt cancer hospital was previously affiliated with another hospital, the margins of the PPS-exempt hospital and the other hospital as separate entities and the margins of such hospitals that existed when the hospitals were previously affiliated.

(3) Payment adequacy for cancer discharges under the Medicare inpatient hospital prospective payment system.

SEC. 506. SKILLED NURSING FACILITY PAYMENT UPDATE.

(a) IN GENERAL.—Section 1888(e)(4)(E)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(E)(ii)) is amended—

(1) in subclause (III), by striking ''and'';

(2) by redesignating subsection (IV) as subclause (VI); and

(3) by inserting after subclause (III) the following new subclauses:

''(IV) for each of fiscal years 2004, 2005, 2006, and 2007, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved;

''(V) for fiscal year 2008, the rate computed for the previous fiscal year; and''.

(b) DELAYED EFFECTIVE DATE.—Section 1888(e)(4)(E)(ii)(V) of the Social Security Act, as inserted by subsection (a)(3), shall not apply to payment for days before January 1, 2008.

SEC. 507. REVOCATION OF UNIQUE DEEMING AUTHORITY OF THE JOINT COMMISSION FOR THE ACCREDITATION OF HEALTHCARE ORGANIZATIONS.

(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) Such section is further amended—

(A) in subsection (a)(1), as so redesignated, 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 Hospitals,'' 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 such 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 such 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 such 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 such 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 such 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 JCAHO AS A NATIONAL ACCREDITATION BODY.—The Secretary of Health and Human Services may recognize the Joint Commission on Accreditation of Healthcare Organizations 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 18 months after the date of the 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 on Accreditation of Healthcare Organizations, or under accreditation or comparable approval standards found to be essentially equivalent to accreditation or approval standards of the Joint Commission on Accreditation of Healthcare Organizations, for the period of time applicable under such accreditation.

TITLE VI—OTHER PROVISIONS RELATING TO MEDICARE PART B

Subtitle A—Payment and Coverage Improvements

SEC. 601. PAYMENT FOR THERAPY SERVICES.

(a) 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 201 of the Medicare Improvements and Extension Act of 2006 (division B of Public Law 109–432), is amended by striking ''2007'' and inserting ''2009''.

(b) STUDY AND REPORT.—

(1) STUDY.—The Secretary of Health and Human Services, in consultation with appropriate stakeholders, shall conduct a study on refined and alternative payment systems to the Medicare payment cap under section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) for physical therapy services and speech-language pathology services, described in paragraph (1) of such section and occupational therapy services described in paragraph (3) of such section. Such study shall consider, with respect to payment amounts under Medicare, the following:

(A) The creation of multiple payment caps for such services to better reflect costs associated with specific health conditions.

(B) The development of a prospective payment system, including an episode-based system of payments, for such services.

(C) The data needed for the development of a system of multiple payment caps (or an alternative payment methodology) for such services and the availability of such data.

(2) REPORT.—Not later than January 1, 2009, the Secretary shall submit to Congress a report on the study conducted under paragraph (1).

SEC. 602. MEDICARE SEPARATE DEFINITION OF OUTPATIENT 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 period 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''.

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

(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. 603. INCREASED REIMBURSEMENT RATE FOR CERTIFIED NURSE-MIDWIVES.

(a) IN GENERAL.—Section 1833(a)(1)(K) of the Social Security Act (42 U.S.C.1395l(a)(1)(K)) is amended by striking ''(but in no event'' and all that follows through ''performed by a physician)''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after April 1, 2008.

SEC. 604. ADJUSTMENT IN OUTPATIENT HOSPITAL FEE SCHEDULE INCREASE FACTOR.

The first sentence of section 1833(t)(3)(C)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(3)(C)(iv)) is amended by inserting before the period at the end the following: ''and reduced by 0.25 percentage point for such factor for such services furnished in 2008''.

SEC. 605. EXCEPTION TO 60-DAY LIMIT ON MEDICARE SUBSTITUTE BILLING ARRANGEMENTS IN CASE OF PHYSICIANS ORDERED TO ACTIVE DUTY IN THE ARMED FORCES.

(a) IN GENERAL.—Section 1842(b)(6)(D)(iii) of the Social Security Act (42 U.S.C. 1395u(b)(6)(D)(iii)) is amended by inserting after ''of more than 60 days'' the following: ''or are provided over a longer continuous period during all of which the first physician has been called or ordered to active duty as a member of a reserve component of the Armed Forces''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after the date of the enactment of this section.

SEC. 606. EXCLUDING CLINICAL SOCIAL WORKER SERVICES FROM COVERAGE UNDER THE MEDICARE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM AND CONSOLIDATED PAYMENT.

(a) IN GENERAL.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting ''clinical social worker services,'' after ''qualified psychologist services,''..

(b) CONFORMING AMENDMENT.—Section 1861(hh)(2) of the Social Security Act (42 U.S.C. 1395x(hh)(2)) is amended by striking ''and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2008.

SEC. 607. COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES.

(a) COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES.—

(1) COVERAGE OF SERVICES.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

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

(B) in subparagraph (AA), by adding ''and'' at the end; and

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

''(BB) marriage and family therapist services (as defined in subsection (ccc));''.

(2) DEFINITION.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''(ccc) MARRIAGE AND FAMILY THERAPIST SERVICES.—(1) The term 'marriage and family therapist services' means services performed by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses, which the marriage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed, provided such services are covered under this title, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(2) The term 'marriage and family therapist' means an individual who—

''(A) possesses a master's or doctoral degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law;

''(B) after obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and

''(C) is licensed or certified as a marriage and family therapist in the State in which marriage and family therapist services are performed.''.

(3) PROVISION FOR PAYMENT UNDER PART B.—Section 1832(a)(2)(B) of the Social Security Act (42 U.S.C. 1395k(a)(2)(B)) is amended by adding at the end the following new clause:

''(v) marriage and family therapist services;''.

(4) AMOUNT OF PAYMENT.—

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

(i) by striking ''and'' before ''(V)''; and

(ii) by inserting before the semicolon at the end the following: '', and (W) with respect to marriage and family therapist services under section 1861(s)(2)(BB), the amounts paid shall be 80 percent of the lesser of (i) the actual charge for the services or (ii) 75 percent of the amount determined for payment of a psychologist under subparagraph (L)''.

(B) DEVELOPMENT OF CRITERIA WITH RESPECT TO CONSULTATION WITH A PHYSICIAN.—The Secretary of Health and Human Services shall, taking into consideration concerns for patient confidentiality, develop criteria with respect to payment for marriage and family therapist services for which payment may be made directly to the marriage and family therapist under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) under which such a therapist must agree to consult with a patient's attending or primary care physician in accordance with such criteria.

(5) EXCLUSION OF MARRIAGE AND FAMILY THERAPIST SERVICES FROM SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)), is amended by inserting ''marriage and family therapist services (as defined in subsection (ccc)(1)),'' after ''qualified psychologist services,''.

(6) COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES PROVIDED IN RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking ''or by a clinical social worker (as defined in subsection (hh)(1)),'' and inserting '', by a clinical social worker (as defined in subsection (hh)(1)), or by a marriage and family therapist (as defined in subsection (ccc)(2)),''.

(7) INCLUSION OF MARRIAGE AND FAMILY THERAPISTS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clause:

''(vii) A marriage and family therapist (as defined in section 1861(ccc)(2)).''.

(b) COVERAGE OF MENTAL HEALTH COUNSELOR SERVICES.—

(1) COVERAGE OF SERVICES.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended in subsection (a)(1), is further amended—

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

(B) in subparagraph (BB), by inserting ''and'' at the end; and

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

''(CC) mental health counselor services (as defined in subsection (ddd)(2));''.

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

''(ddd) MENTAL HEALTH COUNSELOR; MENTAL HEALTH COUNSELOR SERVICES.—(1) The term 'mental health counselor' means an individual who—

''(A) possesses a master's or doctor's degree which qualifies the individual for licensure or certification for the practice of mental health counseling in the State in which the services are performed;

''(B) after obtaining such a degree has performed at least 2 years of supervised mental health counselor practice; and

''(C) is licensed or certified as a mental health counselor or professional counselor by the State in which the services are performed.

''(2) The term 'mental health counselor services' means services performed by a mental health counselor (as defined in paragraph (1)) for the diagnosis and treatment of mental illnesses which the mental health counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are performed, provided such services are covered under this title, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.''.

(3) PROVISION FOR PAYMENT UNDER PART B.—Section 1832(a)(2)(B) of the Social Security Act (42 U.S.C. 1395k(a)(2)(B)), as amended by subsection (a)(3), is further amended by adding at the end the following new clause:

''(vi) mental health counselor services;''.

(4) AMOUNT OF PAYMENT.—

(A) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395*l*(a)(1)), as amended by subsection (a)(4), is further amended—

(i) by striking ''and'' before ''(W)''; and

(ii) by inserting before the semicolon at the end the following: '', and (X) with respect to mental health counselor services under section 1861(s)(2)(CC), the amounts paid shall be 80 percent of the lesser of (i) the actual charge for the services or (ii) 75 percent of the amount determined for payment of a psychologist under subparagraph (L)''.

(B) DEVELOPMENT OF CRITERIA WITH RESPECT TO CONSULTATION WITH A PHYSICIAN.—The Secretary of Health and Human Services shall, taking into consideration concerns for patient confidentiality, develop criteria with respect to payment for mental health counselor services for which payment may be made directly to the mental health counselor under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) under which such a counselor must agree to consult with a patient's attending or primary care physician in accordance with such criteria.

(5) EXCLUSION OF MENTAL HEALTH COUNSELOR SERVICES FROM SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)), as amended by subsection (a)(5), is amended by inserting ''mental health counselor services (as defined in section 1861(ddd)(2)),'' after ''marriage and family therapist services (as defined in subsection (ccc)(1)),''.

(6) COVERAGE OF MENTAL HEALTH COUNSELOR SERVICES PROVIDED IN RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)), as amended by subsection (a)(6), is amended by striking ''or by a marriage and family therapist (as defined in subsection (ccc)(2)),'' and inserting ''by a marriage and family therapist (as defined in subsection (ccc)(2)), or a mental health counselor (as defined in subsection (ddd)(1)),''.

(7) INCLUSION OF MENTAL HEALTH COUNSELORS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)), as amended by subsection (a)(7), is amended by adding at the end the following new clause:

''(viii) A mental health counselor (as defined in section 1861(fff)(1)).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2008.

SEC. 608. RENTAL AND PURCHASE OF POWER-DRIVEN WHEELCHAIRS.

(a) IN GENERAL.—Section 1834(a)(7) of the Social Security Act (42 U.S.C. 1395m(a)(7)) is amended—

(1) in subparagraph (A)—

(A) clause (i)(I), by striking ''Except as provided in clause (iii), payment'' and inserting ''Payment'';

(B) by striking clause (iii); and

(C) in clause (iv)—

(i) by redesignating such clause as clause (iii); and

(ii) by striking ''or in the case of a power-driven wheelchair for which a purchase agreement has been entered into under clause (iii)''; and

(2) in subparagraph (C)(ii)(II), by striking ''or (A)(iii)''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (1), the amendments made by subsection (a) shall take effect on January 1, 2008, and shall apply to power-driven wheelchairs furnished on or after such date.

(2) APPLICATION TO COMPETITIVE ACQUISITION.—The amendments made by subsection (a) shall not apply to contracts entered into under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) pursuant to a bid submitted under such section before July 21, 2007.

SEC. 609. RENTAL AND PURCHASE 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 clause (i)—

(A) by striking ''Payment'' and inserting ''Subject to clause (iii), payment''; and

(B) by striking ''36 months'' and inserting ''13 months'';

(2) in clause (ii)(I), by striking ''36th continuous month'' and inserting ''13th continuous month''; and

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

''(iii) SPECIAL RULE FOR OXYGEN GENERATING PORTABLE EQUIPMENT.—In the case of oxygen generating portable equipment referred to in the final rule published in the Federal Register on November 9, 2006 (71 Fed. Reg. 65897–65899), in applying clauses (i) and (ii)(I) each reference to '13 months' is deemed a reference to '36 months'.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (3), the amendments made by subsection (a) shall apply to oxygen equipment furnished on or after January 1, 2008.

(2) TRANSITION.—In the case of an individual receiving oxygen equipment on December 31, 2007, for which payment is made under section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)), the 13-month period described in paragraph (5)(F)(i) of such section, as amended by subsection (a), shall begin on January 1, 2008, but in no case shall the rental period for such equipment exceed 36 months.

(3) APPLICATION TO COMPETITIVE ACQUISITION.—The amendments made by subsection (a) shall not apply to contracts entered into under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) pursuant to a bid submitted under such section before July 21, 2007.

(c) STUDY AND REPORT.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study to examine the service component and the equipment component of the provision of oxygen to Medicare beneficiaries. The study shall assess—

(A) the type of services provided and variation across suppliers in providing such services;

(B) whether the services are medically necessary or affect patient outcomes;

(C) whether the Medicare program pays appropriately for equipment in connection with the provision of oxygen;

(D) whether such program pays appropriately for necessary services;

(E) whether such payment in connection with the provision of oxygen should be divided between equipment and services, and if so, how; and

(F) how such payment rate compares to a competitively bid rate.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the study conducted under paragraph (1).

SEC. 610. ADJUSTMENT FOR MEDICARE MENTAL HEALTH SERVICES.

(a) IN GENERAL.—For purposes of payment for services furnished under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) during the applicable period, the Secretary of Health and Human Services shall increase the amount otherwise payable for applicable services by 5 percent.

(b) DEFINITIONS.—For purposes of subsection (a):

(1) APPLICABLE PERIOD.—The term ''applicable period'' means the period beginning on January 1, 2008, and ending on December 31 of the year before the effective date of the first review after January 1, 2008, of work relative value units conducted under section 1848(c)(2)(B)(i) of the Social Security Act.

(2) APPLICABLE SERVICES.—The term ''applicable services'' means procedure codes for services—

(A) in the categories of psychiatric therapeutic procedures furnished in office or other outpatient facility settings, or inpatient hospital, partial hospital or residential care facility settings; and

(B) which cover insight oriented, behavior modifying, or supportive psychotherapy and interactive psychotherapy services in the Healthcare Common Procedure Coding System established by the Secretary of Health and Human Services under section 1848(c)(5) of such Act.

(c) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement this section by program instruction or otherwise.

SEC. 611. EXTENSION OF BRACHYTHERAPY SPECIAL RULE.

Section 1833(t)(16)(C) of the Social Security Act (42 U.S.C. 1395l(t)(16)(C)) is amended by striking ''2008'' and inserting ''2009''.

SEC. 612. PAYMENT FOR PART B DRUGS.

(a) APPLICATION OF CONSISTENT VOLUME WEIGHTING IN COMPUTATION OF ASP.—In order to assure that payments for drugs and biologicals under section 1847A of the Social Security Act (42 U.S.C. 1395w–3a) are correct and consistent with law, the Secretary of Health and Human Services shall, for payment for drugs and biologicals furnished on or after July 1, 2008, compute the volume-weighted average sales price using equation #2 (specified in appendix A of the report of the Inspector General of the Department of Health and Human Services on ''Calculation of Volume-Weighted Average Sales Price for Medicare Part B Prescription Drugs'' (February 2006; OEI–03–05–00310)) used by the Office of Inspector General to calculate a volume-weighted ASP.

(b) IMPROVEMENTS IN THE COMPETITIVE ACQUISITION PROGRAM (CAP).—

(1) CONTINUOUS OPEN ENROLLMENT; AUTOMATIC REENROLLMENT WITHOUT NEED FOR REAPPLICATION.—Subsection (a)(1)(A) of section 1847B of the Social Security Act (42 U.S.C. 1395w–3b) is amended—

(A) in clause (ii), by striking ''annually'' and inserting ''on an ongoing basis'';

(B) in clause (iii), by striking ''an annual selection'' and inserting ''a selection (which may be changed on an annual basis)'' ; and

(C) by adding at the end the following: ''An election and selection described in clauses (ii) and (iii) shall continue to be effective without the need for any periodic reelection or reapplication or selection.''.

(2) PERMITTING VENDER TO DELIVER DRUGS TO SITE OF ADMINISTRATION.—Subsection (b)(4)(E) of such section is amended—

(A) by striking ''or'' at the end of clause (I);

(B) by striking the period at the end of clause (ii) and inserting ''; or''; and

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

''(iii) prevent a contractor from delivering drugs and biologicals to the site in which the drugs or biologicals will be administered.''.

(3) PHYSICIAN OUTREACH AND EDUCATION.—Subsection (a)(1) of such section is amended by adding at the end the following new subparagraph:

''(E) PHYSICIAN OUTREACH AND EDUCATION.—The Secretary shall conduct a program of outreach to education physicians concerning the program and the ongoing opportunity of physicians to elect to obtain drugs and biologicals under the program.''.

(4) REBIDDING OF CONTRACTS.—The Secretary of Health and Human Services shall provide for the rebidding of contracts under section 1847B(c) of the Social Security Act (42 U.S.C. 1395w–3b(c)) only for periods on or after the expiration of the contract in effect under such section as of the date of the enactment of this Act.

(c) TREATMENT OF CERTAIN DRUGS.—Section 1847A(b) of the Social Security Act (42 U.S.C. 1395w–3a(b)) is amended—

(1) in paragraph (1), by inserting ''paragraph (6) and'' after ''Subject to''; and

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

''(6) SPECIAL RULE.—.In applying subsection (c)(6)(C)(ii), beginning with January 1, 2008, the average sales price for drugs or biologicals described in section 1842(o)(1)(G) is the lower of the average sales price calculated including drugs or biologicals to which such subsection applies and the average sales price that would have been calculated if such subsection were not applied.''.

(d) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall apply to drugs furnished on or after January 1, 2008.

Subtitle B—Extension of Medicare Rural Access Protections

SEC. 621. 2-YEAR EXTENSION OF FLOOR ON MEDICARE WORK GEOGRAPHIC ADJUSTMENT.

Section 1848(e)(1)(E) of such Act (42 U.S.C. 1395w–4(e)(1)(E)) is amended by striking ''2008'' and inserting ''2010''.

SEC. 622. 2-YEAR EXTENSION OF SPECIAL 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 amended by section 732 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and section 104 of the Medicare Improvements and Extension Act of 2006 (division B of Public Law 109–432), is amended by striking ''and 2007'' and inserting ''2007, 2008, and 2009''.

SEC. 623. 2-YEAR EXTENSION OF MEDICARE REASONABLE COSTS PAYMENTS FOR CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITAL PATIENTS IN CERTAIN RURAL AREAS.

Section 416(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2282; 42 U.S.C. 1395l–4(b)), as amended by section 105 of the Medicare Improvement and Extension Act of 2006 (division B of Public Law 109–432), is amended by striking ''3-year'' and inserting ''5-year''.

SEC. 624. 2-YEAR EXTENSION OF MEDICARE INCENTIVE PAYMENT PROGRAM FOR PHYSICIAN SCARCITY AREAS .

(a) IN GENERAL.—Section 1833(u)(1) of the Social Security Act (42 U.S.C. 1395l(u)(1)) is amended by striking ''2008'' and inserting ''2010''.

(b) TRANSITION.—With respect to physicians' services furnished during 2008 and 2009, for purposes of subsection (a), the Secretary of Health and Human Services shall use the primary care scarcity areas and the specialty care scarcity areas (as identified in section 1833(u)(4)) that the Secretary was using under such subsection with respect to physicians' services furnished on December 31, 2007.

SEC. 625. 2-YEAR EXTENSION OF MEDICARE INCREASE PAYMENTS FOR GROUND AMBULANCE SERVICES IN RURAL AREAS.

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 before clause (i), by striking ''furnished on or after July 1, 2004, and before January 1, 2007,'';

(B) in clause (i), by inserting ''for services furnished on or after July 1, 2004, and before January 1, 2007, and on or after January 1, 2008, and before January 1, 2010,'' after ''in such paragraph,''; and

(C) in clause (ii), by inserting ''for services furnished on or after July 1, 2004, and before January 1, 2007,'' after ''in clause (i),''; and

(2) in subparagraph (B)—

(A) in the heading, by striking ''AFTER 2006'' and inserting ''FOR SUBSEQUENT PERIODS'';

(B) by inserting ''clauses (i) and (ii) of'' before ''subparagraph (A)''; and

(C) by striking ''in such subparagraph'' and inserting ''in the respective clause''.

SEC. 626. EXTENDING HOLD HARMLESS FOR SMALL RURAL HOSPITALS UNDER THE HOPD PROSPECTIVE PAYMENT SYSTEM.

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

(1) by striking ''January 1, 2009'' and inserting ''January 1, 2010'';

(2) by striking ''2007, or 2008,''; and

(3) by striking ''90 percent, and 85 percent, respectively,'' and inserting '', and with respect to such services furnished after 2006 the applicable percentage shall be 90 percent.''.

Subtitle C—End Stage Renal Disease Program

SEC. 631. CHRONIC KIDNEY DISEASE DEMONSTRATION PROJECTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), acting through the Director of the National Institutes of Health, shall establish demonstration projects to—

(1) increase public and medical community awareness (particularly of those who treat patients with diabetes and hypertension) about the factors that lead to chronic kidney disease, how to prevent it, how to diagnose it, and how to treat it;

(2) increase screening and use of prevention techniques for chronic kidney disease for Medicare beneficiaries and the general public (particularly among patients with diabetes and hypertension, where prevention techniques are well established and early detection makes prevention possible); and

(3) enhance surveillance systems and expand research to better assess the prevalence and incidence of chronic kidney disease, (building on work done by Centers for Disease Control and Prevention).

(b) SCOPE AND DURATION.—

(1) SCOPE.—The Secretary shall select at least 3 States in which to conduct demonstration projects under this section. In selecting the States under this paragraph, the Secretary shall take into account the size of the population of individuals with end-stage renal disease who are enrolled in part B of title XVIII of the Social Security Act and ensure the participation of individuals who reside in rural and urban areas.

(2) DURATION.—The demonstration 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.—

(1) EVALUATION.—The Secretary shall conduct an evaluation of the demonstration projects conducted under this section.

(2) REPORT.—Not later than 12 months after the date on which the demonstration projects under this section are completed, the Secretary shall submit to Congress a report on the evaluation conducted under paragraph (1) together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

SEC. 632. MEDICARE COVERAGE OF KIDNEY DISEASE PATIENT EDUCATION SERVICES.

(a) COVERAGE OF KIDNEY DISEASE EDUCATION SERVICES.—

(1) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

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

(B) in subparagraph (AA), by adding ''and'' after the semicolon at the end; and

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

''(BB) kidney disease education services (as defined in subsection (ccc));''.

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

''Kidney Disease Education Services

''(ccc)(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 developed 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 physician, physician assistant, nurse practitioner, or clinical nurse specialist who furnishes services for which payment may be made under the fee schedule established under section 1848. Such term does not include a renal dialysis facility.

''(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 a person or entity 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) In promulgating regulations to carry out this subsection, the Secretary shall ensure that each individual who is eligible for benefits for kidney disease education services under this title receives such services in a timely manner to maximize the benefit of those services.

''(5) The Secretary shall monitor the implementation of this subsection to ensure that individuals who are eligible for benefits for kidney disease education services receive such services in the manner described in paragraph (4).

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

(3) 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)(BB),'' after ''(2)(AA),''.

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

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

(B) in subparagraph (N), by striking the semicolon at the end and inserting '', and''; and

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

''(O) in the case of kidney disease education services (as defined in section 1861(ccc)), which are furnished in excess of the number of sessions covered under such section;''.

(5) GAO REPORT.—Not later than September 1, 2010, the Comptroller General of the United States shall submit to Congress a report on the following:

(A) The number of Medicare beneficiaries who are eligible to receive benefits for kidney disease education services (as defined in section 1861(ccc) of the Social Security Act, as added by paragraph (2)) under title XVIII of such Act and who receive such services.

(B) The extent to which there is a sufficient amount of physicians, physician assistants, nurse practitioners, and clinical nurse specialists to furnish kidney disease education services (as so defined) under such title and whether or not renal dialysis facilities (and appropriate employees of such facilities) should be included as an entity eligible under such section to furnish such services.

(C) Recommendations, if appropriate, for renal dialysis facilities (and appropriate employees of such facilities) to structure kidney disease education services (as so defined) in a manner that is objective and unbiased and that provides a range of options and alternative locations for renal replacement therapy and management of co-morbidities that may delay the need for dialysis.

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

SEC. 633. REQUIRED TRAINING FOR PATIENT CARE DIALYSIS TECHNICIANS.

Section 1881 of the Social Security Act (42 U.S.C. 1395rr) is amended by adding the following new subsection:

''(h)(1) Except as provided in paragraph (2), a provider of services or a renal dialysis facility may not use, for more than 12 months during 2009, or for any period beginning on January 1, 2010, any individual as a patient care dialysis technician unless the individual—

''(A) has completed a training program in the care and treatment of an individual with chronic kidney failure who is undergoing dialysis treatment; and

''(B) has been certified by a nationally recognized certification entity for dialysis technicians.

''(2)(A) A provider of services or a renal dialysis facility may permit an individual enrolled in a training program described in paragraph (1)(A) to serve as a patient care dialysis technician while they are so enrolled.

''(B) The requirements described in subparagraphs (A), (B), and (C) of paragraph (1) do not apply to an individual who has performed dialysis-related services for at least 5 years.

''(3) For purposes of paragraph (1), if, since the most recent completion by an individual of a training program described in paragraph (1)(A), there has been a period of 24 consecutive months during which the individual has not furnished dialysis-related services for monetary compensation, such individual shall be required to complete a new training program or become recertified as described in paragraph (1)(B).

''(4) A provider of services or a renal dialysis facility shall provide such regular performance review and regular in-service education as assures that individuals serving as patient care dialysis technicians for the provider or facility are competent to perform dialysis-related services.''.

SEC. 634. MEDPAC REPORT ON TREATMENT MODALITIES FOR PATIENTS WITH KIDNEY FAILURE.

(a) EVALUATION.—

(1) IN GENERAL.—Not later than March 1, 2009, the Medicare Payment Advisory Commission (established under section 1805 of the Social Security Act) shall submit to the Secretary and Congress a report evaluating the barriers that exist to increasing the number of individuals with end-stage renal disease who elect to receive home dialysis services under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) REPORT DETAILS.—The report shall include the following:

(A) A review of Medicare home dialysis demonstration projects initiated before the date of the enactment of this Act, and the results of such demonstration projects and recommendations for future Medicare home dialysis demonstration projects or Medicare program changes that will test models that can improve Medicare beneficiary access to home dialysis.

(B) A comparison of current Medicare home dialysis costs and payments with current in-center and hospital dialysis costs and payments.

(C) An analysis of the adequacy of Medicare reimbursement for patient training for home dialysis (including hemodialysis and peritoneal dialysis) and recommendations for ensuring appropriate payment for such home dialysis training.

(D) A catalogue and evaluation of the incentives and disincentives in the current reimbursement system that influence whether patients receive home dialysis services or other treatment modalities.

(E) An evaluation of patient education services and how such services impact the treatment choices made by patients.

(F) Recommendations for implementing incentives to encourage patients to elect to receive home dialysis services or other treatment modalities under the Medicare program

(3) SCOPE OF REVIEW.—In preparing the report under paragraph (1), the Medicare Payment Advisory Commission shall consider a variety of perspectives, including the perspectives of physicians, other health care professionals, hospitals, dialysis facilities, health plans, purchasers, and patients.

SEC. 635. ADJUSTMENT FOR ERYTHROPOIETIN STIMULATING AGENTS (ESAS).

(a) IN GENERAL.—Subsection (b)(13) of section 1881 of the Social Security Act (42 U.S.C. 1395rr) is amended—

(1) in subparagraph (A)(iii), by striking ''For such drugs'' and inserting ''Subject to subparagraph (C), for such drugs''; and

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

''(C)(i) The payment amounts under this title for erythropoietin furnished during 2008 or 2009 to an individual with end stage renal disease by a large dialysis facility (as defined in subparagraph (D)) (whether to individuals in the facility or at home), in an amount equal to $8.75 per thousand units (rounded to the nearest 100 units) or, if less, 102 percent of the average sales price (as determined under section 1847A) for such drug or biological.

''(ii) The payment amounts under this title for darbepoetin alfa furnished during 2008 or 2009 to an individual with end stage renal disease by a large dialysis facility (as defined in clause (iii)) (whether to individuals in the facility or at home), in an amount equal to $2.92 per microgram or, if less, 102 percent of the average sales price (as determined under section 1847A) for such drug or biological.

''(iii) For purposes of this subparagraph, the term 'large dialysis facility' means a provider of services or renal dialysis facility that is owned or managed by a corporate entity that, as of July 24, 2007, owns or manages 300 or more such providers or facilities, and includes a successor to such a corporate entity''.

(b) NO IMPACT ON DRUG ADD-ON PAYMENT.—Nothing in the amendments made by subsection (a) shall be construed to affect the amount of any payment adjustment made under section 1881(b)(12)(B)(ii) of the Social Security Act (42 U.S.C. 1395rr(b)(12)(B)(ii)).

SEC. 636. SITE NEUTRAL COMPOSITE RATE.

Subsection (b)(12)(A) of section 1881 of the Social Security Act (42 U.S.C. 1395rr) 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, 2008, by providers of such services for hospital-based facilities shall be the same as the payment rate (computed without regard to this sentence) for such services furnished by renal dialysis facilities that are not hospital-based, except that in applying the geographic index under subparagraph (D) to hospital-based facilities, the labor share shall be based on the labor share otherwise applied for such facilities.''.

SEC. 637. DEVELOPMENT OF ESRD BUNDLING SYSTEM AND QUALITY INCENTIVE PAYMENTS.

(a) DEVELOPMENT OF ESRD BUNDLING SYSTEM.—Subsection (b) of section 1881 of the Social Security Act (42 U.S.C. 1395rr) is further amended—

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

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

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

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

(3) in paragraph (12)(H)—

(A) by inserting ''or paragraph (14)'' after ''under this paragraph'' the first place it appears; and

(B) by inserting before the period at the end the following: ''or, under paragraph (14), the identification of renal dialysis services included in the bundled payment, the adjustment for outliers, the identification of facilities to which the phase-in may apply, and the determination of payment amounts under subparagraph (A) under such paragraph, and the application of paragraph (13)(C)(iii))'';

(4) in paragraph (13)—

(A) in subparagraph (A), by striking ''The payment amounts'' and inserting ''subject to paragraph (14), the payment amounts''; and

(B) in subparagraph (B)—

(i) in clause (i), by striking ''(i)'' after ''(B)'' and by inserting '', subject to paragraph (14)'' before the period at the end; and

(ii) by striking clause (ii); and

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

''(14)(A) Subject to subparagraph (E), for services furnished on or after January 1, 2010, the Secretary shall implement a payment system under which a single payment is made under this title for renal dialysis services (as defined in subparagraph (B)) in lieu of any other payment (including a payment adjustment under paragraph (12)(B)(ii)) for such services and items furnished pursuant to paragraph (4). In implementing the system the Secretary shall ensure that the estimated total amount of payments under this title for 2010 for renal dialysis services shall equal 96 percent of the estimated amount of payments for such services, including payments under paragraph (12)(B)(ii), that would have been made if such system had not been implemented.

''(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, 2009;

''(ii) erythropoietin stimulating agents furnished to individuals with end stage renal disease;

''(iii) other drugs and biologicals and diagnostic laboratory tests, that the Secretary identifies as commonly used in the treatment of such patients and for which payment was (before the application of this paragraph) made separately under this title, and any oral equivalent form of such drugs and biologicals or of drugs and biologicals described in clause (ii); and

''(iv) home dialysis training for which payment was (before the application of this paragraph) made separately under this section.

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, race, ethnicity, 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 erythropoietin stimulating agents necessary for anemia management; and

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

''(I) by a geographic index, such as the index referred to in paragraph (12)(D), as the Secretary determines to be appropriate;

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

''(III) for low volume providers of services and renal dialysis facilities;

''(IV) for providers of services or renal dialysis facilities located in rural areas; and

''(V) for providers of services or renal dialysis facilities that are not large dialysis facilities.

''(E) The Secretary may provide for a phase-in of the payment system described in subparagraph (A) for services furnished by a provider of services or renal dialysis facility described in any of subclauses (II) through (V) of subparagraph (D)(iii), but such payment system shall be fully implemented for services furnished in the case of any such provider or facility on or after January 1, 2013.

''(F) The Secretary shall apply the annual increase that would otherwise apply under subparagraph (F) of paragraph (12) to payment amounts established under such paragraph (if this paragraph did not apply) in an appropriate manner under this paragraph.''.

(6) PROHIBITION OF UNBUNDLING.—Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

(A) by striking ''or'' at the end of paragraph (21);

(B) by striking the period at the end of paragraph (22) and inserting ''; or''; and

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

''(23) 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 (other than under subparagraph (E) of such section) unless such payment is made under such section to a provider of services or a renal dialysis facility for such services.''.

(b) QUALITY INCENTIVE PAYMENTS.—Section 1881 of such Act is amended by adding at the end the following new subsection:

''(i) QUALITY INCENTIVE PAYMENTS IN THE END-STAGE RENAL DISEASE PROGRAM.—

''(1) QUALITY INCENTIVE PAYMENTS FOR SERVICES FURNISHED IN 2008, 2009, AND 2010.—

''(A) IN GENERAL.—With respect to renal dialysis services furnished during a performance period (as defined in subparagraph (B)) by a provider of services or renal dialysis facility that the Secretary determines meets the applicable performance standard for the period under subparagraph (C) and reports on measures for 2009 and 2010 under subparagraph (D) for such services, in addition to the amount otherwise paid under this section, subject to subparagraph (G), there also shall be paid to the provider or facility an amount equal to the applicable percentage (specified in subparagraph (E) for the period) of the Secretary's estimate (based on claims submitted not later than two months after the end of the performance period) of the amount specified in subparagraph (F) for such period.

''(B) PERFORMANCE PERIOD.—In this paragraph, the term 'performance period' means each of the following:

''(i) The period beginning on July 1, 2008, and ending on December 31, 2008.

''(ii) 2009.

''(iii) 2010.

''(C) PERFORMANCE STANDARD.—

''(i) 2008.—For the performance period occurring in 2008, the applicable performance standards for a provider or facility under this subparagraph are—

''(I) 92 percent or more of individuals with end stage renal disease receiving erythopoetin stimulating agents who have an average hematocrit of 33.0 percent or more; and

''(II) less than a percentage, specified by the Secretary, of individuals with end stage renal disease receiving erythopoetin stimulating agents who have an average hematocrit of 39.0 percent or more.

''(ii) 2009 AND 2010.—For the 2009 and 2010 performance periods, the applicable performance standard for a provider or facility under this subparagraph is successful performance (relative to national average) on—

''(I) such measures of anemia management as the Secretary shall specify, including measures of hemoglobin levels or hematocrit levels for erythropoietin stimulating agents that are consistent with the labeling for dosage of erythropoietin stimulating agents approved by the Food and Drug Administration for treatment of anemia in patients with end stage renal disease, taking into account variations in hemoglobin ranges or hematocrit levels of patients; and

''(II) such other measures, relating to subjects described in subparagraph (D)(i), as the Secretary may specify.

''(D) REPORTING PERFORMANCE MEASURES.—The performance measures under this subparagraph to be reported shall include—

''(i) such measures as the Secretary specifies, before the beginning of the performance period involved and taking into account measures endorsed by the National Quality Forum, including, to the extent feasible measures on—

''(I) iron management;

''(II) dialysis adequacy; and

''(III) vascular access, including for maximizing the placement of arterial venous fistula; and

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

The provider or facility submitting information on such measures shall attest to the completeness and accuracy of such information.

''(E) APPLICABLE PERCENTAGE.—The applicable percentage specified in this subparagraph for—

''(i) the performance period occurring in 2008, is 1.0 percent;

''(ii) the 2009 performance period, is 2.0 percent; and

''(iii) the 2010 performance period, is 2.0 percent.

In the case of any performance period which is less than an entire year, the applicable percentage specified in this subparagraph shall be multiplied by the ratio of the number of months in the year to the number of months in such performance period. In the

case of 2010, the applicable percentage specified in this subparagraph shall be multiplied by the Secretary's estimate of the ratio of the aggregate payment amount described in subparagraph (F)(i) that would apply in 2010 if paragraph (14) did not apply, to the aggregate payment base under subparagraph (F)(ii) for 2010.

''(F) PAYMENT BASE.—The payment base described in this subparagraph for a provider or facility is—

''(i) for performance periods before 2010, the payment amount determined under paragraph (12) for services furnished by the provider or facility during the performance period, including the drug payment adjustment described in subparagraph (B)(ii) of such paragraph; and

''(ii) for the 2010 performance period is the amount determined under paragraph (14) for services furnished by the provider or facility during the period.

''(G) LIMITATION ON FUNDING.—

''(i) IN GENERAL.—If the Secretary determines that the total payments under this paragraph for a performance period is projected to exceed the dollar amount specified in clause (ii) for such period, the Secretary shall reduce, in a pro rata manner, the amount of such payments for each provider or facility for such period to eliminate any such projected excess for the period.

''(ii) DOLLAR AMOUNT.—The dollar amount specified in this clause—

''(I) for the performance period occurring in 2008, is $50,000,000;

''(II) for the 2009 performance period is $100,000,000; and

''(III) for the 2010 performance period is $150,000,000.

''(H) FORM OF PAYMENT.—The payment under this paragraph shall be in the form of a single consolidated payment.

''(2) QUALITY INCENTIVE PAYMENTS FOR FACILITIES AND PROVIDERS FOR 2011.—

''(A) INCREASED PAYMENT.—For 2011, in the case of a provider or facility that, for the performance period (as defined in subparagraph (B))—

''(i) meets (or exceeds) the performance standard for anemia management specified in paragraph (1)(C)(ii)(I);

''(ii) has substantially improved performance or exceeds a performance standard (as determined under subparagraph (E)); and

''(iii) reports measures specified in paragraph (1)(D),

with respect to renal dialysis services furnished by the provider or facility during the quality bonus payment period (as specified in subparagraph (C)) the payment amount otherwise made to such provider or facility under subsection (b)(14) shall be increased, subject to subparagraph (F), by the applicable percentage specified in subparagraph (D). Payment amounts under paragraph (1) shall not be counted for purposes of applying the previous sentence.

''(B) PERFORMANCE PERIOD.—In this paragraph, the term 'performance period' means a multi-month period specified by the Secretary .

''(C) QUALITY BONUS PAYMENT PERIOD.—In this paragraph, the term 'quality bonus payment period' means, with respect to a performance period, a multi-month period beginning on January 1, 2011, specified by the Secretary that begins at least 3 months (but not more than 9 months) after the end of the performance period.

''(D) APPLICABLE PERCENTAGE.—The applicable percentage specified in this subparagraph is a percentage, not to exceed the 2.0 percent, specified by the Secretary consistent with subparagraph (F). Such percentage may vary based on the level of performance and improvement. The applicable percentage specified in this subparagraph shall be multiplied by the ratio applied under the third sentence of paragraph (1)(E) for 2010.

''(E) PERFORMANCE STANDARD.—Based on performance of a provider of services or a renal dialysis facility on performance measures described in paragraph (1)(D) for a performance period, the Secretary shall determine a composite score for such period.

''(F) LIMITATION ON FUNDING.—If the Secretary determines that the total amount to be paid under this paragraph for a quality bonus payment period is projected to exceed $200,000,000, the Secretary shall reduce, in a uniform manner, the applicable percentage otherwise applied under subparagraph (D) for services furnished during the period to eliminate any such projected excess.

''(3) APPLICATION.—

''(A) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement by program instruction or otherwise this subsection.

''(B) LIMITATIONS ON REVIEW.—

''(i) IN GENERAL.—There shall be no administrative or judicial review under section 1869 or 1878 or otherwise of—

''(I) the determination of performance measures and standards under this subsection;

''(II) the determination of successful reporting, including a determination of composite scores; and

''(III) the determination of the quality incentive payments made under this subsection.

''(ii) TREATMENT OF DETERMINATIONS.—A determination under this subparagraph shall not be treated as a determination for purposes of section 1869.

''(4) TECHNICAL ASSISTANCE.—The Secretary shall identify or establish an appropriately skilled group or organization, such as the ESRD Networks, to provide technical assistance to consistently low-performing facilities or providers that are in the bottom quintile.

''(5) PUBLIC REPORTING.—

''(A) ANNUAL NOTICE.—The Secretary shall provide an annual written notification to each individual who is receiving renal dialysis services from a provider of services or renal dialysis facility that—

''(i) informs such individual of the composite scores described in subparagraph (A) and other relevant quality measures with respect to providers of services or renal dialysis facilities in the local area;

''(ii) compares such scores and measures to the average local and national scores and measures; and

''(iii) provides information on how to access additional information on quality of such services furnished and options for alternative providers and facilities.

''(B) CERTIFICATES.—The Secretary shall provide certificates to facilities and providers who provide services to individuals with end-stage renal disease under this title to display in patient areas. The certificate shall indicate the composite score obtained by the facility or provider under the quality initiative.

''(C) WEB-BASED QUALITY LIST.—The Secretary shall establish a web-based list of facilities and providers who furnish renal dialysis services under this section that indicates their composite score of each provider and facility.

''(6) RECOMMENDATIONS FOR REPORTING AND QUALITY INCENTIVE INTITIATIVE FOR PHYSICIANS.—The Secretary shall develop recommendations for applying quality incentive payments under this subsection to physicians who receive the monthly capitated payment under this title. Such recommendations shall include the following:

''(A) Recommendations to include pediatric specific measures for physicians with at least 50 percent of their patients with end stage renal disease being individuals under 18 years of age.

''(B) Recommendations on how to structure quality incentive payments for physicians who demonstrate improvements in quality or who attain quality standards, as specified by the Secretary.

''(7) REPORTS.—

''(A) INITIAL REPORT.—Not later than January 1, 2013, the Secretary shall submit to Congress a report on the implementation of the bundled payment system under subsection (b)(14) and the quality initiative under this subsection. Such report shall include the following information:

''(i) A comparison of the aggregate payments under subsection (b)(14) for items and services to the cost of such items and services.

''(ii) The changes in utilization rates for erythropoietin stimulating agents.

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

''(iv) The frequency of dialysis.

''(v) Other differences in practice patterns, such as the adoption of new technology, different modes of practice, and variations in use of drugs other than drugs described in clause (iii).

''(vi) The performance of facilities and providers under paragraph (2).

''(vii) Other recommendations for legislative and administrative actions determined appropriate by the Secretary.

''(B) SUBSEQUENT REPORT.—Not later than January 1, 2015, the Secretary shall submit to Congress a report that contains the information described in each of clauses (ii) through (vii) of subparagraph (A) and a comparison of the results of the payment system under subsection (b)(14) for renal dialysis services furnished during the 2-year period beginning on January 1, 2013, and the results of such payment system for such services furnished during the previous two-year period.''.

SEC. 638. MEDPAC REPORT ON ESRD BUNDLING SYSTEM.

Not later than March 1, 2012, the Medicare Payment Advisory Commission (established under section 1805 of the Social Security Act) shall submit to Congress a report on the implementation of the payment system under section 1881(b)(14) of the Social Security Act (as added by section 7) for renal dialysis services and related services (defined in subparagraph (B) of such section). Such report shall include, with respect to such payment system for such services, an analysis of each of the following:

(1) An analysis of the overall adequacy of payment under such system for all such services.

(2) An analysis that compares the adequacy of payment under such system for services furnished by—

(A) a provider of services or renal dialysis facility that is described in section 1881(b)(13)(C)(iv) of the Social Security Act;

(B) a provider of services or renal dialysis facility not described in such section;

(C) a hospital-based facility;

(D) a freestanding renal dialysis facility;

(E) a renal dialysis facility located in an urban area; and

(F) a renal dialysis facility located in a rural area.

(3) An analysis of the financial status of providers of such services and renal dialysis facilities, including access to capital, return on equity, and return on capital.

(4) An analysis of the adequacy of payment under such method and the adequacy of the quality improvement payments under section 1881(i) of the Social Security Act in ensuring that payments for such services under the Medicare program are consistent with costs for such services.

(5) Recommendations, if appropriate, for modifications to such payment system.

SEC. 639. OIG STUDY AND REPORT ON ERYTHROPOIETIN.

(a) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct a study on the following:

(1) The dosing guidelines, standards, protocols, and alogorithms for erythropoietin stimulating agents recommended or used by providers of services and renal dialysis facilities that are described in section 1881(b)(13)(C)(iv) of the Social Security Act and providers and facilities that are not described in such section.

(2) The extent to which such guidelines, standards, protocols, and algorithms are consistent with the labeling of the Food and Drug Administration for such agents.

(3) The extent to which physicians sign standing orders for such agents that are consistent with such guidelines, standards, protocols, and algorithms recommended or used by the provider or facility involved.

(4) The extent to which the prescribing decisions of physicians, with respect to such agents, are independent of—

(A) such relevant guidelines, standards, protocols, and algorithms; or

(B) recommendations of an anemia management nurse or other appropriate employee of the provider or facility involved.

(5) The role of medical directors of providers of services and renal dialysis facilities and the financial relationships between such providers and facilities and the physicians hired as medical directors of such providers and facilities, respectively.

(b) REPORT.—Not later than January 1, 2009, the Inspector General of the Department of Health and Human Services shall submit to Congress a report on the study conducted under subsection (a), together with such recommendations as the Inspector General determines appropriate.

Subtitle D—Miscellaneous

SEC. 651. LIMITATION ON EXCEPTION TO THE PROHIBITION ON CERTAIN PHYSICIAN REFERRALS FOR HOSPITALS.

(a) IN GENERAL.—Section 1877 of the Social Security Act (42 U.S.C. 1395) is amended—

(1) in subsection (d)(2)—

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

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

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

''(C) if the entity is a hospital, the hospital meets the requirements of paragraph (3)(D).'';

(2) in subsection (d)(3)—

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

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

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

''(D) the hospital meets the requirements described in subsection (i)(1) not later than 18 months after the date of the enactment of this subparagraph.''; and

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

''(i) REQUIREMENTS FOR HOSPITALS TO QUALIFY FOR HOSPITAL EXCEPTION TO OWNERSHIP OR INVESTMENT PROHIBITION.—

''(1) REQUIREMENTS DESCRIBED.—For purposes of paragraphs subsection (d)(3)(D), the requirements described in this paragraph for a hospital are as follows:

''(A) PROVIDER AGREEMENT.—The hospital had a provider agreement under section 1866 in effect on July 24, 2007.

''(B) PROHIBITION OF EXPANSION OF FACILITY CAPACITY.—The number of operating rooms and beds of the hospital at any time on or after the date of the enactment of this subsection are no greater than the number of operating rooms and beds as of such date.

''(C) PREVENTING CONFLICTS OF INTEREST.—

''(i) The hospital submits to the Secretary an annual report containing a detailed description of—

''(I) the identity of each physician owner and any other owners of the hospital; and

''(II) the nature and extent of all ownership interests in the hospital.

''(ii) The hospital has procedures in place to require that any referring physician owner discloses to the patient being referred, by a time that permits the patient to make a meaningful decision regarding the receipt of care ,as determined by the Secretary—

''(I) the ownership interest of such referring physician in the hospital; and

''(II) if applicable, any such ownership interest of the treating physician.

''(iii) The hospital does not condition any physician ownership interests either directly or indirectly on the physician owner making or influencing referrals to the hospital or otherwise generating business for the hospital.

''(D) ENSURING BONA FIDE INVESTMENT.—

''(i) Physician owners in the aggregate do not own more than 40 percent of the total value of the investment interests held in the hospital or in an entity whose assets include the hospital.

''(ii) The investment interest of any individual physician owner does not exceed 2 percent of the total value of the investment interests held in the hospital or in an entity whose assets include the hospital.

''(iii) Any ownership or investment interests that the hospital offers to a physician owner are not offered on more favorable terms than the terms offered to a person who is not a physician owner.

''(iv) The hospital does not directly or indirectly provide loans or financing for any physician owner investments in the hospital.

''(v) The hospital does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any individual physician owner or group of physician owners that is related to acquiring any ownership interest in the hospital.

''(vi) Investment returns are distributed to investors in the hospital in an amount that is directly proportional to the investment of capital by the physician owner in the hospital.

''(vii) Physician owners do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other investors in the hospital or located near the premises of the hospital.

''(viii) The hospital does not offer a physician owner the opportunity to purchase or lease any property under the control of the hospital or any other investor in the hospital on more favorable terms than the terms offered to an individual who is not a physician owner.

''(E) PATIENT SAFETY.—

''(i) Insofar as the hospital admits a patient and does not have any physician available on the premises to provide services during all hours in which the hospital is providing services to such patient, before admitting the patient—

''(I) the hospital discloses such fact to a patient; and

''(II) following such disclosure, the hospital receives from the patient a signed acknowledgment that the patient understands such fact.

''(ii) The hospital has the capacity to—

''(I) provide assessment and initial treatment for patients; and

''(II) refer and transfer patients to hospitals with the capability to treat the needs of the patient involved.

''(2) PUBLICATION OF INFORMATION REPORTED.—The Secretary shall publish, and update on an annual basis, the information submitted by hospitals under paragraph (1)(A)(i) on the public Internet website of the Centers for Medicare & Medicaid Services.

''(3) COLLECTION OF OWNERSHIP AND INVESTMENT INFORMATION.—For purposes of clauses (i) and (ii) of paragraph (1)(D), the Secretary shall collect physician ownership and investment information for each hospital as it existed on the date of the enactment of this subsection.

''(4) PHYSICIAN OWNER DEFINED.—For purposes of this subsection, the term 'physician owner' means a physician (or an immediate family member of such physician) with a direct or an indirect ownership interest in the hospital.''.

(b) ENFORCEMENT.—

(1) ENSURING COMPLIANCE.—The Secretary of Health and Human Services shall establish policies and procedures to ensure compliance with the requirements described in such section 1877(i)(1) of the Social Security Act, as added by subsection (a)(3), beginning on the date such requirements first apply. Such policies and procedures may include unannounced site reviews of hospitals.

(2) AUDITS.—Beginning not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall conduct audits to determine if hospitals violate the requirements referred to in paragraph (1).

TITLE VII—PROVISIONS RELATING TO MEDICARE PARTS A AND B

SEC. 701. HOME HEALTH PAYMENT UPDATE FOR 2008.

Section 1895(b)(3)(B)(ii) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)(ii)) is amended—

(1) in subclause (IV) at the end, by striking ''and'';

(2) by redesignating subclause (V) as subclause (VII); and

(3) by inserting after subclause (IV) the following new subclauses:

''(V) 2007, subject to clause (v), the home health market basket percentage increase;

''(VI) 2008, subject to clause (v), 0 percent; and''.

SEC. 702. 2-YEAR EXTENSION OF TEMPORARY MEDICARE PAYMENT INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

Section 421 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2283; 42 U.S.C. 1395fff note), as amended by section 5201(b) of the Deficit Reduction Act of 2005, is amended—

(1) in the heading, by striking ''**ONE-YEAR**'' and inserting ''**TEMPORARY**''; and

(2) in subsection (a), by striking ''and episodes and visits beginning on or after January 1, 2006, and before January 1, 2007'' and inserting ''episodes and visits beginning on or after January 1, 2006, and before January 1, 2007, and episodes and visits beginning on or after January 1, 2008, and before January 1, 2010''.

SEC. 703. EXTENSION OF MEDICARE SECONDARY PAYER FOR BENEFICIARIES WITH END STAGE RENAL DISEASE FOR LARGE GROUP PLANS.

(a) IN GENERAL.—Section 1862(b)(1)(C) of the Social Security Act (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) by redesignating clauses (i) and (ii) as subclauses (I) and (II), respectively, and indenting accordingly;

(2) by amending the text preceding subclause (I), as so redesignated, to read as follows:

''(C) INDIVIDUALS WITH END STAGE RENAL DISEASE.—

''(i) IN GENERAL.—A group health plan (as defined in subparagraph (A)(v))—'';

(3) in the matter following subclause (II), as so redesignated—

(A) by striking ''clause (i)'' and inserting ''subclause (I)'';

(B) by striking ''clause (ii)'' and inserting ''subclause (II)''; and

(C) by striking ''clauses (i) and (ii)'' and inserting ''subclauses (I) and (II)''; and

(D) in the last sentence, by striking ''Effective for items'' and inserting ''Subject to clause (ii), effective for items''; and

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

''(ii) SPECIAL RULE FOR LARGE GROUP PLANS.—In applying clause (i) to a large group health plan (as defined in subparagraph (B)(iii)). with respect to periods beginning on or after the date that is 30 months prior to January 1, 2008, subclauses (I) and (II) of such clause shall be applied by substituting '42-month' for '12-month' each place it appears.''.

SEC. 704. PLAN FOR MEDICARE PAYMENT ADJUSTMENTS FOR NEVER EVENTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall develop a plan (in this section referred to as the ''never events plan'') to implement, beginning in fiscal year 2010, a policy to reduce or eliminate payments under title XVIII of the Social Security Act for never events.

(b) NEVER EVENT DEFINED.—For purposes of this section, the term ''never event'' means an event involving the delivery of (or failure to deliver) physicians' services, inpatient or outpatient hospital services, or facility services furnished in an ambulatory surgical facility in which there is an error in medical care that is clearly identifiable, usually preventable, and serious in consequences to patients, and that indicates a deficiency in the safety and process controls of the services furnished with respect to the physician, hospital, or ambulatory surgical center involved.

(c) PLAN DETAILS.—

(1) DEFINING NEVER EVENTS.—With respect to criteria for identifying never events under the never events plan, the Secretary should consider whether the event meets the following characteristics:

(A) CLEARLY IDENTIFIABLE.—The event is clearly identifiable and measurable and feasible to include in a reporting system for never events.

(B) USUALLY PREVENTABLE.—The event is usually preventable taking into consideration that, because of the complexity of medical care, certain medical events are not always avoidable.

(C) SERIOUS.—The event is serious and could result in death or loss of a body part, disability, or more than transient loss of a body function.

(D) DEFICIENCY IN SAFETY AND PROCESS CONTROLS.—The event is indicative of a problem in safety systems and process controls used by the physician, hospital, or ambulatory surgical center involved and is indicative of the reliability of the quality of services provided by the physician, hospital, or ambulatory surgical center, respectively.

(2) IDENTIFICATION AND PAYMENT ISSUES.—With respect to policies under the never events plan for identifying and reducing (or eliminating) payment for never events, the Secretary shall consider—

(A) mechanisms used by hospitals and physicians in reporting and coding of services that would reliably identify never events; and

(B) modifications in billing and payment mechanisms that would enable the Secretary to efficiently and accurately reduce or eliminate payments for never events.

(3) PRIORITIES.—Under the never events plan the Secretary shall identify priorities regarding the services to focus on and, among those, the never events for which payments should be reduced or eliminated.

(4) CONSULTATION.—In developing the never events plan, the Secretary shall consult with affected parties that are relevant to payment reductions in response to never events.

(d) CONGRESSIONAL REPORT.—By not later than June 1, 2008, the Secretary shall submit a report to Congress on the never events plan developed under this subsection and shall include in the report recommendations on specific methods for implementation of the plan on a timely basis.

SEC. 705. TREATMENT OF MEDICARE HOSPITAL RECLASSIFICATIONS.

(a) EXTENDING CERTAIN MEDICARE HOSPITAL WAGE INDEX RECLASSIFICATIONS THROUGH FISCAL YEAR 2009.—

(1) IN GENERAL.—Section 106(a) of the Medicare Improvements and Extension Act of 2006 (division B of public Law 109–432) is amended by striking ''September 30, 2007'' and inserting ''September 30, 2009''.

(2) SPECIAL EXCEPTION RECLASSIFICATIONS.—The Secretary of Health and Human Services shall extend for discharges occurring through September 30, 2009, the special exception reclassification made under the authority of section 1886(d)(5)(I)(i) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(I)(i)) and contained in the final rule promulgated by the Secretary in the Federal Register on August 11, 2004 (69 Fed. Reg. 49105, 49107).

(b) DISREGARDING SECTION 508 HOSPITAL RECLASSIFICATIONS FOR PURPOSES OF GROUP RECLASSIFICATIONS.—Section 508 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173, 42 U.S.C. 1395ww note) is amended by adding at the end the following new subsection:

''(g) DISREGARDING HOSPITAL RECLASSIFICATIONS FOR PURPOSES OF GROUP RECLASSIFICATIONS.—For purposes of the reclassification of a group of hospitals in a geographic area under section 1886(d), a hospital reclassified under this section (including any such reclassification which is extended under section 106(a) of the Medicare Improvements and Extension Act of 2006) shall not be taken into account and shall not prevent the other hospitals in such area from establishing such a group for such purpose.''.

TITLE VIII—MEDICAID

Subtitle A—Protecting Existing Coverage

SEC. 801. MODERNIZING TRANSITIONAL MEDICAID.

(a) TWO-YEAR EXTENSION.—

(1) IN GENERAL.—Sections 1902(e)(1)(B) and 1925(f) of the Social Security Act (42 U.S.C. 1396a(e)(1)(B), 1396r–6(f)) are each amended by striking ''September 30, 2003'' and inserting ''September 30, 2009''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on October 1, 2007.

(b) STATE OPTION OF INITIAL 12-MONTH ELIGIBILITY.—Section 1925 of the Social Security Act (42 U.S.C. 1396r–6) is amended—

(1) in subsection (a)(1), by inserting ''but subject to paragraph (5)'' after ''Notwithstanding any other provision of this title'';

(2) by adding at the end of subsection (a) the following:

''(5) OPTION OF 12-MONTH INITIAL ELIGIBILITY PERIOD.—A State may elect to treat any reference in this subsection to a 6-month period (or 6 months) as a reference to a 12-month period (or 12 months). In the case of such an election, subsection (b) shall not apply.''; and

(3) in subsection (b)(1), by inserting ''but subject to subsection (a)(5)'' after ''Notwithstanding any other provision of this title''.

(c) REMOVAL OF REQUIREMENT FOR PREVIOUS RECEIPT OF MEDICAL ASSISTANCE.—Section 1925(a)(1) of such Act (42 U.S.C. 1396r–6(a)(1)), as amended by subsection (b)(1), is further amended—

(1) by inserting ''subparagraph (B) and'' before ''paragraph (5)'';

(2) by redesignating the matter after ''REQUIREMENT.—'' as a subparagraph (A) with the heading ''IN GENERAL.—'' and with the same indentation as subparagraph (B) (as added by paragraph (3)); and

(3) by adding at the end the following:

''(B) STATE OPTION TO WAIVE REQUIREMENT FOR 3 MONTHS BEFORE RECEIPT OF MEDICAL ASSISTANCE.—A State may, at its option, elect also to apply subparagraph (A) in the case of a family that was receiving such aid for fewer than three months or that had applied for and was eligible for such aid for fewer than 3 months during the 6 immediately preceding months described in such subparagraph.''.

(d) CMS REPORT ON ENROLLMENT AND PARTICIPATION RATES UNDER TMA.—Section 1925 of such Act (42 U.S.C. 1396r–6), as amended by this section, is further amended by adding at the end the following new subsection:

''(g) COLLECTION AND REPORTING OF PARTICIPATION INFORMATION.—

''(1) COLLECTION OF INFORMATION FROM STATES.—Each State shall collect and submit to the Secretary (and make publicly available), in a format specified by the Secretary, information on average monthly enrollment and average monthly participation rates for adults and children under this section and of the number and percentage of children who become ineligible for medical assistance under this section whose medical assistance is continued under another eligibility category or who are enrolled under the State's child health plan under title XXI. Such information shall be submitted at the same time and frequency in which other enrollment information under this title is submitted to the Secretary.

''(2) ANNUAL REPORTS TO CONGRESS.—Using the information submitted under paragraph (1), the Secretary shall submit to Congress annual reports concerning enrollment and participation rates described in such paragraph.''.

(e) EFFECTIVE DATE.—The amendments made by subsections (b) through (d) shall take effect on the date of the enactment of this Act.

SEC. 802. FAMILY PLANNING SERVICES.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(A) in subclause (XVIII), by striking ''or'' at the end;

(B) in subclause (XIX), by adding ''or'' at the end; and

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

''(XX) who are described in subsection (ee) (relating to individuals who meet certain income standards);''.

(2) GROUP DESCRIBED.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by section 112(c), is amended by adding at the end the following new subsection:

''(ee)(1) Individuals described in this subsection are individuals

''(A) whose income does not exceed an income eligibility level established by the State that does not exceed the highest income eligibility level established under the State plan under this title (or under its State child health plan under title XXI) for pregnant women; and

''(B) who are not pregnant.

''(2) At the option of a State, individuals described in this subsection may include individuals who are determined to meet the eligibility requirements referred to in paragraph (1) under the terms, conditions, and procedures applicable to making eligibility determinations for medical assistance under this title under a waiver to provide the benefits described in clause (XV) of the matter following subparagraph (G) of section 1902(a)(10) granted to the State under section 1115 as of January 1, 2007.''.

(3) LIMITATION ON BENEFITS.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G)—

(A) by striking ''and (XIV)'' and inserting ''(XIV)''; and

(B) by inserting '', and (XV) the medical assistance made available to an individual described in subsection (ee) shall be limited to family planning services and supplies described in section 1905(a)(4)(C) including medical diagnosis or treatment services that are provided pursuant to a family planning service in a family planning setting provided during the period in which such an individual is eligible;'' after ''cervical cancer''.

(4) CONFORMING AMENDMENTS.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

(A) in clause (xii), by striking ''or'' at the end;

(B) in clause (xii), by adding ''or'' at the end; and

(C) by inserting after clause (xiii) the following:

''(xiv) individuals described in section 1902(ee),''.

(b) PRESUMPTIVE ELIGIBILITY.—

(1) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1920B the following:

''PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING SERVICES

''SEC. 1920C. (a) STATE OPTION.— State plan approved under section 1902 may provide for making medical assistance available to an individual described in section 1902(ee) (relating to individuals who meet certain income eligibility standard) during a presumptive eligibility period. In the case of an individual described in section 1902(ee), such medical assistance shall be limited to family planning services and supplies described in 1905(a)(4)(C) and, at the State's option, medical diagnosis or treatment services that are provided in conjunction with a family planning service in a family planning setting provided during the period in which such an individual is eligible.

''(b) DEFINITIONS.—For purposes of this section:

''(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The term 'presumptive eligibility period' means, with respect to an individual described in subsection (a), the period that—

''(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(ee); and

''(B) ends with (and includes) the earlier of—

''(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

''(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

''(2) QUALIFIED ENTITY.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'qualified entity' means any entity that—

''(i) is eligible for payments under a State plan approved under this title; and

''(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

''(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities in order to prevent fraud and abuse.

''(c) ADMINISTRATION.—

''(1) IN GENERAL.—The State agency shall provide qualified entities with—

''(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

''(B) information on how to assist such individuals in completing and filing such forms.

''(2) NOTIFICATION REQUIREMENTS.—A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

''(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

''(B) inform such individual at the time the determination is made that an application for medical assistance is required to be made by not later than the last day of the month following the month during which the determination is made.

''(3) APPLICATION FOR MEDICAL ASSISTANCE.—In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance by not later than the last day of the month following the month during which the determination is made.

''(d) PAYMENT.—Notwithstanding any other provision of this title, medical assistance that—

''(1) is furnished to an individual described in subsection (a)—

''(A) during a presumptive eligibility period;

''(B) by a entity that is eligible for payments under the State plan; and

''(2) is included in the care and services covered by the State plan, shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b).''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)) is amended by inserting before the semicolon at the end the following: ''and provide for making medical assistance available to individuals described in subsection (a) of section 1920C during a presumptive eligibility period in accordance with such section.''.

(B) Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)(v)) is amended—

(i) by striking ''or for'' and inserting '', for''; and

(ii) by inserting before the period the following: '', or for medical assistance provided to an individual described in subsection (a) of section 1920C during a presumptive eligibility period under such section''.

(e) CLARIFICATION OF COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Section 1937(b) of the Social Security Act (42 U.S.C. 1396u–7(b)) is amended by adding at the end the following:

''(5) COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment of an individual with benchmark coverage or benchmark-equivalent coverage under this section unless such coverage includes for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.''.

(f) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2007.

SEC. 803. AUTHORITY TO CONTINUE PROVIDING ADULT DAY HEALTH SERVICES APPROVED UNDER A STATE MEDICAID PLAN.

(a) IN GENERAL.—During the period described in subsection (b), the Secretary of Health and Human Services shall not—

(1) withhold, suspend, disallow, or otherwise deny Federal financial participation under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) for the provision of adult day health care services, day activity and health services, or adult medical day care services, as defined under a State Medicaid plan approved during or before 1994, during such period if such services are provided consistent with such definition and the requirements of such plan; or

(2) withdraw Federal approval of any such State plan or part thereof regarding the provision of such services (by regulation or otherwise).

(b) PERIOD DESCRIBED.—The period described in this subsection is the period that begins on November 3, 2005, and ends on March 1, 2009.

SEC. 804. STATE OPTION TO PROTECT COMMUNITY SPOUSES OF INDIVIDUALS WITH DISABILITIES.

Section 1924(h)(1)(A) of the Social Security Act (42 U.S.C. 1396r–5(h)(1)(A)) is amended by striking ''is described in section 1902(a)(10)(A)(ii)(VI)'' and inserting ''is being provided medical assistance for home and community-based services under subsection (c), (d), (e), (i), or (j) of section 1915 or pursuant to section 1115''.

SEC. 805. COUNTY MEDICAID HEALTH INSURING ORGANIZATIONS .

(a) IN GENERAL.—Section 9517(c)(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1396b note), as added by section 4734 of the Omnibus Budget Reconciliation Act of 1990 and as amended by section 704 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, is amended—

(1) in subparagraph (A), by inserting '', in the case of any health insuring organization described in such subparagraph that is operated by a public entity established by Ventura County, and in the case of any health insuring organization described in such subparagraph that is operated by a public entity established by Merced County'' after ''described in subparagraph (B)''; and

(2) in subparagraph (C), by striking ''14 percent'' and inserting ''16 percent''.

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

Subtitle B—Payments

SEC. 811. PAYMENTS FOR PUERTO RICO AND TERRITORIES.

(a) PAYMENT CEILING.—Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended—

(1) in paragraph (2), by striking ''paragraph (3)'' and inserting ''paragraphs (3) and (4)''; and

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

''(4) FISCAL YEARS 2009 THROUGH 2012 FOR CERTAIN INSULAR AREAS.—The amounts otherwise determined under this subsection for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for fiscal years 2009 through 2012 shall be increased by the following amounts:

''(A) PUERTO RICO.—For Puerto Rico, $250,000,000 for fiscal year 2009, $350,000,000 for fiscal year 2010, $500,000,000 for fiscal year 2011, and $600,000,000 for fiscal year 2012.

''(B) VIRGIN ISLANDS.—For the Virgin Islands, $5,000,000 for each of fiscal years 2009 through 2012.

''(C) GUAM.—For Guam, $5,000,000 for each of fiscal years 2009 through 2012.

''(D) NORTHERN MARIANA ISLANDS.—For the Northern Mariana Islands, $4,000,000 for each of fiscal years 2009 through 2012.

''(E) AMERICAN SAMOA.—For American Samoa, $4,000,000 for each of fiscal years 2009 through 2012.

Such amounts shall not be taken into account in applying paragraph (2) for fiscal years 2009 through 2012 but shall be taken into account in applying such paragraph for fiscal year 2013 and subsequent fiscal years.''.

(b) REMOVAL OF FEDERAL MATCHING PAYMENTS FOR IMPROVING DATA REPORTING SYSTEMS FROM THE OVERALL LIMIT ON PAYMENTS TO TERRITORIES UNDER TITLE XIX.—Such section is further amended by adding at the end the following new paragraph:

''(5) EXCLUSION OF CERTAIN EXPENDITURES FROM PAYMENT LIMITS.— With respect to fiscal year 2008 and each fiscal year thereafter, if Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa qualify for a payment under subparagraph (A)(i) or (B) of section 1903(a)(3) for a calendar quarter of such fiscal year with respect to expenditures for improvements in data reporting systems described in such subparagraph, the limitation on expenditures under title XIX for such commonwealth or territory otherwise determined under subsection (f) and this subsection for such fiscal year shall be determined without regard to payment for such expenditures.''.

SEC. 812. MEDICAID DRUG REBATE.

(a) BRAND.—Paragraph (1)(B)(i) of section 1927(c) of the Social Security Act (42 U.S.C. 1396r–8(c)) is amended—

(1) by striking ''and'' at the end of subclause (IV);

(2) in subclause (V)—

(A) by inserting ''and before January 1, 2008,'' after ''December 31, 1995''; and

(B) by striking the period at the end and inserting ''; and''; and

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

''(VI) after December 31, 2007, is 20.1 percent.''.

(b) PBMs TO BEST PRICE DEFINITION.—

(1) IN GENERAL.—Section 1927(c)(1)(C)(ii)(I) of the Social Security Act (42 U.S.C. 1396r-8(c)(1)(C)(ii)(I)) is amended—

(A) by striking ''and'' before ''rebates''; and

(B) by inserting before the semicolon at the end the following: '', and rebates, discounts, and other price concessions to pharmaceutical benefit managers (PBMs)''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to calendar quarters beginning on or after January 1, 2008.

SEC. 813. ADJUSTMENT IN COMPUTATION OF MEDICAID FMAP TO DISREGARD AN EXTRAORDINARY EMPLOYER PENSION CONTRIBUTION.

(a) IN GENERAL.—Only for purposes of computing the Federal medical assistance percentage under section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) for a State for a fiscal year (beginning with fiscal year 2006), any significantly disproportionate employer pension contribution described in subsection (b) shall be disregarded in computing the per capita income of such State, but shall not be disregarded in computing the per capita income for the continental United States (and Alaska) and Hawaii.

(b) SIGNIFICANTLY DISPROPORTIONATE EMPLOYER PENSION CONTRIBUTION.—For purposes of subsection (a), a significantly disproportionate employer pension contribution described in this subsection with respect to a State for a fiscal year is an employer contribution towards pensions that is allocated to such State for a period if the aggregate amount so allocated exceeds 25 percent of the total increase in personal income in that State for the period involved.

SEC. 814. MORATORIUM ON CERTAIN PAYMENT RESTRICTIONS.

Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not, prior to the date that is 1 year after the date of enactment of this Act, take any action (through promulgation of regulation, issuance of regulatory guidance, use of federal payment audit procedures, or other administrative action, policy, or practice, including a Medical Assistance Manual transmittal or letter to State Medicaid directors) to restrict coverage or payment under title XIX of the Social Security Act for rehabilitation services, or school-based administration, transportation, or medical services if such restrictions are more restrictive in any aspect than those applied to such coverage or payment as of July 1, 2007.

SEC. 815. TENNESSEE DSH.

The DSH allotments for Tennessee for each fiscal year beginning with fiscal year 2008 under subsection (f)(3) of section 1923 of the Social Security Act (42 U.S.C. 13961396r–4) are deemed to be $30,000,000. The Secretary of Health and Human Services may impose a limitation on the total amount of payments made to hospitals under the TennCare Section 1115 waiver only to the extent that such limitation is necessary to ensure that a hospital does not receive payment in excess of the amounts described in subsection (f) of such section or as necessary to ensure that the waiver remains budget neutral.

SEC. 816. 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 construed 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.

Subtitle C—Miscellaneous

SEC. 821. DEMONSTRATION PROJECT FOR EMPLOYER BUY-IN.

Title XXI of the Social Security Act, as amended by section 115(a)(1), is further amended by adding at the end the following new section:

''SEC. 2112. DEMONSTRATION PROJECT FOR EMPLOYER BUY-IN.

''(a) AUTHORITY.—

''(1) IN GENERAL.—The Secretary shall establish a demonstration project under which up to 10 States (each referred to in this section as a 'participating State') that meets the conditions of paragraph (2) may provide, under its State child health plan (notwithstanding section 2102(b)(3)(C)) for a period of 5 years, for child health assistance in relation to family coverage described in subsection (d) for children who would be targeted low-income children but for coverage as beneficiaries under a group health plan as the children of participants by virtue of a qualifying employer's contribution under subsection (b)(2). :

''(2) CONDITIONS.—The conditions described in this paragraph for a State are as follows:

''(A) NO WAITING LISTS.—The State does not impose any waiting list, enrollment cap, or similar limitation on enrollment of targeted low-income children under the State child health plan.

''(B) ELIGIBILITY OF ALL CHILDREN UNDER 200 PERCENT OF POVERTY LINE.—The State is applying an income eligibility level under section 2110(b)(1)(B)(ii)(I) that is at least 200 percent of the poverty line.

''(3) QUALIFYING EMPLOYER DEFINED.—In this section, the term 'qualifying employer' means an employer that has a majority of its workforce composed of full-time workers with family incomes reasonably estimated by the employer (based on wage information available to the employer) at or below 200 percent of the poverty line. In applying the previous sentence, two part-time workers shall be treated as a single full-time worker.

''(b) FUNDING.—A demonstration project under this section in a participating State shall be funded, with respect to assistance provided to children described in subsection (a)(1), consistent with the following:

''(1) LIMITED FAMILY CONTRIBUTION.—The family involved shall be responsible for providing payment towards the premium for such assistance of such amount as the State may specify, except that the limitations on cost-sharing (including premiums) under paragraphs (2) and (3) of section 2103(e) shall apply to all cost-sharing of such family under this section.

''(2) MINIMUM EMPLOYER CONTRIBUTION.—The qualifying employer involved shall be responsible for providing payment to the State child health plan in the State of at least 50 percent of the portion of the cost (as determined by the State) of the family coverage in which the employer is enrolling the family that exceeds the amount of the family contribution under paragraph (1) applied towards such coverage.

''(3) LIMITATION ON FEDERAL FINANCIAL PARTICIPATION.—In no case shall the Federal financial participation under section 2105 with respect to a demonstration project under this section be made for any portion of the costs of family coverage described in subsection (d) (including the costs of administration of such coverage) that are not attributable to children described in subsection (a)(1).

''(c) UNIFORM ELIGIBILITY RULES.—In providing assistance under a demonstration project under this section—

''(1) a State shall establish uniform rules of eligibility for families to participate; and

''(2) a State shall not permit a qualifying employer to select, within those families that meet such eligibility rules, which families may participate.

''(d) TERMS AND CONDITIONS.—The family coverage offered to families of qualifying employers under a demonstration project under this section in a State shall be the same as the coverage and benefits provided under the State child health plan in the State for targeted low-income children with the highest family income level permitted.''.

SEC. 822. DIABETES GRANTS.

Section 2104 of the Social Security Act (42 U.C.C 1397dd), as amended by section 101, is further amended—

(1) in subsection (a)(11), by inserting before the period at the end the following: ''plus for fiscal year 2009 the total of the amount specified in subsection (j)''; and

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

''(j) FUNDING FOR DIABETES GRANTS.—From the amounts appropriated under subsection (a)(11), for fiscal year 2009 from the amounts—

''(1) $150,000,000 is hereby transferred and made available in such fiscal year for grants under section 330B of the Public Health Service Act; and

''(2) $150,000,000 is hereby transferred and made available in such fiscal year for grants under section 330C of such Act.''.

SEC. 823. TECHNICAL CORRECTION.

(a) CORRECTION OF REFERENCE TO CHILDREN IN FOSTER CARE RECEIVING CHILD WELFARE SERVICES.—Section 1937(a)(2)(B)(viii) of the Social Security Act (42 U.S.C. 1396u–7(a)(2)(B) is amended by striking ''aid or assistance is made available under part B of title IV to children in foster care'' and inserting ''child welfare services are made available under part B of title IV on the basis of being a child in foster care''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the amendment made by section 6044(a) of the Deficit Reduction Act of 2005.

TITLE IX—MISCELLANEOUS

SEC. 901. MEDICARE PAYMENT ADVISORY COMMISSION STATUS.

Section 1805(a) of the Social Security Act (42 U.S.C. 1395b–6(a)) is amended by inserting ''as an agency of Congress'' after ''established''.

SEC. 902. REPEAL OF TRIGGER PROVISION.

Subtitle A of title VIII of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) is repealed and the provisions of law amended by such subtitle are restored as if such subtitle had never been enacted.

SEC. 903. REPEAL OF COMPARATIVE COST ADJUSTMENT (CCA) PROGRAM.

Section 1860C–1 of the Social Security Act (42 U.S.C. 1395w–29), as added by section 241(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173), is repealed.

SEC. 904. COMPARATIVE EFFECTIVENESS RESEARCH.

(a) IN GENERAL.—Part A of title XVIII of the Social Security Act is amended by adding at the end the following new section:

''COMPARATIVE EFFECTIVENESS RESEARCH

''SEC. 1822. (a) CENTER FOR COMPARATIVE EFFECTIVENESS RESEARCH ESTABLISHED.—

''(1) IN GENERAL.—The Secretary shall establish within the Agency of Healthcare Research and Quality a Center for Comparative Effectiveness Research (in this section referred to as the 'Center') to conduct, support, and synthesize research (including research conducted or supported under section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically.

''(2) DUTIES.—The Center shall—

''(A) conduct, support, and synthesize research relevant to the comparative clinical effectiveness of the full spectrum of health care treatments, including pharmaceuticals, medical devices, medical and surgical procedures, and other medical interventions;

''(B) conduct and support systematic reviews of clinical research, including original research conducted subsequent to the date of the enactment of this section;

''(C) use methodologies such as randomized controlled clinical trials as well as other various types of clinical research, such as observational studies;

''(D) submit to the Comparative Effectiveness Research Commission, the Secretary, and Congress appropriate relevant reports described in subsection (d)(2);

''(E) encourage, as appropriate, the development and use of clinical registries and the development of clinical effectiveness research data networks from electronic health records, post marketing drug and medical device surveillance efforts, and other forms of electronic health data; and

''(F) not later than 180 days after the date of the enactment of this section, develop methodological standards to be used when conducting studies of comparative clinical effectiveness and value (and procedures for use of such standards) in order to help ensure accurate and effective comparisons and update such standards at least biennially.

''(b) OVERSIGHT BY COMPARATIVE EFFECTIVENESS RESEARCH COMMISSION.—

''(1) IN GENERAL.—The Secretary shall establish an independent Comparative Effectiveness Research Commission (in this section referred to as the 'Commission') to oversee and evaluate the activities carried out by the Center under subsection (a) to ensure such activities result in highly credible research and information resulting from such research.

''(2) DUTIES.—The Commission shall—

''(A) determine national priorities for research described in subsection (a) and in making such determinations consult with patients and health care providers and payers;

''(B) monitor the appropriateness of use of the CERTF described in subsection (f) with respect to the timely production of comparative effectiveness research determined to be a national priority under subparagraph (A);

''(C) identify highly credible research methods and standards of evidence for such research to be considered by the Center;

''(D) review and approve the methodological standards (and updates to such standards) developed by the Center under subsection (a)(2)(F);

''(E) enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences shall conduct an evaluation and report on standards of evidence for such research;

''(F) support forums to increase stakeholder awareness and permit stakeholder feedback on the efforts of the Agency of Healthcare Research and Quality to advance methods and standards that promote highly credible research;

''(G) make recommendations for public data access policies of the Center that would allow for access of such data by the public while ensuring the information produced from research involved is timely and credible;

''(H) appoint a clinical perspective advisory panel for each research priority determined under subparagraph (A), which shall frame the specific research inquiry to be examined with respect to such priority to ensure that the information produced from such research is clinically relevant to decisions made by clinicians and patients at the point of care;

''(I) make recommendations for the priority for periodic reviews of previous comparative effectiveness research and studies conducted by the Center under subsection (a);

''(J) routinely review processes of the Center with respect to such research to confirm that the information produced by such research is objective, credible, consistent with standards of evidence established under this section, and developed through a transparent process that includes consultations with appropriate stakeholders;

''(K) at least annually, provide guidance or recommendations to health care providers and consumers for the use of information on the comparative effectiveness of health care services by consumers, providers (as defined for purposes of regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996) and public and private purchasers;

''(L) make recommendations for a strategy to disseminate the findings of research conducted and supported under this section that enables clinicians to improve performance, consumers to make more informed health care decisions, and payers to set medical policies that improve quality and value;

''(M) provide for the public disclosure of relevant reports described in subsection (d)(2); and

''(N) submit to Congress an annual report on the progress of the Center in achieving national priorities determined under subparagraph (A) for the provision of credible comparative effectiveness information produced from such research to all interested parties.

''(3) COMPOSITION OF COMMISSION.—

''(A) IN GENERAL.—The members of the Commission shall consist of—

''(i) the Director of the Agency for Healthcare Research and Quality;

''(ii) the Chief Medical Officer of the Centers for Medicare & Medicaid Services; and

''(iii) up to 15 additional members who shall represent broad constituencies of stakeholders including clinicians, patients, researchers, third-party payers, consumers of Federal and State beneficiary programs. .

''(B) QUALIFICATIONS.—

''(i) DIVERSE REPRESENTATION OF PERSPECTIVES.—The members of the Commission shall represent a broad range of perspectives and shall collectively have experience in the following areas:

''(I) Epidemiology.

''(II) Health services research.

''(III) Bioethics.

''(IV) Decision sciences.

''(V) Economics.

''(ii) DIVERSE REPRESENTATION OF HEALTH CARE COMMUNITY.—At least one member shall represent each of the following health care communities:

''(I) Consumers.

''(II) Practicing physicians, including surgeons.

''(III) Employers.

''(IV) Public payers.

''(V) Insurance plans.

''(VI) Clinical researchers who conduct research on behalf of pharmaceutical or device manufacturers.

''(4) APPOINTMENT.—The Comptroller General of the United States, in consultation with the chairs of the committees of jurisdiction of the House of Representatives and

the Senate, shall appoint the members of the Commission.

''(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General of the United States shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General may designate another member for the remainder of that member's term.

''(6) TERMS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), each member of the Commission shall be appointed for a term of 4 years.

''(B) TERMS OF INITIAL APPOINTEES.—Of the members first appointed—

''(i) 10 shall be appointed for a term of 4 years; and

''(ii) 9 shall be appointed for a term of 3 years.

''(7) COORDINATION.—To enhance effectiveness and coordination, the Comptroller General is encouraged, to the greatest extent possible, to seek coordination between the Commission and the National Advisory Council of the Agency for Healthcare Research and Quality.

''(8) CONFLICTS OF INTEREST.—In appointing the members of the Commission or a clinical perspective advisory panel described in paragraph (2)(G), the Comptroller General of the United States or the Commission, respectively, shall take into consideration any financial conflicts of interest.

''(9) COMPENSATION.—While serving on the business of the Commission (including traveltime), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Director of the Commission.

''(10) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

''(11) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Secretary, in consultation with the Comptroller General deems necessary to assure the efficient administration of the Commission, the Commission may—

''(A) employ and fix the compensation of an Executive Director (subject to the approval of the Secretary, in consultation with the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(B) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

''(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(D) make advance, progress, and other payments which relate to the work of the Commission;

''(E) provide transportation and subsistence for persons serving without compensation; and

''(F) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

''(12) POWERS.—

''(A) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Executive Director, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

''(B) DATA COLLECTION.—In order to carry out its functions, the Commission shall—

''(i) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

''(ii) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate, and

''(iii) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

''(C) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data of the Commission, immediately upon request.

''(D) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the Comptroller General.

''(c) RESEARCH REQUIREMENTS.—Any research conducted, supported, or synthesized under this section shall meet the following requirements:

''(1) ENSURING TRANSPARENCY, CREDIBILITY, AND ACCESS.—

''(A) The establishment of the agenda and conduct of the research shall be insulated from inappropriate political or stakeholder influence.

''(B) Methods of conducting such research shall be scientifically based.

''(C) All aspects of the prioritization of research, conduct of the research, and development of conclusions based on the research shall be transparent to all stakeholders.

''(D) The process and methods for conducting such research shall be publicly documented and available to all stakeholders.

''(E) Throughout the process of such research, the Center shall provide opportunities for all stakeholders involved to review and provide comment on the methods and findings of such research.

''(2) USE OF CLINICAL PERSPECTIVE ADVISORY PANELS.—The research shall meet a national research priority determined under subsection (b)(2)(A) and shall examine the specific research inquiry framed by the clinical perspective advisory panel for the national research priority.

''(3) STAKEHOLDER INPUT.—The priorities of the research, the research, and the dissemination of the research shall involve the consultation of patients, health care providers, and health care consumer representatives through transparent mechanisms recommended by the Commission.

''(d) PUBLIC ACCESS TO COMPARATIVE EFFECTIVENESS INFORMATION.—

''(1) IN GENERAL.—Not later than 90 days after receipt by the Center or Commission, as applicable, of a relevant report described in paragraph (2) made by the Center, Commission, or clinical perspective advisory panel under this section, appropriate information contained in such report shall be posted on the official public Internet site of the Center and of the Commission, as applicable.

''(2) RELEVANT REPORTS DESCRIBED.—For purposes of this section, a relevant report is each of the following submitted by a grantee or contractor of the Center:

''(A) An interim progress report.

''(B) A draft final comparative effectiveness review.

''(C) A final progress report on new research submitted for publication by a peer review journal.

''(D) Stakeholder comments.

''(E) A final report.

''(3) ACCESS BY CONGRESS AND THE COMMISSION TO THE CENTER'S INFORMATION.—Congress and the Commission shall each have unrestricted access to all deliberations, records, and nonproprietary data of the Center, immediately upon request.

''(e) DISSEMINATION AND INCORPORATION OF COMPARATIVE EFFECTIVENESS INFORMATION.—

''(1) DISSEMINATION.—The Center shall provide for the dissemination of appropriate findings produced by research supported, conducted, or synthesized under this section to health care providers, patients, vendors of health information technology focused on clinical decision support, appropriate professional associations, and Federal and private health plans.

''(2) INCORPORATION.—The Center shall assist users of health information technology focused on clinical decision support to promote the timely incorporation of the findings described in paragraph (1) into clinical practices and to promote the ease of use of such incorporation.

''(f) REPORTS TO CONGRESS.—

''(1) ANNUAL REPORTS.—Beginning not later than one year after the date of the enactment of this section, the Director of the Agency of Healthcare Research and Quality and the Center for Comparative Effectiveness Research shall submit to Congress an annual report on the activities of the Center and the Commission, as well as the research, conducted under this section.

''(2) RECOMMENDATION FOR FAIR SHARE PER CAPITA AMOUNT FOR ALL-PAYER FINANCING.—Beginning not later than December 31, 2009, the Secretary shall submit to Congress an annual recommendation for a fair share per capita amount described in subsection (c)(1) of section 9511 of the Internal Revenue Code of 1986 for purposes of funding the CERTF under such section.

''(3) ANALYSIS AND REVIEW.—Not later than December 31, 2011, the Secretary, in consultation with the Commission, shall submit to Congress a report on all activities conducted or supported under this section as of such date. Such report shall include an evaluation of the return on investment resulting from such activities, the overall costs of such activities, and an analysis of the backlog of any research proposals approved by the Commission but not funded. Such report shall also address whether Congress should expand the responsibilities of the Center and of the Commission to include studies of the effectiveness of various aspects of the health care delivery system, including health plans and delivery models, such as health plan features, benefit designs and performance, and the ways in which health services are organized, managed, and delivered.

''(g) COORDINATING COUNCIL FOR HEALTH SERVICES RESEARCH.—

''(1) ESTABLISHMENT.—The Secretary shall establish a permanent council (in this section referred to as the 'Council') for the purpose of—

''(A) assisting the offices and agencies of the Department of Health and Human Services, the Department of Veterans Affairs, the Department of Defense, and any other Federal department or agency to coordinate the conduct or support of health services research; and

''(B) advising the President and Congress on—

''(i) the national health services research agenda;

''(ii) strategies with respect to infrastructure needs of health services research; and

''(iii) appropriate organizational expenditures in health services research by relevant Federal departments and agencies.

''(2) MEMBERSHIP.—

''(A) NUMBER AND APPOINTMENT.—The Council shall be composed of 20 members. One member shall be the Director of the Agency for Healthcare Research and Quality. The Director shall appoint the other members not later than 30 days after the enactment of this Act.

''(B) TERMS.—

''(i) IN GENERAL.—Except as provided in clause (ii), each member of the Council shall be appointed for a term of 4 years.

''(ii) TERMS OF INITIAL APPOINTEES.—Of the members first appointed—

''(I) 8 shall be appointed for a term of 4 years; and

''(II) 7 shall be appointed for a term of 3 years.

''(iii) VACANCIES.—Any vacancies shall not affect the power and duties of the Council and shall be filled in the same manner as the original appointment.

''(C) QUALIFICATIONS.—

''(i) IN GENERAL.—The members of the Council shall include one senior official from each of the following agencies:

''(I) The Veterans Health Administration.

''(II) The Department of Defense Military Health Care System.

''(III) The Centers for Disease Control and Prevention.

''(IV) The National Center for Health Statistics.

''(V) The National Institutes of Health.

''(VI) The Center for Medicare & Medicaid Services.

''(VII) The Federal Employees Health Benefits Program.

''(ii) NATIONAL, PHILANTHROPIC FOUNDATIONS.—The members of the Council shall include 4 senior leaders from major national, philanthropic foundations that fund and use health services research.

''(iii) STAKEHOLDERS.—The remaining members of the Council shall be representatives of other stakeholders in health services research, including private purchasers, health plans, hospitals and other health facilities, and health consumer groups.

''(3) ANNUAL REPORT.—The Council shall submit to Congress an annual report on the progress of the implementation of the national health services research agenda.

''(h) FUNDING OF COMPARATIVE EFFECTIVENESS RESEARCH.—For fiscal year 2009 and each subsequent fiscal year, amounts in the Comparative Effectiveness Research Trust Fund (referred to in this section as the 'CERTF') under section 9511 of the Internal Revenue Code of 1986 shall be available to the Secretary to carry out this section.''.

(b) COMPARATIVE EFFECTIVENESS RESEARCH TRUST FUND; FINANCING FOR TRUST FUND.—

(1) ESTABLISHMENT OF TRUST FUND.—

(A) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to trust fund code) is amended by adding at the end the following new section:

''SEC. 9511. HEALTH CARE COMPARATIVE EFFECTIVENESS RESEARCH TRUST FUND.

''(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Health Care Comparative Effectiveness Research Trust Fund' (hereinafter in this section referred to as the 'CERTF'), consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section and section 9602(b).

''(b) TRANSFERS TO FUND.—There are hereby appropriated to the Trust Fund the following:

''(1) For fiscal year 2008, $90,000,000.

''(2) For fiscal year 2009, $100,000,000.

''(3) For fiscal year 2010, $110,000,000.

''(4) For each fiscal year beginning with fiscal year 2011—

''(A) an amount equivalent to the net revenues received in the Treasury from the fees imposed under subchapter B of chapter 34 (relating to fees on health insurance and self-insured plans) for such fiscal year; and

''(B) subject to subsection (c)(2), amounts determined by the Secretary of Health and Human Services to be equivalent to the fair share per capita amount computed under subsection (c)(1) for the fiscal year multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of title XVIII of the Social Security Act during such fiscal year.

The amounts appropriated under paragraphs (1), (2), (3), and (4)(B) shall be transferred from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (established under section 1841 of such Act), and from the Medicare Prescription Drug Account within such Trust Fund, in proportion (as estimated by the Secretary) to the total expenditures during such fiscal year that are made under title XVIII of such Act from the respective trust fund or account.

''(c) FAIR SHARE PER CAPITA AMOUNT.—

''(1) COMPUTATION.—

''(A) IN GENERAL.—Subject to subparagraph (B), the fair share per capita amount under this paragraph for a fiscal year (beginning with fiscal year 2011) is an amount computed by the Secretary of Health and Human Services for such fiscal year that, when applied under this section and subchapter B of chapter 34 of the Internal Revenue Code of 1986, will result in revenues to the CERTF of $375,000,000 for the fiscal year.

''(B) ALTERNATIVE COMPUTATION.—

''(i) IN GENERAL.—If the Secretary is unable to compute the fair share per capita amount under subparagraph (A) for a fiscal year, the fair share per capita amount under this paragraph for the fiscal year shall be the default amount determined under clause (ii) for the fiscal year.

''(ii) DEFAULT AMOUNT.—The default amount under this clause for—

''(I) fiscal year 2011 is equal to $2; or

''(II) a subsequent year is equal to the default amount under this clause for the preceeding fiscal year increased by the annual percentage increase in the medical care component of the consumer price index (United States city average) for the 12-month period ending with April of the preceding fiscal year.

Any amount determined under subclause (II) shall be rounded to the nearest penny.

''(2) LIMITATION ON MEDICARE FUNDING.—In no case shall the amount transferred under subsection (b)(4)(B) for any fiscal year exceed $90,000,000.

''(d) EXPENDITURES FROM FUND.—

''(1) IN GENERAL.—Subject to paragraph (2), amounts in the CERTF are available to the Secretary of Health and Human Services for carrying out section 1822 of the Social Security Act.

''(2) ALLOCATION FOR COMMISSION.—The following amounts in the CERTF for a fiscal year shall be available to carry out the activities of the Comparative Effectiveness Research Commission established under section 1822(b) of the Social Security Act for such fiscal year:

''(A) For fiscal year 2008, $7,000,000.

''(B) For fiscal year 2009, $9,000,000.

''(C) For each fiscal year beginning with 2010, $10,000,000.

Nothing in this paragraph shall be construed as preventing additional amounts in the CERTF from being made available to the Comparative Effectiveness Research Commission for such activities.

''(e) NET REVENUES.—For purposes of this section, the term 'net revenues' means the amount estimated by the Secretary based on the excess of—

''(1) the fees received in the Treasury under subchapter B of chapter 34, over

''(2) the decrease in the tax imposed by chapter 1 resulting from the fees imposed by such subchapter.''.

(B) CLERICAL AMENDMENT.—The table of sections for such subchapter A is amended by adding at the end thereof the following new item:

''Sec. 9511. Health Care Comparative Effectiveness Research Trust Fund.''.

(2) FINANCING FOR FUND FROM FEES ON INSURED AND SELF-INSURED HEALTH PLANS.—

(A) GENERAL RULE.—Chapter 34 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subchapter:

''Subchapter B—Insured and Self-Insured Health Plans

''SEC. 4375. HEALTH INSURANCE.

''(a) IMPOSITION OF FEE.—There is hereby imposed on each specified health insurance policy for each policy year a fee equal to the fair share per capita amount determined under section 9511(c)(1) multiplied by the average number of lives covered under the policy.

''(b) LIABILITY FOR FEE.—The fee imposed by subsection (a) shall be paid by the issuer of the policy.

''(c) SPECIFIED HEALTH INSURANCE POLICY.—For purposes of this section—

''(1) IN GENERAL.—Except as otherwise provided in this section, the term 'specified health insurance policy' means any accident or health insurance policy issued with respect to individuals residing in the United States.

''(2) EXEMPTION OF CERTAIN POLICIES.—The term 'specified health insurance policy' does not include any insurance policy if substantially all of the coverage provided under such policy relates to—

''(A) liabilities incurred under workers' compensation laws,

''(B) tort liabilities,

''(C) liabilities relating to ownership or use of property,

''(D) credit insurance,

''(E) medicare supplemental coverage, or

''(F) such other similar liabilities as the Secretary may specify by regulations.

''(3) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS.—

''(A) IN GENERAL.—In the case of any arrangement described in subparagraph (B)—

''(i) such arrangement shall be treated as a specified health insurance policy, and

''(ii) the person referred to in such subparagraph shall be treated as the issuer.

''(B) DESCRIPTION OF ARRANGEMENTS.—An arrangement is described in this subparagraph if under such arrangement fixed payments or premiums are received as consideration for any person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided.

''SEC. 4376. SELF-INSURED HEALTH PLANS.

''(a) IMPOSITION OF FEE.—In the case of any applicable self-insured health plan for each plan year, there is hereby imposed a fee equal to the fair share per capita amount determined under section 9511(c)(1) multiplied by the average number of lives covered under the plan.

''(b) LIABILITY FOR FEE.—

''(1) IN GENERAL.—The fee imposed by subsection (a) shall be paid by the plan sponsor.

''(2) PLAN SPONSOR.—For purposes of paragraph (1) the term 'plan sponsor' means—

''(A) the employer in the case of a plan established or maintained by a single employer,

''(B) the employee organization in the case of a plan established or maintained by an employee organization,

''(C) in the case of—

''(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

''(ii) a multiple employer welfare arrangement, or

''(iii) a voluntary employees' beneficiary association described in section 501(c)(9),

the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, or

''(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

''(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term 'applicable self-insured health plan' means any plan for providing accident or health coverage if—

''(1) any portion of such coverage is provided other than through an insurance policy, and

''(2) such plan is established or maintained—

''(A) by one or more employers for the benefit of their employees or former employees,

''(B) by one or more employee organizations for the benefit of their members or former members,

''(C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees,

''(D) by a voluntary employees' beneficiary association described in section 501(c)(9),

''(E) by any organization described in section 501(c)(6), or

''(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40) of Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

''SEC. 4377. DEFINITIONS AND SPECIAL RULES.

''(a) DEFINITIONS.—For purposes of this subchapter—

''(1) ACCIDENT AND HEALTH COVERAGE.—The term 'accident and health coverage' means any coverage which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4375(c)).

''(2) INSURANCE POLICY.—The term 'insurance policy' means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended.

''(3) UNITED STATES.—The term 'United States' includes any possession of the United States.

''(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

''(1) IN GENERAL.—For purposes of this subchapter—

''(A) the term 'person' includes any governmental entity, and

''(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the fees imposed by this subchapter except as provided in paragraph (2).

''(2) TREATMENT OF EXEMPT GOVERNMENTAL PROGRAMS.—In the case of an exempt governmental program, no fee shall be imposed under section 4375 or section 4376 on any covered life under such program.

''(3) EXEMPT GOVERNMENTAL PROGRAM DEFINED.—For purposes of this subchapter, the term 'exempt governmental program' means—

''(A) any insurance program established under title XVIII of the Social Security Act,

''(B) the medical assistance program established by title XIX or XXI of the Social Security Act,

''(C) any program established by Federal law for providing medical care (other than through insurance policies) to individuals (or the spouses and dependents thereof) by reason of such individuals being—

''(i) members of the Armed Forces of the United States, or

''(ii) veterans, and

''(D) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

''(c) TREATMENT AS TAX.—For purposes of subtitle F, the fees imposed by this subchapter shall be treated as if they were taxes.

''(d) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States.''

(B) CLERICAL AMENDMENT.—Chapter 34 of such Code is amended by striking the chapter heading and inserting the following:

''CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

''SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

''SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

''Subchapter A—Policies Issued By Foreign Insurers''.

(C) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to policies and plans for portions of policy or plan years beginning on or after October 1, 2010.

SEC. 905. IMPLEMENTATION OF HEALTH INFORMATION TECHNOLOGY (IT) UNDER MEDICARE.

(a) IN GENERAL.—Not later than January 1, 2010, the Secretary of Health and Human Services shall submit to Congress a report that includes—

(1) a plan to develop and implement a health information technology (health IT) system for all health care providers under the Medicare program that meets the specifications described in subsection (b); and

(2) an analysis of the impact, feasibility, and costs associated with the use of health information technology in medically underserved communities.

(b) PLAN SPECIFICATION.—The specifications described in this subsection, with respect to a health information technology system described in subsection (a), are the following:

(1) The system protects the privacy and security of individually identifiable health information.

(2) The system maintains and provides permitted access to health information in an electronic format (such as through computerized patient records or a clinical data repository).

(3) The system utilizes interface software that allows for interoperability.

(4) The system includes clinical decision support.

(5) The system incorporates e-prescribing and computerized physician order entry.

(6) The system incorporates patient tracking and reminders.

(7) The system utilizes technology that is open source (if available) or technology that has been developed by the government.

The report shall include an analysis of the financial and administrative resources necessary to develop such system and recommendations regarding the level of subsidies needed for all such health care providers to adopt the system.

SEC. 906. DEVELOPMENT, REPORTING, AND USE OF HEALTH CARE MEASURES.

(a) 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:

''DEVELOPMENT, REPORTING, AND USE OF HEALTH CARE MEASURES

''SEC. 1890. (a) FOSTERING DEVELOPMENT OF HEALTH CARE MEASURES.—The Secretary shall designate, and have in effect an arrangement with, a single organization (such as the National Quality Forum) that meets the requirements described in subsection (c), under which such organization provides the Secretary with advice on, and recommendations with respect to, the key elements and priorities of a national system for establishing health care measures. The arrangement shall be effective beginning no sooner than January 1, 2008, and no later than September 30, 2008.

''(b) DUTIES.—The duties of the organization designated under subsection (a) (in this title referred to as the 'designated organization') shall, in accordance with subsection (d), include—

''(1) establishing and managing an integrated national strategy and process for setting priorities and goals in establishing health care measures;

''(2) coordinating the development and specifications of such measures;

''(3) establishing standards for the development and testing of such measures;

''(4) endorsing national consensus health care measures; and

''(5) advancing the use of electronic health records for automating the collection, aggregation, and transmission of measurement information.

''(c) REQUIREMENTS DESCRIBED.—For purposes of subsection (a), the requirements described in this subsection, with respect to an organization, are the following:

''(1) PRIVATE NONPROFIT.—The organization is a private nonprofit entity governed by a board and an individual designated as president and chief executive officer.

''(2) BOARD MEMBERSHIP.—The members of the board of the organization include representatives of—

''(A) health care providers or groups representing such providers;

''(B) health plans or groups representing health plans;

''(C) groups representing health care consumers;

''(D) health care purchasers and employers or groups representing such purchasers or employers; and

''(E) health care practitioners or groups representing practitioners.

''(3) OTHER MEMBERSHIP REQUIREMENTS.—The membership of the organization is representative of individuals with 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 arrangement described in subsection (a), the organization conducts its business in an open and transparent manner and provides the opportunity for public comment.

''(5) VOLUNTARY CONSENSUS STANDARDS SETTING ORGANIZATION.—The organization 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 organization has at least 7 years experience in establishing national consensus standards.

''(d) REQUIREMENTS FOR EFFECTIVENESS MEASURES.—In carrying out its duties under subsection (b), the designated organization shall ensure the following:

''(1) MEASURES.—The designated organization shall ensure that the measures established or endorsed under subsection (b) are evidence-based, reliable, and valid; and include—

''(A) measures of clinical processes and outcomes, patient experience, efficiency, and equity;

''(B) measures to assess effectiveness, timeliness, patient self-management, patient centeredness, and safety; and

''(C) measures of under use and over use.

''(2) PRIORITIES.—

''(A) IN GENERAL.—The designated organization shall ensure that priority is given to establishing and endorsing—

''(i) measures with the greatest potential impact for improving the effectiveness and efficiency of health care;

''(ii) measures that may be rapidly implemented by group health plans, health insurance issuers, physicians, hospitals, nursing homes, long-term care providers, and other providers;

''(iii) measures which may inform health care decisions made by consumers and patients; and

''(iv) measures that apply to multiple services furnished by different providers during an episode of care.

''(B) ANNUAL REPORT ON PRIORITIES; SECRETARIAL PUBLICATION AND COMMENT.—

''(i) ANNUAL REPORT.—The designated organization shall issue and submit to the Secretary a report by March 31 of each year (beginning with 2009) on the organization's recommendations for priorities and goals in establishing and endorsing health care measures under this section over the next five years.

''(ii) SECRETARIAL REVIEW AND COMMENT.—After receipt of the report under clause (i) for a year, the Secretary shall publish the report in the Federal Register, including any comments of the Secretary on the priorities and goals set forth in the report.

''(3) RISK ADJUSTMENT.—The designated organization, in consultation with health care measure developers and other stakeholders, shall establish procedures to assure that health care measures established and endorsed under this section account for differences in patient health status, patient characteristics, and geographic location, as appropriate.

''(4) MAINTENANCE.—The designated organization, in consultation with owners and developers of health care measures, shall require the owners or developers of such measures to update and enhance such measures, including the development of more accurate and precise specifications, and retire existing outdated measures. Such updating shall occur not more often than once during each 12-month period, except in the case of emergent circumstances requiring a more immediate update to a measure.

''(e) USE OF HEALTH CARE MEASURES; REPORTING.—

''(1) USE OF MEASURES.—For purposes of activities authorized or required under this title, the Secretary shall select from health care measures—

''(A) recommended by multi-stakeholder groups; and

''(B) endorsed by the designated organization under subsection (b)(4).

''(2) REPORTING.—The Secretary shall implement procedures, consistent with generally accepted standards, to enable the Department of Health and Human Services to accept the electronic submission of data for purposes of—

''(A) effectiveness measurement using the health care measures developed pursuant to this section; and

''(B) reporting to the Secretary measures used to make value-based payments under this title.

''(f) CONTRACTS.—The Secretary, acting through the Agency for Healthcare Research and Quality, may contract with organizations to support the development and testing of health care measures meeting the standards established by the designated organization.

''(g) DISSEMINATION OF INFORMATION.—In order to make comparative effectiveness information available to health care consumers, health professionals, public health officials, oversight organizations, researchers, and other appropriate individuals and entities, the Secretary shall work with multi-stakeholder groups to provide for the dissemination of effectiveness information developed pursuant to this title.

''(h) FUNDING.—For purposes of carrying out subsections (a), (b), (c), and (d), including for expenses incurred for the arrangement under subsection (a) with the designated organization, there is payable from the Federal Hospital Insurance Trust Fund (established under section 1817) and the Federal Supplementary Medical Insurance Trust Fund (established under section 1841)—

''(1) for fiscal year 2008, $15,000,000, multiplied by the ratio of the total number of months in the year to the number of months (and portions of months) of such year during which the arrangement under subsection (a) is effective; and

''(2) for each of the fiscal years, 2009 through 2012, $15,000,000.''.

SEC. 907. IMPROVEMENTS TO THE MEDIGAP PROGRAM.

(a) IMPLEMENTATION OF NAIC RECOMMENDATIONS.—The Secretary of Health and Human Services shall provide, under subsections (p)(1)(E) of section 1882 of the Social Security Act (42 U.S.C. 1395s), for implementation of the changes in the NAIC model law and regulations recommended by the National Association of Insurance Commissioners in its Model #651 (''Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act'') on March 11, 2007, as modified to reflect the changes made under this Act. In carrying out the previous sentence, the benefit packages classified as ''K'' and ''L'' shall be eliminated and such NAIC recommendations shall be treated as having been adopted by such Association as of January 1, 2008.

(b) REQUIRED OFFERING OF A RANGE OF POLICIES.—

(1) IN GENERAL.—Subsection (o) of such section is amended by adding at the end the following new paragraph:

''(4) In addition to the requirement of paragraph (2), the issuer of the policy must make available to the individual at least medicare supplemental policies with benefit packages classified as 'C' or 'F'.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to medicare supplemental policies issued on or after January 1, 2008.

(c) REMOVAL OF NEW BENEFIT PACKAGES.—Such section is further amended—

(1) in subsection (o)(1), by striking ''(p), (v), and (w)'' and inserting ''(p) and (v)'';

(2) in subsection (v)(3)(A)(i), by striking ''or a benefit package described in subparagraph (A) or (B) of subsection (w)(2)''; and

(3) in subsection (w)—

(A) by striking ''POLICIES'' and all that follows through ''The Secretary'' and inserting ''POLICIES.—The Secretary'';

(B) by striking the second sentence; and

(C) by striking paragraph (2) .

TITLE X—REVENUES

SEC. 1001. INCREASE IN RATE OF EXCISE TAXES ON TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES.

(a) SMALL CIGARETTES.—Paragraph (1) of section 5701(b) of the Internal Revenue Code of 1986 is amended by striking ''$19.50 per thousand ($17 per thousand on cigarettes removed during 2000 or 2001)'' and inserting ''$42 per thousand''.

(b) LARGE CIGARETTES.—Paragraph (2) of section 5701(b) of such Code is amended by striking ''$40.95 per thousand ($35.70 per thousand on cigarettes removed during 2000 or 2001)'' and inserting ''$88.20 per thousand''.

(c) SMALL CIGARS.—Paragraph (1) of section 5701(a) of such Code is amended by striking ''$1.828 cents per thousand ($1.594 cents per thousand on cigars removed during 2000 or 2001)'' and inserting ''$42 per thousand''.

(d) LARGE CIGARS.—Paragraph (2) of section 5701(a) of such Code is amended—

(1) by striking ''20.719 percent (18.063 percent on cigars removed during 2000 or 2001)'' and inserting ''44.63 percent'', and

(2) by striking ''$48.75 per thousand ($42.50 per thousand on cigars removed during 2000 or 2001)'' and inserting ''$1 per cigar''.

(e) CIGARETTE PAPERS.—Subsection (c) of section 5701 of such Code is amended by striking ''1.22 cents (1.06 cents on cigarette papers removed during 2000 or 2001)'' and inserting ''2.63 cents''.

(f) CIGARETTE TUBES.—Subsection (d) of section 5701 of such Code is amended by striking ''2.44 cents (2.13 cents on cigarette tubes removed during 2000 or 2001)'' and inserting ''5.26 cents''.

(g) SNUFF.—Paragraph (1) of section 5701(e) of such Code is amended by striking ''58.5 cents (51 cents on snuff removed during 2000 or 2001)'' and inserting ''$1.26''.

(h) CHEWING TOBACCO.—Paragraph (2) of section 5701(e) of such Code is amended by striking ''19.5 cents (17 cents on chewing tobacco removed during 2000 or 2001)'' and inserting ''42 cents''.

(i) PIPE TOBACCO.—Subsection (f) of section 5701 of such Code is amended by striking ''$1.0969 cents (95.67 cents on pipe tobacco removed during 2000 or 2001)'' and inserting ''$2.36''.

(j) ROLL-YOUR-OWN TOBACCO.—

(1) IN GENERAL.—Subsection (g) of section 5701 of such Code is amended by striking ''$1.0969 cents (95.67 cents on roll-your-own tobacco removed during 2000 or 2001)'' and inserting ''$7.4667''.

(2) INCLUSION OF CIGAR TOBACCO.—Subsection (o) of section 5702 of such Code is amended by inserting ''or cigars, or for use as wrappers for making cigars'' before the period at the end.

(k) EFFECTIVE DATE.—The amendments made by this section shall apply to articles removed after December 31, 2007.

(l) FLOOR STOCKS TAXES.—

(1) IMPOSITION OF TAX.—On cigarettes manufactured in or imported into the United States which are removed before January 1, 2008, and held on such date for sale by any person, there is hereby imposed a tax in an amount equal to the excess of—

(A) the tax which would be imposed under section 5701 of the Internal Revenue Code of 1986 on the article if the article had been removed on such date, over

(B) the prior tax (if any) imposed under section 5701 of such Code on such article.

(2) AUTHORITY TO EXEMPT CIGARETTES HELD IN VENDING MACHINES.—To the extent provided in regulations prescribed by the Secretary, no tax shall be imposed by paragraph (1) on cigarettes held for retail sale on January 1, 2008, by any person in any vending machine. If the Secretary provides such a benefit with respect to any person, the Secretary may reduce the $500 amount in paragraph (3) with respect to such person.

(3) CREDIT AGAINST TAX.—Each person shall be allowed as a credit against the taxes imposed by paragraph (1) an amount equal to $500. Such credit shall not exceed the amount of taxes imposed by paragraph (1) for which such person is liable.

(4) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) LIABILITY FOR TAX.—A person holding cigarettes on January 1, 2008, to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(C) TIME FOR PAYMENT.—The tax imposed by paragraph (1) shall be paid on or before April 14, 2008.

(5) ARTICLES IN FOREIGN TRADE ZONES.—Notwithstanding the Act of June 18, 1934 (48 Stat. 998, 19 U.S.C. 81a) and any other provision of law, any article which is located in a foreign trade zone on January 1, 2008, shall be subject to the tax imposed by paragraph (1) if—

(A) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act, or

(B) such article is held on such date under the supervision of a customs officer pursuant to the 2d proviso of such section 3(a).

(6) DEFINITIONS.—For purposes of this subsection—

(A) IN GENERAL.—Terms used in this subsection which are also used in section 5702 of the Internal Revenue Code of 1986 shall have the respective meanings such terms have in such section.

(B) SECRETARY.—The term ''Secretary'' means the Secretary of the Treasury or the Secretary's delegate.

(7) CONTROLLED GROUPS.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this subsection.

(8) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with respect to the taxes imposed by section 5701 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply to the floor stocks taxes imposed by paragraph (1), to the same extent as if such taxes were imposed by such section 5701. The Secretary may treat any person who bore the ultimate burden of the tax imposed by paragraph (1) as the person to whom a credit or refund under such provisions may be allowed or made.

SEC. 1002. EXEMPTION FOR EMERGENCY MEDICAL SERVICES TRANSPORTATION.

(a) IN GENERAL.—Subsection (l) of section 4041 of the Internal Revenue Code of 1986 is amended to read as follows:

''(1) EXEMPTION FOR CERTAIN USES.—

''(1) CERTAIN AIRCRAFT.—No tax shall be imposed under this section on any liquid sold for use in, or used in, a helicopter or a fixed-wing aircraft for purposes of providing transportation with respect to which the requirements of subsection (f) or (g) of section 4261 are met.

''(2) EMERGENCY MEDICAL SERVICES.—No tax shall be imposed under this section on any liquid sold for use in, or used in, any ambulance for purposes of providing transportation for emergency medical services. The preceding sentence shall not apply to any liquid used after December 31, 2009.''.

(b) FUELS NOT USED FOR TAXABLE PURPOSES.—Section 6427 of such Code is amended by inserting after subsection (e) the following new subsection:

''(f) USE TO PROVIDE EMERGENCY MEDICAL SERVICES.—Except as provided in subsection (k), if any fuel on which tax was imposed by section 4081 or 4041 is used in an ambulance for a purpose described in section 4041(l)(2), the Secretary shall pay (without interest) to the ultimate purchaser of such fuel an amount equal to the aggregate amount of the tax imposed on such fuel. The preceding sentence shall not apply to any liquid used after December 31, 2009.''.

(c) TIME FOR FILING CLAIMS; PERIOD COVERED.—Paragraphs (1) and (2)(A) of section 6427(i) of such Code are each amended by inserting ''(f),'' after ''(d),''.

(d) CONFORMING AMENDMENT.—Section 6427(d) of such Code is amended by striking ''4041(l)'' and inserting ''4041(l)(1)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to fuel used in transportation provided in quarters beginning after the date of the enactment of this Act.

The SPEAKER pro tempore (Mr. TIERNEY). Pursuant to House Resolution 594, the amendment in the nature of a substitute printed in the bill, modified by the amendment printed in House Report 110–285, is adopted and the bill, as amended, is considered read.

The text of the bill, as amended, is as follows:

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 ''Children's Health and Medicare Protection Act of 2007''.

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

TITLE I—CHILDREN'S HEALTH INSURANCE PROGRAM

SEC. 100. PURPOSE.

It is the purpose of this title to provide dependable and stable funding for children's

health insurance under titles XXI and XIX of the Social Security Act in order to enroll all six million uninsured children who are eligible, but not enrolled, for coverage today through such titles.

Subtitle A—Funding

SEC. 101. ESTABLISHMENT OF NEW BASE CHIP ALLOTMENTS.

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

(1) in subsection (a)—

(A) in paragraph (9), by striking ''and'' at the end;

(B) in paragraph (10), by striking the period at the end and inserting ''; and''; and

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

''(11) for fiscal year 2008 and each succeeding fiscal year, the sum of the State allotments provided under subsection (i) for such fiscal year.''; and

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

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

''(i) ALLOTMENTS FOR STATES AND TERRITORIES BEGINNING WITH FISCAL YEAR 2008.—

''(1) GENERAL ALLOTMENT COMPUTATION.—Subject to the succeeding provisions of this subsection, the Secretary shall compute a State allotment for each State for each fiscal year as follows:

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

''(i) the State projection (in its submission on forms CMS–21B and CMS–37 for May 2007) of Federal payments to the State under this title for such fiscal year, except that, in the case of a State that has enacted legislation to modify its State child health plan during 2007, the State may substitute its projection in its submission on forms CMS–21B and CMS–37 for August 2007, instead of such forms for May 2007; or

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

''(B) INFLATION UPDATE FOR FISCAL YEAR 2009 AND EACH SECOND SUCCEEDING FISCAL YEAR.—For fiscal year 2009 and each second succeeding fiscal year, the allotment of a State is equal to the amount of the State allotment under this paragraph for the previous fiscal year multiplied by the allotment increase factor under paragraph (2) for the fiscal year involved.

''(C) REBASING IN FISCAL YEAR 2010 AND EACH SECOND SUCCEEDING FISCAL YEAR.—For fiscal year 2010 and each second succeeding fiscal year, the allotment of a State is equal to the Federal payments to the State that are attributable to (and countable towards) the total amount of allotments available under this section to the State (including allotments made available under paragraph (3) as well as amounts redistributed to the State) in the previous fiscal year multiplied by the allotment increase factor under paragraph (2) for the fiscal year involved.

''(D) SPECIAL RULES FOR TERRITORIES.—Notwithstanding the previous subparagraphs, the allotment for a State that is not one of the 50 States or the District of Columbia for fiscal year 2008 and for a succeeding fiscal year is equal to the Federal payments provided to the State under this title for the previous fiscal year multiplied by the allotment increase factor under paragraph (2) for the fiscal year involved (but determined by applying under paragraph (2)(B) as if the reference to 'in the State' were a reference to 'in the United States').

''(2) ALLOTMENT INCREASE FACTOR.—The allotment increase factor under this paragraph for a fiscal year is equal to the product of the following:

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

''(B) CHILD POPULATION GROWTH FACTOR.—1 plus the percentage increase (if any) in the population of children under 19 years of age in the State from July 1 in the previous fiscal year to July 1 in the fiscal year involved, as determined by the Secretary based on the most recent published estimates of the Bureau of the Census before the beginning of the fiscal year involved, plus 1 percentage point.

''(3) PERFORMANCE-BASED SHORTFALL ADJUSTMENT.—

''(A) IN GENERAL.—If a State's expenditures under this title in a fiscal year (beginning with fiscal year 2008) exceed the total amount of allotments available under this section to the State in the fiscal year (determined without regard to any redistribution it receives under subsection (f) that is available for expenditure during such fiscal year, but including any carryover from a previous fiscal year) and if the average monthly unduplicated number of children enrolled under the State plan under this title (including children receiving health care coverage through funds under this title pursuant to a waiver under section 1115) during such fiscal year exceeds its target average number of such enrollees (as determined under subparagraph (B)) for that fiscal year, the allotment under this section for the State for the subsequent fiscal year (or, pursuant to subparagraph (F), for the fiscal year involved) shall be increased by the product of—

''(i) the amount by which such average monthly caseload exceeds such target number of enrollees; and

''(ii) the projected per capita expenditures under the State child health plan (as determined under subparagraph (C) for the original fiscal year involved), multiplied by the enhanced FMAP (as defined in section 2105(b)) for the State and fiscal year involved.

''(B) TARGET AVERAGE NUMBER OF CHILD ENROLLEES.—In this subsection, the target average number of child enrollees for a State—

''(i) for fiscal year 2008 is equal to the monthly average unduplicated number of children enrolled in the State child health plan under this title (including such children receiving health care coverage through funds under this title pursuant to a waiver under section 1115) during fiscal year 2007 increased by the population growth for children in that State for the year ending on June 30, 2006 (as estimated by the Bureau of the Census) plus 1 percentage point; or

''(ii) for a subsequent fiscal year is equal to the target average number of child enrollees for the State for the previous fiscal year increased by the population growth for children in that State for the year ending on June 30 before the beginning of the fiscal year (as estimated by the Bureau of the Census) plus 1 percentage point.

''(C) PROJECTED PER CAPITA EXPENDITURES.—For purposes of subparagraph (A)(ii), the projected per capita expenditures under a State child health plan—

''(i) for fiscal year 2008 is equal to the average per capita expenditures (including both State and Federal financial participation) under such plan for the targeted low-income children counted in the average monthly caseload for purposes of this paragraph during fiscal year 2007, increased by the annual percentage increase in the per capita amount of National Health Expenditures (as estimated by the Secretary) for 2008; or

''(ii) for a subsequent fiscal year is equal to the projected per capita expenditures under such plan for the previous fiscal year (as determined under clause (i) or this clause) increased by the annual percentage increase in the per capita amount of National Health Expenditures (as estimated by the Secretary) for the year in which such subsequent fiscal year ends.

''(D) AVAILABILITY.—Notwithstanding subsection (e), an increase in allotment under this paragraph shall only be available for expenditure during the fiscal year in which it is provided.

''(E) NO REDISTRIBUTION OF PERFORMANCE-BASED SHORTFALL ADJUSTMENT.—In no case shall any increase in allotment under this paragraph for a State be subject to redistribution to other States.

''(F) INTERIM ALLOTMENT ADJUSTMENT.—The Secretary shall develop a process to administer the performance-based shortfall adjustment in a manner so it is applied to (and before the end of) the fiscal year (rather than the subsequent fiscal year) involved for a State that the Secretary estimates will be in shortfall and will exceed its enrollment target for that fiscal year.

''(G) PERIODIC AUDITING.—The Comptroller General of the United States shall periodically audit the accuracy of data used in the computation of allotment adjustments under this paragraph. Based on such audits, the Comptroller General shall make such recommendations to the Congress and the Secretary as the Comptroller General deems appropriate.

''(4) CONTINUED REPORTING.—For purposes of paragraph (3) and subsection (f), the State shall submit to the Secretary the State's projected Federal expenditures, even if the amount of such expenditures exceeds the total amount of allotments available to the State in such fiscal year.''.

SEC. 102. 2-YEAR INITIAL AVAILABILITY OF CHIP ALLOTMENTS.

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

''(e) AVAILABILITY OF AMOUNTS ALLOTTED.—

''(1) IN GENERAL.—Except as provided in paragraph (2) and subsection (i)(3)(D), amounts allotted to a State pursuant to this section—

''(A) for each of fiscal years 1998 through 2007, shall remain available for expenditure by the State through the end of the second succeeding fiscal year; and

''(B) for fiscal year 2008 and each fiscal year thereafter, shall remain available for expenditure by the State through the end of the succeeding fiscal year.

''(2) AVAILABILITY OF AMOUNTS REDISTRIBUTED.—Amounts redistributed to a State under subsection (f) shall be available for expenditure by the State through the end of the fiscal year in which they are redistributed, except that funds so redistributed to a State that are not expended by the end of such fiscal year shall remain available after the end of such fiscal year and shall be available in the following fiscal year for subsequent redistribution under such subsection.''.

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

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

(1) by striking ''The Secretary'' and inserting the following:

''(1) IN GENERAL.—The Secretary'';

(2) by striking ''States that have fully expended the amount of their allotments under this section.'' and inserting ''States that the Secretary determines with respect to the fiscal year for which unused allotments are available for redistribution under this subsection, are shortfall States described in paragraph (2) for such fiscal year, but not to exceed the amount of the shortfall described in paragraph (2)(A) for each such State (as may be adjusted under paragraph (2)(C)). The amount of allotments not expended or redistributed under the previous sentence shall remain available for redistribution in the succeeding fiscal year.''; and

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

''(2) SHORTFALL STATES DESCRIBED.—

''(A) IN GENERAL.—For purposes of paragraph (1), with respect to a fiscal year, a shortfall State described in this subparagraph is a State

with a State child health plan approved under this title for which the Secretary estimates on the basis of the most recent data available to the Secretary, that the projected expenditures under such plan for the State for the fiscal year will exceed the sum of—

''(i) the amount of the State's allotments for any preceding fiscal years that remains available for expenditure and that will not be expended by the end of the immediately preceding fiscal year;

''(ii) the amount (if any) of the performance based adjustment under subsection (i)(3)(A); and

''(iii) the amount of the State's allotment for the fiscal year.

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

''(C) RETROSPECTIVE ADJUSTMENT.—The Secretary may adjust the estimates and determinations made under paragraph (1) and this paragraph with respect to a fiscal year as necessary on the basis of the amounts reported by States not later than November 30 of the succeeding fiscal year, as approved by the Secretary.''.

SEC. 104. EXTENSION OF OPTION FOR QUALIFYING STATES.

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

Subtitle B—Improving Enrollment and Retention of Eligible Children

SEC. 111. CHIP PERFORMANCE BONUS PAYMENT TO OFFSET ADDITIONAL ENROLLMENT COSTS RESULTING FROM ENROLLMENT AND RETENTION EFFORTS.

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

(b) GAO STUDY.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study on the effectiveness of the performance bonus payment program under the amendment made by subsection (a) on the enrollment and retention of eligible children under the Medicaid and CHIP programs and in reducing the rate of uninsurance among such children.

(2) REPORT.—Not later than January 1, 2013, the Comptroller General shall submit a report to Congress on such study and shall include in such report such recommendations for extending or modifying such program as the Comptroller General determines appropriate.

''(3) PERFORMANCE BONUS PAYMENT TO OFFSET ADDITIONAL MEDICAID AND CHIP CHILD ENROLLMENT COSTS RESULTING FROM ENROLLMENT AND RETENTION EFFORTS.—

''(A) IN GENERAL.—In addition to the payments made under paragraph (1), for each fiscal year (beginning with fiscal year 2008 and ending with fiscal year 2013) the Secretary shall pay to each State that meets the condition under paragraph (4) for the fiscal year, an amount equal to the amount described in subparagraph (B) for the State and fiscal year. The payment under this paragraph shall be made, to a State for a fiscal year, as a single payment not later than the last day of the first calendar quarter of the following fiscal year.

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

''(i) FOR ABOVE BASELINE MEDICAID CHILD ENROLLMENT COSTS.—

''(I) FIRST TIER ABOVE BASELINE MEDICAID ENROLLEES.—An amount equal to the number of first tier above baseline child enrollees (as determined under subparagraph (C)(i)) under title XIX for the State and fiscal year multiplied by 35 percent of the projected per capita State Medicaid expenditures (as determined under subparagraph (D)(i)) for the State and fiscal year under title XIX.

''(II) SECOND TIER ABOVE BASELINE MEDICAID ENROLLEES .—An amount equal to the number of second tier above baseline child enrollees (as determined under subparagraph (C)(ii)) under title XIX for the State and fiscal year multiplied by 90 percent of the projected per capita State Medicaid expenditures (as determined under subparagraph (D)(i)) for the State and fiscal year under title XIX.

''(ii) FOR ABOVE BASELINE CHIP ENROLLMENT COSTS.—

''(I) FIRST TIER ABOVE BASELINE CHIP ENROLLEES.—An amount equal to the number of first tier above baseline child enrollees under this title (as determined under subparagraph (C)(i)) for the State and fiscal year multiplied by 5 percent of the projected per capita State CHIP expenditures (as determined under subparagraph (D)(ii)) for the State and fiscal year under this title.

''(II) SECOND TIER ABOVE BASELINE CHIP ENROLLEES.—An amount equal to the number of second tier above baseline child enrollees under this title (as determined under subparagraph (C)(ii)) for the State and fiscal year multiplied by 75 percent of the projected per capita State CHIP expenditures (as determined under subparagraph (D)(ii)) for the State and fiscal year under this title.

''(C) NUMBER OF FIRST AND SECOND TIER ABOVE BASELINE CHILD ENROLLEES; BASELINE NUMBER OF CHILD ENROLLEES.—For purposes of this paragraph:

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

''(I) the monthly average unduplicated number of qualifying children (as defined in subparagraph (E)) enrolled during the fiscal year under the State child health plan under this title or under the State plan under title XIX, respectively; exceeds

''(II) the baseline number of enrollees described in clause (iii) for the State and fiscal year under this title or title XIX, respectively;

but not to exceed 3 percent (in the case of title XIX) or 7.5 percent (in the case of this title) of the baseline number of enrollees described in subclause (II).

''(ii) SECOND TIER ABOVE BASELINE CHILD ENROLLEES.—The number of second tier above baseline child enrollees for a State for a fiscal year under this title or title XIX is equal to the number (if any, as determined by the Secretary) by which—

''(I) the monthly average unduplicated number of qualifying children (as defined in subparagraph (E)) enrolled during the fiscal year under this title or under title XIX, respectively, as described in clause (i)(I); exceeds

''(II) the sum of the baseline number of child enrollees described in clause (iii) for the State and fiscal year under this title or title XIX, respectively, as described in clause (i)(II), and the maximum number of first tier above baseline child enrollees for the State and fiscal year under this title or title XIX, respectively, as determined under clause (i).

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

''(I) for fiscal year 2008 is equal to the monthly average unduplicated number of qualifying children enrolled in the State child health plan under this title or in the State plan under title XIX, respectively, during fiscal year 2007 increased by the population growth for children in that State for the year ending on June 30, 2006 (as estimated by the Bureau of the Census) plus 1 percentage point; or

''(II) for a subsequent fiscal year is equal to the baseline number of child enrollees for the State for the previous fiscal year under this title or title XIX, respectively, increased by the population growth for children in that State for the year ending on June 30 before the beginning of the fiscal year (as estimated by the Bureau of the Census) plus 1 percentage point.

''(D) PROJECTED PER CAPITA STATE EXPENDITURES.—For purposes of subparagraph (B)—

''(i) PROJECTED PER CAPITA STATE MEDICAID EXPENDITURES.—The projected per capita State Medicaid expenditures for a State and fiscal year under title XIX is equal to the average per capita expenditures (including both State and Federal financial participation) for children under the State plan under such title, including under waivers but not including such children eligible for assistance by virtue of the receipt of benefits under title XVI, for the most recent fiscal year for which actual data are available (as determined by the Secretary), increased (for each subsequent fiscal year up to and including the fiscal year involved) by the annual percentage increase in per capita amount of National Health Expenditures (as estimated by the Secretary) for the calendar year in which the respective subsequent fiscal year ends and multiplied by a State matching percentage equal to 100 percent minus the Federal medical assistance percentage (as defined in section 1905(b)) for the fiscal year involved.

''(ii) PROJECTED PER CAPITA STATE CHIP EXPENDITURES.—The projected per capita State CHIP expenditures for a State and fiscal year under this title is equal to the average per capita expenditures (including both State and Federal financial participation) for children under the State child health plan under this title, including under waivers, for the most recent fiscal year for which actual data are available (as determined by the Secretary), increased (for each subsequent fiscal year up to and including the fiscal year involved) by the annual percentage increase in per capita amount of National Health Expenditures (as estimated by the Secretary) for the calendar year in which the respective subsequent fiscal year ends and multiplied by a State matching percentage equal to 100 percent minus the enhanced FMAP (as defined in section 2105(b)) for the fiscal year involved.

''(E) QUALIFYING CHILDREN DEFINED.—For purposes of this subsection, the term 'qualifying children' means, with respect to this title or title XIX, children who meet the eligibility criteria (including income, categorical eligibility, age, and immigration status criteria) in effect as of July 1, 2007, for enrollment under this title or title XIX, respectively, taking into account crtieria applied as of such date under this title or title XIX, respectively, pursuant to a waiver under section 1115.

''(4) ENROLLMENT AND RETENTION PROVISIONS FOR CHILDREN.— For purposes of paragraph (3)(A), a State meets the condition of this paragraph for a fiscal year if it is implementing at least 4 of the following enrollment and retention provisions (treating each subparagraph as a separate enrollment and retention provision) throughout the entire fiscal year:

''(A) CONTINUOUS ELIGIBILITY.—The State has elected the option of continuous eligibility for a full 12 months for all children described in section 1902(e)(12) under title XIX under 19 years of age, as well as applying such policy under its State child health plan under this title.

''(B) LIBERALIZATION OF ASSET REQUIREMENTS.—The State meets the requirement specified in either of the following clauses:

''(i) ELIMINATION OF ASSET TEST.—The State does not apply any asset or resource test for eligibility for children under title XIX or this title.

''(ii) ADMINISTRATIVE VERIFICATION OF ASSETS.—The State—

''(I) permits a parent or caretaker relative who is applying on behalf of a child for medical assistance under title XIX or child health assistance under this title to declare and certify by

signature under penalty of perjury information relating to family assets for purposes of determining and redetermining financial eligibility; and

''(II) takes steps to verify assets through means other than by requiring documentation from parents and applicants except in individual cases of discrepancies or where otherwise justified.

''(C) ELIMINATION OF IN-PERSON INTERVIEW REQUIREMENT.—The State does not require an application of a child for medical assistance under title XIX (or for child health assistance under this title), including an application for renewal of such assistance, to be made in person nor does the State require a face-to-face interview, unless there are discrepancies or individual circumstances justifying an in-person application or face-to-face interview.

''(D) USE OF JOINT APPLICATION FOR MEDICAID AND CHIP.—The application form and supplemental forms (if any) and information verification process is the same for purposes of establishing and renewing eligibility for children for medical assistance under title XIX and child health assistance under this title.

''(E) AUTOMATIC RENEWAL (USE OF ADMINISTRATIVE RENEWAL).—

''(i) IN GENERAL.—The State provides, in the case of renewal of a child's eligibility for medical assistance under title XIX or child health assistance under this title, a pre-printed form completed by the State based on the information available to the State and notice to the parent or caretaker relative of the child that eligibility of the child will be renewed and continued based on such information unless the State is provided other information. Nothing in this clause shall be construed as preventing a State from verifying, through electronic and other means, the information so provided.

''(ii) SATISFACTION THROUGH DEMONSTRATED USE OF EX PARTE PROCESS.—A State shall be treated as satisfying the requirement of clause (i) if renewal of eligibility of children under title XIX or this title is determined without any requirement for an in-person interview, unless sufficient information is not in the State's possession and cannot be acquired from other sources (including other State agencies) without the participation of the applicant or the applicant's parent or caretaker relative.

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

''(G) EXPRESS LANE.—The State is implementing the option described in section 1902(e)(13) under title XIX as well as, pursuant to section 2107(e)(1), under this title.''.

SEC. 112. STATE OPTION TO RELY ON FINDINGS FROM AN EXPRESS LANE AGENCY TO CONDUCT SIMPLIFIED ELIGIBILITY DETERMINATIONS.

(a) MEDICAID.—Section 1902(e) of the Social Security Act (42 U.S.C. 1396a(e)) is amended by adding at the end the following:

''(13) EXPRESS LANE OPTION.—

''(A) IN GENERAL.—

''(i) OPTION TO USE A FINDING FROM AN EXPRESS LANE AGENCY.—At the option of the State, the State plan may provide that in determining eligibility under this title for a child (as defined in subparagraph (F)), the State may rely on a finding made within a reasonable period (as determined by the State) from an Express Lane agency (as defined in subparagraph (E)) when it determines whether a child satisfies one or more components of eligibility for medical assistance under this title. The State may rely on a finding from an Express Lane agency notwithstanding sections 1902(a)(46)(B), 1903(x), and 1137(d) and any differences in budget unit, disregard, deeming or other methodology, if the following requirements are met:

''(I) PROHIBITION ON DETERMINING CHILDREN INELIGIBLE FOR COVERAGE.— If a finding from an Express Lane agency would result in a determination that a child does not satisfy an eligibility requirement for medical assistance under this title and for child health assistance under title XXI, the State shall determine eligibility for assistance using its regular procedures.

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

''(III) COMPLIANCE WITH SCREEN AND ENROLL REQUIREMENT.—The State shall satisfy the requirements under (A) and (B) of section 2102(b)(3) (relating to screen and enroll) before enrolling a child in child health assistance under title XXI. At its option, the State may fulfill such requirements in accordance with either option provided under subparagraph (C) of this paragraph.

''(ii) OPTION TO APPLY TO RENEWALS AND REDETERMINATIONS.— The State may apply the provisions of this paragraph when conducting initial determinations of eligibility, redeterminations of eligibility, or both, as described in the State plan.

''(B) RULES OF CONSTRUCTION.—Nothing in this paragraph shall be construed—

''(i) to limit or prohibit a State from taking any actions otherwise permitted under this title or title XXI in determining eligibility for or enrolling children into medical assistance under this title or child health assistance under title XXI; or

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

''(C) OPTIONS FOR SATISFYING THE SCREEN AND ENROLL REQUIREMENT.—

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

''(ii) ESTABLISHING A SCREENING THRESHOLD.—

''(I) IN GENERAL.—Under this clause, the State establishes a screening threshold set as a percentage of the Federal poverty level that exceeds the highest income threshold applicable under this title to the child by a minimum of 30 percentage points or, at State option, a higher number of percentage points that reflects the value (as determined by the State and described in the State plan) of any differences between income methodologies used by the program administered by the Express Lane agency and the methodologies used by the State in determining eligibility for medical assistance under this title.

''(II) CHILDREN WITH INCOME NOT ABOVE THRESHOLD.—If the income of a child does not exceed the screening threshold, the child is deemed to satisfy the income eligibility criteria for medical assistance under this title regardless of whether such child would otherwise satisfy such criteria.

''(III) CHILDREN WITH INCOME ABOVE THRESHOLD.—If the income of a child exceeds the screening threshold, the child shall be considered to have an income above the Medicaid applicable income level described in section 2110(b)(4) and to satisfy the requirement under section 2110(b)(1)(C) (relating to the requirement that CHIP matching funds be used only for children not eligible for Medicaid). If such a child is enrolled in child health assistance under title XXI, the State shall provide the parent, guardian, or custodial relative with the following:

''(aa) Notice that the child may be eligible to receive medical assistance under the State plan under this title if evaluated for such assistance under the State's regular procedures and notice of the process through which a parent, guardian, or custodial relative can request that the State evaluate the child's eligibility for medical assistance under this title using such regular procedures.

''(bb) A description of differences between the medical assistance provided under this title and child health assistance under title XXI, including differences in cost-sharing requirements and covered benefits.

''(iii) TEMPORARY ENROLLMENT IN CHIP PENDING SCREEN AND ENROLL.—

''(I) IN GENERAL.—Under this clause, a State enrolls a child in child health assistance under title XXI for a temporary period if the child appears eligible for such assistance based on an income finding by an Express Lane agency.

''(II) DETERMINATION OF ELIGIBILITY.—During such temporary enrollment period, the State shall determine the child's eligibility for child health assistance under title XXI or for medical assistance under this title in accordance with this clause.

''(III) PROMPT FOLLOW UP.—In making such a determination, the State shall take prompt action to determine whether the child should be enrolled in medical assistance under this title or child health assistance under title XXI pursuant to subparagraphs (A) and (B) of section 2102(b)(3) (relating to screen and enroll).

''(IV) REQUIREMENT FOR SIMPLIFIED DETERMINATION.—In making such a determination, the State shall use procedures that, to the maximum feasible extent, reduce the burden imposed on the individual of such determination. Such procedures may not require the child's parent, guardian, or custodial relative to provide or verify information that already has been provided to the State agency by an Express Lane agency or another source of information unless the State agency has reason to believe the information is erroneous.

''(V) AVAILABILITY OF CHIP MATCHING FUNDS DURING TEMPORARY ENROLLMENT PERIOD.—Medical assistance for items and services that are provided to a child enrolled in title XXI during a temporary enrollment period under this clause shall be treated as child health assistance under such title.

''(D) OPTION FOR AUTOMATIC ENROLLMENT.—

''(i) IN GENERAL.— At its option, a State may initiate an evaluation of an individual's eligibility for medical assistance under this title without an application and determine the individual's eligibility for such assistance using findings from one or more Express Lane agencies and information from sources other than a child, if the requirements of clauses (ii) and (iii) are met.

''(ii) INDIVIDUAL CHOICE REQUIREMENT.—The requirement of this clause is that the child is enrolled in medical assistance under this title or child health assistance under title XXI only if the child (or a parent, caretaker relative, or guardian on the behalf of the child) has affirmatively assented to such enrollment.

''(iii) INFORMATION REQUIREMENT.—The requirement of this clause is that the State informs the parent, guardian, or custodial relative of the child of the services that will be covered, appropriate methods for using such services, premium or other cost sharing charges (if any) that apply, medical support obligations (under section 1912(a)) created by enrollment (if applicable), and the actions the parent, guardian, or relative must take to maintain enrollment and renew coverage.

''(E) EXPRESS LANE AGENCY DEFINED.—In this paragraph, the term 'express lane agency' means an agency that meets the following requirements:

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

''(ii) The agency notifies the child (or a parent, caretaker relative, or guardian on the behalf of the child)—

''(I) of the information which shall be disclosed;

''(II) that the information will be used by the State solely for purposes of determining eligibility for and for providing medical assistance under this title or child health assistance under title XXI; and

''(III) that the child, or parent, caretaker relative, or guardian, may elect to not have the information disclosed for such purposes.

''(iii) The agency and the State agency are subject to an interagency agreement limiting the disclosure and use of such information to such purposes.

''(iv) The agency is determined by the State agency to be capable of making the determinations described in this paragraph and is identified in the State plan under this title or title XXI.

For purposes of this subparagraph, the term 'State agency' refers to the agency determining eligibility for medical assistance under this title or child health assistance under title XXI.

''(F) CHILD DEFINED.—For purposes of this paragraph, the term 'child' means an individual under 19 years of age, or, at the option of a State, such higher age, not to exceed 21 years of age, as the State may elect.''.

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

''(C) Section 1902(e)(13) (relating to the State option to rely on findings from an Express Lane agency to help evaluate a child's eligibility for medical assistance).''.

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

''(dd) ELECTRONIC TRANSMISSION OF INFORMATION.—If the State agency determining eligibility for medical assistance under this title or child health assistance under title XXI verifies an element of eligibility based on information from an Express Lane Agency (as defined in subsection (e)(13)(F)), or from another public agency, then the applicant's signature under penalty of perjury shall not be required as to such element. Any signature requirement for an application for medical assistance may be satisfied through an electronic signature, as defined in section 1710(1) of the Government Paperwork Elimination Act (44 U.S.C. 3504 note). The requirements of subparagraphs (A) and (B) of section 1137(d)(2) may be met through evidence in digital or electronic form.''.

(d) AUTHORIZATION OF INFORMATION DISCLOSURE.—

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

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

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

''SEC. 1939. AUTHORIZATION TO RECEIVE PERTINENT INFORMATION.

''(a) IN GENERAL.—Notwithstanding any other provision of law, a Federal or State agency or private entity in possession of the sources of data potentially pertinent to eligibility determinations under this title (including eligibility files maintained by Express Lane agencies described in section 1902(e)(13)(F), information described in paragraph (2) or (3) of section 1137(a), vital records information about births in any State, and information described in sections 453(i) and 1902(a)(25)(I)) is authorized to convey such data or information to the State agency administering the State plan under this title, to the extent such conveyance meets the requirements of subsection (b).

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

''(1) The individual whose circumstances are described in the data or information (or such individual's parent, guardian, caretaker relative, or authorized representative) has either provided advance consent to disclosure or has not objected to disclosure after receiving advance notice of disclosure and a reasonable opportunity to object.

''(2) Such data or information are used solely for the purposes of—

''(A) identifying individuals who are eligible or potentially eligible for medical assistance under this title and enrolling or attempting to enroll such individuals in the State plan; and

''(B) verifying the eligibility of individuals for medical assistance under the State plan.

''(3) An interagency or other agreement, consistent with standards developed by the Secretary—

''(A) prevents the unauthorized use, disclosure, or modification of such data and otherwise meets applicable Federal requirements safeguarding privacy and data security; and

''(B) requires the State agency administering the State plan to use the data and information obtained under this section to seek to enroll individuals in the plan.

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

''(d) RULE OF CONSTRUCTION.—The limitations and requirements that apply to disclosure pursuant to this section shall not be construed to prohibit the conveyance or disclosure of data or information otherwise permitted under Federal law (without regard to this section).''.

(2) CONFORMING AMENDMENT TO TITLE XXI.—Section 2107(e)(1) of such Act (42 U.S.C. 1397gg(e)(1)), as amended by subsection (b), is amended by adding at the end the following new subparagraph:

''(J) Section 1939 (relating to authorization to receive data potentially pertinent to eligibility determinations).''.

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

(A) by inserting ''(and, at State option, individuals who are potentially eligible or who apply)'' after ''with respect to individuals who are eligible''; and

(B) by inserting ''under this title (and, at State option, child health assistance under title XXI)'' after ''the State plan''.

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

SEC. 113. APPLICATION OF MEDICAID OUTREACH PROCEDURES TO ALL CHILDREN AND PREGNANT WOMEN.

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

(1) in the matter before subparagraph (A), by striking ''individuals for medical assistance under subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX)'' and inserting ''children and pregnant women for medical assistance under any provision of this title''; and

(2) in subparagraph (B), by inserting before the semicolon at the end the following: '', which need not be the same application form for all such individuals''.

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

SEC. 114. ENCOURAGING CULTURALLY APPROPRIATE ENROLLMENT AND RETENTION PRACTICES.

(a) USE OF MEDICAID FUNDS.—Section 1903(a)(2) of the Social Security Act (42 U.S.C. 1396b(a)(2)) is amended by adding at the end the following new subparagraph:

''(E) an amount equal to 75 percent of so much of the sums expended during such quarter (as found necessary by the Secretary for the proper and efficient administration of the State plan) as are attributable to translation or interpretation services in connection with the enrollment and retention under this title of children of families for whom English is not the primary language; plus''.

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

(1) IN GENERAL.—Section 2102(c)(1) of such Act (42 U.S.C. 1397bb(c)(1)) is amended by inserting ''(through community health workers and others)'' after ''Outreach''.

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

SEC. 115. CONTINUOUS COVERAGE UNDER CHIP.

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

''(5) 12-MONTHS CONTINUOUS ELIGIBILITY.—In the case of a State child health plan that provides child health assistance under this title through a means other than described in section 2101(a)(2), the plan shall provide for implementation under this title of the 12-months continuous eligibility option described in section 1902(e)(12) for targeted low-income children whose family income is below 200 percent of the poverty line.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to determinations (and redeterminations) of eligibility made on or after January 1, 2008.

Subtitle C—Coverage

SEC. 121. ENSURING CHILD-CENTERED COVERAGE.

(a) ADDITIONAL REQUIRED SERVICES.—

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

(A) in subsection (a)—

(i) in the matter before paragraph (1), by striking ''subsection (c)(5)'' and inserting ''paragraphs (5) and (6) of subsection (c)''; and

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

(B) in subsection (c)—

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

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

''(5) DENTAL, FQHC, AND RHC SERVICES.—The child health assistance provided to a targeted low-income child (whether through benchmark coverage or benchmark-equivalent coverage or otherwise) shall include coverage of the following:

''(A) Dental services necessary to prevent disease and promote oral health, restore oral structures to health and function, and treat emergency conditions.

''(B) Federally-qualified health center services (as defined in section 1905(l)(2)) and rural health clinic services (as defined in section 1905(l)(1)).

Nothing in this section shall be construed as preventing a State child health plan from providing such services as part of benchmark coverage or in addition to the benefits provided through benchmark coverage.''.

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

''(D) Section 1902(bb) (relating to payment for services provided by Federally-qualified health centers and rural health clinics).''.

(3) MENTAL HEALTH PARITY.—Section 2103(a)(2)(C) of such Act (42 U.S.C.

1397aa(a)(2)(C)) is amended by inserting ''(or 100 percent in the case of the category of services described in subparagraph (B) of such subsection)'' after ''75 percent''.

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

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

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

(A) in subparagraph (A)—

(i) in the matter before clause (i), by striking ''Notwithstanding any other provision of this title'' and inserting ''Subject to subparagraph (E)''; and

(ii) by striking ''enrollment in coverage that provides'' and all that follows and inserting ''benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2).'';

(B) by striking subparagraph (C) and inserting the following new subparagraph:

''(C) STATE OPTION TO PROVIDE ADDITIONAL BENEFITS.—A State, at its option, may provide such additional benefits to benchmark coverage described in subsection (b)(1) or benchmark equivalent coverage described in subsection (b)(2) as the State may specify.''; and

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

''(E) REQUIRING COVERAGE OF EPSDT SERVICES.—Nothing in this paragraph shall be construed as affecting a child's entitlement to care and services described in subsections (a)(4)(B) and (r) of section 1905 and provided in accordance with section 1902(a)(43) whether provided through benchmark coverage, benchmark equivalent coverage, or otherwise.''.

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

(1) IN GENERAL.—Section 2110(a)(5) of such Act (42 U.S.C. 1397jj(a)(5)) is amended by inserting after ''health center services'' the following: ''and school-based health center services for which coverage is otherwise provided under this title when furnished by a school-based health center that is authorized to furnish such services under State law''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to child health assistance furnished on or after the date of the enactment of this Act.

(d) ASSURING ACCESS TO CARE.—

(1) STATE CHILD HEALTH PLAN REQUIREMENT.—Section 2102(a)(7)(B) of such Act (42 U.S.C. 1397bb(c)(2)) is amended by inserting ''and services described in section 2103(c)(5)'' after ''emergency services''.

(2) REFERENCE TO EFFECTIVE DATE.—For the effective date for the amendments made by this subsection, see subsection (a)(5).

SEC. 122. IMPROVING BENCHMARK COVERAGE OPTIONS.

(a) LIMITATION ON SECRETARY-APPROVED COVERAGE.—

(1) UNDER CHIP.—Section 2103(a)(4) of the Social Security Act (42 U.S.C. 1397cc(a)(4)) is amended by inserting before the period at the end the following: ''if the health benefits coverage is at least equivalent to the benefits coverage in a benchmark benefit package described in subsection (b)''.

(2) UNDER MEDICAID.—Section 1937(b)(1)(D) of the Social Security Act (42 U.S.C. 1396u–7(b)(1)(D)) is amended by inserting before the period at the end the following: ''if the health benefits coverage is at least equivalent to the benefits coverage in benchmark coverage described in subparagraph (A), (B), or (C)''.

(b) REQUIREMENT FOR MOST POPULAR FAMILY COVERAGE FOR STATE EMPLOYEE COVERAGE BENCHMARK.—

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

SEC. 123. PREMIUM GRACE PERIOD.

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

''(C) PREMIUM GRACE PERIOD.—The State child health plan—

''(i) shall afford individuals enrolled under the plan a grace period of at least 30 days from the beginning of a new coverage period to make premium payments before the individual's coverage under the plan may be terminated; and

''(ii) shall provide to such an individual, not later than 7 days after the first day of such grace period, notice—

''(I) that failure to make a premium payment within the grace period will result in termination of coverage under the State child health plan; and

''(II) of the individual's right to challenge the proposed termination pursuant to the applicable Federal regulations.

For purposes of clause (i), the term 'new coverage period' means the month immediately following the last month for which the premium has been paid.''.

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

Subtitle D—Populations

SEC. 131. OPTIONAL COVERAGE OF CHILDREN UP TO AGE 21 UNDER CHIP.

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

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

(F) Section 1932(a)(2)(A) of such Act (42 U.S.C. 1396u–2(a)(2)(A)) is amended by inserting ''(or under such higher age as the State has elected under section 1902(l)(1)(D))'' after ''19 years of age''.

(b) TITLE XXI.—Section 2110(c)(1) of such Act (42 U.S.C. 1397jj(c)(1)) is amended by inserting ''(or, at the option of the State and subject to section 131(d) of the Children's Health and Medicare Protection Act of 2007, under such higher age as the State has elected under section 1902(l)(1)(D))'' after ''19 years of age''.

(c) EFFECTIVE DATE.—Subject to subsection (d), the amendments made by this section take effect on January 1, 2010.

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

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

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

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

(1) in paragraph (1), by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (4)''; and

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

''(4)(A) A State may elect (in a plan amendment under this title) to provide medical assistance under this title, notwithstanding sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996, for aliens who are lawfully residing in the United States (including battered aliens described in section 431(c) of such Act) and who are otherwise eligible for such assistance, within either or both of the following eligibility categories:

''(i) PREGNANT WOMEN.—Women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

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

''(B) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of medical assistance to such category and the cost of such assistance shall not be considered as an unreimbursed cost.''.

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

''(F) Section 1903(v)(4)(A) (relating to optional coverage of certain categories of lawfully residing immigrants), insofar as it relates to the category of pregnant women described in clause (i) of such section, but only if the State has elected to apply such section with respect to such women under title XIX and the State has elected the option under section 2111 to provide assistance for pregnant women under this title.

''(G) Section 1903(v)(4)(A) (relating to optional coverage of categories of lawfully residing immigrants), insofar as it relates to the category of children described in clause (ii) of such section, but only if the State has elected to apply such section with respect to such children under title XIX.''.

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

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

(a) CHIP.—

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

''SEC. 2111. OPTIONAL COVERAGE OF TARGETED LOW-INCOME PREGNANT WOMEN.

''(a) OPTIONAL COVERAGE.—Notwithstanding any other provision of this title, a State may provide for coverage, through an amendment to its State child health plan under section 2102, of assistance for pregnant women for targeted low-income pregnant women in accordance with this section, but only if—

''(1) the State has established an income eligibility level—

''(A) for pregnant women, under any of clauses (i)(III), (i)(IV), or (ii)(IX) of section 1902(a)(10)(A), that is at least 185 percent (or such higher percent as the State has in effect for pregnant women under this title) of the poverty line applicable to a family of the size involved, but in no case a percent lower than the percent in effect under any such clause as of July 1, 2007; and

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

''(2) the State does not impose, with respect to the enrollment under the State child health plan of targeted low-income children during the quarter, any enrollment cap or other numerical limitation on enrollment, any waiting list, any procedures designed to delay the consideration of applications for enrollment, or similar limitation with respect to enrollment.

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

''(1) ASSISTANCE FOR PREGNANT WOMEN.—The term 'assistance for pregnant women' has the meaning given the term child health assistance in section 2110(a) as if any reference to targeted low-income children were a reference to targeted low-income pregnant women.

''(2) TARGETED LOW-INCOME PREGNANT WOMAN.—The term 'targeted low-income pregnant woman' means a woman—

''(A) during pregnancy and through the end of the month in which the 60-day period (beginning on the last day of her pregnancy) ends;

''(B) whose family income exceeds 185 percent (or, if higher, the percent applied under subsection (a)(1)(A)) of the poverty level applicable to a family of the size involved, but does not exceed the income eligibility level established under the State child health plan under this title for a targeted low-income child; and

''(C) who satisfies the requirements of paragraphs (1)(A), (1)(C), (2), and (3) of section 2110(b), applied as if any reference to a child was a reference to a pregnant woman.

''(c) REFERENCES TO TERMS AND SPECIAL RULES.—In the case of, and with respect to, a State providing for coverage of assistance for pregnant women to targeted low-income pregnant women under subsection (a), the following special rules apply:

''(1) Any reference in this title (other than in subsection (b)) to a targeted low-income child is deemed to include a reference to a targeted low-income pregnant woman.

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

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

''(4) In applying section 2102(b)(3)(B), any reference to children found through screening to be eligible for medical assistance under the State medicaid plan under title XIX is deemed a reference to pregnant women.

''(5) There shall be no exclusion of benefits for services described in subsection (b)(1) based on any preexisting condition and no waiting period (including any waiting period imposed to carry out section 2102(b)(3)(C)) shall apply.

''(6) In applying section 2103(e)(3)(B) in the case of a pregnant woman provided coverage under this section, the limitation on total annual aggregate cost-sharing shall be applied to such pregnant woman.

''(7) In applying section 2104(i)—

''(A) in the case of a State which did not provide for coverage for pregnant women under this title (under a waiver or otherwise) during fiscal year 2007, the allotment amount otherwise computed for the first fiscal year in which the State elects to provide coverage under this section shall be increased by an amount (determined by the Secretary) equal to the enhanced FMAP of the expenditures under this title for such coverage, based upon projected enrollment and per capita costs of such enrollment; and

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

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

''(ii) in applying paragraph (3), pregnant women (and per capita expenditures for such women) shall be accounted for separately from children, but shall be included in the total amount of any allotment adjustment under such paragraph.

''(d) AUTOMATIC ENROLLMENT FOR CHILDREN BORN TO WOMEN RECEIVING ASSISTANCE FOR PREGNANT WOMEN.—If a child is born to a targeted low-income pregnant woman who was receiving assistance for pregnant women under this section on the date of the child's birth, the child shall be deemed to have applied for child health assistance under the State child health plan and to have been found eligible for such assistance under such plan or to have applied for medical assistance under title XIX and to have been found eligible for such assistance under such title on the date of such birth, based on the mother's reported income as of the time of her enrollment under this section and applicable income eligibility levels under this title and title XIX, and to remain eligible for such assistance until the child attains 1 year of age. During the period in which a child is deemed under the preceding sentence to be eligible for child health or medical assistance, the assistance for pregnant women or medical assistance eligibility identification number of the mother shall also serve as the identification number of the child, and all claims shall be submitted and paid under such number (unless the State issues a separate identification number for the child before such period expires).''.

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

''(I) Sections 1920 and 1920A (relating to presumptive eligibility for pregnant women and children).''.

(b) AMENDMENTS TO MEDICAID.—

(1) ELIGIBILITY OF A NEWBORN.—Section 1902(e)(4) of the Social Security Act (42 U.S.C. 1396a(e)(4)) is amended in the first sentence by striking ''so long as the child is a member of the woman's household and the woman remains (or would remain if pregnant) eligible for such assistance''.

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

''The term 'qualified provider' also includes a qualified entity, as defined in section 1920A(b)(3).''.

SEC. 134. LIMITATION ON WAIVER AUTHORITY TO COVER ADULTS.

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

''(d) LIMITATION ON COVERAGE OF ADULTS.—Notwithstanding any other provision of this title, the Secretary may not, through the exercise of any waiver authority on or after January 1, 2008, provide for Federal financial participation to a State under this title for health care services for individuals who are not targeted low-income children or pregnant women unless the Secretary determines that no eligible targeted low-income child in the State would be denied coverage under this title for health care services because of such eligibility. In making such determination, the Secretary must receive assurances that—

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

''(2) the State has in place an outreach program to reach all targeted low-income children in families with incomes less than 200 percent of the poverty line.''.

SEC. 135. NO FEDERAL FUNDING FOR ILLEGAL ALIENS.

Nothing in this Act allows Federal payment for individuals who are not legal residents.

SEC. 136. AUDITING REQUIREMENT TO ENFORCE CITIZENSHIP RESTRICTIONS ON ELIGIBILITY FOR MEDICAID AND CHIP BENEFITS.

Section 1903(x) of the Social Security Act (as amended by section 405(c)(1)(A) of division B of the Tax Relief and Health Care Act of 2006 (Public Law 109–432)) is amended by adding at the end the following new paragraph:

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

''(B) The State shall remit to the Secretary the Federal share of any unlawful expenditures for benefits, for aliens who are not legal residents, which are identified under an audit conducted under subparagraph (A).''.

Subtitle E—Access

SEC. 141. CHILDREN'S ACCESS, PAYMENT, AND EQUALITY COMMISSION.

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

''CHILDREN'S ACCESS, PAYMENT, AND EQUALITY COMMISSION

''SEC. 1900. (a) ESTABLISHMENT.—There is hereby established as an agency of Congress the Children's Access, Payment, and Equality Commission (in this section referred to as the 'Commission').

''(b) DUTIES.—

''(1) REVIEW OF PAYMENT POLICIES AND ANNUAL REPORTS.—The Commission shall—

''(A) review Federal and State payment policies of the Medicaid program established under this title (in this section referred to as 'Medicaid') and the State Children's Health Insurance Program established under title XXI (in this section referred to as 'CHIP'), including topics described in paragraph (2);

''(B) review access to, and affordability of, coverage and services for enrollees under Medicaid and CHIP;

''(C) make recommendations to Congress concerning such policies;

''(D) by not later than March 1 of each year, submit to Congress a report containing the results of such reviews and its recommendations concerning such policies; and

''(E) by not later than June 1 of each year, submit to Congress a report containing an examination of issues affecting Medicaid and CHIP, including the implications of changes in health care delivery in the United States and in the market for health care services on such programs.

''(2) SPECIFIC TOPICS TO BE REVIEWED.—Specifically, the Commission shall review the following:

''(A) The factors affecting expenditures for services in different sectors (such as physician, hospital and other sectors), payment methodologies, and their relationship to access and quality of care for Medicaid and CHIP beneficiaries.

''(B) The impact of Federal and State Medicaid and CHIP payment policies on access to services (including dental services) for children (including children with disabilities) and other Medicaid and CHIP populations.

''(C) The impact of Federal and State Medicaid and CHIP policies on reducing health disparities, including geographic disparities and disparities among minority populations.

''(D) The overall financial stability of the health care safety net, including Federally-qualified health centers, rural health centers, school-based clinics, disproportionate share hospitals, public hospitals, providers and grantees under section 2612(a)(5) of the Public Health Service Act (popularly known as the Ryan White CARE Act), and other providers that have a patient base which includes a disproportionate number of uninsured or low-income individuals and the impact of CHIP and Medicaid policies on such stability.

''(E) The relation (if any) between payment rates for providers and improvement in care for children as measured under the children's

health quality measurement program established under section 151 of the Children's Health and Medicare Protection Act of 2007.

''(F) The affordability, cost effectiveness, and accessibility of services needed by special populations under Medicaid and CHIP as compared with private-sector coverage.

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

''(H) The effect of demonstrations under section 1115, benchmark coverage under section 1937, and other coverage under section 1938, on access to care, affordability of coverage, provider ability to achieve children's health quality performance measures, and access to safety net services.

''(3) COMMENTS ON CERTAIN SECRETARIAL REPORTS.—If the Secretary submits to Congress (or a committee of Congress) a report that is required by law and that relates to payment policies under Medicaid or CHIP, the Secretary shall transmit a copy of the report to the Commission. The Commission shall review the report and, not later than 6 months after the date of submittal of the Secretary's report to Congress, shall submit to the appropriate committees of Congress written comments on such report. Such comments may include such recommendations as the Commission deems appropriate.

''(4) AGENDA AND ADDITIONAL REVIEWS.—The Commission shall consult periodically with the Chairmen and Ranking Minority Members of the appropriate committees of Congress regarding the Commission's agenda and progress towards achieving the agenda. The Commission may conduct additional reviews, and submit additional reports to the appropriate committees of Congress, from time to time on such topics relating to the program under this title or title XXI as may be requested by such Chairmen and Members and as the Commission deems appropriate.

''(5) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

''(6) APPROPRIATE COMMITTEE OF CONGRESS.—For purposes of this section, the term 'appropriate committees of Congress' means the Committees on Energy and Commerce of the House of Representatives and the Committee on Finance of the Senate.

''(7) VOTING AND REPORTING REQUIREMENTS.—With respect to each recommendation contained in a report submitted under paragraph (1), each member of the Commission shall vote on the recommendation, and the Commission shall include, by member, the results of that vote in the report containing the recommendation.

''(8) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, the Commission shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.

''(c) APPLICATION OF PROVISIONS.—The following provisions of section 1805 shall apply to the Commission in the same manner as they apply to the Medicare Payment Advisory Commission:

''(1) Subsection (c) (relating to membership), except that the membership of the Commission shall also include representatives of children, pregnant women, individuals with disabilities, seniors, low-income families, and other groups of CHIP and Medicaid beneficiaries.

''(2) Subsection (d) (relating to staff and consultants).

''(3) Subsection (e) (relating to powers).

''(d) AUTHORIZATION OF APPROPRIATIONS.—

''(1) REQUEST FOR APPROPRIATIONS.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

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

SEC. 142. MODEL OF INTERSTATE COORDINATED ENROLLMENT AND COVERAGE PROCESS.

(a) IN GENERAL.—In order to assure continuity of coverage of low-income children under the Medicaid program and the State Children's Health Insurance Program (CHIP), not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States, in consultation with State Medicaid and CHIP directors and organizations representing program beneficiaries, shall develop a model process for the coordination of the enrollment, retention, and coverage under such programs of children who, because of migration of families, emergency evacuations, educational needs, or otherwise, frequently change their State of residency or otherwise are temporarily located outside of the State of their residency.

(b) REPORT TO CONGRESS.—After development of such model process, the Comptroller General shall submit to Congress a report describing additional steps or authority needed to make further improvements to coordinate the enrollment, retention, and coverage under CHIP and Medicaid of children described in subsection (a).

SEC. 143. MEDICAID CITIZENSHIP DOCUMENTATION REQUIREMENTS.

(a) STATE OPTION TO REQUIRE CHILDREN TO PRESENT SATISFACTORY DOCUMENTARY EVIDENCE OF PROOF OF CITIZENSHIP OR NATIONALITY FOR PURPOSES OF ELIGIBILITY FOR MEDICAID; REQUIREMENT FOR AUDITING.—

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

(A) in subsection (a)(46)—

(i) by inserting ''(A)'' after ''(46)''; and

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

''(B) at the option of the State, require that, with respect to a child under 21 years of age (other than an individual described in section 1903(x)(2)) who declares to be a citizen or national of the United States for purposes of establishing initial eligibility for medical assistance under this title (or, at State option, for purposes of renewing or redetermining such eligibility to the extent that such satisfactory documentary evidence of citizenship or nationality has not yet been presented), there is presented satisfactory documentary evidence of citizenship or nationality of the individual (using criteria determined by the State, which shall be no more restrictive than the documentation specified in section 1903(x)(3)); and

''(C) comply with the auditing requirements of section 1903(x)(4);''; and

(B) in subsection (b)(3), by inserting ''or any citizenship documentation requirement for a child under 21 years of age that is more restrictive than what a State may provide under section 1903(x)'' before the period at the end.

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

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

(1) in subparagraph (C), by striking ''or'' at the end;

(2) by redesignating subparagraph (D) as subparagraph (E); and

(3) by inserting after subparagraph (C) the following new subparagraph:

''(D) pursuant to the application of section 1902(e)(4) (and, in the case of an individual who is eligible for medical assistance on such basis, the individual shall be deemed to have provided satisfactory documentary evidence of citizenship or nationality and shall not be required to provide further documentary evidence on any date that occurs during or after the period in which the individual is eligible for medical assistance on such basis; or''.

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

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

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

''(v) For an individual who is a member of, or enrolled in or affiliated with, a federally-recognized Indian tribe, a document issued by such tribe evidencing such membership, enrollment, or affiliation with the tribe (such as a tribal enrollment card or certificate of degree of Indian blood), and, only with respect to those federally-recognized Indian tribes located within States having an international border whose membership includes individuals who are not citizens of the United States, such other forms of documentation (including tribal documentation, if appropriate) as the Secretary, after consulting with such tribes, determines to be satisfactory documentary evidence of citizenship or nationality for purposes of satisfying the requirement of this subparagraph.''.

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

''(5) In the case of an individual declaring to be a citizen or national of the United States with respect to whom a State requires the presentation of satisfactory documentary evidence of citizenship or nationality under section 1902(a)(46)(B), the individual shall be provided at least the reasonable opportunity to present satisfactory documentary evidence of citizenship or nationality under this subsection as is provided under clauses (i) and (ii) of section 1137(d)(4)(A) to an individual for the submittal to the State of evidence indicating a satisfactory immigration status and shall not be denied medical assistance on the basis of failure to provide such documentation until the individual has had such an opportunity.''.

(e) EFFECTIVE DATE.—

(1) RETROACTIVE APPLICATION.—The amendments made by this section shall take effect as if included in the enactment of the Deficit Reduction Act of 2005 (Public Law 109–171; 120 Stat. 4).

(2) RESTORATION OF ELIGIBILITY.—In the case of an individual who, during the period that began on July 1, 2006, and ends on the date of the enactment of this Act, was determined to be ineligible for medical assistance under a State Medicaid program solely as a result of the application of subsections (i)(22) and (x) of section 1903 of the Social Security Act (as in effect during such period), but who would have been determined eligible for such assistance if such subsections, as amended by this section, had applied to the individual, a State may deem the individual to be eligible for such assistance as of the date that the individual was determined to be ineligible for such medical assistance on such basis.

SEC. 144. ACCESS TO DENTAL CARE FOR CHILDREN.

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

(b) PROVISION OF DENTAL SERVICES THROUGH FQHCS.—

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

(A) by striking ''and'' at the end of paragraph (69);

(B) by striking the period at the end of paragraph (70) and inserting ''; and''; and

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

''(71) provide that the State will not prevent a Federally-qualified health center from entering into contractual relationships with private practice dental providers in the provision of Federally-qualified health center services.''.

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

''(B) Section 1902(a)(71) (relating to limiting FQHC contracting for provision of dental services).''.

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

(c) REPORTING INFORMATION ON DENTAL HEALTH.—

(1) MEDICAID.—Section 1902(a)(43)(D)(iii) of such Act (42 U.S.C. 1396a(a)(43)(D)(iii)) is amended by inserting ''and other information relating to the provision of dental services to such children described in section 2108(e)'' after ''receiving dental services,''.

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

''(e) INFORMATION ON DENTAL CARE FOR CHILDREN.—

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

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

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

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

''(2) INCLUSION OF INFORMATION ON ENROLLEES IN MANAGED CARE PLANS.—The information under paragraph (1) shall include information on children who are enrolled in managed care plans and other private health plans and contracts with such plans under this title shall provide for the reporting of such information by such plans to the State.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall be effective for annual reports submitted for years beginning after date of enactment.

(d) GAO STUDY AND REPORT.—

(1) STUDY.—The Comptroller General of the United States shall provide for a study that examines—

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

(B) the feasibility and appropriateness of using qualified mid-level dental health providers, in coordination with dentists, to improve access for children to oral health services and public health overall.

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

SEC. 145. PROHIBITING INITIATION OF NEW HEALTH OPPORTUNITY ACCOUNT DEMONSTRATION PROGRAMS.

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

Subtitle F—Quality and Program Integrity

SEC. 151. PEDIATRIC HEALTH QUALITY MEASUREMENT PROGRAM.

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

(1) ESTABLISHMENT OF PROGRAM TO DEVELOP QUALITY MEASURES FOR CHILDREN'S HEALTH.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish a child health care quality measurement program (in this subsection referred to as the ''children's health quality measurement program'') to develop and implement—

(A) pediatric quality measures on children's health care that may be used by public and private health care purchasers (and a system for reporting such measures); and

(B) measures of overall program performance that may be used by public and private health care purchasers.

The Secretary shall publish, not later than September 30, 2009, the recommended measures under the program for application under the amendments made by subsection (b) for years beginning with 2010.

(2) MEASURES.—

(A) SCOPE.—The measures developed under the children's health quality measurement program shall—

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

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

(iii) be designed to ensure that the data required for such measures is collected and reported in a standard format that permits comparison at a State, plan, and provider level, and between insured and uninsured children;

(iv) take into account existing measures of child health quality and be periodically updated;

(v) include measures of clinical health care quality which meet the requirements for pediatric quality measures in paragraph (1);

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

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

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

(i) The proportion of insured (and uninsured) children who receive age-appropriate preventive health and dental care (including age appropriate immunizations) at each stage of child health development.

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

(iii) The effectiveness of early health care interventions for children whose assessments indicate the presence or risk of physical or mental conditions that could adversely affect growth and development.

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

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

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

In carrying out clause (vi), the Secretary shall develop quality measures and best practices relating to cystic fibrosis.

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

(C) REPORTING METHODOLOGY FOR ANALYSIS BY PEDIATRIC CHARACTERISTICS.—The children's health quality measurement program shall describe with specificity such measures and the process by which such measures will be reported in a manner that permits analysis based on each of the following pediatric characteristics:

(i) Age.

(ii) Gender.

(iii) Race.

(iv) Ethnicity.

(v) Primary language of the child's parents (or caretaker relative).

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

(vii) Geographic location.

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

(D) PEDIATRIC QUALITY MEASURE.—In this subsection, the term ''pediatric quality measure'' means a measurement of clinical care that assesses one or more aspects of pediatric health care quality (in various settings) including the structure of the clinical care system, the process and outcome of care, or patient experience in such care.

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

(A) States;

(B) pediatric hospitals, pediatricians, and other primary and specialized pediatric health care professionals (including members of the allied health professions) who specialize in the care and treatment of children, particularly children with special physical, mental, and developmental health care needs;

(C) dental professionals;

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

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

(F) national organizations and individuals with expertise in pediatric health quality performance measurement; and

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

(4) USE OF GRANTS AND CONTRACTS.—In carrying out the children's health quality measurement program, the Secretary may award grants and contracts to develop, test, validate, update, and disseminate quality measures under the program.

(5) TECHNICAL ASSISTANCE.—The Secretary shall provide technical assistance to States to establish for the reporting of quality measures under titles XIX and XXI of the Social Security Act in accordance with the children's health quality measurement program.

(b) DISSEMINATION OF INFORMATION ON THE QUALITY OF PROGRAM PERFORMANCE.—Not later than January 1, 2009, and annually thereafter, the Secretary shall collect, analyze, and make publicly available on a public website of the Department of Health and Human Services in an online format—

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

(2) information on health care quality for children contained in external quality review reports required under section 1932(c)(2) of such

Act (42 U.S.C. 1396u–2) or produced by States that administer separate plans under title XXI of such Act.

(c) REPORTS TO CONGRESS ON PROGRAM PERFORMANCE.—Not later than January 1, 2010, and every 2 years thereafter, the Secretary shall report to Congress on—

(1) the quality of health care for children enrolled under title XIX and XXI of the Social Security Act under the children's health quality measurement program; and

(2) patterns of health care utilization with respect to the measures specified in subsection (a)(2)(B) among children by the pediatric characteristics listed in subsection (a)(2)(C).

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

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

''(3) COMPLIANCE WITH MANAGED CARE REQUIREMENTS.—The State child health plan shall provide for the application of subsections (a)(4), (a)(5), (b), (c), (d), and (e) of section 1932 (relating to requirements for managed care) to coverage, State agencies, enrollment brokers, managed care entities, and managed care organizations under this title in the same manner as such subsections apply to coverage and such entities and organizations under title XIX.''.

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

SEC. 153. UPDATED FEDERAL EVALUATION OF CHIP.

Section 2108(c) of the Social Security Act (42 U.S.C. 1397hh(c)) is amended by striking paragraph (5) and inserting the following:

''(5) SUBSEQUENT EVALUATION USING UPDATED INFORMATION.—

''(A) IN GENERAL.—The Secretary, directly or through contracts or interagency agreements, shall conduct an independent subsequent evaluation of 10 States with approved child health plans.

''(B) SELECTION OF STATES AND MATTERS INCLUDED.—Paragraphs (2) and (3) shall apply to such subsequent evaluation in the same manner as such provisions apply to the evaluation conducted under paragraph (1).

''(C) SUBMISSION TO CONGRESS.—Not later than December 31, 2010, the Secretary shall submit to Congress the results of the evaluation conducted under this paragraph.

''(D) FUNDING.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated $10,000,000 for fiscal year 2009 for the purpose of conducting the evaluation authorized under this paragraph. Amounts appropriated under this subparagraph shall remain available for expenditure through fiscal year 2011.'' .

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

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

''(d) ACCESS TO RECORDS FOR IG AND GAO AUDITS AND EVALUATIONS.—For the purpose of evaluating and auditing the program established under this title, the Secretary, the Office of Inspector General, and the Comptroller General shall have access to any books, accounts, records, correspondence, and other documents that are related to the expenditure of Federal funds under this title and that are in the possession, custody, or control of States receiving Federal funds under this title or political subdivisions thereof, or any grantee or contractor of such States or political subdivisions.''.

SEC. 155. REFERENCES TO TITLE XXI.

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

SEC. 156. RELIANCE ON LAW; EXCEPTION FOR STATE LEGISLATION.

(a) RELIANCE ON LAW.—With respect to amendments made by this title or title VIII that become effective as of a date—

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

(2) Federal financial participation for medical assistance or child health assistance furnished under title XIX or XXI, respectively, of the Social Security Act on or after such date by a State in good faith reliance on such amendments before the date of promulgation of final regulations, if any, to carry out such amendments (or before the date of guidance, if any, regarding the implementation of such amendments) shall not be denied on the basis of the State's failure to comply with such regulations or guidance.

(b) EXCEPTION FOR STATE LEGISLATION.—In the case of a State plan under title XIX or State child health plan under XXI of the Social Security Act, which the Secretary of Health and Human Services determines requires State legislation in order for respective plan to meet one or more additional requirements imposed by amendments made by this title or title VIII, the respective 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 such an additional requirement 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 shall be considered to be a separate regular session of the State legislature.

TITLE II—MEDICARE BENEFICIARY IMPROVEMENTS

Subtitle A—Improvements in Benefits

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

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

(1) in subsection (s)(2)—

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

(B) in subparagraph (AA), by adding ''and'' after the semicolon at the end; and

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

''(BB) additional preventive services (described in subsection (ccc)(1)(M));''; and

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

''Preventive Services

''(ccc)(1) The term 'preventive services' means the following:

''(A) Prostate cancer screening tests (as defined in subsection (oo)).

''(B) Colorectal cancer screening tests (as defined in subsection (pp)).

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

''(D) Screening for glaucoma for certain individuals (as described in subsection (s)(2)(U)).

''(E) Medical nutrition therapy services for certain individuals (as described in subsection (s)(2)(V)).

''(F) An initial preventive physical examination (as defined in subsection (ww)).

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

''(H) Diabetes screening tests (as defined in subsection described in subsection (s)(2)(Y)).

''(I) Ultrasound screening for abdominal aortic aneurysm for certain individuals (as described in described in subsection (s)(2)(AA)).

''(J) Pneumococcal and influenza vaccine and their administration (as described in subsection (s)(10)(A)).

''(K) Hepatitis B vaccine and its administration for certain individuals (as described in subsection (s)(10)(B)).

''(L) Screening mammography (as defined in subsection (jj)).

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

''(N) Bone mass measurement (as defined in subsection (rr)).

''(O) Additional preventive services (as determined under paragraph (2)).

''(2)(A) The term 'additional preventive services' means items and services, including mental health services, not described in subparagraphs (A) through (N) of paragraph (1) that the Secretary determines to be reasonable and necessary for the prevention or early detection of an illness or disability.

''(B) In making determinations under subparagraph (1), the Secretary shall—

''(i) take into account evidence-based recommendations by the United States Preventive Services Task Force and other appropriate organizations; and

''(ii) use the process for making national coverage determinations (as defined in section 1869(f)(1)(B)) under this title.''.

(b) PAYMENT AND ELIMINATION OF COST-SHARING.—

(1) IN GENERAL.—

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

(i) in clause (T), by striking ''80 percent'' and inserting ''100 percent''; and

(ii) by striking ''and'' before ''(V)''; and

(iii) by inserting before the semicolon at the end the following: '', and (W) with respect to additional preventive services (as defined in section 1861(ccc)(2)) and other preventive services for which a payment rate is not otherwise established under this section, the amount paid shall be 100 percent of the lesser of the actual charge for the services or the amount determined under a fee schedule established by the Secretary for purposes of this clause''.

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

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

''(ii) NO COINSURANCE.—In the case of a beneficiary who receives services described in clause (i), there shall be no coinsurance applied.''; and.

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

''(ii) NO COINSURANCE.—In the case of a beneficiary who receives services described in clause (i), there shall be no coinsurance applied.''.

(2) ELIMINATION OF COINSURANCE IN OUTPATIENT HOSPITAL SETTINGS.—

(A) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by striking ''screening mammography (as defined in section 1861(jj)) and diagnostic mammography'' and inserting ''diagnostic mammography and preventive services (as defined in section 1861(ccc)(1))''.

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

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

(ii) in subparagraph (G)(ii), by adding ''and'' at the end; and

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

''(H) with respect to additional preventive services (as defined in section 1861(ccc)(2)) furnished by an outpatient department of a hospital, the amount determined under paragraph (1)(W);''.

(3) WAIVER OF APPLICATION OF DEDUCTIBLE FOR ALL PREVENTIVE SERVICES.—The first sentence of section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)) is amended—

(A) in clause (1), by striking ''items and services described in section 1861(s)(10)(A)'' and inserting ''preventive services (as defined in section 1861(ccc)(1))'';

(B) by inserting ''and'' before ''(4)''; and

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

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

''(M) Additional preventive services (as defined in subsection (ccc)(2)).''.

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

SEC. 202. WAIVER OF DEDUCTIBLE FOR COLORECTAL CANCER SCREENING TESTS REGARDLESS OF CODING, SUBSEQUENT DIAGNOSIS, OR ANCILLARY TISSUE REMOVAL.

(a) IN GENERAL.—Section 1833(b) of the Social Security Act (42 U.S.C. 1395l(b)), as amended by section 201(b), is amended by adding at the end the following new sentence: ''Clause (1) of the first sentence of this subsection shall apply with respect to a colorectal cancer screening test regardless of the code applied, of the establishment of a diagnosis as a result of the test, or of the removal of tissue or other matter or other procedure that is performed in connection with and as a result of the screening test.''.

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

SEC. 203. PARITY FOR MENTAL HEALTH COINSURANCE.

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

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

SEC. 211. IMPROVING ASSETS TESTS FOR MEDICARE SAVINGS PROGRAM AND LOW-INCOME SUBSIDY PROGRAM.

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

(1) TO FULL-PREMIUM SUBSIDY ELIGIBLE INDIVIDUALS.—Section 1860D–14(a) of the Social Security Act (42 U.S.C. 1395w–114(a)) is amended—

(A) in paragraph (1), in the matter before subparagraph (A), by inserting ''(or, beginning with 2009, paragraph (3)(E))'' after ''paragraph (3)(D)''; and

(B) in paragraph (3)(A)(iii), by striking ''(D) or''.

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

(A) by striking ''and'' at the end of subclause (I);

(B) in subclause (II), by inserting ''(before 2009)'' after ''subsequent year'';

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

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

''(III) for 2009, $17,000 (or $34,000 in the case of the combined value of the individual's assets or resources and the assets or resources of the individual's spouse); and

''(IV) for a subsequent year, the dollar amounts specified in this subclause (or subclause (III)) for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year; and,''

(E) in the last sentence, by inserting ''or (IV)'' after ''subclause (II)''.

(3) APPLICATION OF LIS TEST UNDER MEDICARE SAVINGS PROGRAM.—Section 1905(p)(1)(C) of such Act (42 U.S.C. 1396d(p)(1)(C)) is amended by inserting before the period at the end the following: ''or, effective beginning with January 1, 2009, whose resources (as so determined) do not exceed the maximum resource level applied for the year under section 1860D–14(a)(3)(E) applicable to an individual or to the individual and the individual's spouse (as the case may be)''.

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

SEC. 212. MAKING QI PROGRAM PERMANENT AND EXPANDING ELIGIBILITY.

(a) MAKING PROGRAM PERMANENT.—

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

(A) by striking ''sections 1933 and'' and by inserting ''section''; and

(B) by striking ''(but only for'' and all that follows through ''September 2007)''.

(2) ELIMINATION OF FUNDING LIMITATION.—

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

(i) in subsection (a), by striking ''who are selected to receive such assistance under subsection (b)''

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

(iii) in subsection (d), by striking ''furnished in a State'' and all that follows and inserting ''the Federal medical assistance percentage shall be equal to 100 percent.''; and

(iv) by redesignating subsections (d) and (f) as subsections (b) and (c), respectively.

(B) CONFORMING AMENDMENT.—Section 1905(b) of such Act (42 U.S.C. 1396d(b)) is amended by striking ''1933(d)'' and inserting ''1933(b)''.

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

(b) INCREASE IN ELIGIBILITY TO 150 PERCENT OF THE FEDERAL POVERTY LEVEL.—Section 1902(a)(10)(E)(iv) of such Act is further amended by inserting ''(or, effective January 1, 2008, 150 percent)'' after ''135 percent''.

SEC. 213. ELIMINATING BARRIERS TO ENROLLMENT.

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

''(iii) CERTIFICATION OF INCOME AND RESOURCES.—For purposes of applying this section—

''(I) an individual shall be permitted to apply on the basis of self-certification of income and resources; and

''(II) matters attested to in the application shall be subject to appropriate methods of verification without the need of the individual to provide additional documentation, except in extraordinary situations as determined by the Commissioner.''.

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

''(G) AUTOMATIC REENROLLMENT.—For purposes of applying this section, in the case of an individual who has been determined to be a subsidy eligible individual (and within a particular class of such individuals, such as a full-subsidy eligible individual or a partial subsidy eligible individual), the individual shall be deemed to continue to be so determined without the need for any annual or periodic application unless and until the individual notifies a Federal or State official responsible for such determinations that the individual's eligibility conditions have changed so that the individual is no longer a subsidy eligible individual (or is no longer within such class of such individuals).''.

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

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

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

''(c) ASSISTANCE WITH MEDICARE SAVINGS PROGRAM AND LOW-INCOME SUBSIDY PROGRAM APPLICATIONS.—

''(1) DISTRIBUTION OF APPLICATIONS TO APPLICANTS FOR MEDICARE.—In the case of each individual applying for hospital insurance benefits under section 226 or 226A, the Commissioner shall provide the following:

''(A) Information describing the low-income subsidy program under section 1860D–14 and the medicare savings program under title XIX.

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

''(C) Information on how the individual may obtain assistance in completing such applications, including information on how the individual may contact the State health insurance assistance program (SHIP) for the State in which the individual is located.

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

''(2) TRAINING PERSONNEL IN ASSISTING IN COMPLETING APPLICATIONS.—The Commissioner shall provide training to those employees of the Social Security Administration who are involved in receiving applications for benefits described in paragraph (1) in assisting applicants in completing a medicare savings program application described in paragraph (1). Such employees who are so trained shall provide such assistance upon request.

''(3) TRANSMITTAL OF APPLICATION.—If such an employee assists in completing such an application, the employee, with the consent of the applicant, shall transmit the application to the appropriate State medicaid agency for processing.

''(4) COORDINATION WITH OUTREACH.—The Commissioner shall coordinate outreach activities under this subsection with outreach activities conducted by States in connection with the low-income subsidy program and the medicare savings program.''.

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

''(4) CONSIDERATION OF MSP APPLICATIONS.—The State shall accept medicare savings program applications transmitted under section 1144(c)(3) and act on such applications in the same manner and deadlines as if they had been submitted directly by the applicant.''.

(f) TRANSLATION OF MODEL FORM.—Section 1905(p)(5)(A) of the Social Security Act (42 U.S.C. 1396d(p)(5)(A)) is amended by adding at the end the following: ''The Secretary shall provide for the translation of such application form into at least the 10 languages (other than English) that are most often used by individuals applying for hospital insurance benefits under section 226 or 226A and shall make the translated forms available to the States and to the Commissioner of Social Security.''.

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

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

''(21) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF PROVIDING LOW-INCOME SUBSIDIES UNDER MEDICARE.—

''(A) RETURN INFORMATION FROM INTERNAL REVENUE SERVICE TO SOCIAL SECURITY ADMINISTRATION.—The Secretary, upon written request from the Commissioner of Social Security, shall disclose to the officers and employees of the Social Security Administration with respect to any individual identified by the Commissioner as potentially eligible (based on information other than return information) for low-income subsidies under section 1860D–14 of the Social Security Act—

''(i) whether the adjusted gross income for the applicable year is less than 135 percent of the poverty line (as specified by the Commissioner in such request),

''(ii) whether such adjusted gross income is between 135 percent and 150 percent of the poverty line (as so specified),

''(iii) whether any designated distributions (as defined in section 3405(e)(1)) were reported with respect to such individual under section 6047(d) for the applicable year, and the amount (if any) of the distributions so reported,

''(iv) whether the return was a joint return for the applicable year, and

''(v) the applicable year.

''(B) APPLICABLE YEAR.—

''(i) IN GENERAL.—For the purposes of this paragraph, the term 'applicable year' means the most recent taxable year for which information is available in the Internal Revenue Service's taxpayer data information systems, or, if there is no return filed for the individual for such year, the prior taxable year.

''(ii) NO RETURN.—If no return is filed for such individual for both taxable years referred to in clause (i), the Secretary shall disclose the fact that there is no return filed for such individual for the applicable year in lieu of the information described in subparagraph (A).

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

''(D) TERMINATION.—No disclosure shall be made under this paragraph after the 2-year period beginning on the date of the enactment of this paragraph.''.

(2) PROCEDURES AND RECORDKEEPING RELATED TO DISCLOSURES.—Paragraph (4) of section 6103(p) of such Code is amended by striking ''or (17)'' each place it appears and inserting ''(17), or (21)''.

(3) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Secretary of the Treasury, after consultation with the Commissioner of Social Security, shall submit a written report to Congress regarding the use of disclosures made under section 6103(l)(21) of the Internal Revenue Code of 1986, as added by this subsection, in identifying individuals eligible for the low-income subsidies under section 1860D–14 of the Social Security Act.

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

(h) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall take effect on January 1, 2009.

SEC. 214. ELIMINATING APPLICATION OF ESTATE RECOVERY.

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

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

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

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

(1) by striking ''INSTITUTIONALIZED INDIVIDUALS.—In'' and inserting ''ELIMINATION OF COST-SHARING FOR CERTAIN FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS.—

''(I) INSTITUTIONALIZED INDIVIDUALS.—In''; and

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

''(II) CERTAIN OTHER INDIVIDUALS.—In the case of an individual who is a full-benefit dual eligible individual and with respect to whom there has been a determination that but for the provision of home and community based care (whether under section 1915 or under a waiver under section 1115) the individual would require the level of care provided in a hospital or a nursing facility or intermediate care facility for the mentally retarded the cost of which could be reimbursed under the State plan under title XIX, the elimination of any beneficiary coinsurance described in section 1860D–2(b)(2) (for all amounts through the total amount of expenditures at which benefits are available under section 1860D–2(b)(4)).''.

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

SEC. 216. EXEMPTIONS FROM INCOME AND RESOURCES FOR DETERMINATION OF ELIGIBILITY FOR LOW-INCOME SUBSIDY.

(a) IN GENERAL.—Section 1860D–14(a)(3) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)), as amended by subsections (a) and (b) of section 213, is further amended—

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

(2) in subparagraph (D), in the matter before clause (i), by inserting ''subject to the additional exclusions provided under subparagraph (G)'' before '')'';

(3) in subparagraph (E)(i), in the matter before subclause (I), by inserting ''subject to the additional exclusions provided under subparagraph (G)'' before '')''; and

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

''(I) ADDITIONAL EXCLUSIONS.—In determining the resources of an individual (and the eligible spouse of the individual, if any) under section 1613 for purposes of subparagraphs (D) and (E) the following additional exclusions shall apply:

''(i) LIFE INSURANCE POLICY.—No part of the value of any life insurance policy shall be taken into account.

''(ii) PENSION OR RETIREMENT PLAN.—No balance in any pension or retirement plan shall be taken into account.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2009, and shall apply to determinations of eligibility for months beginning with January 2009.

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

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

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

''(iv) OVERALL LIMITATION ON COST-SHARING.—In the case of all such individuals, a limitation on aggregate cost-sharing under this part for a year not to exceed 5 percent of income.''; and

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

''(F) OVERALL LIMITATION ON COST-SHARING.—A limitation on aggregate cost-sharing under this part for a year not to exceed 5 percent of income.''.

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

SEC. 218. INTELLIGENT ASSIGNMENT IN ENROLLMENT.

(a) IN GENERAL.—Section 1860D–1(b)(1) of the Social Security Act (42 U.S.C. 1395w-101(b)(1)) is amended—

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

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

''(D) INTELLIGENT ASSIGNMENT.—In the case of any auto-enrollment under subparagraph (C), no part D eligible individual described in such subparagraph shall be enrolled in a prescription drug plan which does not meet the following requirements:

''(i) FORMULARY.—The plan has a formulary that covers at least—

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

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

''(ii) PHARMACY NETWORK.—The plan has a network of pharmacies that substantially exceeds the minimum requirements for prescription drug plans in the State and that provides access in areas where lower income individuals reside.

''(iii) QUALITY.—

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

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

''(iv) LOW COST.—The total cost under this title of providing prescription drug coverage under the plan consistent with the previous clauses of this subparagraph is among the lowest 25th percentile of prescription drug plans under this part in the State.

In the case that no plan meets the requirements under clauses (i) through (iv), the Secretary shall implement this subparagraph to the greatest extent possible with the goal of protecting beneficiary access to drugs without increasing the cost relative to the enrollment process under subparagraph (C) as in existence before the date of the enactment of this subparagraph.''.

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

Subtitle C—Part D Beneficiary Improvements

SEC. 221. INCLUDING COSTS INCURRED BY AIDS DRUG ASSISTANCE PROGRAMS AND INDIAN HEALTH SERVICE IN PROVIDING PRESCRIPTION DRUGS TOWARD THE ANNUAL OUT OF POCKET THRESHOLD UNDER PART D.

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

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

(2) in clause (ii)—

(A) by striking ''such costs shall be treated as incurred only if'' and inserting ''subject to clause (iii), such costs shall be treated as incurred only if'';

(B) by striking '', under section 1860D–14, or under a State Pharmaceutical Assistance Program''; and

(C) by striking the period at the end and inserting ''; and''; and

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

''(iii) such costs shall be treated as incurred and shall not be considered to be reimbursed

under clause (ii) if such costs are borne or paid—

''(I) under section 1860D–14;

''(II) under a State Pharmaceutical Assistance Program;

''(III) by the Indian Health Service, an Indian tribe or tribal organization, or an urban Indian organization (as defined in section 4 of the Indian Health Care Improvement Act); or

''(IV) under an AIDS Drug Assistance Program under part B of title XXVI of the Public Health Service Act.''.

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

SEC. 222. PERMITTING MID-YEAR CHANGES IN ENROLLMENT FOR FORMULARY CHANGES ADVERSELY IMPACT AN ENROLLEE.

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

''(F) CHANGE IN FORMULARY RESULTING IN INCREASE IN COST-SHARING.—

''(i) IN GENERAL.—Except as provided in clause (ii), in the case of an individual enrolled in a prescription drug plan (or MA–PD plan) who has been prescribed a covered part D drug while so enrolled, if the formulary of the plan is materially changed (other than at the end of a contract year) so to reduce the coverage (or increase the cost-sharing) of the drug under the plan.

''(ii) EXCEPTION.—Clause (i) shall not apply in the case that a drug is removed from the formulary of a plan because of a recall or withdrawal of the drug issued by the Food and Drug Administration.''.

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

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

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

(1) by striking ''subparagraph (E)'' and inserting ''subparagraphs (E) and (J)''; and

(2) by inserting ''and benzodiazepines, respectively'' after ''smoking cessation agents''.

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

SEC. 224. PERMITTING UPDATING DRUG COMPENDIA UNDER PART D USING PART B UPDATE PROCESS.

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

''(iv) UPDATING DRUG COMPENDIA USING PART B PROCESS.—The Secretary may apply under this subparagraph the same process for updating drug compendia that is used for purposes of section 1861(t)(2)(B)(ii).''.

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

(a) IN GENERAL.—Section 1860D–4(b)(3) of the Social Security Act (42 U.S.C. 1395w-104(b)(3)) is amended—

(1) in subparagraph (C)(i), by inserting '', except as provided in subparagraph (G),'' after ''although''; and

(2) by inserting after subparagraph (F) the following new subparagraph:

''(G) REQUIRED INCLUSION OF DRUGS IN CERTAIN THERAPEUTIC CLASSES.—

''(i) IN GENERAL.—The formulary must include all or substantially all covered part D drugs in each of the following therapeutic classes of covered part D drugs:

''(I) Anticonvulsants.

''(II) Antineoplastics.

''(III) Antiretrovirals.

''(IV) Antidepressants.

''(V) Antipsychotics.

''(VI) Immunosuppresessants.

''(ii) USE OF UTILIZATION MANAGEMENT TOOLS.—A PDP sponsor of a prescription drug plan may use prior authorization or step therapy for the initiation of medications within one of the classifications specified in clause (i) but only when approved by the Secretary, except that such prior authorization or step therapy may not be used in the case of antiretrovirals and in the case of individuals who already are stabilized on a drug treatment regimen.''.

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

SEC. 226. ELIMINATION OF MEDICARE PART D LATE ENROLLMENT PENALTIES PAID BY LOW-INCOME SUBSIDY-ELIGIBLE INDIVIDUALS.

(a) INDIVIDUALS WITH INCOME BELOW 135 PERCENT OF POVERTY LINE.—Paragraph (1)(A)(ii) of section 1860D–14(a) of the Social Security Act (42 U.S.C. 1395w-114(a)) is amended to read as follows:

''(ii) 100 percent of any late enrollment penalties imposed under section 1860D–13(b) for such individual.''.

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

(1) by inserting ''equal to (i) an amount'' after ''premium subsidy'';

(2) by striking ''paragraph (1)(A)'' and inserting ''clause (i) of paragraph (1)(A)''; and

(3) by adding at the end before the period the following: '', plus (ii) 100 percent of the amount described in clause (ii) of such paragraph for such individual''.

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

SEC. 227. SPECIAL ENROLLMENT PERIOD FOR SUBSIDY ELIGIBLE INDIVIDUALS.

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

''(G) ELIGIBILITY FOR LOW-INCOME SUBSIDY.—

''(i) IN GENERAL.—In the case of an applicable subsidy eligible individual (as defined in clause (ii)), the special enrollment period described in clause (iii).

''(ii) APPLICABLE SUBSIDY ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this subparagraph, the term 'applicable subsidy eligible individual' means a part D eligible individual who is determined under subparagraph (B) of section 1860D–14(a)(3) to be a subsidy eligible individual (as defined in subparagraph (A) of such section), and includes such an individual who was enrolled in a prescription drug plan or an MA–PD plan on the date of such determination.

''(iii) SPECIAL ENROLLMENT PERIOD DESCRIBED.—The special enrollment period described in this clause, with respect to an applicable subsidy eligible individual, is the 90-day period beginning on the date the individual receives notification that such individual has been determined under section 1860D–14(a)(3)(B) to be a subsidy eligible individual (as so defined).''.

(b) AUTOMATIC ENROLLMENT PROCESS FOR CERTAIN SUBSIDY ELIGIBLE INDIVIDUALS.—Section 1860D–1(b)(1) of the Social Security Act (42 U.S.C. 1395w-101(b)(1)), as amended by section 218(a)(2), is further amended by adding at the end the following new subparagraph:

''(E) SPECIAL RULE FOR SUBSIDY ELIGIBLE INDIVIDUALS.—The process established under subparagraph (A) shall include, in the case of an applicable subsidy eligible individual (as defined in clause (ii) of paragraph (3)(F)) who fails to enroll in a prescription drug plan or an MA–PD plan during the special enrollment period described in clause (iii) of such paragraph applicable to such individual, a process for the facilitated enrollment of the individual in the prescription drug plan or MA–PD plan that is most appropriate for such individual (as determined by the Secretary). Nothing in the previous sentence shall prevent an individual described in such sentence from declining enrollment in a plan determined appropriate by the Secretary (or in the program under this part) or from changing such enrollment.''.

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

Subtitle D—Reducing Health Disparities

SEC. 231. MEDICARE DATA ON RACE, ETHNICITY, AND PRIMARY LANGUAGE.

(a) REQUIREMENTS.—

(1) IN GENERAL.—The Secretary of Health and Human Services (in this subtitle referred to as the ''Secretary'') shall—

(A) collect data on the race, ethnicity, and primary language of each applicant for and recipient of benefits under title XVIII of the Social Security Act—

(i) using, at a minimum, the categories for race and ethnicity described in the 1997 Office of Management and Budget Standards for Maintaining, Collecting, and Presenting Federal Data on Race and Ethnicity;

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

(iii) where practicable, collecting data for additional population groups if such groups can be aggregated into the minimum race and ethnicity categories; and

(iv) where practicable, through self-reporting;

(B) with respect to the collection of the data described in subparagraph (A) for applicants and recipients who are minors or otherwise legally incapacitated, require that—

(i) such data be collected from the parent or legal guardian of such an applicant or recipient; and

(ii) the preferred language of the parent or legal guardian of such an applicant or recipient be collected;

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

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

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

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

(A) to permit the use of information collected under this subsection in a manner that would adversely affect any individual providing any such information; and

(B) to require health care providers to collect data.

(b) PROTECTION OF DATA.—The Secretary shall ensure (through the promulgation of regulations or otherwise) that all data collected pursuant to subsection (a) is protected—

(1) under the same privacy protections as the Secretary applies to other health data under the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (Public Law 104–191; 110 Stat. 2033) relating to the privacy of individually identifiable health information and other protections; and

(2) from all inappropriate internal use by any entity that collects, stores, or receives the data, including use of such data in determinations of eligibility (or continued eligibility) in health plans, and from other inappropriate uses, as defined by the Secretary.

(c) COLLECTION PLAN.—In carrying out the duties specified in subsection (a), the Secretary shall develop and implement a plan to improve the collection, analysis, and reporting of racial, ethnic, and primary language data within the programs administered under title XVIII of the Social Security Act, and, in consultation with the National Committee on Vital Health Statistics, the Office of Minority Health, and other appropriate public and private entities, shall make recommendations on how to—

(1) implement subsection (a) while minimizing the cost and administrative burdens of data collection and reporting;

(2) expand awareness that data collection, analysis, and reporting by race, ethnicity, and primary language is legal and necessary to assure equity and non-discrimination in the quality of health care services;

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

(4) improve health and health care data collection and analysis for more population groups if such groups can be aggregated into the minimum race and ethnicity categories;

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

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

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

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

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

(1) IN GENERAL.—The Secretary may, either directly or through grant or contract, provide technical assistance to enable a health care provider or plan operating under the Medicare program to comply with the requirements of this section.

(2) TYPES OF ASSISTANCE.—Assistance provided under this subsection may include assistance to—

(A) enhance or upgrade computer technology that will facilitate racial, ethnic, and primary language data collection and analysis;

(B) improve methods for health data collection and analysis including additional population groups beyond the Office of Management and Budget categories if such groups can be aggregated into the minimum race and ethnicity categories;

(C) develop mechanisms for submitting collected data subject to existing privacy and confidentiality regulations; and

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

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

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

(1) identify appropriate quality assurance mechanisms to monitor for health disparities under the Medicare program;

(2) specify the clinical, diagnostic, or therapeutic measures which should be monitored;

(3) develop new quality measures relating to racial and ethnic disparities in health and health care;

(4) identify the level at which data analysis should be conducted; and

(5) share data with external organizations for research and quality improvement purposes, in compliance with applicable Federal privacy laws.

(h) REPORT.—Not later than 2 years after the date of enactment of this Act, and biennially thereafter, the Secretary shall submit to the appropriate committees of Congress a report on the effectiveness of data collection, analysis, and reporting on race, ethnicity, and primary language under the programs administered through title XVIII of the Social Security Act. The report shall evaluate the progress made with respect to the plan under subsection (c) or subsequent revisions thereto.

(i) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out this section, such sums as may be necessary for each of fiscal years 2008 through 2012.

SEC. 232. ENSURING EFFECTIVE COMMUNICATION IN MEDICARE.

(a) ENSURING EFFECTIVE COMMUNICATION BY THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(1) STUDY ON MEDICARE PAYMENTS FOR LANGUAGE SERVICES.—The Secretary of Health and Human Services shall conduct a study that examines ways that Medicare should develop payment systems for language services using the results of the demonstration program conducted under section 233.

(2) ANALYSES.— The study shall include an analysis of each of the following:

(A) How to develop and structure appropriate payment systems for language services for all Medicare service providers.

(B) The feasibility of adopting a payment methodology for on-site interpreters, including interpreters who work as independent contractors and interpreters who work for agencies that provide on-site interpretation, pursuant to which such interpreters could directly bill Medicare for services provided in support of physician office services for an LEP Medicare patient.

(C) The feasibility of Medicare contracting directly with agencies that provide off-site interpretation including telephonic and video interpretation pursuant to which such contractors could directly bill Medicare for the services provided in support of physician office services for an LEP Medicare patient.

(D) The feasibility of modifying the existing Medicare resource-based relative value scale (RBRVS) by using adjustments (such as multipliers or add-ons) when a patient is LEP.

(E) How each of options described in a previous paragraph would be funded and how such funding would affect physician payments, a physician's practice, and beneficiary cost-sharing.

(3) VARIATION IN PAYMENT SYSTEM DESCRIBED.—The payment systems described in subsection (b) may allow variations based upon types of service providers, available delivery methods, and costs for providing language services including such factors as—

(A) the type of language services provided (such as provision of health care or health care related services directly in a non-English language by a bilingual provider or use of an interpreter);

(B) type of interpretation services provided (such as in-person, telephonic, video interpretation);

(C) the methods and costs of providing language services (including the costs of providing language services with internal staff or through contract with external independent contractors and/or agencies);

(D) providing services for languages not frequently encountered in the United States; and

(E) providing services in rural areas.

(4) REPORT.—The Secretary shall submit a report on the study conducted under subsection (a) to appropriate committees of Congress not later than 1 year after the expiration of the demonstration program conducted under section 3.

(b) HEALTH PLANS.—Section 1857(g)(1) of the Social Security Act (42 U.S.C. 1395w-27(g)(1)) is amended—

(1) by striking ''or'' at the end of subparagraph (F);

(2) by adding ''or'' at the end of subparagraph (G); and

(3) by inserting after subparagraph (G) the following new subparagraph:

''(H) fails substantially to provide language services to limited English proficient beneficiaries enrolled in the plan that are required under law;''.

SEC. 233. DEMONSTRATION TO PROMOTE ACCESS FOR MEDICARE BENEFICIARIES WITH LIMITED ENGLISH PROFICIENCY BY PROVIDING REIMBURSEMENT FOR CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES.

(a) IN GENERAL.—Within one year after the date of the enactment of this Act the Secretary, acting through the Centers for Medicare & Medicaid Services, shall award 24 3-year demonstration grants to eligible Medicare service providers to improve effective communication between such providers and Medicare beneficiaries who are ''living in communities where racial and ethnic minorities, including populations that face language barriers, are underserved with respect to such services''. The Secretary shall not authorize a grant larger than $500,000 over three years for any grantee.

(b) ELIGIBILITY; PRIORITY.—

(1) ELIGIBILITY.—To be eligible to receive a grant under subsection (1) an entity shall—

(A) be—

(i) a provider of services under part A of title XVIII of the Social Security Act;

(ii) a service provider under part B of such title;

(iii) a part C organization offering a Medicare part C plan under part C of such title; or

(iv) a PDP sponsor of a prescription drug plan under part D of such title; and

(B) prepare and submit to the Secretary an application, at such time, in such manner, and accompanied by such additional information as the Secretary may require.

(2) PRIORITY.—

(A) DISTRIBUTION.—To the extent feasible, in awarding grants under this section, the Secretary shall award—

(i) 6 grants to providers of services described in paragraph (1)(A)(i);

(ii) 6 grants to service providers described in paragraph (1)(A)(ii);

(iii) 6 grants to organizations described in paragraph (1)(A)(iii); and

(iv) 6 grants to sponsors described in paragraph (1)(A)(iv).

(B) FOR COMMUNITY ORGANIZATIONS.—The Secretary shall give priority to applicants that have developed partnerships with community organizations or with agencies with experience in language access.

(C) VARIATION IN GRANTEES.—The Secretary shall also ensure that the grantees under this section represent, among other factors, variations in—

(i) different types of service providers and organizations under parts A through D of title XVIII of the Social Security Act;

(ii) languages needed and their frequency of use;

(iii) urban and rural settings;

(iv) at least two geographic regions; and

(v) at least two large metropolitan statistical areas with diverse populations.

(c) USE OF FUNDS.—

(1) IN GENERAL.—A grantee shall use grant funds received under this section to pay for the provision of competent language services to Medicare beneficiaries who are limited English proficient. Competent interpreter services may be provided through on-site interpretation, telephonic interpretation, or video interpretation or direct provision of health care or health care related services by a bilingual health care provider. A grantee may use bilingual providers, staff, or contract interpreters. A grantee may use grant funds to pay for competent translation services. A grantee may use up to 10 percent of the grant funds to pay for administrative costs associated with the provision of competent language services and for reporting required under subsection (E).

(2) ORGANIZATIONS.—Grantees that are part C organizations or PDP sponsors must ensure that their network providers receive at least 50 percent of the grant funds to pay for the provision of competent language services to Medicare beneficiaries who are limited English proficient, including physicians and pharmacies.

(3) DETERMINATION OF PAYMENTS FOR LANGUAGE SERVICES.—Payments to grantees shall be calculated based on the estimated numbers of LEP Medicare beneficiaries in a grantee's service area utilizing—

(A) data on the numbers of limited English proficient individuals who speak English less than ''very well'' from the most recently available data from the Bureau of the Census or other State-based study the Secretary determines likely to yield accurate data regarding the number of LEP individuals served by the grantee; or

(B) the grantee's own data if the grantee routinely collects data on Medicare beneficiaries' primary language in a manner determined by the Secretary to yield accurate data and such data shows greater numbers of LEP individuals than the data listed in subparagraph (A).

(4) LIMITATIONS.—

(A) REPORTING.—Payments shall only be provided under this section to grantees that report their costs of providing language services as required under subsection (e). If a grantee fails to provide the reports under such section for the first year of a grant, the Secretary may terminate the grant and solicit applications from new grantees to participate in the subsequent two years of the demonstration program.

(B) TYPE OF SERVICES.—

(i) IN GENERAL.—Subject to clause (ii), payments shall be provided under this section only to grantees that utilize competent bilingual staff or competent interpreter or translation services which—

(I) if the grantee operates in a State that has statewide health care interpreter standards, meet the State standards currently in effect; or

(II) if the grantee operates in a State that does not have statewide health care interpreter standards, utilizes competent interpreters who follow the National Council on Interpreting in Health Care's Code of Ethics and Standards of Practice.

(ii) EXEMPTIONS.—The requirements of clause (i) shall not apply—

(I) in the case of a Medicare beneficiary who is limited English proficient (who has been informed in the beneficiary's primary language of the availability of free interpreter and translation services) and who requests the use of family, friends, or other persons untrained in interpretation or translation and the grantee documents the request in the beneficiary's record; and

(II) in the case of a medical emergency where the delay directly associated with obtaining a competent interpreter or translation services would jeopardize the health of the patient.

Nothing in clause (ii)(II) shall be construed to exempt an emergency rooms or similar entities that regularly provide health care services in medical emergencies from having in place systems to provide competent interpreter and translation services without undue delay.

(d) ASSURANCES.—Grantees under this section shall—

(1) ensure that appropriate clinical and support staff receive ongoing education and training in linguistically appropriate service delivery; ensure the linguistic competence of bilingual providers;

(2) offer and provide appropriate language services at no additional charge to each patient with limited English proficiency at all points of contact, in a timely manner during all hours of operation;

(3) notify Medicare beneficiaries of their right to receive language services in their primary language;

(4) post signage in the languages of the commonly encountered group or groups present in the service area of the organization; and

(5) ensure that—

(A) primary language data are collected for recipients of language services; and

(B) consistent with the privacy protections provided under the regulations promulgated pursuant to section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note), if the recipient of language services is a minor or is incapacitated, the primary language of the parent or legal guardian is collected and utilized.

(e) REPORTING REQUIREMENTS.—Grantees under this section shall provide the Secretary with reports at the conclusion of the each year of a grant under this section. each report shall include at least the following information:

(1) The number of Medicare beneficiaries to whom language services are provided.

(2) The languages of those Medicare beneficiaries.

(3) The types of language services provided (such as provision of services directly in non-English language by a bilingual health care provider or use of an interpreter).

(4) Type of interpretation (such as in-person, telephonic, or video interpretation).

(5) The methods of providing language services (such as staff or contract with external independent contractors or agencies).

(6) The length of time for each interpretation encounter.

(7) The costs of providing language services (which may be actual or estimated, as determined by the Secretary).

(f) NO COST SHARING.—LEP Beneficiaries shall not have to pay cost-sharing or co-pays for language services provided through this demonstration program.

(g) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the demonstration program under this section and shall submit to the appropriate committees of Congress a report not later than 1 year after the completion of the program. The report shall include the following:

(1) An analysis of the patient outcomes and costs of furnishing care to the LEP Medicare beneficiaries participating in the project as compared to such outcomes and costs for limited English proficient Medicare beneficiaries not participating.

(2) The effect of delivering culturally and linguistically appropriate services on beneficiary access to care, utilization of services, efficiency and cost-effectiveness of health care delivery, patient satisfaction, and select health outcomes.

(3) Recommendations regarding the extension of such project to the entire Medicare program.

(h) GENERAL PROVISIONS.—Nothing in this section shall be construed to limit otherwise existing obligations of recipients of Federal financial assistance under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000(d) et. seq.) or any other statute.

(i) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to carry out this section $10,000,000 for each fiscal year of the demonstration.

SEC. 234. DEMONSTRATION TO IMPROVE CARE TO PREVIOUSLY UNINSURED.

(a) ESTABLISHMENT.—Within one year after the date of enactment of this Act, the Secretary shall establish a demonstration project to determine the greatest needs and most effective methods of outreach to medicare beneficiaries who were previously uninsured.

(b) SCOPE.—The demonstration shall be in no fewer than 10 sites, and shall include state health insurance assistance programs, community health centers, community-based organizations, community health workers, and other service providers under parts A, B, and C of title XVIII of the Social Security Act. Grantees that are plans operating under part C shall document that enrollees who were previously uninsured receive the ''Welcome to Medicare'' physical exam.

(c) DURATION.—The Secretary shall conduct the demonstration project for a period of 2 years.

(d) REPORT AND EVALUATION.—The Secretary shall conduct an evaluation of the demonstration and not later than 1 year after the completion of the project shall submit to Congress a report including the following:

(1) An analysis of the effectiveness of outreach activities targeting beneficiaries who were previously uninsured, such as revising outreach and enrollment materials (including the potential for use of video information), providing one-on-one counseling, working with community health workers, and amending the Medicare and You handbook.

(2) The effect of such outreach on beneficiary access to care, utilization of services, efficiency and cost-effectiveness of health care delivery, patient satisfaction, and select health outcomes.

SEC. 235. OFFICE OF THE INSPECTOR GENERAL REPORT ON COMPLIANCE WITH AND ENFORCEMENT OF NATIONAL STANDARDS ON CULTURALLY AND LINGUISTICALLY APPROPRIATE SERVICES (CLAS) IN MEDICARE.

(a) REPORT.—Not later than two years after the date of the enactment of this Act, the Inspector General of the Department of Health and Human Services shall prepare and publish a report on—

(1) the extent to which Medicare providers and plans are complying with the Office for Civil Rights' Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons and the Office of Minority Health's Culturally and Linguistically Appropriate Services Standards in health care; and

(2) a description of the costs associated with or savings related to the provision of language services.

Such report shall include recommendations on improving compliance with CLAS Standards and recommendations on improving enforcement of CLAS Standards.

(b) IMPLEMENTATION.—Not later than one year after the date of publication of the report under subsection (a), the Department of Health and Human Services shall implement changes responsive to any deficiencies identified in the report.

SEC. 236. IOM REPORT ON IMPACT OF LANGUAGE ACCESS SERVICES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall seek to enter into an arrangement with the Institute of Medicine under which the Institute will prepare and publish, not later than 3 years after the date of the enactment of this Act, a report on the impact of language access services on the health and health care of limited English proficient populations.

(b) CONTENTS.—Such report shall include—

(1) recommendations on the development and implementation of policies and practices by

health care organizations and providers for limited English proficient patient populations;

(2) a description of the effect of providing language access services on quality of health care and access to care and reduced medical error; and

(3) a description of the costs associated with or savings related to provision of language access services.

SEC. 237. DEFINITIONS.

In this subtitle:

(1) BILINGUAL.—The term ''bilingual'' with respect to an individual means a person who has sufficient degree of proficiency in two languages and can ensure effective communication can occur in both languages.

(2) COMPETENT INTERPRETER SERVICES.—The term ''competent interpreter services'' means a trans-language rendition of a spoken message in which the interpreter comprehends the source language and can speak comprehensively in the target language to convey the meaning intended in the source language. The interpreter knows health and health-related terminology and provides accurate interpretations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source message.

(3) COMPETENT TRANSLATION SERVICES.—The term ''competent translation services'' means a trans-language rendition of a written document in which the translator comprehends the source language and can write comprehensively in the target language to convey the meaning intended in the source language. The translator knows health and health-related terminology and provides accurate translations by choosing equivalent expressions that convey the best matching and meaning to the source language and captures, to the greatest possible extent, all nuances intended in the source document.

(4) EFFECTIVE COMMUNICATION.—The term ''effective communication'' means an exchange of information between the provider of health care or health care-related services and the limited English proficient recipient of such services that enables limited English proficient individuals to access, understand, and benefit from health care or health care-related services.

(5) INTERPRETING/INTERPRETATION.—The terms ''interpreting'' and ''interpretation'' mean the transmission of a spoken message from one language into another, faithfully, accurately, and objectively.

(6) HEALTH CARE SERVICES.—The term ''health care services'' means services that address physical as well as mental health conditions in all care settings.

(7) HEALTH CARE-RELATED SERVICES.—The term ''health care-related services'' means human or social services programs or activities that provide access, referrals or links to health care.

(8) LANGUAGE ACCESS.—The term ''language access'' means the provision of language services to an LEP individual designed to enhance that individual's access to, understanding of or benefit from health care or health care-related services.

(9) LANGUAGE SERVICES.—The term ''language services'' means provision of health care services directly in a non-English language, interpretation, translation, and non-English signage.

(10) LIMITED ENGLISH PROFICIENT.—The term ''limited English proficient'' or ''LEP'' with respect to an individual means an individual who speaks a primary language other than English and who cannot speak, read, write or understand the English language at a level that permits the individual to effectively communicate with clinical or nonclinical staff at an entity providing health care or health care related services.

(11) MEDICARE PROGRAM.—The term ''Medicare program'' means the programs under parts A through D of title XVIII of the Social Security Act.

(12) SERVICE PROVIDER.—The term ''service provider'' includes all suppliers, providers of services, or entities under contract to provide coverage, items or services under any part of title XVIII of the Social Security Act.

TITLE III—PHYSICIANS' SERVICE PAYMENT REFORM

SEC. 301. ESTABLISHMENT OF SEPARATE TARGET GROWTH RATES FOR SERVICE CATEGORIES.

(a) ESTABLISHMENT OF SERVICE CATEGORIES.—Subsection (j) of section 1848 of the Social Security Act (42 U.S.C. 1395w-4) is amended by adding at the end the following new paragraph:

''(5) SERVICE CATEGORIES.—For services furnished on or after January 1, 2008, each of the following categories of physicians' services shall be treated as a separate 'service category':

''(A) Evaluation and management services for primary care (including new and established patient office visits delivered by physicians who the Secretary determines provide accessible, continuous, coordinated, and comprehensive care for Medicare beneficiaries, emergency department visits, and home visits), and for preventive services (including screening mammography, colorectal cancer screening, and other services as defined by the Secretary, limited to the recommendations of the United States Preventive Services Task Force).

''(B) Evaluation and management services not described in subparagraph (A).

''(C) Imaging services (as defined in subsection (b)(4)(B)) and diagnostic tests (other than clinical diagnostic laboratory tests) not described in subparagraph (A).

''(D) Procedures that are subject (under regulations promulgated to carry out this section) to a 10-day or 90-day global period (in this paragraph referred to as 'major procedures'), except that the Secretary may reclassify as minor procedures under subparagraph (F) any procedures that would otherwise be included in this category if the Secretary determines that such procedures are not major procedures.

''(E) Anesthesia services that are paid on the basis of the separate conversion factor for anesthesia services determined under subsection (d)(1)(D).

''(F) Minor procedures and any other physicians' services that are not described in a preceding subparagraph.''.

(b) ESTABLISHMENT OF SEPARATE CONVERSION FACTORS FOR EACH SERVICE CATEGORY.—Subsection (d)(1) of section 1848 of the Social Security Act (42 U.S.C. 1395w-4) is amended—

(1) in subparagraph (A)—

(A) by designating the sentence beginning ''The conversion factor'' as clause (i) with the heading ''APPLICATION OF SINGLE CONVERSION FACTOR.—'' and with appropriate indentation;

(B) by striking ''The conversion factor'' and inserting ''Subject to clause (ii), the conversion factor''; and

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

''(ii) APPLICATION OF MULTIPLE CONVERSION FACTORS BEGINNING WITH 2008.—

''(I) IN GENERAL.—In applying clause (i) for years beginning with 2008, separate conversion factors shall be established for each service category of physicians' services (as defined in subsection (j)(5)) and any reference in this section to a conversion factor for such years shall be deemed to be a reference to the conversion factor for each of such categories.

''(II) INITIAL CONVERSION FACTORS; SPECIAL RULE FOR ANESTHESIA SERVICES.— Such factors for 2008 shall be based upon the single conversion factor for 2007 multiplied by the update established under paragraph (8) for such category for 2008. In the case of the service category described in subsection (j)(5)(F) (relating to anesthesia services), the conversion factor for 2008 shall be based on the separate conversion factor specified in subparagraph (D) for 2007 multiplied by the update established under paragraph (8) for such category for 2008.

''(III) UPDATING OF CONVERSION FACTORS.—Such factor for a service category for a subsequent year shall be based upon the conversion factor for such category for the previous year and adjusted by the update established for such category under paragraph (8) for the year involved.''; and

(2) in subparagraph (D), by inserting ''(before 2008)'' after ''for a year''.

(c) ESTABLISHING UPDATES FOR CONVERSION FACTORS FOR SERVICE CATEGORIES.—Section 1848(d) of the Social Security Act (42 U.S.C. 1395w-4(d)) is amended—

(1) in paragraph (4)(B), by striking ''and (6)'' and inserting '', (6), (8), and (9).

(2) in paragraph (4)(C)(iii), by striking ''The allowed'' and inserting ''Subject to paragraph (8)(B), the allowed'';

(3) in paragraph (4)(D), by striking ''The update'' and inserting ''Subject to paragraph (8)(E), the update''; and

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

''(8) UPDATES FOR SERVICE CATEGORIES BEGINNING WITH 2008 AND ENDING WITH 2012.

''(9) NO UPDATE FOR SERVICE CATEGORIES BEGINNING WITH 2013.—THE UPDATE TO THE CONVERSION FACTOR FOR EACH OF THE SERVICE CATEGORIES ESTABLISHED UNDER PARAGRAPH (8) FOR 2013 AND EACH SUCCEEDING YEAR SHALL BE 0 PERCENT.''.

''(A) IN GENERAL.—In applying paragraph (4) for a year beginning with 2008 and ending with 2012, the following rules apply:

''(i) APPLICATION OF SEPARATE UPDATE ADJUSTMENTS FOR EACH SERVICE CATEGORY.—Pursuant to paragraph (1)(A)(ii)(I), the update shall be made to the conversion factor for each service category (as defined in subsection (j)(5)) based upon an update adjustment factor for the respective category and year and the update adjustment factor shall be computed, for a year, separately for each service category.

''(ii) COMPUTATION OF ALLOWED AND ACTUAL EXPENDITURES BASED ON SERVICE CATEGORIES.—In computing the prior year adjustment component and the cumulative adjustment component under clauses (i) and (ii) of paragraph (4)(B), the following rules apply:

''(I) APPLICATION BASED ON SERVICE CATEGORIES.—The allowed expenditures and actual expenditures shall be the allowed and actual expenditures for the service category, as determined under subparagraph (B).

''(II) LIMITATION TO PHYSICIAN FEE-SCHEDULE SERVICES.—Actual expenditures shall only take into account expenditures for services furnished under the physician fee schedule.

''(III) APPLICATION OF CATEGORY SPECIFIC TARGET GROWTH RATE.—The growth rate applied under clause (ii)(II) of such paragraph shall be the target growth rate for the service category involved under subsection (f)(5).

''(IV) ALLOCATION OF CUMULATIVE OVERHANG.—There shall be substituted for the difference described in subparagraph (B)(ii)(I) of such paragraph the amount described in subparagraph (C)(i) for the service category involved.

''(B) DETERMINATION OF ALLOWED EXPENDITURES.—In applying paragraph (4) for a year beginning with 2008, notwithstanding subparagraph (C)(iii) of such paragraph, the allowed expenditures for a service category for a year is an amount computed by the Secretary as follows:

''(i) FOR 2008.— For 2008:

''(I) TOTAL 2007 ALLOWED EXPENDITURES FOR ALL SERVICES INCLUDED IN SGR COMPUTATION.—Compute total allowed expenditures for physicians' services (as defined in subsection (f)(4)(A)) for 2007 that would otherwise be calculated under subsection (d) but for this paragraph.

''(II) TOTAL 2007 ALLOWED EXPENDITURES FOR PHYSICIAN FEE SCHEDULE SERVICES.—Compute total allowed expenditures for services furnished under the physician fee schedule for 2007 by

subtracting, from the total allowed expenditures computed under subclause (I), the Secretary's estimate of the amount of the actual expenditures for 2007 for services included in such subclause for which payment is not made under the fee schedule established pursuant to this section.

''(III) ALLOCATION OF 2007 ALLOWED EXPENDITURES TO SERVICE CATEGORY.—Compute allowed expenditures for the service category involved for 2007 by multiplying the total allowed expenditures computed under subclause (II) by the overhang allocation factor for the service category (as defined in subparagraph (C)(iii)).

''(IV) INCREASE BY GROWTH RATE TO OBTAIN 2008 ALLOWED EXPENDITURES FOR SERVICE CATEGORY.—Compute allowed expenditures for the service category for 2008 by increasing the allowed expenditures for the service category for 2007 computed under subclause (III) by the target growth rate for such service category under subsection (f) for 2008.

''(ii) FOR SUBSEQUENT YEARS.—For a subsequent year, take the amount of allowed expenditures for such category for the preceding year (under clause (i) or this clause) and increase it by the target growth rate determined under subsection (f) for such category and year.

''(C) COMPUTATION AND APPLICATION OF CUMULATIVE OVERHANG AMONG CATEGORIES.—

''(i) IN GENERAL.—For purposes of applying paragraph (4)(B)(ii)(II) under clause (ii)(IV), the amount described in this clause for a year (beginning with 2008) is the sum of the following:

''(I) PRE-2008 CUMULATIVE OVERHANG.—The amount of the pre-2008 cumulative excess spending (as defined in clause (ii)) multiplied by the overhang allocation factor for the service category (under clause (iii)).

''(II) POST-2007 CUMULATIVE AMOUNTS.—For a year beginning with 2009, the difference (which may be positive or negative) between the amount of the allowed expenditures for physicians' services (as determined under paragraph (4)(C)) in the service category from January 1, 2008, through the end of the prior year and the amount of the actual expenditures for such services in such category during that period.

''(ii) PRE-2008 CUMULATIVE EXCESS SPENDING DEFINED.—For purposes of clause (i)(I), the term 'pre-2008 cumulative excess spending' means the difference described in paragraph (4)(B)(ii)(I) as determined for the year 2008, taking into account expenditures through December 31, 2007. Such difference takes into account expenditures included in subsection (f)(4)(A).

''(iii) OVERHANG ALLOCATION FACTOR.—For purposes of this paragraph, the term 'overhang allocation factor' means, for a service category, the proportion, as determined by the Secretary of total actual expenditures under this part for items and services in such category during 2007 to the total of such actual expenditures for all the service categories. In calculating such proportion, the Secretary shall only take into account services furnished under the physician fee schedule.

''(D) UPDATES FOR 2008 AND 2009.—The update to the conversion factors for each service category for each of 2008 and 2009 shall be equal to 0.5 percent.

''(E) CHANGE IN RESTRICTION ON UPDATE ADJUSTMENT FACTOR FOR 2010 AND 2011.—The update adjustment factor determined under subparagraph (4)(B), as modified by this paragraph, for a service category for a year (beginning with 2010 and ending with 2011) may be less than -0.07, but may not be less than -0.14.''.

(d) APPLICATION OF SEPARATE TARGET GROWTH RATES FOR EACH CATEGORY.—

(1) IN GENERAL.—Section 1848(f) of the Social Security Act (42 U.S.C. 1395w-4(f)) is amended by adding at the end the following new paragraph:

''(5) APPLICATION OF SEPARATE TARGET GROWTH RATES FOR EACH SERVICE CATEGORY BEGINNING WITH 2008.—The target growth rate for a year beginning with 2008 shall be computed and applied separately under this subsection for each service category (as defined in subsection (j)(5)) and shall be computed using the same method for computing the sustainable growth rate except for the following:

''(A) The reference in paragraphs (2)(A) and (2)(D) to 'all physicians' services' is deemed a reference to the physicians' services included in such category but shall not take into account items and services included in physicians' services through the operation of paragraph (4)(A).

''(B) The factor described in paragraph (2)(C) for the service category described in subsection (j)(5)(A) shall be increased by 0.025.

''(C) A national coverage determination (as defined in section 1869(f)(1)(B)) shall be treated as a change in regulation described in paragraph (2)(D).''.

(2) USE OF TARGET GROWTH RATES.—Section 1848 of such Act is further amended—

(A) in subsection (d)—

(i) in paragraph (1)(E)(ii), by inserting ''or target'' after ''sustainable''; and

(ii) in paragraph (4)(B)(ii)(II), by inserting ''or target'' after ''sustainable''; and

(B) in subsection (f)—

(i) in the heading by inserting ''; TARGET GROWTH RATE'' after ''SUSTAINABLE GROWTH RATE''

(ii) in paragraph (1)—

(I) by striking ''and'' at the end of subparagraph (A);

(II) in subparagraph (B), by inserting ''before 2008'' after ''each succeeding year'' and by striking the period at the end and inserting ''; and''; and

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

''(C) November 1 of each succeeding year the target growth rate for such succeeding year and each of the 2 preceding years.''; and

(iii) in paragraph (2), in the matter before subparagraph (A), by inserting after ''beginning with 2000'' the following: ''and ending with 2007'' .

(e) REPORTS ON EXPENDITURES FOR PART B DRUGS AND CLINICAL DIAGNOSTIC LABORATORY TESTS.—

(1) REPORTING REQUIREMENT.—The Secretary of Health and Human Services shall include information in the annual physician fee schedule proposed rule on the change in the annual rate of growth of actual expenditures for clinical diagnostic laboratory tests or drugs, biologicals, and radiopharmaceuticals for which payment is made under part B of title XVIII of the Social Security Act.

(2) RECOMMENDATIONS.—The report submitted under paragraph (1) shall include an analysis of the reasons for such excess expenditures and recommendations for addressing them in the future.

SEC. 302. IMPROVING ACCURACY OF RELATIVE VALUES UNDER THE MEDICARE PHYSICIAN FEE SCHEDULE.

(a) USE OF EXPERT PANEL TO IDENTIFY MISVALUED PHYSICIANS' SERVICES.—Section 1848(c) of the Social Security Act (42 U.S.C. 1395w(c)) is amended by adding at the end the following new paragraph:

''(7) USE OF EXPERT PANEL TO IDENTIFY MISVALUED PHYSICIANS' SERVICES.—

''(A) IN GENERAL.—The Secretary shall establish an expert panel (in this paragraph referred to as the 'expert panel')—

''(i) to identify, through data analysis, physicians' services for which the relative value under this subsection is potentially misvalued, particularly those services for which such relative value may be overvalued;

''(ii) to assess whether those misvalued services warrant review using existing processes (referred to in paragraph (2)(J)(ii)) for the consideration of coding changes; and

''(iii) to advise the Secretary concerning the exercise of authority under clauses (ii)(III) and (vi) of paragraph (2)(B).

''(B) COMPOSITION OF PANEL.—The expert panel shall be appointed by the Secretary and composed of—

''(i) members with expertise in medical economics and technology diffusion;

''(ii) members with clinical expertise;

''(iii) physicians, particularly physicians (such as a physician employed by the Veterans Administration or a physician who has a full time faculty appointment at a medical school) who are not directly affected by changes in the physician fee schedule under this section;

''(iv) carrier medical directors; and

''(v) representatives of private payor health plans.

''(C) APPOINTMENT CONSIDERATIONS.—In appointing members to the expert panel, the Secretary shall assure racial and ethnic diversity on the panel and may consider appointing a liaison from organizations with experience in the consideration of coding changes to the panel.''.

(b) EXAMINATION OF SERVICES WITH SUBSTANTIAL CHANGES.—Such section is further amended by adding at the end the following new paragraph:

''(8) EXAMINATION OF SERVICES WITH SUBSTANTIAL CHANGES.—The Secretary, in consultation with the expert panel under paragraph (7), shall—

''(A) conduct a five-year review of physicians' services in conjunction with the RUC 5-year review, particularly for services that have experienced substantial changes in length of stay, site of service, volume, practice expense, or other factors that may indicate changes in physician work;

''(B) identify new services to determine if they are likely to experience a reduction in relative value over time and forward a list of the services so identified for such five-year review; and

''(C) for physicians' services that are otherwise unreviewed under the process the Secretary has established, periodically review a sample of relative value units within different types of services to assess the accuracy of the relative values contained in the Medicare physician fee schedule.''.

(c) AUTHORITY TO REDUCE WORK COMPONENT FOR SERVICES WITH ACCELERATED VOLUME GROWTH.—

(1) IN GENERAL.—Paragraph (2)(B) of such section is amended—

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

''(III) REDUCTIONS IN WORK VALUE UNITS FOR SERVICES WITH ACCELERATED VOLUME GROWTH.—Effective January 1, 2009, reduced expenditures attributable to clause (vi).''; and

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

''(vi) AUTHORIZING REDUCTION IN WORK VALUE UNITS FOR SERVICES WITH ACCELERATED VOLUME GROWTH.—The Secretary may provide (without using existing processes the Secretary has established for review of relative value) for a reduction in the work value units for a particular physician's service if the annual rate of growth in the expenditures for such service for which payment is made under this part for individuals for 2006 or a subsequent year exceeds the average annual rate of growth in expenditures of all physicians' services for which payment is made under this part by more than 10 percentage points for such year.

''(vii) CONSULTATION WITH EXPERT PANEL AND BASED ON CLINICAL EVIDENCE.—The Secretary shall exercise authority under clauses (ii)(III) and (vi) in consultation with the expert panel established under paragraph (7) and shall take into account clinical evidence supporting or refuting the merits of such accelerated growth.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply with respect to payment for services furnished on or after January 1, 2009.

(d) ADJUSTMENT AUTHORITY FOR EFFICIENCY GAINS FOR NEW PROCEDURES.—Paragraph (2)(B)(ii) of such section is amended by adding at the end the following new subclause:

''(III) ADJUSTMENT AUTHORITY FOR EFFICIENCY GAINS FOR NEW PROCEDURES.—In carrying out subclauses (I) and (II), the Secretary may apply a methodology, based on supporting evidence, under which there is imposed a reduction over a period of years in specified relative value units in the case of a new (or newer) procedure to take into account inherent efficiencies that are typically or likely to be gained during the period of initial increased application of the procedure.''.

SEC. 303. FEEDBACK MECHANISM ON PRACTICE PATTERNS.

By not later than July 1, 2008, the Secretary of Health and Human Services shall develop and implement a mechanism to measure resource use on a per capita and an episode basis in order to provide confidential feedback to physicians in the Medicare program on how their practice patterns compare to physicians generally, both in the same locality as well as nationally. Such feedback shall not be subject to disclosure under section 552 of title 5, United States Code). The Secretary shall consider extending such mechanism to other suppliers as necessary.

SEC. 304. PAYMENTS FOR EFFICIENT AREAS.

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 EFFICIENT AREAS.—

''(1) IN GENERAL.—In the case of services furnished under the physician fee schedule under section 1848 on or after January 1, 2009, and before January 1, 2011, by a supplier that is paid under such fee schedule in an efficient area (as identified under paragraph (2)), in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid an amount equal to 5 percent of the payment amount for the services under this part.

''(2) IDENTIFICATION OF EFFICIENT AREAS.—

''(A) IN GENERAL.—Based upon available data, the Secretary shall identify those counties or equivalent areas in the United States in the lowest fifth percentile of utilization based on per capita spending for services provided in 2007 under this part and part A, ''as standardized to eliminate the effect of geographic adjustments in payment rates''.

''(B) IDENTIFICATION OF COUNTIES WHERE SERVICE IS FURNISHED..—For purposes of paying the additional amount specified in paragraph (1), if the Secretary uses the 5-digit postal ZIP Code where the service is furnished, the dominant county of the postal ZIP Code (as determined by the United States Postal Service, or otherwise) shall be used to determine whether the postal ZIP Code is in a county described in subparagraph (A).

''(C) JUDICIAL REVIEW.— There shall be no administrative or judicial review under section 1869, 1878, or otherwise, respecting—

''(i) the identification of a county or other area under subparagraph (A); or

''(ii) the assignment of a postal ZIP Code to a county or other area under subparagraph (B).

''(D) PUBLICATION OF LIST OF COUNTIES; POSTING ON WEBSITE.—With respect to a year for which a county or area is identified under this paragraph, the Secretary shall identify such counties or areas as part of the proposed and final rule to implement the physician fee schedule under section 1848 for the applicable year. The Secretary shall post the list of counties identified under this paragraph on the Internet website of the Centers for Medicare & Medicaid Services.''.

SEC. 305. RECOMMENDATIONS ON REFINING THE PHYSICIAN FEE SCHEDULE.

(a) RECOMMENDATIONS ON CONSOLIDATED CODING FOR SERVICES COMMONLY PERFORMED TOGETHER.—Not later than December 31, 2008, the Comptroller General of the United States shall—

(1) complete an analysis of codes paid under the Medicare physician fee schedule to determine whether the codes for procedures that are commonly furnished together should be combined; and

(2) submit to Congress a report on such analysis and include in the report recommendations on whether an adjustment should be made to the relative value units for such combined code.

(b) RECOMMENDATIONS ON INCREASED USE OF BUNDLED PAYMENTS.—Not later than December 31, 2008, the Comptroller General of the United States shall—

(1) complete an analysis of those procedures under the Medicare physician fee schedule for which no global payment methodology is applied but for which a ''bundled'' payment methodology would be appropriate; and

(2) submit to Congress a report on such analysis and include in the report recommendations on increasing the use of ''bundled'' payment methodology under such schedule.

(c) MEDICARE PHYSICIAN FEE SCHEDULE.—In this section, the term ''Medicare physician fee schedule'' means the fee schedule established under section 1848 of the Social Security Act (42 U.S.C. 1395w-4).

SEC. 306. IMPROVED AND EXPANDED MEDICAL HOME DEMONSTRATION PROJECT.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall establish under title XVIII of the Social Security Act an expanded medical home demonstration project (in this section referred to as the ''expanded project'') under this section. The expanded project supersedes the project that was initiated under section 204 of the Medicare Improvement and Extension Act of 2006 (division B of Public Law 109–432). The purpose of the expanded project is—

(1) to guide the redesign of the health care delivery system to provide accessible, continuous, comprehensive, and coordinated, care to Medicare beneficiaries; and

(2) to provide care management fees to personal physicians delivering continuous and comprehensive care in qualified medical homes.

(b) NATURE AND SCOPE OF PROJECT.—

(1) DURATION; SCOPE.—The expanded project shall operate during a period of three years, beginning not later than October 1, 2009, and shall include a nationally representative sample of physicians serving urban, rural, and underserved areas throughout the United States.

(2) ENCOURAGING PARTICIPATION OF SMALL PHYSICIAN PRACTICES.—

(A) IN GENERAL.—The expanded project shall be designed to include the participation of physicians in practices with fewer than four full-time equivalent physicians, as well as physicians in larger practices particularly in rural and underserved areas.

(B) TECHNICAL ASSISTANCE.— In order to facilitate the participation under the expanded project of physicians in such practices, the Secretary shall make available additional technical assistance to such practices during the first year of the expanded project.

(3) SELECTION OF HOMES TO PARTICIPATE.—The Secretary shall select up to 500 medical homes to participate in the expanded project and shall give priority to—

(A) the selection of up to 100 HIT-enhanced medical homes; and

(B) the selection of other medical homes that serve communities whose populations are at higher risk for health disparities,

(4) BENEFICIARY PARTICIPATION.—The Secretary shall establish a process for any Medicare beneficiary who is served by a medical home participating in the expanded project to elect to participate in the project. Each beneficiary who elects to so participate shall be eligible—

(A) for enhanced medical home services under the project with no cost sharing for the additional services; and

(B) for a reduction of up to 50 percent in the coinsurance for services furnished under the physician fee schedule under section 1848 of the Social Security Act by the medical home.

The Secretary shall develop standard recruitment materials and election processes for Medicare beneficiaries who are electing to participate in the expanded project.

(c) STANDARDS FOR MEDICAL HOMES, HIT-ENHANCED MEDICAL HOMES.—

(1) STANDARD SETTING AND CERTIFICATION PROCESS.—The Secretary shall establish a process for selection of a qualified standard setting and certification organization—

(A) to establish standards, consistent with this section, for medical practices to qualify as medical homes or as HIT-enhanced medical homes; and

(B) to provide for the review and certification of medical practices as meeting such standards.

(2) BASIC STANDARDS FOR MEDICAL HOMES.—For purposes of this subsection, the term ''medical home'' means a physician-directed practice that has been certified, under paragraph (1), as meeting the following standards:

(A) ACCESS AND COMMUNICATION WITH PATIENTS.—The practice applies standards for access to care and communication with participating beneficiaries.

(B) MANAGING PATIENT INFORMATION AND USING INFORMATION IN MANAGEMENT TO SUPPORT PATIENT CARE.—The practice has readily accessible, clinically useful information on participating beneficiaries that enables the practice to treat such beneficiaries comprehensively and systematically.

(C) MANAGING AND COORDINATING CARE ACCORDING TO INDIVIDUAL NEEDS.—The practice maintains continuous relationships with participating beneficiaries by implementing evidence-based guidelines and applying them to the identified needs of individual beneficiaries over time and with the intensity needed by such beneficiaries.

(D) PROVIDING ONGOING ASSISTANCE AND ENCOURAGEMENT IN PATIENT SELF-MANAGEMENT.—The practice—

(i) collaborates with participating beneficiaries to pursue their goals for optimal achievable health; and

(ii) assesses patient-specific barriers to communication and conducts activities to support patient self-management.

(E) RESOURCES TO MANAGE CARE.—The practice has in place the resources and processes necessary to achieve improvements in the management and coordination of care for participating beneficiaries.

(F) MONITORING PERFORMANCE.—The practice monitors its clinical process and performance (including outcome measures) in meeting the applicable standards under this subsection and provides information in a form and manner specified by the Secretary with respect to such process and performance.

(3) ADDITIONAL STANDARDS FOR HIT-ENHANCED MEDICAL HOME.—For purposes of this subsection, the term ''HIT-enhanced medical home'' means a medical home that has been certified, under paragraph (1), as using a health information technology system that includes at least the following elements:

(A) ELECTRONIC HEALTH RECORD (EHR).—The system uses, for participating beneficiaries, an electronic health record that meets the following standards:

(i) IN GENERAL.—The record—

(I) has the capability of interoperability with secure data acquisition from health information technology systems of other health care providers in the area served by the home; or

(II) the capability to securely acquire clinical data delivered by such other health care providers to a secure common data source.

(ii) The record protects the privacy and security of health information.

(iii) The record has the capability to acquire, manage, and display all the types of clinical information commonly relevant to services furnished by the medical home, such as complete medical records, radiographic image retrieval, and clinical laboratory information.

(iv) The record is integrated with decision support capacities that facilitate the use of evidence-based medicine and clinical decision support tools to guide decision-making at the point-of-care based on patient-specific factors.

(B) E-PRESCRIBING.—The system supports e-prescribing and computerized physician order entry.

(C) OUTCOME MEASUREMENT.—The system supports the secure, confidential provision of clinical process and outcome measures approved by the National Quality Forum to the Secretary for use in confidential manner for provider feedback and peer review and for outcomes and clinical effectiveness research.

(D) PATIENT EDUCATION CAPABILITY.—The system actively facilitates participating beneficiaries engaging in the management of their own health through education and support systems and tools for shared decision-making.

(E) SUPPORT OF BASIC STANDARDS.— The elements of such system, such as the electronic health record, email communications, patient registries, and clinical-decision support tools, are integrated in a manner to better achieve the basic standards specified in paragraph (2) for a medical home.

(4) USE OF DATA.—The Secretary shall use the data submitted under paragraph (1)(F) in a confidential manner for feedback and peer review for medical homes and for outcomes and clinical effectiveness research. After the first two years of the expanded project, these data may be used for adjustment in the monthly medical home care management fee under subsection (d)(2)(E).

(d) MONTHLY MEDICAL HOME CARE MANAGEMENT FEE.—

(1) IN GENERAL.—Under the expanded project, the Secretary shall provide for payment to the personal physician of each participating beneficiary of a monthly medical home care management fee.

(2) AMOUNT OF PAYMENT.— In determining the amount of such fee, the Secretary shall consider the following:

(A) OPERATING EXPENSES.—The additional practice expenses for the delivery of services through a medical home, taking into account the additional expenses for an HIT-enhanced medical home. Such expenses include costs associated with—

(i) structural expenses, such as equipment, maintenance, and training costs;

(ii) enhanced access and communication functions;

(iii) population management and registry functions;

(iv) patient medical data and referral tracking functions;

(v) provision of evidence-based care;

(vi) implementation and maintenance of health information technology;

(vii) reporting on performance and improvement conditions; and

(viii) patient education and patient decision support, including print and electronic patient education materials.

(B) ADDED VALUE SERVICES.—The value of additional physician work, such as augmented care plan oversight, expanded e-mail and telephonic consultations, extended patient medical data review (including data stored and transmitted electronically), and physician supervision of enhanced self management education, and expanded follow-up accomplished by non-physician personnel, in a medical home that is not adequately taken into account in the establishment of the physician fee schedule under section 1848 of the Social Security Act.

(C) RISK ADJUSTMENT.—The development of an appropriate risk adjustment mechanism to account for the varying costs of medical homes based upon characteristics of participating beneficiaries.

(D) HIT ADJUSTMENT.—Variation of the fee based on the extensiveness of use of the health information technology in the medical home.

(E) PERFORMANCE-BASED.—After the first two years of the expanded project, an adjustment of the fee based on performance of the medical home in achieving quality or outcomes standards.

(3) PERSONAL PHYSICIAN DEFINED.—For purposes of this subsection, the term ''personal physician'' means, with respect to a participating Medicare beneficiary, a physician (as defined in section 1861(r)(1) of the Social Security Act (42 U.S.C. 1395x(r)(1)) who provides accessible, continuous, coordinated, and comprehensive care for the beneficiary as part of a medical practice that is a qualified medical home. Such a physician may be a specialist for a beneficiary requiring ongoing care for a chronic condition or multiple chronic conditions (such as severe asthma, complex diabetes, cardiovascular disease, rheumatologic disorder) or for a beneficiary with a prolonged illness.

(e) FUNDING.—

(1) USE OF CURRENT PROJECT FUNDING.— Funds otherwise applied to the demonstration under section 204 of the Medicare Improvement and Extension Act of 2006 (division B of Public Law 109–432) shall be available to carry out the expanded project

(2) ADDITIONAL FUNDING FROM SMI TRUST FUND.—

(A) IN GENERAL.—In addition to the funds provided under paragraph (1), there shall be available, from the Federal Supplementary Medical Insurance Trust Fund (under section 1841 of the Social Security Act), the amount of $500,000,000 to carry out the expanded project, including payments to of monthly medical home care management fees under subsection (d), reductions in coinsurance for participating beneficiaries under subsection (b)(4)(B), and funds for the design, implementation, and evaluation of the expanded project.

(B) MONITORING EXPENDITURES; EARLY TERMINATION.—The Secretary shall monitor the expenditures under the expanded project and may terminate the project early in order that expenditures not exceed the amount of funding provided for the project under subparagraph (A).

(f) EVALUATIONS AND REPORTS.—.

(1) ANNUAL INTERIM EVALUATIONS AND REPORTS.—For each year of the expanded project, the Secretary shall provide for an evaluation of the project and shall submit to Congress, by a date specified by the Secretary, a report on the project and on the evaluation of the project for each such year.

(2) FINAL EVALUATION AND REPORT.—The Secretary shall provide for an evaluation of the expanded project and shall submit to Congress, not later than 18 months after the date of completion of the project, a report on the project and on the evaluation of the project.

SEC. 307. REPEAL OF PHYSICIAN ASSISTANCE AND QUALITY INITIATIVE FUND.

Subsection (l) of section 1848 of the Social Security Act (42 U.S.C. 1395w-4) is repealed.

SEC. 308. ADJUSTMENT TO MEDICARE PAYMENT LOCALITIES.

Section 1848(e) of the Social Security Act (42 U.S.C.1395w-4(e)) is amended by adding at the end the following new paragraph:

''(6) FEE SCHEDULE GEOGRAPHIC AREAS.—

''(A) IN GENERAL.—

''(i) REVISION.—Subject to clause (ii), for services furnished on or after January 1, 2008, the Secretary shall revise the fee schedule areas used for payment under this section applicable to the State of California using the county-based geographic adjustment factor as specified in option 3 (table 9) in the proposed rule for the 2008 physician fee schedule published at 72 Fed. Reg. 38,122 (July 12, 2007).

''(ii) TRANSITION.—For services furnished during the period beginning January 1, 2008, and ending December 31, 2010, after calculating the work, practice expense, and malpractice geographic indices described in clauses (i), (ii), and (iii) of paragraph (1)(A) that would otherwise apply, the Secretary shall increase any such geographic index for any county in California that is lower than the geographic index used for payment for services under this section as of December 31, 2007, in such county to such geographic index level.

''(B) SUBSEQUENT REVISIONS.—

''(i) TIMING.—Not later than January 1, 2011, the Secretary shall review and make revisions to fee schedule areas in all States for which more than one fee schedule area is used for payment of services under this section. The Secretary may revise fee schedule areas in States in which a single fee schedule area is used for payment for services under this section using the same methodology applied in the previous sentence.

''(ii) LINK WITH GEOGRAPHIC INDEX DATA REVISION.—The revision described in clause (i) shall be made effective concurrently with the application of the periodic review of geographic adjustment factors required under paragraph (1)(C) for 2011 and subsequent periods.''.

SEC. 309. PAYMENT FOR IMAGING SERVICES.

(a) PAYMENT UNDER PART B OF THE MEDICARE PROGRAM FOR DIAGNOSTIC IMAGING SERVICES FURNISHED IN FACILITIES CONDITIONED ON ACCREDITATION OF FACILITIES.—

(1) SPECIAL PAYMENT RULE.—

(A) IN GENERAL.—Section 1848(b)(4) of the Social Security Act (42 U.S.C. 1395w-4(b)(4)) is amended—

(i) in the heading, by striking ''RULE'' and inserting ''RULES'';

(ii) in subparagraph (A), by striking ''IN GENERAL'' and inserting ''LIMITATION''; and

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

''(C) PAYMENT ONLY FOR SERVICES PROVIDED IN ACCREDITED FACILITIES.—

''(i) IN GENERAL.—In the case of imaging services that are diagnostic imaging services described in clause (ii), the payment amount for the technical component and the professional component of the services established for a year under the fee schedule described in paragraph (1) shall each be zero, unless the services are furnished at a diagnostic imaging services facility that meets the certificate requirement described in section 354(b)(1) of the Public Health Service Act, as applied under subsection (m). The previous sentence shall not apply with respect to the technical component if the imaging equipment meets certification standards and the professional component of a diagnostic imaging service that is furnished by a physician.

''(ii) DIAGNOSTIC IMAGING SERVICES.—For purposes of clause (i) and subsection (m), the term 'diagnostic imaging services' means all imaging modalities, including diagnostic magnetic resonance imaging ('MRI'), computed tomography ('CT'), positron emission tomography ('PET'), nuclear medicine procedures, x-rays, sonograms, ultrasounds, echocardiograms, and such emerging diagnostic imaging technologies as specified by the Secretary.''.

(B) EFFECTIVE DATE.—

(i) IN GENERAL.—Subject to clause (ii), the amendments made by subparagraph (A) shall apply to diagnostic imaging services furnished on or after January 1, 2010.

(ii) EXTENSION FOR ULTRASOUND SERVICES.—The amendments made by subparagraph (A) shall apply to diagnostic imaging services that are ultrasound services on or after January 1, 2012.

(2) CERTIFICATION OF FACILITIES THAT FURNISH DIAGNOSTIC IMAGING SERVICES.—Section 1848 of the Social Security Act (42 U.S.C. 1395w-4) is amended by adding at the end the following new subsection:

''(m) CERTIFICATION OF FACILITIES THAT FURNISH DIAGNOSTIC IMAGING SERVICES.—

''(1) IN GENERAL.—For purposes of subsection (b)(4)(C)(i), except as provided under paragraphs (2) through (8), the provisions of section 354 of the Public Health Service Act (as in effect as of June 1, 2007), relating to the certification of mammography facilities, shall apply, with respect to the provision of diagnostic imaging

services (as defined in subsection (b)(4)(C)(ii)) and to a diagnostic imaging services facility defined in paragraph (8) (and to the process of accrediting such facilities) in the same manner that such provisions apply, with respect to the provision of mammograms and to a facility defined in subsection (a)(3) of such section (and to the process of accrediting such mammography facilities).

''(2) TERMINOLOGY AND REFERENCES.—For purposes of applying section 354 of the Public Health Service Act under paragraph (1)—

''(A) any reference to 'mammography', or 'breast imaging' is deemed a reference to 'diagnostic imaging services (as defined in section 1848(b)(4)(C)(ii) of the Social Security Act)';

''(B) any reference to a mammogram or film is deemed a reference to an image, as defined in paragraph (8);

''(C) any reference to 'mammography facility' or to a 'facility' under such section 354 is deemed a reference to a diagnostic imaging services facility, as defined in paragraph (8);

''(D) any reference to radiological equipment used to image the breast is deemed a reference to medical imaging equipment used to provide diagnostic imaging services;

''(E) any reference to radiological procedures or radiological is deemed a reference to medical imaging services, as defined in paragraph (8) or medical imaging, respectively;

''(F) any reference to an inspection (as defined in subsection (a)(4) of such section) or inspector is deemed a reference to an audit (as defined in paragraph (8)) or auditor, respectively;

''(G) any reference to a medical physicist (as described in subsection (f)(1)(E) of such section) is deemed to include a reference to a magnetic resonance scientist or the appropriate qualified expert as determined by the accrediting body;

''(H) in applying subsection (d)(1)(A)(i) of such section, the reference to 'type of each x-ray machine, image receptor, and processor' is deemed a reference to 'type of imaging equipment';

''(I) in applying subsection (d)(1)(B) of such section, the reference that 'the person or agent submits to the Secretary' is deemed a reference that 'the person or agent submits to the Secretary, through the appropriate accreditation body';

''(J) in applying subsection (d)(1)(B)(i) of such section, the reference to standards established by the Secretary is deemed a reference to standards established by an accreditation body and approved by the Secretary;

''(K) in applying subsection (e) of such section, relating to an accreditation body—

''(i) in paragraph (1)(A), the reference to 'may' is deemed a reference to 'shall';

''(ii) in paragraph (1)(B)(i)(II), the reference to 'a random sample of clinical images from such facilities' is deemed a reference to 'a statistically significant random sample of clinical images from a statistically significant random sample of facilities';

''(iii) in paragraph (3)(A) of such section—

''(I) the reference to 'paragraph (1)(B)' in such subsection is deemed to be a reference to 'paragraph (1)(B) and subsection (f)'; and

''(II) the reference to the 'Secretary' is deemed a reference to 'an accreditation body, with the approval of the Secretary'; and

''(iv) in paragraph (6)(B), the reference to the Committee on Labor and Human Resources of the Senate is deemed to be the Committee on Finance of the Senate and the reference to the Committee on Energy and Commerce of the House of Representatives is deemed to include a reference to the Committee on Ways and Means of the House of Representatives;

''(L) in applying subsection (f), relating to quality standards—

''(i) each reference to standards established by the Secretary is deemed a reference to standards established by an accreditation body involved and approved by the Secretary under subsection (d)(1)(B)(i) of such section

''(ii) in paragraph (1)(A), the reference to 'radiation dose' is deemed a reference to 'radiation dose, as appropriate';

''(iii) in paragraph (1)(B), the reference to 'radiological standards' is deemed a reference to 'medical imaging standards, as appropriate';

''(iv) in paragraphs (1)(D)(ii) and (1)(E)(iii), the reference to 'the Secretary' is deemed a reference to 'an accreditation body with the approval of the Secretary';

''(v) in each of subclauses (III) and (IV) of paragraph (1)(G)(ii), each reference to 'patient' is deemed a reference to 'patient, if requested by the patient'; and

''(M) in applying subsection (g), relating to inspections—

''(i) each reference to the 'Secretary or State or local agency acting on behalf of the Secretary' is deemed to include a reference to an accreditation body involved;

''(ii) in the first sentence of paragraph (1)(F), the reference to 'annual inspections required under this paragraph' is deemed a reference to 'the audits carried out in facilities at least every three years from the date of initial accreditation under this paragraph'; and

''(iii) in the second sentence of paragraph (1)(F), the reference to 'inspections carried out under this paragraph' is deemed a reference to 'audits conducted under this paragraph during the previous year'.

''(3) DATES AND PERIODS.—For purposes of paragraph (1), in applying section 354 of the Public Health Service Act, the following applies:

''(A) IN GENERAL.—Except as provided in subparagraph (B)—

''(i) any reference to 'October 1, 1994' shall be deemed a reference to 'January 1, 2010';

''(ii) the reference to 'the date of the enactment of this section' in each of subsections (e)(1)(D) and (f)(1)(E)(iii) is deemed to be a reference to 'the date of the enactment of the Children's Health and Medicare Protection Act of 2007';

''(iii) the reference to 'annually' in subsection (g)(1)(E) is deemed a reference to 'every three years';

''(iv) the reference to 'October 1, 1996' in subsection (l) is deemed to be a reference to 'January 1, 2011';

''(v) the reference to 'October 1, 1999' in subsection (n)(3)(H) is deemed to be a reference to 'January 1, 2012'; and

''(vi) the reference to 'October 1, 1993' in the matter following paragraph (3)(J) of subsection (n) is deemed to be a reference 'January 1, 2010'.

''(B) ULTRASOUND SERVICES.—With respect to diagnostic imaging services that are ultrasounds—

''(i) any reference to 'October 1, 1994' shall be deemed a reference to 'January 1, 2012';

''(ii) the reference to 'the date of the enactment of this section' in subsection (f)(1)(E)(iii) is deemed to be a reference to '7 years after the date of the enactment of the Children's Health and Medicare Protection Act of 2007';

''(iii) the reference to 'October 1, 1996' in subsection (l) is deemed to be a reference to 'January 1, 2013';

''(4) PROVISIONS NOT APPLICABLE.—For purposes of paragraph (1), in applying section 354 of the Public Health Service Act, the following provision shall not apply:

''(A) Subsections (e) and (f) of such section, in so far as the respective subsection imposes any requirement for a physician to be certified, accredited, or otherwise meet requirements, with respect to the provision of any diagnostic imaging services, as a condition of payment under subsection (b)(4)(C)(i), with respect to the professional or technical component, for such service.

''(B) Subsection (e)(1)(B)(v).

''(C) Subsection (f)(1)(H) of such section, relating to standards for special techniques for mammograms of patients with breast implants.

''(D) Subsection (g)(6) of such section, relating to an inspection demonstration program.

''(E) Subsection (n) of such section, relating to the national advisory committee.

''(F) Subsection (p) of such section, relating to breast cancer screening surveillance research grants.

''(g) Paragraphs (1)(B) and (2) of subsection (r) of such section, related to funding.

''(5) ACCREDITATION BODIES.—For purposes of paragraph (1), in applying section 354(e)(1) of the Public Health Service, the following shall apply:

''(A) APPROVAL OF TWO ACCREDITATION BODIES FOR EACH TREATMENT MODALITY.—In the case that there is more than one accreditation body for a treatment modality that qualifies for approval under this subsection, the Secretary shall approve at least two accreditation bodies for such treatment modality.

''(B) ADDITIONAL ACCREDITATION BODY STANDARDS.—In addition to the standards described in subparagraph (B) of such section for accreditation bodies, the Secretary shall establish standards that require—

''(i) the timely integration of new technology by accreditation bodies for purposes of accrediting facilities under this subsection; and

''(ii) the accreditation body involved to evaluate the annual medical physicist survey (or annual medical survey of another appropriate qualified expert chosen by the accreditation body) of a facility upon onsite review of such facility.

''(6) ADDITIONAL QUALITY STANDARDS.—For purposes of paragraph (1), in applying subsection (f)(1) of section 354 of the Public Health Service—

''(A) the quality standards under such subsection shall, with respect to a facility include—

''(i) standards for qualifications of medical personnel who are not physicians and who perform diagnostic imaging services at the facility that require such personnel to ensure that individuals, prior to performing medical imaging, demonstrate compliance with the standards established under subsection (a) through successful completion of certification by a nationally recognized professional organization, licensure, completion of an examination, pertinent coursework or degree program, verified pertinent experience, or through other ways determined appropriate by an accreditation body (with the approval of the Secretary, or through some combination thereof);

''(ii) standards requiring the facility to maintain records of the credentials of physicians and other medical personnel described in clause (i);

''(iii) standards for qualifications and responsibilities of medical directors and other personnel with supervising roles at the facility;

''(iv) standards that require the facility has procedures to ensure the safety of patients of the facility; and

''(v) standards for the establishment of a quality control program at the facility to be implemented as described in subparagraph (E) of such subsection;

''(B) the quality standards described in subparagraph (B) of such subsection shall be deemed to include standards that require the establishment and maintenance of a quality assurance and quality control program at each facility that is adequate and appropriate to ensure the reliability, clarity, and accuracy of the technical quality of diagnostic images produced at such facilities; and

''(C) the quality standard described in subparagraph (C) of such subsection, relating to a requirement for personnel who perform specified services, shall include in such requirement that such personnel must meet continuing medical education standards as

specified by an accreditation body (with the approval of the Secretary) and update such standards at least once every three years.

''(7) ADDITIONAL REQUIREMENTS.—Notwithstanding any provision of section 354 of the Public Health Service Act, the following shall apply to the accreditation process under this subsection for purposes of subsection (b)(4)(C)(i):

''(A) Any diagnostic imaging services facility accredited before January 1, 2010 (or January 1, 2012 in the case of ultrasounds), by an accrediting body approved by the Secretary shall be deemed a facility accredited by an approved accreditation body for purposes of such subsection as of such date if the facility submits to the Secretary proof of such accreditation by transmittal of the certificate of accreditation, including by electronic means.

''(B) The Secretary may require the accreditation under this subsection of an emerging technology used in the provision of a diagnostic imaging service as a condition of payment under subsection (b)(4)(C)(i) for such service at such time as the Secretary determines there is sufficient empirical and scientific information to properly carry out the accreditation process for such technology.

''(8) DEFINITIONS.—For purposes of this subsection:

''(A) AUDIT.—The term 'audit' means an onsite evaluation, with respect to a diagnostic imaging services facility, by the Secretary, State or local agency on behalf of the Secretary, or accreditation body approved under this subsection that includes the following:

''(i) Equipment verification.

''(ii) Evaluation of policies and procedures for compliance with accreditation requirements.

''(iii) Evaluation of personnel qualifications and credentialing.

''(iv) Evaluation of the technical quality of images.

''(v) Evaluation of patient reports.

''(vi) Evaluation of peer-review mechanisms and other quality assurance activities.

''(vii) Evaluation of quality control procedures, results, and follow-up actions.

''(viii) Evaluation of medical physicists (or other appropriate professionals chosen by the accreditation body) and magnetic resonance scientist surveys.

''(ix) Evaluation of consumer complaint mechanisms.

''(x) Provision of recommendations for improvement based on findings with respect to clauses (i) through (ix).

''(B) DIAGNOSTIC IMAGING SERVICES FACILITY.—The term 'diagnostic imaging services facility' has the meaning given the term 'facility' in section 354(a)(3) of the Public Health Service Act (42 U.S.C. 263b(a)(3)) subject to the reference changes specified in paragraph (2), but does not include any facility that does not furnish diagnostic imaging services for which payment may be made under this section.

''(C) IMAGE.—The term 'image' means the portrayal of internal structures of the human body for the purpose of detecting and determining the presence or extent of disease or injury and may be produced through various techniques or modalities, including radiant energy or ionizing radiation and ultrasound and magnetic resonance. Such term does not include image guided procedures.

''(D) MEDICAL IMAGING SERVICE.—The term 'medical imaging service' means a service that involves the science of an image.''.

(b) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—Section 1848 of the Social Security Act (42 U.S.C. 1395w) is amended—

(1) in subsection (b)(4)—

(A) in subparagraph (B), by striking ''subparagraph (A)'' and inserting ''this paragraph''; and

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

''(D) ADJUSTMENT IN PRACTICE EXPENSE TO REFLECT HIGHER PRESUMED UTILIZATION.—In computing the number of practice expense relative value units under subsection (c)(2)(C)(ii) with respect to imaging services described in subparagraph (B), the Secretary shall adjust such number of units so it reflects a 75 percent (rather than 50 percent) presumed rate of utilization of imaging equipment.''; and

(2) in subsection (c)(2)(B)(v)(II), by inserting ''AND OTHER PROVISIONS'' after ''OPD PAYMENT CAP''

(c) ADJUSTMENT IN TECHNICAL COMPONENT ''DISCOUNT'' ON SINGLE-SESSION IMAGING TO CONSECUTIVE BODY PARTS.—Section 1848(b)(4) of such Act is further amended by adding at the end the following new subparagraph:

''(E) ADJUSTMENT IN TECHNICAL COMPONENT DISCOUNT ON SINGLE-SESSION IMAGING INVOLVING CONSECUTIVE BODY PARTS.—The Secretary shall increase the reduction in expenditures attributable to the multiple procedure payment reduction applicable to the technical component for imaging under the final rule published by the Secretary in the Federal Register on November 21, 2005 (42 CFR 405, et al.) from 25 percent to 50 percent.''.

(d) ADJUSTMENT IN ASSUMED INTEREST RATE FOR CAPITAL PURCHASES.—Section 1848(b)(4) of such Act is further amended by adding at the end the following new subparagraph:

''(F) ADJUSTMENT IN ASSUMED INTEREST RATE FOR CAPITAL PURCHASES.—In computing the practice expense component for imaging services under this section, the Secretary shall change the interest rate assumption for capital purchases of imaging devices to reflect the prevailing rate in the market, but in no case higher than 11 percent.''.

(e) DISALLOWANCE OF GLOBAL BILLING.—Effective for claims filed for imaging services (as defined in subsection (b)(4)(B) of section 1848 of the Social Security Act) furnished on or after the first day of the first month that begins more than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall not accept (or pay) a claim under such section unless the claim is made separately for each component of such services.

(f) EFFECTIVE DATE.—Except as otherwise provided, this section, and the amendments made by this section, shall apply to services furnished on or after January 1, 2008.

SEC. 310. REDUCING FREQUENCY OF MEETINGS OF THE PRACTICING PHYSICIANS ADVISORY COUNCIL.

Section 1868(a)(2) of the Social Security Act (42 U.S.C. 1395ee(a)(2)) is amended by striking ''once during each calendar quarter'' and inserting ''once each year (and at such other times as the Secretary may specify)''.

TITLE IV—MEDICARE ADVANTAGE REFORMS

Subtitle A—Payment Reform

SEC. 401. EQUALIZING PAYMENTS BETWEEN MEDICARE ADVANTAGE PLANS AND FEE-FOR-SERVICE MEDICARE.

(a) PHASE IN OF PAYMENT BASED ON FEE-FOR-SERVICE COSTS.—Section 1853 of the Social Security Act (42 U.S.C. 1395w–23) is amended—

(1) in subsection (j)(1)(A)—

(A) by striking ''beginning with 2007'' and inserting ''for 2007 and 2008''; and

(B) by inserting after ''(k)(1)'' the following: '', or, beginning with 2009, 1/12 of the blended benchmark amount determined under subsection (l)(1)''; and

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

''(l) DETERMINATION OF BLENDED BENCHMARK AMOUNT.—

''(1) IN GENERAL.—For purposes of subsection (j), subject to paragraphs (2) and (3), the term 'blended benchmark amount' means for an area—

''(A) for 2009 the sum of—

''(i) 2/3 of the applicable amount (as defined in subsection (k)(1)) for the area and year; and

''(ii) 1/3 of the amount specified in subsection (c)(1)(D)(i) for the area and year;

''(B) for 2010 the sum of—

''(i) 1/3 of the applicable amount for the area and year; and

''(ii) 2/3 of the amount specified in subsection (c)(1)(D)(i) for the area and year; and

''(C) for a subsequent year the amount specified in subsection (c)(1)(D)(i) for the area and year.

''(2) FEE-FOR-SERVICE PAYMENT FLOOR.—In no case shall the blended benchmark amount for an area and year be less than the amount specified in subsection (c)(1)(D)(i) for the area and year.

''(3) EXCEPTION FOR PACE PLANS.—This subsection shall not apply to payments to a PACE program under section 1894.''.

(b) PHASE IN OF PAYMENT BASED ON IME COSTS.—

(1) IN GENERAL.—Section 1853(c)(1)(D)(i) of such Act (42 U.S.C. 1395w–23(c)(1)(D)(i)) is amended by inserting ''and costs attributable to payments under section 1886(d)(5)(B)'' after ''1886(h)''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to the capitation rate for years beginning with 2009.

(c) LIMITATION ON PLAN ENROLLMENT IN CASES OF EXCESS BIDS FOR 2009 AND 2010.—

(1) IN GENERAL.—In the case of a Medicare Part C organization that offers a Medicare Part C plan in the 50 States or the District of Columbia for which—

(A) bid amount described in paragraph (2) for a Medicare Part C plan for 2009 or 2010, exceeds

(B) the percent specified in paragraph (4) of the fee-for-service amount described in paragraph (3),

the Medicare Part C plan may not enroll any new enrollees in the plan during the annual, coordinated election period (under section 1851(e)(3)(B) of such Act (42 U.S.C. 1395w–21(e)(3)(B)) for the year or during the year (if the enrollment becomes effective during the year).

(2) BID AMOUNT FOR PART A AND B SERVICES.—

(A) IN GENERAL.—Except as provided in subparagraph (B), the bid amount described in this paragraph is the unadjusted Medicare Part C statutory non-drug monthly bid amount (as defined in section 1854(b)(2)(E) of the Social Security Act (42 U.S.C. 1395w–24(b)(2)(E)).

(B) TREATMENT OF MSA PLANS.—In the case of an MSA plan (as defined in section 1859(b)(3) of the Social Security Act, 42 U.S.C. 1935w–28(b)(3)), the bid amount described in this paragraph is the amount described in section 1854(a)(3)(A) of such Act (42 U.S.C. 1395w–24(a)(3)(A)).

(3) FEE-FOR-SERVICE AMOUNT DESCRIBED.—

(A) IN GENERAL.—Subject to subparagraph (B), the fee-for-service amount described in this paragraph for an Medicare Part C local area is the amount described in section 1853(c)(1)(D)(i) of the Social Security Act (42 U.S.C. 1395w–23) for such area.

(B) TREATMENT OF MULTI-COUNTY PLANS.—In the case of an MA plan the service area for which covers more than one Medicare Part C local area, the fee-for-service amount described in this paragraph is the amount described in section 1853(c)(1)(D)(i) of the Social Security Act for each such area served, weighted for each such area by the proportion of the enrollment of the plan that resides in the county (as determined based on amounts posted by the Administrator of the Centers for Medicare & Medicaid Services in the April bid notice for the year involved).

(4) PERCENTAGE PHASE DOWN.—For purposes of paragraph (1), the percentage specified in this paragraph—

(A) for 2009 is 106 percent; and

(B) for 2010 is 103 percent.

(5) EXEMPTION OF AGE-INS.—For purposes of paragraph (1), the term ''new enrollee'' with respect to a Medicare Part C plan offered by a Medicare Part C organization, does not include an individual who was enrolled in a plan offered by the organization in the month immediately before the month in which the individual was eligible to enroll in such a Medicare Part C plan offered by the organization.

(d) ANNUAL REBASING OF FEE-FOR-SERVICE RATES.—Section 1853(c)(1)(D)(ii) of the Social Security Act (42 U.S.C. 1395w–23(c)(1)(D)(ii)) is amended—

(1) by inserting ''(before 2009)'' after ''for subsequent years''; and

(2) by inserting before the period at the end the following: ''and for each year beginning with 2009''.

(e) REPEAL OF PPO STABILIZATION FUND.—Section 1858 of the Social Security Act (42 U.S.C. 1395) is amended—

(1) by striking subsection (e); and

(2) in subsection (f)(1), by striking ''subject to subsection (e),''.

Subtitle B—Beneficiary Protections

SEC. 411. NAIC DEVELOPMENT OF MARKETING, ADVERTISING, AND RELATED PROTECTIONS.

(a) IN GENERAL.—Section 1852 of the Social Security Act (42 U.S.C. 1395w–22) is amended by adding at the end the following new subsection:

''(m) APPLICATION OF MODEL MARKETING AND ENROLLMENT STANDARDS.—

''(1) IN GENERAL.—The National Association of Insurance Commissioners (in this subsection referred to as the 'NAIC') is requested to develop, and to submit to the Secretary of Health and Human Services not later than 12 months after the date of the enactment of this Act, model regulations (in this section referred to as 'model regulations') regarding Medicare plan marketing, enrollment, broker and agent training and certification, agent and broker commissions, and market conduct by plans, agents and brokers for implementation (under paragraph (7)) under this part and part D, including for enforcement by States under section 1856(b)(3).

''(2) MARKETING GUIDELINES.—

''(A) IN GENERAL.—The model regulations shall address the sales and advertising techniques used by Medicare private plans, agents and brokers in selling plans, including defining and prohibiting cold calls, unsolicited door-to-door sales, cross-selling, and co-branding.

''(B) SPECIAL CONSIDERATIONS.—The model regulations shall specifically address the marketing—

''(i) of plans to full benefit dual-eligible individuals and qualified medicare beneficiaries;

''(ii) of plans to populations with limited English proficiency;

''(iii) of plans to beneficiaries in senior living facilities; and

''(iv) of plans at educational events.

''(3) ENROLLMENT GUIDELINES.—

''(A) IN GENERAL.—The model regulations shall address the disclosures Medicare private plans, agents, and brokers must make when enrolling beneficiaries, and a process—

''(i) for affirmative beneficiary sign off before enrollment in a plan; and

''(ii) in the case of Medicare Part C plans, for plans to conduct a beneficiary call-back to confirm beneficiary sign off and enrollment.

''(B) SPECIFIC CONSIDERATIONS.—The model regulations shall specially address beneficiary understanding of the Medicare plan through required disclosure (or beneficiary verification) of each of the following:

''(i) The type of Medicare private plan involved.

''(ii) Attributes of the plan, including premiums, cost sharing, formularies (if applicable), benefits, and provider access limitations in the plan.

''(iii) Comparative quality of the plan.

''(iv) The fact that plan attributes may change annually.

''(4) APPOINTMENT, CERTIFICATION AND TRAINING OF AGENTS AND BROKERS.—The model regulations shall establish procedures and requirements for appointment, certification (and periodic recertification), and training of agents and brokers that market or sell Medicare private plans consistent with existing State appointment and certification procedures and with this paragraph.

''(5) AGENT AND BROKER COMMISSIONS.—

''(A) IN GENERAL.—The model regulations shall establish standards for fair and appropriate commissions for agents and brokers consistent with this paragraph.

''(B) LIMITATION ON TYPES OF COMMISSION.—The model regulations shall specifically prohibit the following:

''(i) Differential commissions—

''(I) for Medicare Part C plans based on the type of Medicare private plan; or

''(II) prescription drug plans under part D based on the type of prescription drug plan.

''(ii) Commissions in the first year that are more than 200 percent of subsequent year commissions.

''(iii) The payment of extra bonuses or incentives (such as trips, gifts, and other non-commission cash payments).

''(C) AGENT DISCLOSURE.—In developing the model regulations, the NAIC shall consider requiring agents and brokers to disclose commissions to a beneficiary upon request of the beneficiary before enrollment.

''(D) PREVENTION OF FRAUD.—The model regulations shall consider the opportunity for fraud and abuse and beneficiary steering in setting standards under this paragraph and shall provide for the ability of State commissioners to investigate commission structures.

''(6) MARKET CONDUCT.—

''(A) IN GENERAL.—The model regulations shall establish standards for the market conduct of organizations offering Medicare private plans, and of agents and brokers selling such plans, and for State review of plan market conduct.

''(B) MATTERS TO BE INCLUDED.—Such standards shall include standards for—

''(i) timely payment of claims;

''(ii) beneficiary complaint reporting and disclosure; and

''(iii) State reporting of market conduct violations and sanctions.

''(7) IMPLEMENTATION.—

''(A) PUBLICATION OF NAIC MODEL REGULATIONS.—If the model regulations are submitted on a timely basis under paragraph (1)—

''(i) the Secretary shall publish them in the Federal Register upon receipt and request public comment on the issue of whether such regulations are consistent with the requirements established in this subsection for such regulations;

''(ii) not later than 6 months after the date of such publication, the Secretary shall determine whether such regulations are so consistent with such requirements and shall publish notice of such determination in the Federal Register; and

''(iii) if the Secretary makes the determination under clause (ii) that such regulations are consistent with such requirements, in the notice published under clause (ii) the Secretary shall publish notice of adoption of such model regulations as constituting the marketing and enrollment standards adopted under this subsection to be applied under this title; and

''(iv) if the Secretary makes the determination under such clause that such regulations are not consistent with such requirements, the procedures of clauses (ii) and (iii) of subparagraph (B) shall apply (in relation to the notice published under clause (ii)), in the same manner as such clauses would apply in the case of publication of a notice under subparagraph (B)(i).

''(B) NO MODEL REGULATIONS.—If the model regulations are not submitted on a timely basis under paragraph (1)—

''(i) the Secretary shall publish notice of such fact in the Federal Register;

''(ii) not later than 6 months after the date of publication of such notice, the Secretary shall propose regulations that provide for marketing and enrollment standards that incorporate the requirements of this subsection for the model regulations and request public comments on such proposed regulations; and

''(iii) not later than 6 months after the date of publication of such proposed regulations, the Secretary shall publish final regulations that shall constitute the marketing and enrollment standards adopted under this subsection to be applied under this title.

''(C) REFERENCES TO MARKETING AND ENROLLMENT STANDARDS.—In this title, a reference to marketing and enrollment standards adopted under this subsection is deemed a reference to the regulations constituting such standards adopted under subparagraph (A) or (B), as the case may be.

''(D) EFFECTIVE DATE OF STANDARDS.—In order to provide for the orderly and timely implementation of marketing and enrollment standards adopted under this subsection, the Secretary, in consultation with the NAIC, shall specify (by program instruction or otherwise) effective dates with respect to all components of such standards consistent with the following:

''(i) In the case of components that relate predominantly to operations in relation to Medicare private plans, the effective date shall be for plan years beginning on or after such date (not later than 1 year after the date of promulgation of the standards) as the Secretary specifies.

''(ii) In the case of other components, the effective date shall be such date, not later than 1 year after the date of promulgation of the standards, as the Secretary specifies.

''(E) CONSULTATION.— In promulgating marketing and enrollment standards under this paragraph, the NAIC or Secretary shall consult with a working group composed of representatives of issuers of Medicare private plans, consumer groups, medicare beneficiaries, State Health Insurance Assistance Programs, and other qualified individuals. Such representatives shall be selected in a manner so as to assure balanced representation among the interested groups.

''(8) ENFORCEMENT.—

''(A) IN GENERAL.—Any Medicare private plan that violates marketing and enrollment standards is subject to sanctions under section 1857(g).

''(B) STATE RESPONSIBILITIES.—Nothing in this subsection or section 1857(g) shall prohibit States from imposing sanctions against Medicare private plans, agents, or brokers for violations of the marketing and enrollment standards adopted under section 1852(m). States shall have the sole authority to regulate agents and brokers.

''(9) MEDICARE PRIVATE PLAN DEFINED.—In this subsection, the term 'Medicare private plan' means a Medicare Part C plan and a prescription drug plan under part D.''.

(b) EXPANSION OF EXCEPTION TO PREEMPTION OF STATE ROLE.—

(1) IN GENERAL.—Section 1856(b)(3) of the Social Security Act (42 U.S.C. 1395w–26(b)(3)) is amended by striking ''(other than State licensing laws or State laws relating to plan solvency)'' and inserting ''(other than State laws relating to licensing or plan solvency and State laws or regulations adopting the marketing and enrollment standards adopted under section 1852(m))''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to plans offered on or after July 1, 2008.

(c) APPLICATION TO PRESCRIPTION DRUG PLANS.—

(1) IN GENERAL.—Section 1860D–1 of such Act is amended by adding at the end the following new subsection:

''(d) APPLICATION OF MARKETING AND ENROLLMENT STANDARDS.—The marketing and enrollment standards adopted under section 1852(m) shall apply to prescription drug plans (and sponsors of such plans) in the same manner as they apply to Medicare Part C plans and organizations offering such plans.''.

(2) REFERENCE TO CURRENT LAW PROVISIONS.—The amendment made by subsection (a) and (b) apply, pursuant to section 1860D–1(b)(1)(B)(ii) of the Social Security Act (42 U.S.C. 1395w–101(b)(1)(B)(ii)), to prescription drug plans under part D of title XVIII of such Act.

(d) CONTRACT REQUIREMENT TO MEET MARKETING AND ADVERTISING STANDARDS.—

(1) IN GENERAL.—Section 1857(d) of the Social Security Act (42 U.S.C. 1395w–27(d)), as amended by subsection (b)(1), is further amended by adding at the end the following new paragraph:

''(7) MARKETING AND ADVERTISING STANDARDS.—The contract shall require the organization to meet all standards adopted under section 1852(m) (including those enforced by the State involved pursuant to section 1856(b)(3)) relating to marketing and advertising conduct.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to contracts for plan years beginning on or after January 1, 2011.

(e) APPLICATION OF SANCTIONS.—

(1) APPLICATION TO VIOLATION OF MARKETING AND ENROLLMENT STANDARDS.—Section 1857(g)(1) of such Act (42 U.S.C. 1395w–27(g)(1)), as amended by the preceding provisions of this Act, is further amended—

(A) by striking ''and'' at the end of subparagraph (G);

(B) by adding ''and'' at the end of subparagraph (H); and

(C) by inserting after subparagraph (H) the following new subparagraph:

''(I) violates marketing and enrollment standards adopted under section 1852(m);''.

(2) ENHANCED CIVIL MONEY SANCTIONS.—Such section is further amended—

(A) in paragraph (2)(A), by striking ''$25,000'', ''$100,000'', and ''$15,000'' and inserting ''$50,000'', ''$200,000'', and ''$30,000'', respectively; and

(B) in subparagraphs (A), (B), and (D) of paragraph (3), by striking ''$25,000'', ''$10,000'', and ''$100,000'', respectively, and inserting ''$50,000'', ''$20,000'', and ''$200,000'', respectively.

(3) EFFECTIVE DATE.—The amendments made by paragraph (2) shall apply to violations occurring on or after the date of the enactment of this Act.

(f) DISCLOSURE OF MARKET AND ADVERTISING CONTRACT VIOLATIONS AND IMPOSED SANCTIONS.—Section 1857 of such Act is amended by adding at the end the following new subsection

''(j) DISCLOSURE OF MARKET AND ADVERTISING CONTRACT VIOLATIONS AND IMPOSED SANCTIONS.—For years beginning with 2009, the Secretary shall post on its public website for the Medicare program an annual report that—

''(1) lists each MA organization for which the Secretary made during the year a determination under subsection (c)(2) the basis of which is described in paragraph (1)(E); and

''(2) that describes any applicable sanctions under subsection (g) applied to such organization pursuant to such determination.''.

(g) STANDARD DEFINITIONS OF BENEFITS AND FORMATS FOR USE IN MARKETING MATERIALS.—Section 1851(h) of such Act (42 U.S.C. 1395w–21(h)) is amended by adding at the end the following new paragraph:

''(6) STANDARD DEFINITIONS OF BENEFITS AND FORMATS FOR USE IN MARKETING MATERIALS.—

''(A) IN GENERAL.—Not later than January 1, 2010, the Secretary, in consultation with the National Association of Insurance Commissioners and a working group of the type described in section 1852(m)(7)(E), shall develop standard descriptions and definitions for benefits under this title for use in marketing material distributed by Medicare Part C organizations and formats for including such descriptions in such marketing material.

''(B) REQUIRED USE OF STANDARD DEFINITIONS.— For plan years beginning on or after January 1, 2011, the Secretary shall disapprove the distribution of marketing material under paragraph (1)(B) if such marketing material does not use, without modification, the applicable descriptions and formats specified under subparagraph (A).''.

(h) SUPPORT FOR STATE HEALTH INSURANCE ASSISTANCE PROGRAMS (SHIPS).—Section 1857(e)(2) of the Social Security Act (42 U.S.C. 1395w–27(e)(2)) is amended—

(1) in subparagraph (B), by adding at the end the following: ''Of the amounts so collected, no less than $55,000,000 for fiscal year 2009, $65,000,000 for fiscal year 2010, $75,000,000 for fiscal year 2011, and $85,000,000 for fiscal year 2012 and each succeeding fiscal year shall be used to support Medicare Part C and Part D counseling and assistance provided by State Health Insurance Assistance Programs.'';

(2) in subparagraph (C)—

(A) by striking ''and'' after ''$100,000,000,'' and

(B) by striking ''an amount equal to $200,000,000'' and inserting ''and ending with fiscal year 2008 an amount equal to $200,000,000, for fiscal year 2009 an amount equal to $255,000,000, for fiscal year 2010 an amount equal to $265,000,000, for fiscal year 2011 an amount equal to $275,000,000, and for fiscal year 2012 and each succeeding fiscal year an amount equal to $285,000,000.''

(3) in subparagraph (D)(ii)—

(A) by striking ''and'' at the end of subclause (IV);

(B) in subclause (V), by striking the period at the end and inserting ''before fiscal year 2009; and''; and

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

''(VI) for fiscal year 2009 and each succeeding fiscal year the applicable portion (as so defined) of the amount specified in subparagraph (C) for that fiscal year.''.

SEC. 412. LIMITATION ON OUT-OF-POCKET COSTS FOR INDIVIDUAL HEALTH SERVICES.

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

(1) in subparagraph (A), by inserting before the period at the end the following: ''with cost-sharing that is no greater (and may be less) than the cost-sharing that would otherwise be imposed under such program option'';

(2) in subparagraph (B)(i), by striking ''or an actuarially equivalent level of cost-sharing as determined in this part''; and

(3) by amending clause (ii) of subparagraph (B) to read as follows:

''(ii) PERMITTING USE OF FLAT COPAYMENT OR PER DIEM RATE.—Nothing in clause (i) shall be construed as prohibiting a Medicare part C plan from using a flat copayment or per diem rate, in lieu of the cost-sharing that would be imposed under part A or B, so long as the amount of the cost-sharing imposed does not exceed the amount of the cost-sharing that would be imposed under the respective part if the individual were not enrolled in a plan under this part.''.

(b) LIMITATION FOR DUAL ELIGIBLES AND QUALIFIED MEDICARE BENEFICIARIES.—Section 1852(a) of such Act is amended by adding at the end the following new paragraph:

''(7) LIMITATION ON COST-SHARING FOR DUAL ELIGIBLES AND QUALIFIED MEDICARE BENEFICIARIES.—In the case of a individual who is a full-benefit dual eligible individual (as defined in section 1935(c)(6)) or a qualified medicare beneficiary (as defined in section 1905(p)(1)) who is enrolled in a Medicare Part C plan, the plan may not impose cost-sharing that exceeds the amount of cost-sharing that would be permitted with respect to the individual under this title and title XIX if the individual were not enrolled with such plan.''.

(c) EFFECTIVE DATES.—

(1) The amendments made by subsection (a) shall apply to plan years beginning on or after January 1, 2009.

(2) The amendments made by subsection (b) shall apply to plan years beginning on or after January 1, 2008.

SEC. 413. MA PLAN ENROLLMENT MODIFICATIONS.

(a) IMPROVED PLAN ENROLLMENT, DISENROLLMENT, AND CHANGE OF ENROLLMENT.—

(1) CONTINUOUS OPEN ENROLLMENT FOR FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS AND QUALIFIED MEDICARE BENEFICIARIES (QMB).—Section 1851(e)(2)(D) of the Social Security Act (42 U.S.C. 1395w–21(e)(2)(D)) is amended—

(A) in the heading, by inserting'', FULL-BENEFIT DUAL ELIGIBLE INDIVIDUALS, AND QUALIFIED MEDICARE BENEFICIARIES'' after ''INSTITUTIONALIZED INDIVIDUALS''; and

(B) in the matter before clause (i), by inserting '', a full-benefit dual eligible individual (as defined in section 1935(c)(6)), or a qualified medicare beneficiary (as defined in section 1905(p)(1))'' after ''institutionalized (as defined by the Secretary)''; and

(C) in clause (i), by inserting ''or disenroll'' after ''enroll''.

(2) SPECIAL ELECTION PERIODS FOR ADDITIONAL CATEGORIES OF INDIVIDUALS.—Section 1851(e)(4) of such Act (42 U.S.C. 1395w(e)(4)) is amended—

(A) in subparagraph (C), by striking at the end ''or'';

(B) in subparagraph (D), by inserting '', taking into account the health or well-being of the individual'' before the period and redesignating such subparagraph as subparagraph (F); and

(C) by inserting after subparagraph (C) the following new subparagraphs:

''(D) the individual is described in section 1902(a)(10)(E)(iii) (relating to specified low-income medicare beneficiaries);

''(E) the individual is enrolled in an MA plan and enrollment in the plan is suspended under paragraph (2)(B) or (3)(C) of section 1857(g) because of a failure of the plan to meet applicable requirements; or''.

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

(b) ACCESS TO MEDIGAP COVERAGE FOR INDIVIDUALS WHO LEAVE MA PLANS.—

(1) IN GENERAL.—Section 1882(s)(3) of the Social Security Act (42 U.S.C. 1395ss(s)(3)) is amended—

(A) in each of clauses (v)(III) and (vi) of subparagraph (B), by striking ''12 months'' and inserting ''24 months''; and

(B) in each of subclauses (I) and (II) of subparagraph (F)(i), by striking ''12 months'' and inserting ''24 months''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to terminations of enrollments in MA plans occurring on or after the date of the enactment of this Act.

(c) IMPROVED ENROLLMENT POLICIES.—

(1) NO AUTO-ENROLLMENT OF MEDICAID BENEFICIARIES.—

(A) IN GENERAL.—Section 1851(e) of such Act (42 U.S.C. 1395w–21(e)) is amended by adding at the end the following new paragraph:

''(7) NO AUTO-ENROLLMENT OF MEDICAID BENEFICIARIES.—In no case may the Secretary provide for the enrollment in a MA plan of a Medicare Advantage eligible individual who is eligible to receive medical assistance under title XIX as a full-benefit dual eligible individual or a qualified medicare beneficiary, without the affirmative application of such individual (or authorized representative of the individual) to be enrolled in such plan.''.

(B) NO APPLICATION TO PRESCRIPTION DRUG PLANS.—Section 1860D–1(b)(1)(B)(iii) of such Act (42 U.S.C. 1395w–101(b)(1)(B)(iii)) is amended—

(i) by striking ''paragraph (2) and'' and by inserting ''paragraph (2),''; and

''(ii) by inserting '', and paragraph (7),'' after ''paragraph (4)''.

(C) EFFECTIVE DATE.—The amendments made by this paragraph shall apply to enrollments that are effective on or after the date of the enactment of this Act.

SEC. 414. INFORMATION FOR BENEFICIARIES ON MA PLAN ADMINISTRATIVE COSTS.

(a) DISCLOSURE OF MEDICAL LOSS RATIOS AND OTHER EXPENSE DATA.—Section 1851 of the Social Security Act (42 U.S.C. 1395w21) is amended by adding at the end the following new subsection:

''(j) PUBLICATION OF MEDICAL LOSS RATIOS AND OTHER COST-RELATED INFORMATION.—

''(1) IN GENERAL.—The Secretary shall publish, not later than October 1 of each year (beginning with 2009), for each Medicare Part C plan contract, the following:

''(A) The medical loss ratio of the plan in the previous year.

''(B) The per enrollee payment under this part to the plan, as adjusted to reflect a risk score (based on factors described in section 1853(a)(1)(C)(i)) of 1.0.

''(C) The average risk score (as so based).

''(2) SUBMISSION OF DATA.—

''(A) IN GENERAL.—Each Medicare Part C organization shall submit to the Secretary, in a form and manner specified by the Secretary, data necessary for the Secretary to publish the information described in paragraph (1) on a timely basis, including the information described in paragraph (3).

''(B) DATA FOR 2008 AND 2009.—The data submitted under subparagraph (A) for 2008 and for 2009 shall be consistent in content with the data reported as part of the Medicare Part C plan bid in June 2007 for 2008.

''(C) MEDICAL LOSS RATIO DATA.—The data to be submitted under subparagraph (A) relating to medical loss ratio for a year—

''(i) shall be submitted not later than June 1 of the following year; and

''(ii) beginning with 2010, shall be submitted based on the standardized elements and definitions developed under paragraph (4).

''(D) AUDITED DATA.—Data submitted under this paragraph shall be data that has been audited by an independent third party auditor.

''(3) MLR INFORMATION.—The information described in this paragraph with respect to a Medicare Part C plan for a year is as follows:

''(A) The costs for the plan in the previous year for each of the following:

''(i) Total medical expenses, separately indicated for benefits for the original medicare fee-for-service program option and for supplemental benefits.

''(ii) Non-medical expenses, shown separately for each of the following categories of expenses:

''(I) Marketing and sales.

''(II) Direct administration.

''(III) Indirect administration.

''(IV) Net cost of private reinsurance.

''(B) Gain or loss margin.

''(C) Total revenue requirement, computed as the total of medical and nonmedical expenses and gain or loss margin, multiplied by the gain or loss margin.

''(D) Percent of revenue ratio, computed as the total revenue requirement expressed as a percentage of revenue.

''(4) DEVELOPMENT OF DATA REPORTING STANDARDS.—

''(A) IN GENERAL.—The Secretary shall develop and implement standardized data elements and definitions for reporting under this subsection, for contract years beginning with 2010, of data necessary for the calculation of the medical loss ratio for Medicare Part C plans. Not later than December 31, 2008, the Secretary shall publish a report describing the elements and definitions so developed.

''(B) CONSULTATION.—The Secretary shall consult with representatives of Medicare Part C organizations, experts on health plan accounting systems, and representatives of the National Association of Insurance Commissioners, in the development of such data elements and definitions

''(5) MEDICAL LOSS RATIO DEFINED.—For purposes of this part, the term 'medical loss ratio' means, with respect to an MA plan for a year, the ratio of—

''(A) the aggregate benefits (excluding non-medical expenses described in paragraph (3)(A)(ii)) paid under the plan for the year, to

''(B) the aggregate amount of premiums (including basic and supplemental beneficiary premiums) and payments made under sections 1853 and 1860D–15) collected for the plan and year.

Such ratio shall be computed without regard to whether the benefits or premiums are for required or supplemental benefits under the plan.''.

(b) AUDIT OF ADMINISTRATIVE COSTS AND COMPLIANCE WITH THE FEDERAL ACQUISITION REGULATION.—

(1) IN GENERAL.—Section 1857(d)(2)(B) of such Act (42 U.S.C. 1395w–27(d)(2)(B)) is amended—

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

(B) by inserting before the period at the end the following: '', or (iii) to compliance with the requirements of subsection (e)(4) and the extent to which administrative costs comply with the applicable requirements for such costs under the Federal Acquisition Regulation''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply for contract years beginning after the date of the enactment of this Act.

(c) MINIMUM MEDICAL LOSS RATIO.—Section 1857(e) of the Social Security Act (42 U.S.C. 1395w–27(e)) is amended by adding at the end the following new paragraph:

''(4) REQUIREMENT FOR MINIMUM MEDICAL LOSS RATIO.—If the Secretary determines for a contract year (beginning with 2010) that an MA plan has failed to have a medical loss ratio (as defined in section 1851(j)(4)) of at least .85—

''(A) for that contract year, the Secretary shall reduce the blended benchmark amount under subsection (l) for the second succeeding contract year by the numer of percentage points by which such loss ratio was less than 85 percent;

''(B) for 3 consecutive contract years, the Secretary shall not permit the enrollment of new enrollees under the plan for coverage during the second succeeding contract year; and

''(C) the Secretary shall terminate the plan contract if the plan fails to have such a medical loss ratio for 5 consecutive contract years.''.

(d) INFORMATION ON MEDICARE PART C PLAN ENROLLMENT AND SERVICES.—Section 1851 of such Act, as amended by subsection (a), is further amended by adding at the end the following new subsection:

''(k) PUBLICATION OF ENROLLMENT AND OTHER INFORMATION.—

''(1) MONTHLY PUBLICATION OF PLAN-SPECIFIC ENROLLMENT DATA.—The Secretary shall publish (on the public website of the Centers for Medicare & Medicaid Services or otherwise) not later than 30 days after the end of each month (beginning with January 2008) on the actual enrollment in each Medicare Part C plan by contract and by county.

''(2) AVAILABILITY OF OTHER INFORMATION.—The Secretary shall make publicly available data and other information in a format that may be readily used for analysis of the Medicare Part C program under this part and will contribute to the understanding of the organization and operation of such program.''.

(e) MEDPAC REPORT ON VARYING MINIMUM MEDICAL LOSS RATIOS.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study of the need and feasibility of providing for different minimum medical loss ratios for different types of Medicare Part C plans, including coordinated care plans, group model plans, coordinated care independent practice association plans, preferred provider organization plans, and private fee-for-services plans.

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

Subtitle C—Quality and Other Provisions

SEC. 421. REQUIRING ALL MA PLANS TO MEET EQUAL STANDARDS.

(a) COLLECTION AND REPORTING OF INFORMATION.—

(1) IN GENERAL.—Section 1852(e)(1) of the Social Security Act (42 U.S.C. 1395w–112(e)(1)) is amended by striking ''(other than an MA private fee-for-service plan or an MSA plan)''.

(2) REPORTING FOR PRIVATE FEE-FOR-SERVICES AND MSA PLANS.—Section 1852(e)(3) of such Act is amended by adding at the end the following new subparagraph:

''(C) DATA COLLECTION REQUIREMENTS BY PRIVATE FEE-FOR-SERVICE PLANS AND MSA PLANS.—

''(i) USING MEASURES FOR PPOS FOR CONTRACT YEAR 2009.—For contract year 2009, the Medicare Part C organization offering a private fee-for-service plan or an MSA plan shall submit to the Secretary for such plan the same information on the same performance measures for which such information is required to be submitted for Medicare Part C plans that are preferred provider organization plans for that year.

''(ii) APPLICATION OF SAME MEASURES AS COORDINATED CARE PLANS BEGINNING IN CONTRACT YEAR 2010.—For a contract year beginning with 2010, a Medicare Part C organization offering a private fee-for-service plan or an MSA plan shall submit to the Secretary for such plan the same information on the same performance measures for which such information is required to be submitted for such contract year Medicare Part C plans described in section 1851(a)(2)(A)(i) for contract year such contract year.''.

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

(b) EMPLOYER PLANS.—

(1) IN GENERAL.—The first sentence of paragraph (2) of section 1857(i) of such Act (42 U.S.C. 1395w–27(i)) is amended by inserting before the period at the end the following: '', but only if 90 percent of the Medicare part C eligible individuals enrolled under such plan reside in a county in which the Medicare Part C organization offers a Medicare Part C local plan''.

(2) LIMITATION ON APPLICATION OF WAIVER AUTHORITY.—Paragraphs (1) and (2) of such section are each amended by inserting ''that were in effect before the date of the enactment of the Children's Health and Medicare Protection Act of 2007'' after ''waive or modify requirements''.

(3) EFFECTIVE DATES.—The amendment made by paragraph (1) shall apply for plan years beginning on or after January 1, 2009, and the amendments made by paragraph (2) shall take effect on the date of the enactment of this Act.

SEC. 422. DEVELOPMENT OF NEW QUALITY REPORTING MEASURES ON RACIAL DISPARITIES.

(a) NEW QUALITY REPORTING MEASURES.—

(1) IN GENERAL.—Section 1852(e)(3) of the Social Security Act (42 U.S.C. 1395w–22(e)(3)), as amended by section 421(a)(2), is amended—

(A) in subparagraph (B)—

(i) in clause (i), by striking ''The Secretary'' and inserting ''Subject to subparagraph (D), the Secretary''; and

(ii) in clause (ii), by striking ''subclause (iii)'' and inserting ''clause (iii) and subparagraph (C)'' ; and

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

''(D) ADDITIONAL QUALITY REPORTING MEASURES.—

''(i) IN GENERAL.—The Secretary shall develop by October 1, 2009, quality measures for Medicare Part C plans that measure disparities in the amount and quality of health services provided to racial and ethnic minorities.

''(ii) DATA TO MEASURE RACIAL AND ETHNIC DISPARITIES IN THE AMOUNT AND QUALITY OF CARE PROVIDED TO ENROLLEES.—The Secretary shall provide for Medicare Part C organizations to submit data under this paragraph, including data similar to those submitted for other quality measures, that permits analysis of disparities among racial and ethnic minorities in health services, quality of care, and health status among Medicare Part C plan enrollees for use in submitting the reports under paragraph (5).''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall apply to reporting of quality measures for plan years beginning on or after January 1, 2010.

(b) BIENNIAL REPORT ON RACIAL AND ETHNIC MINORITIES.—Section 1852(e) of such Act (42 U.S.C. 1395w–22(e)) is amended by adding at the end the following new paragraph:

''(5) REPORT TO CONGRESS.—

''(A) IN GENERAL.—Not later than 2 years after the date of the enactment of this paragraph, and biennially thereafter, the Secretary shall submit to Congress a report regarding how quality assurance programs conducted under this subsection measure and report on disparities in the amount and quality of health care services furnished to racial and ethnic minorities.

''(B) CONTENTS OF REPORT.—Each such report shall include the following:

''(i) A description of the means by which such programs focus on such racial and ethnic minorities.

''(ii) An evaluation of the impact of such programs on eliminating health disparities and on improving health outcomes, continuity and coordination of care, management of chronic conditions, and consumer satisfaction.

''(iii) Recommendations on ways to reduce clinical outcome disparities among racial and ethnic minorities.

''(iv) Data for each MA plan from HEDIS and other source reporting the disparities in the amount and quality of health services furnished to racial and ethnic minorities.''.

SEC. 423. STRENGTHENING AUDIT AUTHORITY.

(a) FOR PART C PAYMENTS RISK ADJUSTMENT.—Section 1857(d)(1) of the Social Security Act (42 U.S.C. 1395w–27(d)(1)) is amended by inserting after ''section 1858(c))'' the following: '', and data submitted with respect to risk adjustment under section 1853(a)(3)''.

(b) ENFORCEMENT OF AUDITS AND DEFICIENCIES.—

(1) IN GENERAL.—Section 1857(e) of such Act is amended by adding at the end the following new paragraph:

''(5) ENFORCEMENT OF AUDITS AND DEFICIENCIES.—

''(A) INFORMATION IN CONTRACT.—The Secretary shall require that each contract with a Medicare Part C organization under this section shall include terms that inform the organization of the provisions in subsection (d).

''(B) ENFORCEMENT AUTHORITY.—The Secretary is authorized, in connection with conducting audits and other activities under subsection (d), to take such actions, including pursuit of financial recoveries, necessary to address deficiencies identified in such audits or other activities.''.

(2) APPLICATION UNDER PART D.—For provision applying the amendment made by paragraph (1) to prescription drug plans under part D, see section 1860D–12(b)(3)(D) of the Social Security Act.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect the date of the enactment of this Act and shall apply to audits and activities conducted for contract years beginning on or after January 1, 2009.

SEC. 424. IMPROVING RISK ADJUSTMENT FOR MA PAYMENTS.

(a) IN GENERAL.—Not later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report that evaluates the adequacy of the Medicare Advantage risk adjustment system under section 1853(a)(1)(C) of the Social Security Act (42 U.S.C. 1395–23(a)(1)(C)).

(b) PARTICULARS.—The report under subsection (a) shall include an evaluation of at least the following:

(1) The need and feasibility of improving the adequacy of the risk adjustment system in predicting costs for beneficiaries with co-morbid conditions and associated cognitive impairments.

(2) The need and feasibility of including further gradations of diseases and conditions (such as the degree of severity of congestive heart failure).

(3) The feasibility of measuring difference in coding over time between Medicare part C plans and the medicare traditional fee-for-service program and, to the extent this difference exists, the options for addressing it.

(4) The feasibility and value of including part D and other drug utilization data in the risk adjustment model.

SEC. 425. ELIMINATING SPECIAL TREATMENT OF PRIVATE FEE-FOR-SERVICE PLANS.

(a) ELIMINATION OF EXTRA BILLING PROVISION.—Section 1852(k)(2) of the Social Security Act (42 U.S.C. 1395w–22(k)(2)) is amended—

(1) in subparagraph (A)(i), by striking ''115 percent'' and inserting ''100 percent''; and

(2) in subparagraph (C)(i), by striking ''including any liability for balance billing consistent with this subsection)''.

(b) REVIEW OF BID INFORMATION.—Section 1854(a)(6)(B) of such Act (42 U.S.C. 1395w–24(a)(6)(B)) is amended—

(1) in clause (i), by striking ''clauses (iii) and (iv)'' and inserting ''clause (iii)''; and

(2) by striking clause (iv).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to contract years beginning with 2009.

SEC. 426. RENAMING OF MEDICARE ADVANTAGE PROGRAM.

(a) IN GENERAL.—The program under part C of title XVIII of the Social Security Act is henceforth to be known as the ''Medicare Part C program''.

(b) CHANGE IN REFERENCES.—

(1) AMENDING SOCIAL SECURITY ACT.—The Social Security Act is amended by striking ''Medicare Advantage'', ''MA'', and ''Medicare+Choice'' and inserting ''Medicare Part C'' each place it appears, with the appropriate, respective typographic formatting, including typeface and capitalization.

(2) ADDITIONAL REFERENCES.—Notwithstanding section 201(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173), any reference to the program under part C of title XVIII of the Social Security Act shall be deemed a reference to the ''Medicare Part C'' program and, with respect to such part, any reference to ''Medicare+Choice''. ''Medicare Advantage'', or ''MA'' is deemed a reference to the program under such part.

Subtitle D—Extension of Authorities

SEC. 431. EXTENSION AND REVISION OF AUTHORITY FOR SPECIAL NEEDS PLANS (SNPS).

(a) EXTENDING RESTRICTION ON ENROLLMENT AUTHORITY FOR SNPS FOR 3 YEARS.—Subsection (f) of section 1859 of the Social Security Act (42 U.S.C. 1395w–28) is amended by striking ''2009'' and inserting ''2012''.

(b) STRUCTURE OF AUTHORITY FOR SNPS.—

(1) IN GENERAL.—Such section is further amended—

(A) in subsection (b)(6)(A), by striking all that follows ''means'' and inserting the following: ''an MA plan and

''(i) that serves special needs individuals (as defined in subparagraph (B));

''(ii) as of January 1, 2009—

''(I) at least 90 percent of the enrollees in which are described in subparagraph (B)(i), as determined under regulations in effect as of July 1, 2007;

''(II) at least 90 percent of the enrollees in which are described in subparagraph (B)(ii) and are full-benefit dual eligible individuals (as defined in section 1935(c)(6)) or qualified medicare beneficiaries (as defined in section 1905(p)(1)); or

''(III) at least 90 percent of the enrollees in which have a severe or disabling chronic condition of the type that the plan is committed to serve as indicated by the data submitted for the risk-adjustment of plan payments; and''.

''(iii) as of January 1, 2009, meets the applicable requirements of paragraph (2) or (3) of subsection (f), as the case may be.'';

(B) in subsection (f)—

(i) by amending the heading to read as follows: ''REQUIREMENTS FOR ENROLLMENT IN PART C PLANS FOR SPECIAL NEEDS BENEFICIARIES'';

(ii) by designating the sentence beginning ''In the case of'' as paragraph (1) with the heading ''REQUIREMENTS FOR 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)(A)(ii)(I), the applicable requirements of this subsection are as follows:

''(A) The plan has an agreement with the State that includes provisions regarding cooperation on the coordination of care for such individuals. Such agreement shall include a description of the manner that the State Medicaid program under title XIX will pay for the costs of services for individuals eligible under such title for medical assistance for acute care and long-term care services.

''(B) The plan has a contract with long-term care facilities and other providers in the area sufficient to provide care for enrollees described in subsection (b)(6)(B)(i).

''(C) The plan reports to the Secretary information on additional quality measures specified by the Secretary under section 1852(e)(3)(D)(iv)(I) for such plans.

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

''(A) The plan has an agreement with the State Medicaid agency that—

''(i) includes provisions regarding cooperation on the coordination of the financing of care for such individuals;

''(ii) includes a description of the manner that the State Medicaid program under title XIX will pay for the costs of cost-sharing and supplemental services for individuals enrolled in the plan eligible under such title for medical assistance for acute and long-term care services; and

''(iii) effective January 1, 2011, provides for capitation payments to cover costs of supplemental benefits for individuals described in subsection (b)(6)(A)(ii)(II).

''(B) The out-of-pocket costs for services under parts A and B that are charged to enrollees may not exceed the out-of-pocket costs for same services permitted for such individuals under title XIX.

''(C) The plan reports to the Secretary information on additional quality measures specified by the Secretary under section 1852(e)(3)(D)(iv)(II) for such plans.''.

''(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)(A)(ii)(III), the applicable requirements of this subsection are as follows:

''(A) The plan is designated to serve, and serves, Medicare beneficiaries with one or more of the following specific severe or disabling chronic conditions:

''(i) Cardiovascular.

''(ii) Cerebrovascular.
''(iii) Congestive health failure.
''(iv) Diabetes.
''(v) Chronic obstructive pulmonary disease.
''(vi) HIV/AIDS.

''(B) The plan has an average risk score under section 1853(a)(1)(C) of 1.35 or greater.

''(C) The plan has established and actively manages a chronic care improvement program under section 1852(e)(2) for each of the conditions that it serves under subparagraph (A) that significantly exceeds the features and results of such programs established and managed by Medicare Part C plans that are not specialized Medicare Part C plans for special needs individuals of the type described in this paragraph.

''(D) The plan has a network of a sufficient number of primary care and specialty physicians, hospitals, and other health care providers under contract to the plan so that the plan can clearly meet the routine and specialty needs of the severely ill and disabled enrollees of the plan throughout the service area of the plan.

''(E) The plan reports to the Secretary information on additional quality measures specified by the Secretary under section 1852(e)(3)(D)(iv)(III) for such plans.''.

(2) QUALITY STANDARDS AND QUALITY REPORTING.—Section 1852(e)(3) of such Act (42 U.S.C. 1395w-22(e)(3) is amended—

(A) in subparagraph (A)(i), by adding at the end the following: ''In the case of a specialized Medicare Part C plan for special needs individuals described in paragraph (2), (3), or (4) of section 1859(f), the organization shall provide for the reporting on quality measures developed for the plan under subparagraph (D)(iii).''; and

(B) in subparagraph (D), as added by section 422(a)(1), by adding at the end the following new clause:

''(iii) SPECIFICATION OF ADDITIONAL QUALITY MEASUREMENTS FOR SPECIALIZED PART C PLANS.—For implementation for plan years beginning not later than January 1, 2010, the Secretary shall develop new quality measures appropriate to meeting the needs of—

''(I) beneficiaries enrolled in specialized Medicare Part C plans for special needs individuals (described in section 1859(b)(6)(A)(ii)(I)) that serve predominantly individuals who are dual-eligible individuals eligible for medical assistance under title XIX by measuring the special needs for care of individuals who are both Medicare and Medicaid beneficiaries; and

''(II) beneficiaries enrolled in specialized Medicare Part C plans for special needs individuals (described in section 1859(b)(6)(A)(ii)(II)) that serve predominantly institutionalized individuals by measuring the special needs for care of individuals who are a resident in long-term care institution.''; and

''(III) beneficiaries enrolled in specialized Medicare Part C plans for special needs individuals (described in section 1859(b)(6)(A)(ii)(III)) that serve predominantly individuals with severe or disabling chronic conditions by measuring the special needs for care of such individuals.''.

(3) EFFECTIVE DATE; GRANDFATHER.—The amendments made by paragraph (1) shall take effect for enrollments occurring on or after January 1, 2009, and shall not apply—

(A) to a Medicare Advantage plan with a contract with a State Medicaid integrated Medicare-Medicaid plan program that had been approved by the Centers for Medicare & Medicaid Services as of January 1, 2004; and

(B) to plans that are operational as of the date of the enactment of this Act as approved Medicare demonstration projects and that provide services predominantly to individuals with end-stage renal disease.

(4) TRANSITION FOR NON-QUALIFYING SNPS.—

(A) RESTRICTIONS IN 2008 FOR CHRONIC CARE SNPS.—In the case of a specialized MA plan for special needs individuals (as defined in section 1859(b)(6)(A) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(A)) that, as of December 31, 2007, is not described in either subclause (I) or subclause (II) of clause (ii) of such section, as amended by paragraph (1), then as of January 1, 2008—

(i) the plan may not be offered unless it was offered before such date;

(ii) no new members may be enrolled with the plan; and

(iii) there may be no expansion of the service area of such plan.

(B) TRANSITION OF ENROLLEES.—The Secretary of Health and Human Services shall provide for an orderly transition of those specialized MA plans for special needs individuals (as defined in section 1859(b)(6)(A) of the Social Security Act (42 U.S.C. 1395w–28(b)(6)(A)), as of the date of the enactment of this Act), and their enrollees, that no longer qualify as such plans under such section, as amended by this subsection.

(c) SUNSET OF ADDITIONAL DESIGNATION AUTHORITY.—

(1) IN GENERAL.—Subsection (d) of section 231 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) is repealed.

(2) EFFECTIVE DATE.—The repeal made by paragraph (1) shall take effect on January 1, 2009, and shall apply to plans offered on or after such date.

SEC. 432. EXTENSION AND REVISION OF AUTHORITY FOR MEDICARE REASONABLE COST CONTRACTS.

(a) EXTENSION FOR 3 YEARS OF PERIOD REASONABLE COST PLANS CAN REMAIN IN THE MARKET.—Section 1876(h)(5)(C)(ii) of the Social Security Act (42 U.S.C. 1395mm(h)(5)(C)(ii)) is amended, in the matter preceding subclause (I), by striking ''January 1, 2008'' and inserting ''January 1, 2011''.

(b) APPLICATION OF CERTAIN MEDICARE ADVANTAGE REQUIREMENTS TO COST CONTRACTS EXTENDED OR RENEWED AFTER ENACTMENT.—Section 1876(h) of such Act (42 U.S.C. 1395mm(h)), as amended by subsection (a), is amended—

(1) by redesignating paragraph (5) as paragraph (6); and

(2) by inserting after paragraph (4) the following new paragraph:

''(5)(A) Any reasonable cost reimbursement contract with an eligible organization under this subsection that is extended or renewed on or after the date of enactment of the Children's Health and Medicare Protection Act of 2007 shall provide that the provisions of the Medicare Part C program described in subparagraph (B) shall apply to such organization and such contract in a substantially similar manner as such provisions apply to Medicare Part C organizations and Medicare Part C plans under part C.

''(B) The provisions described in this subparagraph are as follows:

''(i) Section 1851(h) (relating to the approval of marketing material and application forms).

''(ii) Section 1852(e) (relating to the requirement of having an ongoing quality improvement program and treatment of accreditation in the same manner as such provisions apply to Medicare Part C local plans that are preferred provider organization plans).

''(iii) Section 1852(f) (relating to grievance mechanisms).

''(iv) Section 1852(g) (relating to coverage determinations, reconsiderations, and appeals).

''(v) Section 1852(j)(4) (relating to limitations on physician incentive plans).

''(vi) Section 1854(c) (relating to the requirement of uniform premiums among individuals enrolled in the plan).

''(vii) Section 1854(g) (relating to restrictions on imposition of premium taxes with respect to payments to organizations).

''(viii) Section 1856(b)(3) (relating to relation to State laws).

''(ix) The provisions of part C relating to timelines for contract renewal and beneficiary notification.''.

TITLE V—PROVISIONS RELATING TO MEDICARE PART A

SEC. 501. INPATIENT HOSPITAL PAYMENT UPDATES.

(a) FOR ACUTE HOSPITALS.—Clause (i) of section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)) is amended—

(1) in subclause (XIX), by striking ''and'';

(2) by redesignating subclause (XX) as subclause (XXII); and

(3) by inserting after subclause (XIX) the following new subclauses:

''(XX) for fiscal year 2007, subject to clause (viii), the market basket percentage increase for hospitals in all areas,

''(XXI) for fiscal year 2008, subject to clause (viii), the market basket percentage increase minus 0.25 percentage point for hospitals in all areas, and''.

(b) FOR OTHER HOSPITALS.—Clause (ii) of such section is amended—

(1) in subclause (VII) by striking ''and'';

(2) by redesignating subclause (VIII) as subclause (X); and

(3) by inserting after subclause (VII) the following new subclauses:

''(VIII) fiscal years 2003 through 2007, is the market basket percentage increase,

''(IX) fiscal year 2008, is the market basket percentage increase minus 0.25 percentage point, and''.

(c) DELAYED EFFECTIVE DATE.—

(1) ACUTE CARE HOSPITALS.—The amendments made by subsection (a) shall not apply to discharges occurring before January 1, 2008.

(2) OTHER HOSPITALS.—The amendments made by subsection (b) shall be applied, only with respect to cost reporting periods beginning during fiscal year 2008 and not with respect to the computation for any succeeding cost reporting period, by substituting ''0.1875 percentage point'' for ''0.25 percentage point''.

SEC. 502. PAYMENT FOR INPATIENT REHABILITATION FACILITY (IRF) SERVICES.

(a) PAYMENT UPDATE.—

(1) IN GENERAL.—Section 1886(j)(3)(C) of the Social Security Act (42 U.S.C. 1395ww(j)(3)(C)) is amended by adding at the end the following: ''The increase factor to be applied under this subparagraph for fiscal year 2008 shall be 1 percent.''

(2) DELAYED EFFECTIVE DATE.—The amendment made by paragraph (1) shall not apply to payment units occurring before January 1, 2008.

(b) INPATIENT REHABILITATION FACILITY CLASSIFICATION CRITERIA.—

(1) IN GENERAL.—Section 5005 of the Deficit Reduction Act of 2005 (Public Law 109–171) is amended—

(A) in subsection (a), by striking ''apply the applicable percent specified in subsection (b)'' and inserting ''require a compliance rate that is no greater than the 60 percent compliance rate that became effective for cost reporting periods beginning on or after July 1, 2006,''; and

(B) by amending subsection (b) to read as follows:

''(b) CONTINUED USE OF COMORBIDITIES.—For portions of cost reporting periods occurring on or after the date of the enactment of the Children's Health and Medicare Protection Act of 2007, the Secretary shall include patients with comorbidities as described in section 412.23(b)(2)(i) of title 42, Code of Federal Regulations (as in effect as of January 1, 2007), in the inpatient population that counts towards the percent specified in subsection (a).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1)(A) shall apply to portions of cost reporting periods beginning on or after the date of the enactment of this Act.

(c) PAYMENT FOR CERTAIN MEDICAL CONDITIONS TREATED IN INPATIENT REHABILITATION FACILITIES.—

(1) IN GENERAL.—Section 1886(j) of the Social Security Act (42 U.S.C. 1395ww(j)) is amended—

(A) by redesignating paragraph (7) as paragraph (8);

(B) by inserting after paragraph (6) the following new paragraph:

''(7) SPECIAL PAYMENT RULE FOR CERTAIN MEDICAL CONDITIONS.—

''(A) IN GENERAL.—Subject to subparagraph (H), in the case of discharges occurring on or after October 1, 2008, in lieu of the standardized payment amount (as determined pursuant to the preceding provisions of this subsection) that would otherwise be applicable under this subsection, the Secretary shall substitute, for payment units with respect to an applicable medical condition (as defined in subparagraph (G)(i)) that is treated in an inpatient rehabilitation facility, the modified standardized payment amount determined under subparagraph (B).

''(B) MODIFIED STANDARDIZED PAYMENT AMOUNT.—The modified standardized payment amount for an applicable medical condition shall be based on the amount determined under subparagraph (C) for such condition, as adjusted under subparagraphs (D), (E), and (F).

''(C) AMOUNT DETERMINED.—

''(i) IN GENERAL.—The amount determined under this subparagraph for an applicable medical condition shall be based on the sum of the following:

''(I) An amount equal to the average per stay skilled nursing facility payment rate for the applicable medical condition (as determined under clause (ii)).

''(II) An amount equal to 25 percent of the difference between the overhead costs (as defined in subparagraph (G)(ii)) component of the average inpatient rehabilitation facility per stay payment amount for the applicable medical condition (as determined under the preceding paragraphs of this subsection) and the overhead costs component of the average per stay skilled nursing facility payment rate for such condition (as determined under clause (ii)).

''(III) An amount equal to 33 percent of the difference between the patient care costs (as defined in subparagraph (G)(iii)) component of the average inpatient rehabilitation facility per stay payment amount for the applicable medical condition (as determined under the preceding paragraphs of this subsection) and the patient care costs component of the average per stay skilled nursing facility payment rate for such condition (as determined under clause (ii)).

''(ii) DETERMINATION OF AVERAGE PER STAY SKILLED NURSING FACILITY PAYMENT RATE.—For purposes of clause (i), the Secretary shall convert skilled nursing facility payment rates for applicable medical conditions, as determined under section 1888(e), to average per stay skilled nursing facility payment rates for each such condition.

''(D) ADJUSTMENTS.—The Secretary shall adjust the amount determined under subparagraph (C) for an applicable medical condition using the adjustments to the prospective payment rates for inpatient rehabilitation facilities described in paragraphs (2), (3), (4), and (6).

''(E) UPDATE FOR INFLATION.—Except in the case of a fiscal year for which the Secretary rebases the amounts determined under subparagraph (C) for applicable medical conditions pursuant to subparagraph (F), the Secretary shall annually update the amounts determined under subparagraph (C) for each applicable medical condition by the increase factor for inpatient rehabilitation facilities (as described in paragraph (3)(C)).

''(F) REBASING.—The Secretary shall periodically (but in no case less than once every 5 years) rebase the amounts determined under subparagraph (C) for applicable medical conditions using the methodology described in such subparagraph and the most recent and complete cost report and claims data available.

''(G) DEFINITIONS.—In this paragraph:

''(i) APPLICABLE MEDICAL CONDITION.—The term 'applicable medical condition' means—

''(I) unilateral knee replacement;

''(II) unilateral hip replacement; and

''(III) unilateral hip fracture.

''(ii) OVERHEAD COSTS.—The term 'overhead costs' means those Medicare-allowable costs that are contained in the General Service cost centers of the Medicare cost reports for inpatient rehabilitation facilities and for skilled nursing facilities, respectively, as determined by the Secretary.

''(iii) PATIENT CARE COSTS.—The term 'patient care costs' means total Medicare-allowable costs minus overhead costs.

''(H) SUNSET.—The provisions of this paragraph shall cease to apply as of the date the Secretary implements an integrated, site-neutral payment methodology under this title for post-acute care.''; and

(C) in paragraph (8), as redesignated by paragraph (1)—

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

(ii) in subparagraph (D), by striking the period at the end and inserting '', and''; and

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

''(E) modified standardized payment amounts under paragraph (7).''.

(2) SPECIAL RULE FOR DISCHARGES OCCURRING IN THE SECOND HALF OF FISCAL YEAR 2008.—

(A) IN GENERAL.—In the case of discharges from an inpatient rehabilitation facility occurring during the period beginning on April 1, 2008, and ending on September 30, 2008, for applicable medical conditions (as defined in paragraph (7)(G)(i) of section 1886(j) of the Social Security Act (42 U.S.C. 1395ww(j)), as inserted by paragraph (1)(B), in lieu of the standardized payment amount determined pursuant to such section, the standardized payment amount shall be $9,507 for unilateral knee replacement, $10,398 for unilateral hip replacement, and $10,958 for unilateral hip fracture. Such amounts are the amounts that are estimated would be determined under paragraph (7)(C) of such section 1886(j) for such conditions if such paragraph applied for such period. Such standardized payment amounts shall be multiplied by the relative weights for each case-mix group and tier, as published in the final rule of the Secretary of Health and Human Services for inpatient rehabilitation facility services prospective payment for fiscal year 2008, to obtain the applicable payment amounts for each such condition for each case-mix group and tier.

(B) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement this subsection by program instruction or otherwise. Paragraph (8)(E) of such section 1886(j) of the Social Security Act, as added by paragraph (1)(C), shall apply for purposes of this subsection in the same manner as such paragraph applies for purposes of paragraph (7) of such section 1886(j).

(d) RECOMMENDATIONS FOR CLASSIFYING INPATIENT REHABILITATION HOSPITALS AND UNITS.—

(1) REPORT TO CONGRESS.—Not later than 12 months after the date of the enactment of this Act, the Secretary of Health and Human Services, in consultation with physicians (including geriatricians and physiatrists), administrators of inpatient rehabilitation, acute care hospitals, skilled nursing facilities, and other settings providing rehabilitation services, Medicare beneficiaries, trade organizations representing inpatient rehabilitation hospitals and units and skilled nursing facilities, and the Medicare Payment Advisory Commission, shall submit to the Committee on Ways and Means of the House of Representatives and the Committee on Finance of the Senate a report that includes—

(A) an examination of Medicare beneficiaries' access to medically necessary rehabilitation services;

(B) alternatives or refinements to the 75 percent rule policy for determining exclusion criteria for inpatient rehabilitation hospital and unit designation under the Medicare program, including determining clinical appropriateness of inpatient rehabilitation hospital and unit admissions and alternative criteria which would consider a patient's functional status, diagnosis, co-morbidities, and other relevant factors; and

(C) an examination that identifies any condition for which individuals are commonly admitted to inpatient rehabilitation hospitals that is not included as a condition described in section 412.23(b)(2)(iii) of title 42, Code of Federal Regulations, to determine the appropriate setting of care, and any variation in patient outcomes and costs, across settings of care, for treatment of such conditions.

For the purposes of this subsection, the term ''75 percent rule'' means the requirement of section 412.23(b)(2) of title 42, Code of Federal Regulations, that 75 percent of the patients of a rehabilitation hospital or converted rehabilitation unit are in 1 or more of 13 listed treatment categories.

(2) CONSIDERATIONS.—In developing the report described in paragraph (1), the Secretary shall include the following:

(A) The potential effect of the 75 percent rule on access to rehabilitation care by Medicare beneficiaries for the treatment of a condition, whether or not such condition is described in section 412.23(b)(2)(iii) of title 42, Code of Federal Regulations.

(B) An analysis of the effectiveness of rehabilitation care for the treatment of conditions, whether or not such conditions are described in section 412.23(b)(2)(iii) of title 42, Code of Federal Regulations, available to Medicare beneficiaries in various health care settings, taking into account variation in patient outcomes and costs across different settings of care, and which may include whether the Medicare program and Medicare beneficiaries may incur higher costs of care for the entire episode of illness due to readmissions, extended lengths of stay, and other factors.

SEC. 503. LONG-TERM CARE HOSPITALS.

(a) LONG-TERM CARE HOSPITAL PAYMENT UPDATE.—

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

''(m) PROSPECTIVE PAYMENT FOR LONG-TERM CARE HOSPITALS.—

''(1) REFERENCE TO ESTABLISHMENT AND IMPLEMENTATION OF SYSTEM.—For provisions related to the establishment and implementation of a prospective payment system for payments under this title for inpatient hospital services furnished by a long-term care hospital described in subsection (d)(1)(B)(iv), see section 123 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 and section 307(b) of Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

''(2) UPDATE FOR RATE YEAR 2008.—In implementing the system described in paragraph (1) for discharges occurring during the rate year ending in 2008 for a hospital, the base rate for such discharges for the hospital shall be the same as the base rate for discharges for the hospital occurring during the previous rate year.''.

(2) DELAYED EFFECTIVE DATE.—Subsection (m)(2) of section 1886 of the Social Security Act, as added by paragraph (1), shall not apply to discharges occurring on or after July 1, 2007, and before January 1, 2008.

(b) PAYMENT FOR LONG-TERM CARE HOSPITAL SERVICES; PATIENT AND FACILITY CRITERIA.—

(1) DEFINITION OF LONG-TERM CARE HOSPITAL.—

(A) DEFINITION.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by section 201(a)(2), is amended by adding at the end the following new subsection:

''Long-Term Care Hospital

''(ddd) The term 'long-term care hospital' means an institution which—

''(1) is primarily engaged in providing inpatient services, by or under the supervision of a physician, to Medicare beneficiaries whose

medically complex conditions require a long hospital stay and programs of care provided by a long-term care hospital;

''(2) has an average inpatient length of stay (as determined by the Secretary) for Medicare beneficiaries of greater than 25 days, or as otherwise defined in section 1886(d)(1)(B)(iv);

''(3) satisfies the requirements of subsection (e);

''(4) meets the following facility criteria:

''(A) the institution has a patient review process, documented in the patient medical record, that screens patients prior to admission for appropriateness of admission to a long-term care hospital, validates within 48 hours of admission that patients meet admission criteria for long-term care hospitals, regularly evaluates patients throughout their stay for continuation of care in a long-term care hospital, and assesses the available discharge options when patients no longer meet such continued stay criteria;

''(B) the institution has active physician involvement with patients during their treatment through an organized medical staff, physician-directed treatment with physician on-site availability on a daily basis to review patient progress, and consulting physicians on call and capable of being at the patient's side within a moderate period of time, as determined by the Secretary;

''(C) the institution has interdisciplinary team treatment for patients, requiring interdisciplinary teams of health care professionals, including physicians, to prepare and carry out an individualized treatment plan for each patient; and

''(5) meets patient criteria relating to patient mix and severity appropriate to the medically complex cases that long-term care hospitals are designed to treat, as measured under section 1886(n).''.

(B) NEW PATIENT CRITERIA FOR LONG-TERM CARE HOSPITAL PROSPECTIVE PAYMENT.—Section 1886 of such Act (42 U.S.C. 1395ww), as amended by subsection (a), is further amended by adding at the end the following new subsection:

''(n) PATIENT CRITERIA FOR PROSPECTIVE PAYMENT TO LONG-TERM CARE HOSPITALS.—

''(1) IN GENERAL.—To be eligible for prospective payment under this section as a long-term care hospital, a long-term care hospital must admit not less than a majority of patients who have a high level of severity, as defined by the Secretary, and who are assigned to one or more of the following major diagnostic categories:

''(A) Circulatory diagnoses.

''(B) Digestive, endocrine, and metabolic diagnoses.

''(C) Infection disease diagnoses.

''(D) Neurological diagnoses.

''(E) Renal diagnoses.

''(F) Respiratory diagnoses.

''(G) Skin diagnoses.

''(H) Other major diagnostic categories as selected by the Secretary.

''(2) MAJOR DIAGNOSTIC CATEGORY DEFINED.—In paragraph (1), the term 'major diagnostic category' means the medical categories formed by dividing all possible principle diagnosis into mutually exclusive diagnosis areas which are referred to in 67 Federal Register 49985 (August 1, 2002).''.

(C) ESTABLISHMENT OF REHABILITATION UNITS WITHIN CERTAIN LONG-TERM CARE HOSPITALS.—If the Secretary of Health and Human Services does not include rehabilitation services within a major diagnostic category under section 1886(n)(2) of the Social Security Act, as added by subparagraph (B), the Secretary shall approve for purposes of title XVIII of such Act distinct part inpatient rehabilitation hospital units in long-term care hospitals consistent with the following:

(i) A hospital that, on or before October 1, 2004, was classified by the Secretary as a long-term care hospital, as described in section 1886(d)(1)(B)(iv)(I) of such Act (42 U.S.C. 1395ww(d)(1)(V)(iv)(I)), and was accredited by the Commission on Accreditation of Rehabilitation Facilities, may establish a hospital rehabilitation unit that is a distinct part of the long-term care hospital, if the distinct part meets the requirements (including conditions of participation) that would otherwise apply to a distinct-part rehabilitation unit if the distinct part were established by a subsection (d) hospital in accordance with the matter following clause (v) of section 1886(d)(1)(B) of such Act, including any regulations adopted by the Secretary in accordance with this section, except that the one-year waiting period described in section 412.30(c) of title 42, Code of Federal Regulations, applicable to the conversion of hospital beds into a distinct-part rehabilitation unit shall not apply to such units.

(ii) Services provided in inpatient rehabilitation units established under clause (i) shall not be reimbursed as long-term care hospital services under section 1886 of such Act and shall be subject to payment policies established by the Secretary to reimburse services provided by inpatient hospital rehabilitation units.

(D) EFFECTIVE DATE.—The amendments made by subparagraphs (A) and (B), and the provisions of subparagraph (C), shall apply to discharges occurring on or after January 1, 2008.

(2) IMPLEMENTATION OF FACILITY AND PATIENT CRITERIA.—

(A) REPORT.—No later than 1 year after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall submit to the appropriate committees of Congress a report containing recommendations regarding the promulgation of the national long-term care hospital facility and patient criteria for application under paragraphs (4) and (5) of section 1861(ccc) and section 1886(n) of the Social Security Act, as added by subparagraphs (A) and (B), respectively, of paragraph (1). In the report, the Secretary shall consider recommendations contained in a report to Congress by the Medicare Payment Advisory Commission in June 2004 for long-term care hospital-specific facility and patient criteria to ensure that patients admitted to long-term care hospitals are medically complex and appropriate to receive long-term care hospital services.

(B) IMPLEMENTATION.—No later than 1 year after the date of submittal of the report under subparagraph (A), the Secretary shall, after rulemaking, implement the national long-term care hospital facility and patient criteria referred to in such subparagraph. Such long-term care hospital facility and patient criteria shall be used to screen patients in determining the medical necessity and appropriateness of a Medicare beneficiary's admission to, continued stay at, and discharge from, long-term care hospitals under the Medicare program and shall take into account the medical judgment of the patient's physician, as provided for under sections 1814(a)(3) and 1835(a)(2)(B) of the Social Security Act (42 U.S.C. 1395f(a)(3), 1395n(a)(2)(B)).

(3) EXPANDED REVIEW OF MEDICAL NECESSITY.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall provide, under contracts with one or more appropriate fiscal intermediaries or medicare administrative contractors under section 1874A(a)(4)(G) of the Social Security Act (42 U.S.C. 1395kk(a)(4)(G)), for reviews of the medical necessity of admissions to long-term care hospitals (described in section 1886(d)(1)(B)(iv) of such Act) and continued stay at such hospitals, of individuals entitled to, or enrolled for, benefits under part A of title XVIII of such Act on a hospital-specific basis consistent with this paragraph. Such reviews shall be made for discharges occurring on or after October 1, 2007.

(B) REVIEW METHODOLOGY.—The medical necessity reviews under paragraph (A) shall be conducted for each such long-term care hospital on an annual basis in accordance with rules (including a sample methodology) specified by the Secretary. Such sample methodology shall—

(i) provide for a statistically valid and representative sample of admissions of such individuals sufficient to provide results at a 95 percent confidence interval; and

(ii) guarantee that at least 75 percent of overpayments received by long-term care hospitals for medically unnecessary admissions and continued stays of individuals in long-term care hospitals will be identified and recovered and that related days of care will not be counted toward the length of stay requirement contained in section 1886(d)(1)(B)(iv) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(iv)).

(C) CONTINUATION OF REVIEWS.—Under contracts under this paragraph, the Secretary shall establish a denial rate with respect to such reviews that, if exceeded, could require further review of the medical necessity of admissions and continued stay in the hospital involved.

(D) TERMINATION OF REQUIRED REVIEWS.—

(i) IN GENERAL.—Subject to clause (iii), the previous provisions of this subsection shall cease to apply as of the date specified in clause (ii).

(ii) DATE SPECIFIED.—The date specified in this clause is the later of January 1, 2013, or the date of implementation of national long-term care hospital facility and patient criteria under section paragraph (2)(B).

(iii) CONTINUATION.—As of the date specified in clause (ii), the Secretary shall determine whether to continue to guarantee, through continued medical review and sampling under this paragraph, recovery of at least 75 percent of overpayments received by long-term care hospitals due to medically unnecessary admissions and continued stays.

(E) FUNDING.—The costs to fiscal intermediaries or medicare administrative contractors conducting the medical necessity reviews under subparagraph (A) shall be funded from the aggregate overpayments recouped by the Secretary of Health and Human Services from long-term care hospitals due to medically unnecessary admissions and continued stays. The Secretary may use an amount not in excess of 40 percent of the overpayments recouped under this paragraph to compensate the fiscal intermediaries or Medicare administrative contractors for the costs of services performed.

(4) LIMITED, QUALIFIED MORATORIUM OF LONG-TERM CARE HOSPITALS.—

(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall impose a temporary moratorium on the certification of new long-term care hospitals (and satellite facilities), and new long-term care hospital and satellite facility beds, for purposes of the Medicare program under title XVIII of the Social Security Act. The moratorium shall terminate at the end of the 4-year period beginning on the date of the enactment of this Act.

(B) EXCEPTIONS.—

(i) IN GENERAL.—The moratorium under subparagraph (A) shall not apply as follows:

(I) To a long-term care hospital, satellite facility, or additional beds under development as of the date of the enactment of this Act.

(II) To an existing long-term care hospital that requests to increase its number of long-term care hospital beds, if the Secretary determines there is a need at the long-term care hospital for additional beds to accommodate—

(aa) infectious disease issues for isolation of patients;

(bb) bedside dialysis services;

(cc) single-sex accommodation issues;

(dd) behavioral issues; or

(ee) any requirements of State or local law.

(III) To an existing long-term care hospital that requests an increase in beds because of the closure of a long-term care hospital or significant decrease in the number of long-term care hospital beds, in a State where there is only one other long-term care hospital.

There shall be no administrative or judicial review from a decision of the Secretary under this subparagraph.

(ii) ''UNDER DEVELOPMENT'' DEFINED.—For purposes of clause (i)(I), a long-term care hospital or satellite facility is considered to be ''under development'' as of a date if any of the following have occurred on or before such date:

(I) The hospital or a related party has a binding written agreement with an outside, unrelated party for the construction, reconstruction, lease, rental, or financing of the long-term care hospital and the hospital has expended, before the date of the enactment of this Act, at least 10 percent of the estimated cost of the project (or, if less, $2,500,000).

(II) Actual construction, renovation or demolition for the long-term care hospital has begun and the hospital has expended, before the date of the enactment of this Act, at least 10 percent of the estimated cost of the project (or, if less, $2,500,000).

(III) A certificate of need has been approved in a State where one is required or other necessary approvals from appropriate State agencies have been received for the operation of the hospital.

(IV) The hospital documents that, within 3 months after the date of the enactment of this Act, it is within a 6-month long-term care hospital demonstration period required by section 412.23(e)(1)–(3) of title 42, Code of Federal Regulations, to demonstrate that it has a greater than 25 day average length of stay.

(5) NO APPLICATION OF 25 PERCENT PATIENT THRESHOLD PAYMENT ADJUSTMENT TO FREESTANDING AND GRANDFATHERED LTCHS.—The Secretary shall not apply, during the 5-year period beginning on the date of the enactment of this Act, section 412.536 of title 42, Code of Federal Regulations, or any similar provision, to freestanding long-term care hospitals and the Secretary shall not apply such section or section 412.534 of title 42, Code of Federal Regulations, or any similar provisions, to a long-term care hospital identified by section 4417(a) of the Balanced Budget Act of 1997 (Public Law 105–33). A long-term care hospital identified by such section 4417(a) shall be deemed to be a freestanding long-term care hospital for the purpose of this section. Section 412.536 of title 42, Code of Federal Regulations, shall be void and of no effect.

(6) PAYMENT FOR HOSPITALS-WITHIN-HOSPITALS.—

(A) IN GENERAL.—Payments to an applicable long-term care hospital or satellite facility which is located in a rural area or which is co-located with an urban single or MSA dominant hospital under paragraphs (d)(1), (e)(1), and (e)(4) of section 412.534 of title 42, Code of Federal Regulations, shall not be subject to any payment adjustment under such section if no more than 75 percent of the hospital's Medicare discharges (other than discharges described in paragraphs (d)(2) or (e)(3) of such section) are admitted from a co-located hospital.

(B) CO-LOCATED LONG-TERM CARE HOSPITALS AND SATELLITE FACILITIES.—

(i) IN GENERAL.—Payment to an applicable long-term care hospital or satellite facility which is co-located with another hospital shall not be subject to any payment adjustment under section 412.534 of title 42, Code of Federal Regulations, if no more than 50 percent of the hospital's Medicare discharges (other than discharges described in section 412.534(c)(3) of such title) are admitted from a co-located hospital.

(ii) APPLICABLE LONG-TERM CARE HOSPITAL OR SATELLITE FACILITY DEFINED.—In this paragraph, the term ''applicable long-term care hospital or satellite facility'' means a hospital or satellite facility that is subject to the transition rules under section 412.534(g) of title 42, Code of Federal Regulations.

(C) EFFECTIVE DATE.—Subparagraphs (A) and (B) shall apply to discharges occurring on or after October 1, 2007, and before October 1, 2012.

(7) NO APPLICATION OF VERY SHORT-STAY OUTLIER POLICY.—The Secretary shall not apply, during the 5-year period beginning on the date of the enactment of this Act, the amendments finalized on May 11, 2007 (72 Federal Register 26904) made to the short-stay outlier payment provision for long-term care hospitals contained in section 412.529(c)(3)(i) of title 42, Code of Federal Regulations, or any similar provision.

(8) NO APPLICATION OF ONE TIME ADJUSTMENT TO STANDARD AMOUNT.—The Secretary shall not, during the 5-year period beginning on the date of the enactment of this Act, make the one-time prospective adjustment to long-term care hospital prospective payment rates provided for in section 412.523(d)(3) of title 42, Code of Federal Regulations, or any similar provision.

(c) SEPARATE CLASSIFICATION FOR CERTAIN LONG-STAY CANCER HOSPITALS.—

(1) IN GENERAL.—Subsection (d)(1)(B) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended—

(A) in clause (iv)—

(i) in subclause (I), by striking ''(iv)(I)'' and inserting ''(iv)'' and by striking ''or'' at the end; and

(ii) in subclause (II)—

(I) by striking '', or'' at the end and inserting a semicolon; and

(II) by redesignating such subclause as clause (vi) and by moving it to immediately follow clause (v); and

(B) in clause (v), by striking the semicolon at the end and inserting '', or''.

(2) CONFORMING PAYMENT REFERENCES.—Subsection (b) of such section is amended—

(A) in paragraph (2)(E)(ii), by adding at the end the following new subclause:

''(III) Hospitals described in clause (vi) of such subsection.'';

(B) in paragraph (3)(F)(iii), by adding at the end the following new subclause:

''(VI) Hospitals described in clause (vi) of such subsection.'';

(C) in paragraphs (3)(G)(ii), (3)(H)(i), and (3)(H)(ii)(I), by inserting ''or (vi)'' after ''clause (iv)'' each place it appears;

(D) in paragraph (3)(H)(iv), by adding at the end the following new subclause:

''(IV) Hospitals described in clause (vi) of such subsection.'';

(E) in paragraph (3)(J), by striking ''subsection (d)(1)(B)(iv)'' and inserting ''clause (iv) or (vi) of subsection (d)(1)(B)''; and

(F) in paragraph (7)(B), by adding at the end the following new clause:

''(iv) Hospitals described in clause (vi) of such subsection.''.

(3) ADDITIONAL CONFORMING AMENDMENTS.—The second sentence of subsection (d)(1)(B) of such section is amended—

(A) by inserting ''(as in effect as of such date)'' after ''clause (iv)''; and

(B) by inserting ''(or, in the case of a hospital classified under clause (iv)(II), as so in effect, shall be classified under clause (vi) on and after the effective date of such clause)'' after ''so classified''.

(4) IN GENERAL.—In the case of a hospital that is classified under clause (iv)(II) of section 1886(d)(1)(B) of the Social Security Act immediately before the date of the enactment of this Act and which is classified under clause (vi) of such section after such date of enactment, payments under section 1886 of such Act for cost reporting periods beginning after the date of the enactment of this Act shall be based upon payment rates in effect for the cost reporting period for such hospital beginning during fiscal year 2001, increased for each succeeding cost reporting period (beginning before the date of the enactment of this Act) by the applicable percentage increase under section 1886(b)(3)(B)(ii) of such Act.

(5) CLARIFICATION OF TREATMENT OF SATELLITE FACILITIES AND REMOTE LOCATIONS.—A long-stay cancer hospital described in section 1886(d)(1)(B)(vi) of the Social Security Act, as designated under paragraph (1), shall include satellites or remote site locations for such hospital established before or after the date of the enactment ''without regard to section 412.22(h)(2)(i) of title 42, Code of Federal Regulations,'' if the provider-based requirements under section 413.65 of such title, applicable certification requirements under title XVIII of the Social Security, and such other applicable State licensure and certificate of need requirements are met with respect to such satellites or remote site locations.

SEC. 504. INCREASING THE DSH ADJUSTMENT CAP.

(a) IN GENERAL.—Section 1886(d)(5)(F)(xiv) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)(xiv)) is amended—

(b) SPECIAL RULE IN COMPUTING DISPROPORTIONATE PATIENT PERCENTAGE.—

(1) IN GENERAL.—Section 1886(d)(5)(F)(vi) of such Act (42 U.S.C. 1395ww(d)(5)(F)(vi)) is amended by adding at the end the following: ''In applying this clause in the case of hospitals located in Puerto Rico, the Secretary shall substitute for the fraction described in subclause (I) one-half of the national average of such fraction for all subsection (d) hospitals, as estimated by the Secretary.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to discharges in cost reporting periods of hospitals beginning on or after January 1, 2008.

(1) in subclause (II), by striking ''12 percent'' and inserting ''the percent specified in subclause (III)''; and

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

''(III) The percent specified in this subclause is, in the case of discharges occurring—

''(a) before October 1, 2007, 12 percent;

''(b) during fiscal year 2008, 16 percent;

''(c) during fiscal year 2009, 18 percent; and

''(d) on or after October 1, 2009, 12 percent.''.

SEC. 505. PPS-EXEMPT CANCER HOSPITALS.

(a) AUTHORIZING REBASING FOR PPS-EXEMPT CANCER HOSPITALS.—Section 1886(b)(3)(F) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(F)) is amended by adding at the end the following new clause:

''(iv) In the case of a hospital (or unit described in the matter following clause (v) of subsection (d)(1)(B)) that received payment under this subsection for inpatient hospital services furnished during cost reporting periods beginning before October 1, 1999, that is within a class of hospital described in clause (iii) (other than subclause (IV), relating to long-term care hospitals, and that requests the Secretary (in a form and manner specified by the Secretary) to effect a rebasing under this clause for the hospital, the Secretary may compute the target amount for the hospital's 12-month cost reporting period beginning during fiscal year 2008 as an amount equal to the average described in clause (ii) but determined as if any reference in such clause to 'the date of the enactment of this subparagraph' were a reference to 'the date of the enactment of this clause'.''.

(b) ADDITIONAL CANCER HOSPITAL PROVISIONS.—

(1) IN GENERAL.—Section 1886(d)(1) of the Social Security Act (42 U.S.C. 1395ww(d)(1)) is amended—

(A) in subparagraph (B)(v)—

(i) by striking ''or'' at the end of subclause (II); and

(ii) by adding at the end the following:

''(IV) a hospital that is a nonprofit corporation, the sole member of which is affiliated with a university that has been the recipient of a cancer center support grant from the National Cancer Institute of the National Institutes of Health, and which sole member (or its predecessors or such university) was recognized as a comprehensive cancer center by the National Cancer Institute of the National Institutes of Health as of April 20, 1983, if the hospital's articles of incorporation specify that at least 50 percent of its total discharges have a principal finding of neoplastic disease (as defined in subparagraph (E)) and if, of December 31, 2005, the

hospital was licensed for less than 150 acute care beds, or

''(V) a hospital (aa) that the Secretary has determined to be, at any time on or before December 31, 2011, a hospital involved extensively in treatment for, or research on, cancer, (bb) that is (as of the date of such determination) a freestanding facility, (cc) for which the hospital's predecessor provider entity was University Hospitals of Cleveland with medicare provider number 36–0137;''; and

(B) in subparagraph (B), by inserting after clause (vi), as redesignated by section 503(c)(1)(A)(ii)(II), the following new clause:

''(vii) a hospital that—

''(I) is located in a State that as of December 31, 2006, had only one center under section 414 of the Public Health Service Act that has been designated by the National Cancer Institute as a comprehensive center currently serving all 21 counties in the most densely populated State in the nation (U.S. Census estimate for 2005: 8,717,925 persons; 1,134.5 persons per square mile), serving more than 70,000 patient visits annually;

''(II) as of December 31, 2006, served as the teaching and clinical care, research and training hospital for the Center described in subclause (II), providing significant financial and operational support to such Center;

''(III) as of December 31, 2006, served as a core and essential element in such Center which conducts more than 130 clinical trial activities, national cooperative group studies, investigator-initiated and peer review studies and has received as of 2005 at least $93,000,000 in research grant awards;

''(IV) as of December 31, 2006, includes dedicated patient care units organized primarily for the treatment of and research on cancer with approximately 125 beds, 75 percent of which are dedicated to cancer patients, and contains a radiation oncology department as well as specialized emergency services for oncology patients; and

''(V) as of December 31, 2004, is identified as the focus of the Center's inpatient activities in the Center's application as a NCI-designated comprehensive cancer center and shares the NCI comprehensive cancer designation with the Center; and

(D) in subparagraph (E)—

(i) by striking ''subclauses (II) and (III)'' and inserting ''subclauses (II), (III), and (IV)''; and

(ii) by inserting ''and subparagraph (B)(vi)'' after ''subparagraph (B)(v)''.

(2) EFFECTIVE DATES; PAYMENTS.—

(A) APPLICATION TO COST REPORTING PERIODS.—

(i) Any classification by reason of section 1886(d)(1)(B)(vi) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(vi)), as inserted by paragraph (1), shall apply to cost reporting periods beginning on or after January 1, 2006.

(ii) The provisions of section 1886(d)(1)(B)(v)(IV) of the Social Security Act, as added by paragraph (1), shall take effect on January 1, 2008.

(B) BASE TARGET AMOUNT.—Notwithstanding subsection (b)(3)(E) of section 1886 of the Social Security Act (42 U.S.C. 1395ww), in the case of a hospital described in subsection (d)(1)(B)(vi) of such section, as inserted by paragraph (1)—

(i) the hospital shall be permitted to resubmit the 2006 Medicare 2552 cost report incorporating a cancer hospital sub-provider number and to apply the Medicare ratio-of-cost-to-charge settlement methodology for outpatient cancer services; and

(ii) the hospital's target amount under subsection (b)(3)(E)(i) of such section for the first cost reporting period beginning on or after January 1, 2006, shall be the allowable operating costs of inpatient hospital services (referred to in subclause (I) of such subsection) for such first cost reporting period.

(C) DEADLINE FOR PAYMENTS.—Any payments owed to a hospital as a result of this subsection for periods occurring before the date of the enactment of this Act shall be made expeditiously, but in no event later than 1 year after such date of enactment.

(3) APPLICATION TO CERTAIN HOSPITALS.—

(A) INAPPLICABILITY OF CERTAIN REQUIREMENTS.—The provisions of section 412.22(e) of title 42, Code of Federal Regulations, shall not apply to a hospital described in section 1886(d)(1)(B)(v)(V) of the Social Security Act, as added by paragraph (1).

(B) APPLICATION TO COST REPORTING PERIODS.—If the Secretary makes a determination that a hospital is described in section 1886(d)(1)(B)(v)(V) of the Social Security Act, as added by paragraph (1), such determination shall apply as of the first cost reporting period beginning on or after the date of such determination.

(C) BASE PERIOD.—Notwithstanding the provisions of section 1886(b)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(E)) or any other provision of law, the base cost reporting period for purposes of determining the target amount for any hospital for which a determination described in subparagraph (B) has been made shall be the first full 12-month cost reporting period beginning on or after the date of such determination.

(D) RULE.—A hospital described in subclause (V) of section 1886(b)(1)(B)(v) of the Social Security Act, as added by paragraph (1), shall not qualify as a hospital described in such subclause for any cost reporting period in which less than 50 percent of its total discharges have a principal finding of neoplastic disease. With respect to the first cost reporting period for which a determination described in subparagraph (B) has been made, the Secretary shall accept a self-certification by the hospital, which shall be applicable to such first cost reporting period, that the hospital intends to have total discharges during such first cost reporting period of which 50 percent or more have a principal finding of neoplastic disease.

(c) MEDPAC REPORT ON PPS-EXEMPT CANCER HOSPITALS.—Not later than March 1, 2009, the Medicare Payment Advisory Commission (established under section 1805 of the Social Security Act (42 U.S.C. 1395b-6)) shall submit to the Secretary and Congress a report evaluating the following:

(1) Measures of payment adequacy and Medicare margins for PPS-exempt cancer hospitals, as established under section 1886(d)(1)(B)(v) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)(v)).

(2) To the extent a PPS-exempt cancer hospital was previously affiliated with another hospital, the margins of the PPS-exempt hospital and the other hospital as separate entities and the margins of such hospitals that existed when the hospitals were previously affiliated.

(3) Payment adequacy for cancer discharges under the Medicare inpatient hospital prospective payment system.

SEC. 506. SKILLED NURSING FACILITY PAYMENT UPDATE.

(a) IN GENERAL.—Section 1888(e)(4)(E)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(E)(ii)) is amended—

(1) in subclause (III), by striking ''and'' at the end;

(2) by redesignating subclause (IV) as subclause (VI); and

(3) by inserting after subclause (III) the following new subclauses:

''(IV) for each of fiscal years 2004, 2005, 2006, and 2007, the rate computed for the previous fiscal year increased by the skilled nursing facility market basket percentage change for the fiscal year involved;

''(V) for fiscal year 2008, the rate computed for the previous fiscal year; and''.

(b) DELAYED EFFECTIVE DATE.—Section 1888(e)(4)(E)(ii)(V) of the Social Security Act, as inserted by subsection (a)(3), shall not apply to payment for days before January 1, 2008.

SEC. 507. REVOCATION OF UNIQUE DEEMING AUTHORITY OF THE JOINT COMMISSION FOR THE ACCREDITATION OF HEALTHCARE ORGANIZATIONS.

(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) Such section is further amended—

(A) in subsection (a)(1), as so redesignated, 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 Hospitals,'' 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 such 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 such 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 such 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 such 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 such 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 JCAHO AS A NATIONAL ACCREDITATION BODY.—The Secretary of Health and Human Services may recognize the Joint Commission on Accreditation of Healthcare Organizations 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 18 months after the date of the 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 on Accreditation of Healthcare Organizations, or under accreditation or comparable approval standards found to be essentially equivalent to accreditation or approval standards of the Joint Commission on Accreditation of Healthcare Organizations, for the period of time applicable under such accreditation.

SEC. 508. TREATMENT OF MEDICARE HOSPITAL RECLASSIFICATIONS.

(a) EXTENDING CERTAIN MEDICARE HOSPITAL WAGE INDEX RECLASSIFICATIONS THROUGH FISCAL YEAR 2009.—

(1) IN GENERAL.—Section 106(a) of the Medicare Improvements and Extension Act of 2006 (division B of Public Law 109–432) is amended by striking ''September 30, 2007'' and inserting ''September 30, 2009''.

(2) SPECIAL EXCEPTION RECLASSIFICATIONS.—The Secretary of Health and Human Services shall extend for discharges occurring through September 30, 2009, the special exception reclassification made under the authority of section 1886(d)(5)(I)(i) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(I)(i)) and contained in the final rule promulgated by the Secretary in the Federal Register on August 11, 2004 (69 Fed. Reg. 49105, 49107).

(b) DISREGARDING SECTION 508 HOSPITAL RECLASSIFICATIONS FOR PURPOSES OF GROUP RECLASSIFICATIONS.—Section 508 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173, 42 U.S.C. 1395ww note) is amended by adding at the end the following new subsection:

''(g) DISREGARDING HOSPITAL RECLASSIFICATIONS FOR PURPOSES OF GROUP RECLASSIFICATIONS.—For purposes of the reclassification of a group of hospitals in a geographic area under section 1886(d), a hospital reclassified under this section (including any such reclassification which is extended under section 106(a) of the Medicare Improvements and Extension Act of 2006) shall not be taken into account and shall not prevent the other hospitals in such area from establishing such a group for such purpose.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to payments for discharges occurring on or after October 1, 2008.

(c) OTHER HOSPITAL RECLASSIFICATION PROVISIONS.—Notwithstanding any other provision of law—

(1) In the case of a subsection (d) hospital (as defined for purposes of section 1886 of the Social Security Act (42 U.S.C. 1395ww)) located in Putnam County, Tennessee with respect to which a reclassification of its wage index for purposes of such section would (but for this subsection) expire on September 30, 2007, such reclassification of such hospital shall be extended through September 30, 2008.

(2) For purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), the Secretary of Health and Human Services shall classify any hospital located in Orange County, New York that was reclassified under the authority of section 508 of the the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Public Law 108-173) as being located in the New York-White Plains-Wayne, NY-NJ Core Based Statistical Area. Any reclassification under this subsection shall be treated as a reclassification under section 1886(d)(8) of such Act.

(3) For purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), the large urban area of New York, New York is deemed to include hospitals, required by State law enacted prior to June 30, 2007, to join under a single unified governance structure if—

(A) such hospitals are located in a city with a population of no less than 20,000 and no greater than 30,000; and

(B) such hospitals are less than 3/4 miles apart.

(4) For purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) the large urban area of Buffalo-Niagara Falls, New York is deemed to include Chautauqua County, New York. In no case shall there be a reduction in the hospital wage index for Erie County, New York, or any adjoining county, as a result of the application of this paragraph, (other than as a result of a general reduction required to carry out paragraph (8)(D) of that section).

(5) For purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) a hospital shall be reclassified into the New York-White Plains-Wayne, New York-New Jersey core based statistical area (CBSA code 35644) if the hospital is a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)) that—

(A) is licensed by the State in which it is located as a specialty hospital;

(B) specializes in the treatment of cardiac, vascular, and pulmonary diseases;

(C) provides at least 100 beds; and

(D) is located in Burlington County, New Jersey.

(6)(A) Any hospital described in subparagraph (B) shall be treated as located in the core based statistical area described in subparagraph (C) for purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)).

(B) A hospital described in this subparagraph is any hospital that—

(i) is located in a core based statistical area (CBSA) that—

(I) had a population (as reported in the decennial census for the year 2000) of at least 500,000, but not more than 750,000;

(II) had a population (as reported in such census) that was at least 10,000 below the population for the area as reported in the previous decennial census; and

(III) has as of January 1, 2006, at least 5, and no more than 7, subsection (d) hospitals; and

(ii) demonstrates that its average hourly wage amount (as determined consistent with section 1886(d)(10)(D)(vi) of the Social Security Act is not less than 96 percent of such average hourly wage amount rate for all subsection (d) hospitals located in same core base statistical area of the hospital.

(C) The area described in this subparagraph, with respect to a hospital described in subparagraph (B), is the core based statistical area that—

(i) is within the same State as, and is adjacent to, the core based statistical area in which the hospital is located; and

(ii) has an average hourly wage amount (described in subparagraph (B)(ii)) that is closest to (but does not exceed) such average hourly wage amount of the hospital.

(7) For purposes of making payments under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), the large urban area of Hartford, Connecticut is deemed to include Albany, Schenectady, and Rensselaer Counties, New York.

(8) For purposes of making payment under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), the Nashville-Davidson-Murfreesboro core based statistical area is deemed to include Cumberland County, Tennessee.

(9) For purposes of making payment under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), any hospital that is co-located in Marinette, Wisconsin and the Menominee, Michigan is deemed to be located in Chicago, Illinois.

(10) In the case of a hospital located in Massachusetts or Clinton County, New York, that is reclassified based on wages under paragraph (8) or (10) of section 1886(d) of the Social Security Act into an area the area wage index for which is increased under section 4410(a) of the Balanced Budget Act of 1997 (Public Law 105-33), such increased area wage index shall also apply to such hospital under such section 1886(d).

(11) For purposes of applying the area wage index under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), hospital provider numbers 360112 and 23005 shall be treated as located in the same urban area as Ann Arbor, Michigan.

(12) For purposes of making payment under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), any hospital that is located in Columbia County, New York, with less 250 beds is deemed to be located in the New York-White Plains-Wayne, NY-NJ core based statistical area.

(13) For purposes of the previous provisions of this subsection (other than paragraph (1))—

(A) any reclassification effected under such provisions shall be treated as a decision of the Medicare Geographic Classification Review Board under section 1886(d) of the Social Security Act and subject to budget neutrality under paragraph (8)(D) of such section.; and

(B) such provisions shall only apply to discharges occurring on or after October 1, 2008, during the 3-year reclassification period beginning on such date.

SEC. 509. MEDICARE CRITICAL ACCESS HOSPITAL DESIGNATIONS.

(a) IN GENERAL.—

(1) 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 Minnesota 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) and is located in Cass County, Minnesota, 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

''(i) has been granted an exception by the State to an otherwise applicable statutory restriction on hospital construction or licensing prior to the date of enactment of this subparagraph; and

''(ii) is located on property which the State has approved for conveyance to a county within the State prior to such date of enactment.''.

(2) Section 1820(c)(2)(B)(i)(I) of the Social Security Act (42 U.S.C. 1395i-4(c)(2)(B)(i)(I)) is amended by striking ''or,'' and inserting ''or, in the case of a hospital that is located in the county seat of Butler, Alabama, a 32-mile drive, or,''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a)(2) shall apply to cost reporting periods beginning on or after the date of the enactment of this Act.

TITLE VI—OTHER PROVISIONS RELATING TO MEDICARE PART B

Subtitle A—Payment and Coverage Improvements

SEC. 601. PAYMENT FOR THERAPY SERVICES.

(a) 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 201 of the Medicare Improvements and Extension Act of 2006 (division B of Public Law 109–432), is amended by striking ''2007'' and inserting ''2009''.

(b) STUDY AND REPORT.—

(1) STUDY.—The Secretary of Health and Human Services, in consultation with appropriate stakeholders, shall conduct a study on refined and alternative payment systems to the Medicare payment cap under section 1833(g) of the Social Security Act (42 U.S.C. 1395l(g)) for physical therapy services and speech-language pathology services, described in paragraph (1) of such section and occupational therapy services described in paragraph (3) of such section. Such study shall consider, with respect to payment amounts under Medicare, the following:

(A) The creation of multiple payment caps for such services to better reflect costs associated with specific health conditions.

(B) The development of a prospective payment system, including an episode-based system of payments, for such services.

(C) The data needed for the development of a system of multiple payment caps (or an alternative payment methodology) for such services and the availability of such data.

(2) REPORT.—Not later than January 1, 2009, the Secretary shall submit to Congress a report on the study conducted under paragraph (1).

SEC. 602. MEDICARE SEPARATE DEFINITION OF OUTPATIENT 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''.

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

(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. 603. INCREASED REIMBURSEMENT RATE FOR CERTIFIED NURSE-MIDWIVES.

(a) IN GENERAL.—Section 1833(a)(1)(K) of the Social Security Act (42 U.S.C.1395l(a)(1)(K)) is amended by striking ''(but in no event'' and all that follows through ''performed by a physician)''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after April 1, 2008.

SEC. 604. ADJUSTMENT IN OUTPATIENT HOSPITAL FEE SCHEDULE INCREASE FACTOR.

The first sentence of section 1833(t)(3)(C)(iv) of the Social Security Act (42 U.S.C. 1395l(t)(3)(C)(iv)) is amended by inserting before the period at the end the following: ''and reduced by 0.25 percentage point for such factor for such services furnished in 2008''.

SEC. 605. EXCEPTION TO 60-DAY LIMIT ON MEDICARE SUBSTITUTE BILLING ARRANGEMENTS IN CASE OF PHYSICIANS ORDERED TO ACTIVE DUTY IN THE ARMED FORCES.

(a) IN GENERAL.—Section 1842(b)(6)(D)(iii) of the Social Security Act (42 U.S.C. 1395u(b)(6)(D)(iii)) is amended by inserting after ''of more than 60 days'' the following: ''or are provided over a longer continuous period during all of which the first physician has been called or ordered to active duty as a member of a reserve component of the Armed Forces''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to services furnished on or after the date of the enactment of this section.

SEC. 606. EXCLUDING CLINICAL SOCIAL WORKER SERVICES FROM COVERAGE UNDER THE MEDICARE SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM AND CONSOLIDATED PAYMENT.

(a) IN GENERAL.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)) is amended by inserting ''clinical social worker services,'' after ''qualified psychologist services,''.

(b) CONFORMING AMENDMENT.—Section 1861(hh)(2) of the Social Security Act (42 U.S.C. 1395x(hh)(2)) is amended by striking ''and other than services furnished to an inpatient of a skilled nursing facility which the facility is required to provide as a requirement for participation''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2008.

SEC. 607. COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES AND MENTAL HEALTH COUNSELOR SERVICES.

(a) COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES.—

(1) COVERAGE OF SERVICES.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by section 201(a)(1), is amended—

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

(B) in subparagraph (BB), by adding ''and'' at the end; and

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

''(CC) marriage and family therapist services (as defined in subsection (eee));''.

(2) DEFINITION.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by sections 201(a)(2) and 503(b)(1), is amended by adding at the end the following new subsection:

''Marriage and Family Therapist Services

''(eee)(1) The term 'marriage and family therapist services' means services performed by a marriage and family therapist (as defined in paragraph (2)) for the diagnosis and treatment of mental illnesses, which the marriage and family therapist is legally authorized to perform under State law (or the State regulatory mechanism provided by State law) of the State in which such services are performed, provided such services are covered under this title, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.

''(2) The term 'marriage and family therapist' means an individual who—

''(A) possesses a master's or doctoral degree which qualifies for licensure or certification as a marriage and family therapist pursuant to State law;

''(B) after obtaining such degree has performed at least 2 years of clinical supervised experience in marriage and family therapy; and

''(C) is licensed or certified as a marriage and family therapist in the State in which marriage and family therapist services are performed.''.

(3) PROVISION FOR PAYMENT UNDER PART B.—Section 1832(a)(2)(B) of the Social Security Act (42 U.S.C. 1395k(a)(2)(B)) is amended by adding at the end the following new clause:

''(v) marriage and family therapist services;''.

(4) AMOUNT OF PAYMENT.—

(A) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by section 201(b)(1), is amended—

(i) by striking ''and'' before ''(W)''; and

(ii) by inserting before the semicolon at the end the following: '', and (X) with respect to marriage and family therapist services under section 1861(s)(2)(CC), the amounts paid shall be 80 percent of the lesser of (i) the actual charge for the services or (ii) 75 percent of the amount determined for payment of a psychologist under subparagraph (L)''.

(B) DEVELOPMENT OF CRITERIA WITH RESPECT TO CONSULTATION WITH A PHYSICIAN.—The Secretary of Health and Human Services shall, taking into consideration concerns for patient confidentiality, develop criteria with respect to payment for marriage and family therapist services for which payment may be made directly to the marriage and family therapist under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) under which such a therapist must agree to consult with a patient's attending or primary care physician in accordance with such criteria.

(5) EXCLUSION OF MARRIAGE AND FAMILY THERAPIST SERVICES FROM SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)), is amended by inserting ''marriage and family therapist services (as defined in subsection (eee)(1)),'' after ''qualified psychologist services,''.

(6) COVERAGE OF MARRIAGE AND FAMILY THERAPIST SERVICES PROVIDED IN RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)) is amended by striking ''or by a clinical social worker (as defined in subsection (hh)(1)),'' and inserting '', by a clinical social worker (as defined in subsection (hh)(1)), or by a marriage and family therapist (as defined in subsection (eee)(2)),''.

(7) INCLUSION OF MARRIAGE AND FAMILY THERAPISTS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)) is amended by adding at the end the following new clause:

''(vii) A marriage and family therapist (as defined in section 1861(eee)(2)).''.

(b) COVERAGE OF MENTAL HEALTH COUNSELOR SERVICES.—

(1) COVERAGE OF SERVICES.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by subsection (a)(1), is further amended—

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

(B) in subparagraph (CC), by inserting ''and'' at the end; and

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

''(DD) mental health counselor services (as defined in subsection (fff)(2));''.

(2) DEFINITION.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by sections 201(a)(2) and 503(b)(1) and subsection (a)(2), is amended by adding at the end the following new subsection:

''Mental Health Counselor; Mental Health Counselor Services

''(fff)(1) The term 'mental health counselor' means an individual who—

''(A) possesses a master's or doctor's degree which qualifies the individual for licensure or certification for the practice of mental health counseling in the State in which the services are performed;

''(B) after obtaining such a degree has performed at least 2 years of supervised mental health counselor practice; and

''(C) is licensed or certified as a mental health counselor or professional counselor by the State in which the services are performed.

''(2) The term 'mental health counselor services' means services performed by a mental health counselor (as defined in paragraph (1)) for the diagnosis and treatment of mental illnesses which the mental health counselor is legally authorized to perform under State law (or the State regulatory mechanism provided by the State law) of the State in which such services are performed, provided such services are covered under this title, as would otherwise be covered if furnished by a physician or as incident to a physician's professional service, but only if no facility or other provider charges or is paid any amounts with respect to the furnishing of such services.''.

(3) PROVISION FOR PAYMENT UNDER PART B.—Section 1832(a)(2)(B) of the Social Security Act (42 U.S.C. 1395k(a)(2)(B)), as amended by subsection (a)(3), is further amended by adding at the end the following new clause:

''(vi) mental health counselor services;''.

(4) AMOUNT OF PAYMENT.—

(A) IN GENERAL.—Section 1833(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)), as amended by subsection (a)(4), is further amended—

(i) by striking ''and'' before ''(X)''; and

(ii) by inserting before the semicolon at the end the following: '', and (Y) with respect to mental health counselor services under section 1861(s)(2)(DD), the amounts paid shall be 80 percent of the lesser of (i) the actual charge for the services or (ii) 75 percent of the amount determined for payment of a psychologist under subparagraph (L)''.

(B) DEVELOPMENT OF CRITERIA WITH RESPECT TO CONSULTATION WITH A PHYSICIAN.—The Secretary of Health and Human Services shall, taking into consideration concerns for patient confidentiality, develop criteria with respect to payment for mental health counselor services for which payment may be made directly to the mental health counselor under part B of title XVIII of the Social Security Act (42 U.S.C. 1395j et seq.) under which such a counselor must agree to consult with a patient's attending or primary care physician in accordance with such criteria.

(5) EXCLUSION OF MENTAL HEALTH COUNSELOR SERVICES FROM SKILLED NURSING FACILITY PROSPECTIVE PAYMENT SYSTEM.—Section 1888(e)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(2)(A)(ii)), as amended by subsection (a)(5), is amended by inserting ''mental health counselor services (as defined in section 1861(ddd)(2)),'' after ''marriage and family therapist services (as defined in subsection (eee)(1)),''.

(6) COVERAGE OF MENTAL HEALTH COUNSELOR SERVICES PROVIDED IN RURAL HEALTH CLINICS AND FEDERALLY QUALIFIED HEALTH CENTERS.—Section 1861(aa)(1)(B) of the Social Security Act (42 U.S.C. 1395x(aa)(1)(B)), as amended by subsection (a)(6), is amended by striking ''or by a marriage and family therapist (as defined in subsection (eee)(2)),'' and inserting ''by a marriage and family therapist (as defined in subsection (eee)(2)), or a mental health counselor (as defined in subsection (fff)(1)),''.

(7) INCLUSION OF MENTAL HEALTH COUNSELORS AS PRACTITIONERS FOR ASSIGNMENT OF CLAIMS.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395u(b)(18)(C)), as amended by subsection (a)(7), is amended by adding at the end the following new clause:

''(viii) A mental health counselor (as defined in section 1861(fff)(1)).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after January 1, 2008.

SEC. 608. RENTAL AND PURCHASE OF POWER-DRIVEN WHEELCHAIRS.

(a) IN GENERAL.—Section 1834(a)(7) of the Social Security Act (42 U.S.C. 1395m(a)(7)) is amended—

(1) in subparagraph (A)—

(A) in clause (i)(I), by striking ''Except as provided in clause (iii), payment'' and inserting ''Payment'';

(B) by striking clause (iii); and

(C) in clause (iv)—

(i) by redesignating such clause as clause (iii); and

(ii) by striking ''or in the case of a power-driven wheelchair for which a purchase agreement has been entered into under clause (iii)''; and

(2) in subparagraph (C)(ii)(II), by striking ''or (A)(iii)''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (1), the amendments made by subsection (a) shall take effect on January 1, 2008, and shall apply to power-driven wheelchairs furnished on or after such date.

(2) APPLICATION TO COMPETITIVE ACQUISITION.—The amendments made by subsection (a) shall not apply to contracts entered into under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) pursuant to a bid submitted under such section before October 1, 2007.

SEC. 609. RENTAL AND PURCHASE 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 clause (i)—

(A) by striking ''Payment'' and inserting ''Subject to clause (iii), payment''; and

(B) by striking ''36 months'' and inserting ''18 months'';

(2) in clause (ii)(I), by striking ''36th continuous month'' and inserting ''18th continuous month''; and

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

''(iii) SPECIAL RULE FOR OXYGEN GENERATING PORTABLE EQUIPMENT.—In the case of oxygen generating portable equipment referred to in the final rule published in the Federal Register on November 9, 2006 (71 Fed. Reg. 65897–65899), in applying clauses (i) and (ii)(I) each reference to '18 months' is deemed a reference to '36 months'.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Subject to paragraph (3), the amendments made by subsection (a) shall apply to oxygen equipment furnished on or after January 1, 2008.

(2) TRANSITION.—In the case of an individual receiving oxygen equipment on December 31, 2007, for which payment is made under section 1834(a) of the Social Security Act (42 U.S.C. 1395m(a)), the 18-month period described in paragraph (5)(F)(i) of such section, as amended by subsection (a), shall begin on January 1, 2008, but in no case shall the rental period for such equipment exceed 36 months.

(3) APPLICATION TO COMPETITIVE ACQUISITION.—The amendments made by subsection (a) shall not apply to contracts entered into under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) pursuant to a bid submitted under such section before October 1, 2007.

(c) STUDY AND REPORT.—

(1) STUDY.—The Secretary of Health and Human Services shall conduct a study to examine the service component and the equipment component of the provision of oxygen to Medicare beneficiaries. The study shall assess—

(A) the type of services provided and variation across suppliers in providing such services;

(B) whether the services are medically necessary or affect patient outcomes;

(C) whether the Medicare program pays appropriately for equipment in connection with the provision of oxygen;

(D) whether such program pays appropriately for necessary services;

(E) whether such payment in connection with the provision of oxygen should be divided between equipment and services, and if so, how; and

(F) how such payment rate compares to a competitively bid rate.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to Congress a report on the study conducted under paragraph (1).

SEC. 610. ADJUSTMENT FOR MEDICARE MENTAL HEALTH SERVICES.

(a) IN GENERAL.—For purposes of payment for services furnished under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w-4) during the applicable period, the Secretary of Health and Human Services shall increase the amount otherwise payable for applicable services by 5 percent.

(b) DEFINITIONS.—For purposes of subsection (a):

(1) APPLICABLE PERIOD.—The term ''applicable period'' means the period beginning on January 1, 2008, and ending on December 31 of the year before the effective date of the first review after January 1, 2008, of work relative value units conducted under section 1848(c)(2)(B)(i) of the Social Security Act.

(2) APPLICABLE SERVICES.—The term ''applicable services'' means procedure codes for services—

(A) in the categories of psychiatric therapeutic procedures furnished in office or other outpatient facility settings, or inpatient hospital, partial hospital or residential care facility settings; and

(B) which cover insight oriented, behavior modifying, or supportive psychotherapy and interactive psychotherapy services in the Healthcare Common Procedure Coding System established by the Secretary of Health and Human Services under section 1848(c)(5) of such Act.

(c) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary of Health and Human Services may implement this section by program instruction or otherwise.

SEC. 611. EXTENSION OF BRACHYTHERAPY SPECIAL RULE.

Section 1833(t)(16)(C) of the Social Security Act (42 U.S.C. 1395l(t)(16)(C)) is amended by striking ''2008'' and inserting ''2009''.

SEC. 612. PAYMENT FOR PART B DRUGS.

(a) APPLICATION OF CONSISTENT VOLUME WEIGHTING IN COMPUTATION OF ASP.—In order to assure that payments for drugs and

biologicals under section 1847A of the Social Security Act (42 U.S.C. 1395w-3a) are correct and consistent with law, the Secretary of Health and Human Services shall, for payment for drugs and biologicals furnished on or after July 1, 2008, compute the volume-weighted average sales price using equation #2 (specified in appendix A of the report of the Inspector General of the Department of Health and Human Services on ''Calculation of Volume-Weighted Average Sales Price for Medicare Part B Prescription Drugs'' (February 2006; OEI–03-05-00310)) used by the Office of Inspector General to calculate a volume-weighted ASP.

(b) IMPROVEMENTS IN THE COMPETITIVE ACQUISITION PROGRAM (CAP).—

(1) CONTINUOUS OPEN ENROLLMENT; AUTOMATIC REENROLLMENT WITHOUT NEED FOR REAPPLICATION.—Subsection (a)(1)(A) of section 1847B of the Social Security Act (42 U.S.C. 1395w-3b) is amended—

(A) in clause (ii), by striking ''annually'' and inserting ''on an ongoing basis'';

(B) in clause (iii), by striking ''an annual selection'' and inserting ''a selection (which may be changed on an annual basis)'' ; and

(C) by adding at the end the following: ''An election and selection described in clauses (ii) and (iii) shall continue to be effective without the need for any periodic reelection or reapplication or selection.''.

(2) PERMITTING APPROPRIATE DELIVERY AND TRANSPORT OF DRUGS.—Subsection (b)(4)(E) of such section is amended—

(A) by striking ''or'' at the end of clause (i);

(B) by striking the period at the end of clause (ii) and inserting a semicolon; and

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

''(iii) prevent a contractor from delivering drugs to a satellite office designated by the prescribing physician; or

''(iv) prevent a contractor from allowing a selecting physician to transport drugs or biologicals to the site of administration consistent with State law and other applicable laws and regulations.''.

(3) PHYSICIAN OUTREACH AND EDUCATION.—Subsection (a)(1) of such section is amended by adding at the end the following new subparagraph:

''(E) PHYSICIAN OUTREACH AND EDUCATION.—The Secretary shall conduct a program of outreach to education physicians concerning the program and the ongoing opportunity of physicians to elect to obtain drugs and biologicals under the program.''.

(4) REBIDDING OF CONTRACTS.—The Secretary of Health and Human Services shall provide for the rebidding of contracts under section 1847B(c) of the Social Security Act (42 U.S.C. 1395w-3b(c)) only for periods on or after the expiration of the contract in effect under such section as of the date of the enactment of this Act, except in the case of a contractor terminated as a result of the application of section 1847B(b)(2)(B) of such Act.''

(c) TREATMENT OF CERTAIN DRUGS.—Section 1847A(b) of the Social Security Act (42 U.S.C. 1395w-3a(b)) is amended—

(1) in paragraph (1), by inserting ''paragraph (6) and'' after ''Subject to''; and

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

''(6) SPECIAL RULE.—Beginning with January 1, 2008, the payment amount for—

''(A) each single source drug or biological described in section 1842(o)(1)(G) (including a single source drug or biological that is treated as a multiple source drug because of the application of subsection (c)(6)(C)(ii)) is the lower of—

''(i) the payment amount that would be determined for such drug or biological applying such subsection; or

''(ii) the payment amount that would have been determined for such drug or biological if such subsection were not applied; and

''(B) a multiple source drug (excluding a drug or biological that is treated as a multiple source drug because of the application of such subsection) is the lower of—

''(i) the payment amount that would be determined for such drug or biological taking into account the application of such subsection; or

''(ii) the payment amount that would have been determined for such drug or biological if such subsection were not applied.''.

(d) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall apply to drugs furnished on or after January 1, 2008.

Subtitle B—Extension of Medicare Rural Access Protections

SEC. 621. 2-YEAR EXTENSION OF FLOOR ON MEDICARE WORK GEOGRAPHIC ADJUSTMENT.

Section 1848(e)(1)(E) of such Act (42 U.S.C. 1395w–4(e)(1)(E)) is amended by striking ''2008'' and inserting ''2010''.

SEC. 622. 2-YEAR EXTENSION OF SPECIAL 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 amended by section 732 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and section 104 of the Medicare Improvements and Extension Act of 2006 (division B of Public Law 109–432), is amended by striking ''and 2007'' and inserting ''2007, 2008, and 2009''.

SEC. 623. 2-YEAR EXTENSION OF MEDICARE REASONABLE COSTS PAYMENTS FOR CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITAL PATIENTS IN CERTAIN RURAL AREAS.

Section 416(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2282; 42 U.S.C. 1395l–4(b)), as amended by section 105 of the Medicare Improvement and Extension Act of 2006 (division B of Public Law 109–432), is amended by striking ''3-year'' and inserting ''5-year''.

SEC. 624. 2-YEAR EXTENSION OF MEDICARE INCENTIVE PAYMENT PROGRAM FOR PHYSICIAN SCARCITY AREAS .

(a) IN GENERAL.—Section 1833(u)(1) of the Social Security Act (42 U.S.C. 1395l(u)(1)) is amended by striking ''2008'' and inserting ''2010''.

(b) TRANSITION.—With respect to physicians' services furnished during 2008 and 2009, for purposes of subsection (a), the Secretary of Health and Human Services shall use the primary care scarcity areas and the specialty care scarcity areas (as identified in section 1833(u)(4)) that the Secretary was using under such subsection with respect to physicians' services furnished on December 31, 2007.

SEC. 625. 2-YEAR EXTENSION OF MEDICARE INCREASE PAYMENTS FOR GROUND AMBULANCE SERVICES IN RURAL AREAS.

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 before clause (i), by striking ''furnished on or after July 1, 2004, and before January 1, 2007,'';

(B) in clause (i), by inserting ''for services furnished on or after July 1, 2004, and before January 1, 2007, and on or after January 1, 2008, and before January 1, 2010,'' after ''in such paragraph,''; and

(C) in clause (ii), by inserting ''for services furnished on or after July 1, 2004, and before January 1, 2007,'' after ''in clause (i),''; and

(2) in subparagraph (B)—

(A) in the heading, by striking ''AFTER 2006'' and inserting ''FOR SUBSEQUENT PERIODS'';

(B) by inserting ''clauses (i) and (ii) of'' before ''subparagraph (A)''; and

(C) by striking ''in such subparagraph'' and inserting ''in the respective clause''.

SEC. 626. EXTENDING HOLD HARMLESS FOR SMALL RURAL HOSPITALS UNDER THE HOPD PROSPECTIVE PAYMENT SYSTEM.

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

(1) by striking ''January 1, 2009'' and inserting ''January 1, 2010'';

(2) by striking ''2007, or 2008,''; and

(3) by striking ''90 percent, and 85 percent, respectively.'' and inserting ''and with respect to such services furnished after 2006 the applicable percentage shall be 90 percent.''.

Subtitle C—End Stage Renal Disease Program

SEC. 631. CHRONIC KIDNEY DISEASE DEMONSTRATION PROJECTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary''), acting through the Director of the National Institutes of Health, shall establish demonstration projects to—

(1) increase public and medical community awareness (particularly of those who treat patients with diabetes and hypertension) about the factors that lead to chronic kidney disease, how to prevent it, how to diagnose it, and how to treat it;

(2) increase screening and use of prevention techniques for chronic kidney disease for Medicare beneficiaries and the general public (particularly among patients with diabetes and hypertension, where prevention techniques are well established and early detection makes prevention possible); and

(3) enhance surveillance systems and expand research to better assess the prevalence and incidence of chronic kidney disease, (building on work done by Centers for Disease Control and Prevention).

(b) SCOPE AND DURATION.—

(1) SCOPE.—The Secretary shall select at least 3 States in which to conduct demonstration projects under this section. In selecting the States under this paragraph, the Secretary shall take into account the size of the population of individuals with end-stage renal disease who are enrolled in part B of title XVIII of the Social Security Act and ensure the participation of individuals who reside in rural and urban areas.

(2) DURATION.—The demonstration 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.—

(1) EVALUATION.—The Secretary shall conduct an evaluation of the demonstration projects conducted under this section.

(2) REPORT.—Not later than 12 months after the date on which the demonstration projects under this section are completed, the Secretary shall submit to Congress a report on the evaluation conducted under paragraph (1) together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

SEC. 632. MEDICARE COVERAGE OF KIDNEY DISEASE PATIENT EDUCATION SERVICES.

(a) COVERAGE OF KIDNEY DISEASE EDUCATION SERVICES.—

(1) COVERAGE.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)), as amended by sections 201(a)(1), 607(a)(1), and 607(b)(1), is amended—

(A) in subparagraph (CC), by striking ''and'' after the semicolon at the end;

(B) in subparagraph (DD), by adding ''and'' after the semicolon at the end; and

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

''(EE) kidney disease education services (as defined in subsection (ggg));''.

(2) SERVICES DESCRIBED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x), as amended by sections 201(a)(2), 503(b)(1), 607(a)(2), and 607(b)(2), is amended by adding at the end the following new subsection:

''Kidney Disease Education Services

''(ggg)(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 developed 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 physician, physician assistant, nurse practitioner, or clinical nurse specialist who furnishes services for which payment may be made under the fee schedule established under section 1848. Such term does not include a renal dialysis facility.

''(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 a person or entity 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) In promulgating regulations to carry out this subsection, the Secretary shall ensure that each individual who is eligible for benefits for kidney disease education services under this title receives such services in a timely manner to maximize the benefit of those services.

''(5) The Secretary shall monitor the implementation of this subsection to ensure that individuals who are eligible for benefits for kidney disease education services receive such services in the manner described in paragraph (4).

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

(3) 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)(DD),'' after ''(2)(AA),''.

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

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

(B) in subparagraph (N), by striking the semicolon at the end and inserting '', and''; and

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

''(O) in the case of kidney disease education services (as defined in section 1861(ggg)), which are furnished in excess of the number of sessions covered under such section;''.

(5) GAO REPORT.—Not later than September 1, 2010, the Comptroller General of the United States shall submit to Congress a report on the following:

(A) The number of Medicare beneficiaries who are eligible to receive benefits for kidney disease education services (as defined in section 1861(ggg) of the Social Security Act, as added by paragraph (2)) under title XVIII of such Act and who receive such services.

(B) The extent to which there is a sufficient amount of physicians, physician assistants, nurse practitioners, and clinical nurse specialists to furnish kidney disease education services (as so defined) under such title and whether or not renal dialysis facilities (and appropriate employees of such facilities) should be included as an entity eligible under such section to furnish such services.

(C) Recommendations, if appropriate, for renal dialysis facilities (and appropriate employees of such facilities) to structure kidney disease education services (as so defined) in a manner that is objective and unbiased and that provides a range of options and alternative locations for renal replacement therapy and management of co-morbidities that may delay the need for dialysis.

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

SEC. 633. REQUIRED TRAINING FOR PATIENT CARE DIALYSIS TECHNICIANS.

Section 1881 of the Social Security Act (42 U.S.C. 1395rr) is amended by adding the following new subsection:

''(h)(1) Except as provided in paragraph (2), a provider of services or a renal dialysis facility may not use, for more than 12 months during 2009, or for any period beginning on January 1, 2010, any individual as a patient care dialysis technician unless the individual—

''(A) has completed a training program in the care and treatment of an individual with chronic kidney failure who is undergoing dialysis treatment; and

''(B) has been certified by a nationally recognized certification entity for dialysis technicians.

''(2)(A) A provider of services or a renal dialysis facility may permit an individual enrolled in a training program described in paragraph (1)(A) to serve as a patient care dialysis technician while they are so enrolled.

''(B) The requirements described in subparagraphs (A), (B), and (C) of paragraph (1) do not apply to an individual who has performed dialysis-related services for at least 5 years.

''(3) For purposes of paragraph (1), if, since the most recent completion by an individual of a training program described in paragraph (1)(A), there has been a period of 24 consecutive months during which the individual has not furnished dialysis-related services for monetary compensation, such individual shall be required to complete a new training program or become recertified as described in paragraph (1)(B).

''(4) A provider of services or a renal dialysis facility shall provide such regular performance review and regular in-service education as assures that individuals serving as patient care dialysis technicians for the provider or facility are competent to perform dialysis-related services.''.

SEC. 634. MEDPAC REPORT ON TREATMENT MODALITIES FOR PATIENTS WITH KIDNEY FAILURE.

(a) EVALUATION.—

(1) IN GENERAL.—Not later than March 1, 2009, the Medicare Payment Advisory Commission (established under section 1805 of the Social Security Act) shall submit to the Secretary and Congress a report evaluating the barriers that exist to increasing the number of individuals with end-stage renal disease who elect to receive home dialysis services under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) REPORT DETAILS.—The report shall include the following:

(A) A review of Medicare home dialysis demonstration projects initiated before the date of the enactment of this Act, and the results of such demonstration projects and recommendations for future Medicare home dialysis demonstration projects or Medicare program changes that will test models that can improve Medicare beneficiary access to home dialysis.

(B) A comparison of current Medicare home dialysis costs and payments with current in-center and hospital dialysis costs and payments.

(C) An analysis of the adequacy of Medicare reimbursement for patient training for home dialysis (including hemodialysis and peritoneal dialysis) and recommendations for ensuring appropriate payment for such home dialysis training.

(D) A catalogue and evaluation of the incentives and disincentives in the current reimbursement system that influence whether patients receive home dialysis services or other treatment modalities.

(E) An evaluation of patient education services and how such services impact the treatment choices made by patients.

(F) Recommendations for implementing incentives to encourage patients to elect to receive home dialysis services or other treatment modalities under the Medicare program

(3) SCOPE OF REVIEW.—In preparing the report under paragraph (1), the Medicare Payment Advisory Commission shall consider a variety of perspectives, including the perspectives of physicians, other health care professionals, hospitals, dialysis facilities, health plans, purchasers, and patients.

SEC. 635. ADJUSTMENT FOR ERYTHROPOIETIN STIMULATING AGENTS (ESAS).

(a) IN GENERAL.—Subsection (b)(13) of section 1881 of the Social Security Act (42 U.S.C. 1395rr) is amended—

(1) in subparagraph (A)(iii), by striking ''For such drugs'' and inserting ''Subject to subparagraph (C), for such drugs''; and

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

''(C)(i) The payment amounts under this title for erythropoietin furnished during 2008 or 2009 to an individual with end stage renal disease by a large dialysis facility (as defined in subparagraph (D)) (whether to individuals in the facility or at home), in an amount equal to $8.75 per thousand units (rounded to the nearest 100 units) or, if less, 102 percent of the average sales price (as determined under section 1847A) for such drug or biological.

''(ii) The payment amounts under this title for darbepoetin alfa furnished during 2008 or 2009 to an individual with end stage renal disease by a large dialysis facility (as defined in clause (iii)) (whether to individuals in the facility or at home), in an amount equal to $2.92 per microgram or, if less, 102 percent of the average sales price (as determined under section 1847A) for such drug or biological.

''(iii) For purposes of this subparagraph, the term 'large dialysis facility' means a provider of services or renal dialysis facility that is owned or managed by a corporate entity that, as of July 24, 2007, owns or manages 300 or more such providers or facilities, and includes a successor to such a corporate entity.''.

(b) NO IMPACT ON DRUG ADD-ON PAYMENT.—Nothing in the amendments made by subsection (a) shall be construed to affect the amount of any payment adjustment made under section 1881(b)(12)(B)(ii) of the Social Security Act (42 U.S.C. 1395rr(b)(12)(B)(ii)).

SEC. 636. SITE NEUTRAL COMPOSITE RATE.

Subsection (b)(12)(A) of section 1881 of the Social Security Act (42 U.S.C. 1395rr) 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, 2008, by providers of such services for hospital-based facilities shall be the same as the payment rate (computed without regard to this

sentence) for such services furnished by renal dialysis facilities that are not hospital-based, except that in applying the geographic index under subparagraph (D) to hospital-based facilities, the labor share shall be based on the labor share otherwise applied for such facilities.''.

SEC. 637. DEVELOPMENT OF ESRD BUNDLING SYSTEM AND QUALITY INCENTIVE PAYMENTS.

(a) DEVELOPMENT OF ESRD BUNDLING SYSTEM.—Subsection (b) of section 1881 of the Social Security Act (42 U.S.C. 1395rr) is further amended—

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

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

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

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

(3) in paragraph (12)(H)—

(A) by inserting ''or paragraph (14)'' after ''under this paragraph'' the first place it appears; and

(B) by inserting before the period at the end the following: ''or, under paragraph (14), the identification of renal dialysis services included in the bundled payment, the adjustment for outliers, the identification of facilities to which the phase-in may apply, and the determination of payment amounts under subparagraph (A) under such paragraph, and the application of paragraph (13)(C)(iii)'';

(4) in paragraph (13)—

(A) in subparagraph (A), by striking ''The payment amounts'' and inserting ''subject to paragraph (14), the payment amounts''; and

(B) in subparagraph (B)—

(i) in clause (i), by striking ''(i)'' after ''(B)'' and by inserting '', subject to paragraph (14)'' before the period at the end; and

(ii) by striking clause (ii); and

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

''(14)(A) Subject to subparagraph (E), for services furnished on or after January 1, 2010, the Secretary shall implement a payment system under which a single payment is made under this title for renal dialysis services (as defined in subparagraph (B)) in lieu of any other payment (including a payment adjustment under paragraph (12)(B)(ii)) for such services and items furnished pursuant to paragraph (4). In implementing the system the Secretary shall ensure that the estimated total amount of payments under this title for 2010 for renal dialysis services shall equal 96 percent of the estimated amount of payments for such services, including payments under paragraph (12)(B)(ii), that would have been made if such system had not been implemented.

''(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, 2009;

''(ii) erythropoietin stimulating agents furnished to individuals with end stage renal disease;

''(iii) other drugs and biologicals and diagnostic laboratory tests, that the Secretary identifies as commonly used in the treatment of such patients and for which payment was (before the application of this paragraph) made separately under this title, and any oral equivalent form of such drugs and biologicals or of drugs and biologicals described in clause (ii); and

''(iv) home dialysis training for which payment was (before the application of this paragraph) made separately under this section.

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, race, ethnicity, 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 erythropoietin stimulating agents necessary for anemia management; and

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

''(I) by a geographic index, such as the index referred to in paragraph (12)(D), as the Secretary determines to be appropriate;

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

''(III) for low volume providers of services and renal dialysis facilities;

''(IV) for providers of services or renal dialysis facilities located in rural areas; and

''(V) for providers of services or renal dialysis facilities that are not large dialysis facilities.

''(E) The Secretary may provide for a phase-in of the payment system described in subparagraph (A) for services furnished by a provider of services or renal dialysis facility described in any of subclauses (II) through (V) of subparagraph (D)(iii), but such payment system shall be fully implemented for services furnished in the case of any such provider or facility on or after January 1, 2013.

''(F) The Secretary shall apply the annual increase that would otherwise apply under subparagraph (F) of paragraph (12) to payment amounts established under such paragraph (if this paragraph did not apply) in an appropriate manner under this paragraph.''.

(b) PROHIBITION OF UNBUNDLING.—Section 1862(a) of such Act (42 U.S.C. 1395y(a)) is amended—

(1) by striking ''or'' at the end of paragraph (21);

(2) by striking the period at the end of paragraph (22) and inserting ''; or''; and

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

''(23) 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 (other than under subparagraph (E) of such section) unless such payment is made under such section to a provider of services or a renal dialysis facility for such services.''.

(c) QUALITY INCENTIVE PAYMENTS.—Section 1881 of such Act is amended by adding at the end the following new subsection:

''(i) QUALITY INCENTIVE PAYMENTS IN THE END-STAGE RENAL DISEASE PROGRAM.—

''(1) QUALITY INCENTIVE PAYMENTS FOR SERVICES FURNISHED IN 2008, 2009, AND 2010.—

''(A) IN GENERAL.—With respect to renal dialysis services furnished during a performance period (as defined in subparagraph (B)) by a provider of services or renal dialysis facility that the Secretary determines meets the applicable performance standard for the period under subparagraph (C) and reports on measures for 2009 and 2010 under subparagraph (D) for such services, in addition to the amount otherwise paid under this section, subject to subparagraph (G), there also shall be paid to the provider or facility an amount equal to the applicable percentage (specified in subparagraph (E) for the period) of the Secretary's estimate (based on claims submitted not later than two months after the end of the performance period) of the amount specified in subparagraph (F) for such period.

''(B) PERFORMANCE PERIOD.—In this paragraph, the term 'performance period' means each of the following:

''(i) The period beginning on July 1, 2008, and ending on December 31, 2008.

''(ii) 2009.

''(iii) 2010.

''(C) PERFORMANCE STANDARD.—

''(i) 2008.—For the performance period occurring in 2008, the applicable performance standards for a provider or facility under this subparagraph are—

''(I) 92 percent or more of individuals with end stage renal disease receiving erythopoetin stimulating agents who have an average hematocrit of 33.0 percent or more; and

''(II) less than a percentage, specified by the Secretary, of individuals with end stage renal disease receiving erythopoetin stimulating agents who have an average hematocrit of 39.0 percent or more.

''(ii) 2009 AND 2010.—For the 2009 and 2010 performance periods, the applicable performance standard for a provider or facility under this subparagraph is successful performance (relative to national average) on—

''(I) such measures of anemia management as the Secretary shall specify, including measures of hemoglobin levels or hematocrit levels for erythropoietin stimulating agents that are consistent with the labeling for dosage of erythropoietin stimulating agents approved by the Food and Drug Administration for treatment of anemia in patients with end stage renal disease, taking into account variations in hemoglobin ranges or hematocrit levels of patients; and

''(II) such other measures, relating to subjects described in subparagraph (D)(i), as the Secretary may specify.

''(D) REPORTING PERFORMANCE MEASURES.—The performance measures under this subparagraph to be reported shall include—

''(i) such measures as the Secretary specifies, before the beginning of the performance period involved and taking into account measures endorsed by the National Quality Forum, including, to the extent feasible measures on—

''(I) iron management;

''(II) dialysis adequacy; and

''(III) vascular access, including for maximizing the placement of arterial venous fistula; and

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

The provider or facility submitting information on such measures shall attest to the completeness and accuracy of such information.

''(E) APPLICABLE PERCENTAGE.—The applicable percentage specified in this subparagraph for—

''(i) the performance period occurring in 2008, is 1.0 percent;

''(ii) the 2009 performance period, is 2.0 percent; and

''(iii) the 2010 performance period, is 3.0 percent.

In the case of any performance period which is less than an entire year, the applicable percentage specified in this subparagraph shall be multiplied by the ratio of the number of months in the year to the number of months in such performance period. In the case of 2010, the applicable percentage specified in this subparagraph shall be multiplied by the Secretary's estimate of the ratio of the aggregate payment amount described in subparagraph (F)(i) that would apply in 2010 if paragraph (14) did not apply, to the aggregate payment base under subparagraph (F)(ii) for 2010.

''(F) PAYMENT BASE.—The payment base described in this subparagraph for a provider or facility is—

''(i) for performance periods before 2010, the payment amount determined under paragraph (12) for services furnished by the provider or facility during the performance period, including the drug payment adjustment described in subparagraph (B)(ii) of such paragraph; and

''(ii) for the 2010 performance period is the amount determined under paragraph (14) for services furnished by the provider or facility during the period.

''(G) LIMITATION ON FUNDING.—

''(i) IN GENERAL.—If the Secretary determines that the total payments under this paragraph for a performance period is projected to exceed the dollar amount specified in clause (ii) for such period, the Secretary shall reduce, in a pro rata manner, the amount of such payments for each provider or facility for such period to eliminate any such projected excess for the period.

''(ii) DOLLAR AMOUNT.—The dollar amount specified in this clause—

''(I) for the performance period occurring in 2008, is $50,000,000;

''(II) for the 2009 performance period is $100,000,000; and

''(III) for the 2010 performance period is $150,000,000.

''(H) FORM OF PAYMENT.—The payment under this paragraph shall be in the form of a single consolidated payment.

''(2) QUALITY INCENTIVE PAYMENTS FOR FACILITIES AND PROVIDERS FOR 2011.—

''(A) INCREASED PAYMENT.—For 2011, in the case of a provider or facility that, for the performance period (as defined in subparagraph (B))—

''(i) meets (or exceeds) the performance standard for anemia management specified in paragraph (1)(C)(ii)(I);

''(ii) has substantially improved performance or exceeds a performance standard (as determined under subparagraph (E)); and

''(iii) reports measures specified in paragraph (1)(D),

with respect to renal dialysis services furnished by the provider or facility during the quality bonus payment period (as specified in subparagraph (C)) the payment amount otherwise made to such provider or facility under subsection (b)(14) shall be increased, subject to subparagraph (F), by the applicable percentage specified in subparagraph (D). Payment amounts under paragraph (1) shall not be counted for purposes of applying the previous sentence.

''(B) PERFORMANCE PERIOD.—In this paragraph, the term 'performance period' means a multi-month period specified by the Secretary .

''(C) QUALITY BONUS PAYMENT PERIOD.—In this paragraph, the term 'quality bonus payment period' means, with respect to a performance period, a multi-month period beginning on January 1, 2011, specified by the Secretary that begins at least 3 months (but not more than 9 months) after the end of the performance period.

''(D) APPLICABLE PERCENTAGE.—The applicable percentage specified in this subparagraph is a percentage, not to exceed the 4.0 percent, specified by the Secretary consistent with subparagraph (F). Such percentage may vary based on the level of performance and improvement. The applicable percentage specified in this subparagraph shall be multiplied by the ratio applied under the third sentence of paragraph (1)(E) for 2010.

''(E) PERFORMANCE STANDARD.—Based on performance of a provider of services or a renal dialysis facility on performance measures described in paragraph (1)(D) for a performance period, the Secretary shall determine a composite score for such period.

''(F) LIMITATION ON FUNDING.—If the Secretary determines that the total amount to be paid under this paragraph for a quality bonus payment period is projected to exceed $200,000,000, the Secretary shall reduce, in a uniform manner, the applicable percentage otherwise applied under subparagraph (D) for services furnished during the period to eliminate any such projected excess.

''(3) APPLICATION.—

''(A) IMPLEMENTATION.—Notwithstanding any other provision of law, the Secretary may implement by program instruction or otherwise this subsection.

''(B) LIMITATIONS ON REVIEW.—

''(i) IN GENERAL.—There shall be no administrative or judicial review under section 1869 or 1878 or otherwise of—

''(I) the determination of performance measures and standards under this subsection;

''(II) the determination of successful reporting, including a determination of composite scores; and

''(III) the determination of the quality incentive payments made under this subsection.

''(ii) TREATMENT OF DETERMINATIONS.—A determination under this subparagraph shall not be treated as a determination for purposes of section 1869.

''(4) TECHNICAL ASSISTANCE.—The Secretary shall identify or establish an appropriately skilled group or organization, such as the ESRD Networks, to provide technical assistance to consistently low-performing facilities or providers that are in the bottom quintile.

''(5) PUBLIC REPORTING.—

''(A) ANNUAL NOTICE.—The Secretary shall provide an annual written notification to each individual who is receiving renal dialysis services from a provider of services or renal dialysis facility that—

''(i) informs such individual of the composite scores described in subparagraph (A) and other relevant quality measures with respect to providers of services or renal dialysis facilities in the local area;

''(ii) compares such scores and measures to the average local and national scores and measures; and

''(iii) provides information on how to access additional information on quality of such services furnished and options for alternative providers and facilities.

''(B) CERTIFICATES.—The Secretary shall provide certificates to facilities and providers who provide services to individuals with end-stage renal disease under this title to display in patient areas. The certificate shall indicate the composite score obtained by the facility or provider under the quality initiative.

''(C) WEB-BASED QUALITY LIST.—The Secretary shall establish a web-based list of facilities and providers who furnish renal dialysis services under this section that indicates their composite score of each provider and facility.

''(6) RECOMMENDATIONS FOR REPORTING AND QUALITY INCENTIVE INTITIATIVE FOR PHYSICIANS.—The Secretary shall develop recommendations for applying quality incentive payments under this subsection to physicians who receive the monthly capitated payment under this title. Such recommendations shall include the following:

''(A) Recommendations to include pediatric specific measures for physicians with at least 50 percent of their patients with end stage renal disease being individuals under 18 years of age.

''(B) Recommendations on how to structure quality incentive payments for physicians who demonstrate improvements in quality or who attain quality standards, as specified by the Secretary.

''(7) REPORTS.—

''(A) INITIAL REPORT.—Not later than January 1, 2013, the Secretary shall submit to Congress a report on the implementation of the bundled payment system under subsection (b)(14) and the quality initiative under this subsection. Such report shall include the following information:

''(i) A comparison of the aggregate payments under subsection (b)(14) for items and services to the cost of such items and services.

''(ii) The changes in utilization rates for erythropoietin stimulating agents.

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

''(iv) The frequency of dialysis.

''(v) Other differences in practice patterns, such as the adoption of new technology, different modes of practice, and variations in use of drugs other than drugs described in clause (iii).

''(vi) The performance of facilities and providers under paragraph (2).

''(vii) Other recommendations for legislative and administrative actions determined appropriate by the Secretary.

''(B) SUBSEQUENT REPORT.—Not later than January 1, 2015, the Secretary shall submit to Congress a report that contains the information described in each of clauses (ii) through (vii) of subparagraph (A) and a comparison of the results of the payment system under subsection (b)(14) for renal dialysis services furnished during the 2-year period beginning on January 1, 2013, and the results of such payment system for such services furnished during the previous two-year period.''.

SEC. 638. MEDPAC REPORT ON ESRD BUNDLING SYSTEM.

Not later than March 1, 2012, the Medicare Payment Advisory Commission (established under section 1805 of the Social Security Act) shall submit to Congress a report on the implementation of the payment system under section 1881(b)(14) of the Social Security Act (as added by section 7) for renal dialysis services and related services (defined in subparagraph (B) of such section). Such report shall include, with respect to such payment system for such services, an analysis of each of the following:

(1) An analysis of the overall adequacy of payment under such system for all such services.

(2) An analysis that compares the adequacy of payment under such system for services furnished by—

(A) a provider of services or renal dialysis facility that is described in section 1881(b)(13)(C)(iv) of the Social Security Act;

(B) a provider of services or renal dialysis facility not described in such section;

(C) a hospital-based facility;

(D) a freestanding renal dialysis facility;

(E) a renal dialysis facility located in an urban area; and

(F) a renal dialysis facility located in a rural area.

(3) An analysis of the financial status of providers of such services and renal dialysis facilities, including access to capital, return on equity, and return on capital.

(4) An analysis of the adequacy of payment under such method and the adequacy of the quality improvement payments under section 1881(i) of the Social Security Act in ensuring that payments for such services under the Medicare program are consistent with costs for such services.

(5) Recommendations, if appropriate, for modifications to such payment system.

SEC. 639. OIG STUDY AND REPORT ON ERYTHROPOIETIN.

(a) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct a study on the following:

(1) The dosing guidelines, standards, protocols, and alogorithms for erythropoietin stimulating agents recommended or used by providers of services and renal dialysis facilities that are described in section 1881(b)(13)(C)(iv) of the Social Security Act and providers and facilities that are not described in such section.

(2) The extent to which such guidelines, standards, protocols, and algorithms are consistent with the labeling of the Food and Drug Administration for such agents.

(3) The extent to which physicians sign standing orders for such agents that are consistent with such guidelines, standards, protocols, and algorithms recommended or used by the provider or facility involved.

(4) The extent to which the prescribing decisions of physicians, with respect to such agents, are independent of—

(A) such relevant guidelines, standards, protocols, and algorithms; or

(B) recommendations of an anemia management nurse or other appropriate employee of the provider or facility involved.

(5) The role of medical directors of providers of services and renal dialysis facilities and the

financial relationships between such providers and facilities and the physicians hired as medical directors of such providers and facilities, respectively.

(b) REPORT.—Not later than January 1, 2009, the Inspector General of the Department of Health and Human Services shall submit to Congress a report on the study conducted under subsection (a), together with such recommendations as the Inspector General determines appropriate.

Subtitle D—Miscellaneous

SEC. 651. LIMITATION ON EXCEPTION TO THE PROHIBITION ON CERTAIN PHYSICIAN REFERRALS FOR HOSPITALS.

(a) IN GENERAL.—Section 1877 of the Social Security Act (42 U.S.C. 1395) is amended—

(1) in subsection (d)(2)—

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

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

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

''(C) if the entity is a hospital, the hospital meets the requirements of paragraph (3)(D).'';

(2) in subsection (d)(3)—

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

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

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

''(D) the hospital meets the requirements described in subsection (i)(1) not later than 18 months after the date of the enactment of this subparagraph.''; and

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

''(i) REQUIREMENTS FOR HOSPITALS TO QUALIFY FOR HOSPITAL EXCEPTION TO OWNERSHIP OR INVESTMENT PROHIBITION.—

''(1) REQUIREMENTS DESCRIBED.—For purposes of paragraphs subsection (d)(3)(D), the requirements described in this paragraph for a hospital are as follows:

''(A) PROVIDER AGREEMENT.—The hospital had a provider agreement under section 1866 in effect on July 24, 2007.

''(B) PROHIBITION OF EXPANSION OF FACILITY CAPACITY.—The number of operating rooms and beds of the hospital at any time on or after the date of the enactment of this subsection are no greater than the number of operating rooms and beds as of such date.

''(C) PREVENTING CONFLICTS OF INTEREST.—

''(i) The hospital submits to the Secretary an annual report containing a detailed description of—

''(I) the identity of each physician owner and any other owners of the hospital; and

''(II) the nature and extent of all ownership interests in the hospital.

''(ii) The hospital has procedures in place to require that any referring physician owner discloses to the patient being referred, by a time that permits the patient to make a meaningful decision regarding the receipt of care, as determined by the Secretary—

''(I) the ownership interest of such referring physician in the hospital; and

''(II) if applicable, any such ownership interest of the treating physician.

''(iii) The hospital does not condition any physician ownership interests either directly or indirectly on the physician owner making or influencing referrals to the hospital or otherwise generating business for the hospital.

''(D) ENSURING BONA FIDE INVESTMENT.—

''(i) Physician owners in the aggregate do not own more than 40 percent of the total value of the investment interests held in the hospital or in an entity whose assets include the hospital.

''(ii) The investment interest of any individual physician owner does not exceed 2 percent of the total value of the investment interests held in the hospital or in an entity whose assets include the hospital.

''(iii) Any ownership or investment interests that the hospital offers to a physician owner are not offered on more favorable terms than the terms offered to a person who is not a physician owner.

''(iv) The hospital does not directly or indirectly provide loans or financing for any physician owner investments in the hospital.

''(v) The hospital does not directly or indirectly guarantee a loan, make a payment toward a loan, or otherwise subsidize a loan, for any individual physician owner or group of physician owners that is related to acquiring any ownership interest in the hospital.

''(vi) Investment returns are distributed to investors in the hospital in an amount that is directly proportional to the investment of capital by the physician owner in the hospital.

''(vii) Physician owners do not receive, directly or indirectly, any guaranteed receipt of or right to purchase other business interests related to the hospital, including the purchase or lease of any property under the control of other investors in the hospital or located near the premises of the hospital.

''(viii) The hospital does not offer a physician owner the opportunity to purchase or lease any property under the control of the hospital or any other investor in the hospital on more favorable terms than the terms offered to an individual who is not a physician owner.

''(E) PATIENT SAFETY.—

''(i) Insofar as the hospital admits a patient and does not have any physician available on the premises to provide services during all hours in which the hospital is providing services to such patient, before admitting the patient—

''(I) the hospital discloses such fact to a patient; and

''(II) following such disclosure, the hospital receives from the patient a signed acknowledgment that the patient understands such fact.

''(ii) The hospital has the capacity to—

''(I) provide assessment and initial treatment for patients; and

''(II) refer and transfer patients to hospitals with the capability to treat the needs of the patient involved.

''(2) PUBLICATION OF INFORMATION REPORTED.—The Secretary shall publish, and update on an annual basis, the information submitted by hospitals under paragraph (1)(C)(i) on the public Internet website of the Centers for Medicare & Medicaid Services.

''(3) COLLECTION OF OWNERSHIP AND INVESTMENT INFORMATION.—For purposes of clauses (i) and (ii) of paragraph (1)(D), the Secretary shall collect physician ownership and investment information for each hospital as it existed on the date of the enactment of this subsection.

''(4) PHYSICIAN OWNER DEFINED.—For purposes of this subsection, the term 'physician owner' means a physician (or an immediate family member of such physician) with a direct or an indirect ownership interest in the hospital.''.

(b) ENFORCEMENT.—

(1) ENSURING COMPLIANCE.—The Secretary of Health and Human Services shall establish policies and procedures to ensure compliance with the requirements described in such section 1877(i)(1) of the Social Security Act, as added by subsection (a)(3), beginning on the date such requirements first apply. Such policies and procedures may include unannounced site reviews of hospitals.

(2) AUDITS.—Beginning not later than 18 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall conduct audits to determine if hospitals violate the requirements referred to in paragraph (1).

TITLE VII—PROVISIONS RELATING TO MEDICARE PARTS A AND B

SEC. 701. HOME HEALTH PAYMENT UPDATE FOR 2008.

Section 1895(b)(3)(B)(ii) of the Social Security Act (42 U.S.C. 1395fff(b)(3)(B)(ii)) is amended—

(1) in subclause (IV) at the end, by striking ''and'';

(2) by redesignating subclause (V) as subclause (VII); and

(3) by inserting after subclause (IV) the following new subclauses:

''(V) 2007, subject to clause (v), the home health market basket percentage increase;

''(VI) 2008, subject to clause (v), 0 percent; and''.

SEC. 702. 2-YEAR EXTENSION OF TEMPORARY MEDICARE PAYMENT INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

Section 421 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2283; 42 U.S.C. 1395fff note), as amended by section 5201(b) of the Deficit Reduction Act of 2005, is amended—

*(1) in the heading, by striking ''**ONE-YEAR**'' and inserting ''**TEMPORARY**''; and*

(2) in subsection (a), by striking ''and episodes and visits beginning on or after January 1, 2006, and before January 1, 2007'' and inserting ''episodes and visits beginning on or after January 1, 2006, and before January 1, 2007, and episodes and visits beginning on or after January 1, 2008, and before January 1, 2010''.

SEC. 703. EXTENSION OF MEDICARE SECONDARY PAYER FOR BENEFICIARIES WITH END STAGE RENAL DISEASE FOR LARGE GROUP PLANS.

(a) IN GENERAL.—Section 1862(b)(1)(C) of the Social Security Act (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) by redesignating clauses (i) and (ii) as subclauses (I) and (II), respectively, and indenting accordingly;

(2) by amending the text preceding subclause (I), as so redesignated, to read as follows:

''(C) INDIVIDUALS WITH END STAGE RENAL DISEASE.—

''(i) IN GENERAL.—A group health plan (as defined in subparagraph (A)(v))—'';

(3) in the matter following subclause (II), as so redesignated—

(A) by striking ''clause (i)'' and inserting ''subclause (I)'';

(B) by striking ''clause (ii)'' and inserting ''subclause (II)''; and

(C) by striking ''clauses (i) and (ii)'' and inserting ''subclauses (I) and (II)''; and

(D) in the last sentence, by striking ''Effective for items'' and inserting ''Subject to clause (ii), effective for items''; and

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

''(ii) SPECIAL RULE FOR LARGE GROUP PLANS.—In applying clause (i) to a large group health plan (as defined in subparagraph (B)(iii)). effective for items and services furnished on or after January 1, 2008, (with respect to periods beginning on or after the date that is 30 months prior to January 1, 2008), subclauses (I) and (II) of such clause shall be applied by substituting '42-month' for '12-month' each place it appears.''.

SEC. 704. PLAN FOR MEDICARE PAYMENT ADJUSTMENTS FOR NEVER EVENTS.

(a) IN GENERAL.—The Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall develop a plan (in this section referred to as the ''never events plan'') to implement, beginning in fiscal year 2010, a policy to reduce or eliminate payments under title XVIII of the Social Security Act for never events.

(b) NEVER EVENT DEFINED.—For purposes of this section, the term ''never event'' means an event involving the delivery of (or failure to deliver) physicians' services, inpatient or outpatient hospital services, or facility services furnished in an ambulatory surgical facility in which there is an error in medical care that is clearly identifiable, usually preventable, and serious in consequences to patients, and that indicates a deficiency in the safety and process controls of the services furnished with respect to the

physician, hospital, or ambulatory surgical center involved.

(c) PLAN DETAILS.—

(1) DEFINING NEVER EVENTS.—With respect to criteria for identifying never events under the never events plan, the Secretary should consider whether the event meets the following characteristics:

(A) CLEARLY IDENTIFIABLE.—The event is clearly identifiable and measurable and feasible to include in a reporting system for never events.

(B) USUALLY PREVENTABLE.—The event is usually preventable taking into consideration that, because of the complexity of medical care, certain medical events are not always avoidable.

(C) SERIOUS.—The event is serious and could result in death or loss of a body part, disability, or more than transient loss of a body function.

(D) DEFICIENCY IN SAFETY AND PROCESS CONTROLS.—The event is indicative of a problem in safety systems and process controls used by the physician, hospital, or ambulatory surgical center involved and is indicative of the reliability of the quality of services provided by the physician, hospital, or ambulatory surgical center, respectively.

(2) IDENTIFICATION AND PAYMENT ISSUES.—With respect to policies under the never events plan for identifying and reducing (or eliminating) payment for never events, the Secretary shall consider—

(A) mechanisms used by hospitals and physicians in reporting and coding of services that would reliably identify never events; and

(B) modifications in billing and payment mechanisms that would enable the Secretary to efficiently and accurately reduce or eliminate payments for never events.

(3) PRIORITIES.—Under the never events plan the Secretary shall identify priorities regarding the services to focus on and, among those, the never events for which payments should be reduced or eliminated.

(4) CONSULTATION.—In developing the never events plan, the Secretary shall consult with affected parties that are relevant to payment reductions in response to never events.

(d) CONGRESSIONAL REPORT.—By not later than June 1, 2008, the Secretary shall submit a report to Congress on the never events plan developed under this subsection and shall include in the report recommendations on specific methods for implementation of the plan on a timely basis.

SEC. 705. REINSTATEMENT OF RESIDENCY SLOTS.

(a) IN GENERAL.—Section 1886(h) of the Social Security Act (42 U.S.C. 1395ww(h)) is amended—

(1) in paragraph (4)(H), by adding at the end the following new clauses:

''(v) INCREASE IN RESIDENT LIMIT DUE TO CLOSURE OF OTHER HOSPITALS.—If one or more hospitals with approved medical residency training programs, which are located within the same metropolitan statistical area as of January 1, 2001, closed, the Secretary shall increase by not more than 10 (subject to the limitation set forth in the last sentence of this clause) the otherwise applicable resident limit under subparagraph (F) for each hospital within the same metropolitan statistical area that meets all the following criteria:

''(I) The hospital is described in subsection (d)(5)(F)(i).

''(II) The hospital instituted a medical residency training program in internal medicine that was accredited by the American Osteopathic Association on or after January 1, 2004.

''(III) The hospital had a provider number and a resident limit as of January 1, 2000, and remained open as of October 1, 2007.

''(IV) The hospital did not receive an increase in its resident limit under paragraph (7)(B).

''(V) The hospital maintains no more than 400 beds.

In no event may the resident limit for any hospital be increased above 50 through application of this clause and in no event may the total of the residency positions added by this clause for all hospitals exceed 10.

''(vi) INCREASE IN RESIDENCY SLOTS.—In the case of a hospital located in Peoria County, Illinois, that has more than 500 beds, the Secretary shall increase by two the otherwise applicable resident limit under subparagraph (F) for such hospital.''.

(2) in paragraph (7)—

(A) by redesignating subparagraph (D) as subparagraph (E); and

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

''(D) ADJUSTMENT BASED ON SETTLED COST REPORT.—In the case of a hospital with a dual accredited osteopathic and allopathic family practice program for which—

''(i) the otherwise applicable resident limit was reduced under subparagraph (A)(i)(I); and

''(ii) such reduction was based on a reference resident level that was determined using a cost report and where a revised or corrected notice of program reimbursement was issued between September 1, 2006 and September 15, 2006, whether as a result of an appeal or otherwise, and the reference resident level under such settled cost report is higher than the level used for the reduction under subparagraph (A)(i)(I);

the Secretary shall apply subparagraph (A)(i)(I) using the higher resident reference level and make any necessary adjustments to such reduction. Any such necessary adjustments shall be effective for portions of cost reporting periods occurring on or after July 1, 2005.''.

(b) EFFECTIVE DATES.—The amendment made by paragraph (1) shall be effective for cost reporting periods beginning on or after October 1, 2007, and the amendments made by paragraph (2) shall take effect as if included in the enactment of section 422 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173).

SEC. 706. STUDIES RELATING TO HOME HEALTH.

(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study of Medicare beneficiaries utilizing home health care services to determine—

(1) the impact that remote monitoring equipment and related services have on improving health care outcomes in the home health care setting for beneficiaries with chronic conditions;

(2) the differences in the percentage of inpatient hospital admissions and emergency room visits for beneficiaries with a similar health care risk profile who utilize remote monitoring equipment and services compared to those who do not use such equipment and services;

(3) the percentage of Medicare beneficiaries currently utilizing remote monitoring equipment and related services;

(4) the estimated reduction in aggregate expenditures under parts A and B of title XVIII of the Social Security Act expenditures if home health agencies increased their utilization of remote monitoring equipment and related services for patients with chronic disease conditions; and

(5) the variation of utilization of remote monitoring equipment and related services within geographic regions and by size of home health agency.

(b) DATA COLLECTION.—As a condition of a home health agency's participation in the program under title XVIII of the Social Security Act, beginning no later than January 1, 2008, the Secretary of Health and Human Services shall require such agencies to collect, in a form and manner determined by the Secretary, the following data:

(1) The extent of home health agency's usage of remote monitoring equipment and related services for beneficiaries with chronic conditions.

(2) Whether such equipment and services are used to monitor patients' with chronic conditions vital signs on a daily basis.

(3) Whether standing physician orders accompany the use of remote monitoring equipment and services.

(4) The costs of remote monitoring equipment and related services.

(c) REPORT TO CONGRESS.—Not later than June 1, 2010, the Commission shall report to Congress on its findings on the study conducted under subsection (a). Such report shall include recommendations regarding how Congress may enact reimbursement policies that increase the appropriate utilization of remote monitoring equipment and services under the home health program for Medicare beneficiaries with chronic conditions in a manner that facilitates health care outcomes and leads to the long-term reduction of aggregate expenditures under the Medicare program.

SEC. 707. RURAL HOME HEALTH QUALITY DEMONSTRATION PROJECTS.

(a) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the ''Secretary'') shall make grants to eligible entities for demonstration projects to assist home health agencies to better serve their Medicare populations while aiming to reduce costs to the Medicare program through utilization of technologies, including telemonitoring and other telehealth technologies, health information technologies, and telecommunications technologies that—

(1) implement procedures and standards that reduce the need for inpatient hospital services and health center visits; and

(2) address the aims of safety, effectiveness, patient- or community-centeredness, timeliness, efficiency, and equity identified by the Institute of Medicine of the National Academies in its report entitled ''Crossing the Quality Chasm: A New Health System for the 21st Century'' released on March 1, 2001, when determining when and what care is needed.

(b) ELIGIBLE ENTITIES.—In this section, the term ''eligible entity'' means a State that includes—

(1) a rural academic medical center;

(2) no urban regional medical center; and

(3) a Medicare population whose enrollees in the Medicare Part C program is less than 3 percent.

(c) CONSULTATION.—In developing the program for awarding grants under this section, the Secretary shall consult with the Administrator of the Centers for Medicare & Medicaid Services, home health agencies, rural health care researchers, and private and non-profit groups (including national associations) which are undertaking similar efforts.

(d) DURATION.—Each demonstration project under this section shall be for a period of 2 years.

(e) REPORT.—Not later than one year after the conclusion of all of the demonstration projects funded under this section, the Secretary shall submit a report to the Congress on the results of such projects. The report shall include—

(1) an evaluation of technologies utilized and effects on patient access to home health care, patient outcomes, and an analysis of the cost effectiveness of each such project; and

(2) recommendations on Federal legislation, regulations, or administrative policies to enhance rural home health quality and outcomes.

(f) FUNDING.— Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary for fiscal year 2008, $3,000,000 to carry out this section. Funds appropriated under this subsection shall remain available until expended.

TITLE VIII—MEDICAID

Subtitle A—Protecting Existing Coverage

SEC. 801. MODERNIZING TRANSITIONAL MEDICAID.

(a) FOUR-YEAR EXTENSION.—

(1) IN GENERAL.—Sections 1902(e)(1)(B) and 1925(f) of the Social Security Act (42 U.S.C.

1396a(e)(1)(B), 1396r–6(f)) are each amended by striking ''September 30, 2003'' and inserting ''September 30, 2011''.

(2) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on October 1, 2007.

(b) STATE OPTION OF INITIAL 12-MONTH ELIGIBILITY.—Section 1925 of the Social Security Act (42 U.S.C. 1396r–6) is amended—

(1) in subsection (a)(1), by inserting ''but subject to paragraph (5)'' after ''Notwithstanding any other provision of this title'';

(2) by adding at the end of subsection (a) the following:

''(5) OPTION OF 12-MONTH INITIAL ELIGIBILITY PERIOD.—A State may elect to treat any reference in this subsection to a 6-month period (or 6 months) as a reference to a 12-month period (or 12 months). In the case of such an election, subsection (b) shall not apply.''; and

(3) in subsection (b)(1), by inserting ''but subject to subsection (a)(5)'' after ''Notwithstanding any other provision of this title''.

(c) REMOVAL OF REQUIREMENT FOR PREVIOUS RECEIPT OF MEDICAL ASSISTANCE.—Section 1925(a)(1) of such Act (42 U.S.C. 1396r–6(a)(1)), as amended by subsection (b)(1), is further amended—

(1) by inserting ''subparagraph (B) and'' before ''paragraph (5)'';

(2) by redesignating the matter after ''REQUIREMENT.—'' as a subparagraph (A) with the heading ''IN GENERAL.—'' and with the same indentation as subparagraph (B) (as added by paragraph (3)); and

(3) by adding at the end the following:

''(B) STATE OPTION TO WAIVE REQUIREMENT FOR 3 MONTHS BEFORE RECEIPT OF MEDICAL ASSISTANCE.—A State may, at its option, elect also to apply subparagraph (A) in the case of a family that was receiving such aid for fewer than three months or that had applied for and was eligible for such aid for fewer than 3 months during the 6 immediately preceding months described in such subparagraph.''.

(d) CMS REPORT ON ENROLLMENT AND PARTICIPATION RATES UNDER TMA.—Section 1925 of such Act (42 U.S.C. 1396r–6), as amended by this section, is further amended by adding at the end the following new subsection:

''(g) COLLECTION AND REPORTING OF PARTICIPATION INFORMATION.—

''(1) COLLECTION OF INFORMATION FROM STATES.—Each State shall collect and submit to the Secretary (and make publicly available), in a format specified by the Secretary, information on average monthly enrollment and average monthly participation rates for adults and children under this section and of the number and percentage of children who become ineligible for medical assistance under this section whose medical assistance is continued under another eligibility category or who are enrolled under the State's child health plan under title XXI. Such information shall be submitted at the same time and frequency in which other enrollment information under this title is submitted to the Secretary.

''(2) ANNUAL REPORTS TO CONGRESS.—Using the information submitted under paragraph (1), the Secretary shall submit to Congress annual reports concerning enrollment and participation rates described in such paragraph.''.

(e) EFFECTIVE DATE.—The amendments made by subsections (b) through (d) shall take effect on the date of the enactment of this Act.

SEC. 802. FAMILY PLANNING SERVICES.

(a) COVERAGE AS OPTIONAL CATEGORICALLY NEEDY GROUP.—

(1) IN GENERAL.—Section 1902(a)(10)(A)(ii) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(ii)) is amended—

(A) in subclause (XVIII), by striking ''or'' at the end;

(B) in subclause (XIX), by adding ''or'' at the end; and

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

''(XX) who are described in subsection (ee) (relating to individuals who meet certain income standards);''.

(2) GROUP DESCRIBED.—Section 1902 of the Social Security Act (42 U.S.C. 1396a), as amended by section 112(c), is amended by adding at the end the following new subsection:

''(ee)(1) Individuals described in this subsection are individuals—

''(A) whose income does not exceed an income eligibility level established by the State that does not exceed the highest income eligibility level established under the State plan under this title (or under its State child health plan under title XXI) for pregnant women; and

''(B) who are not pregnant.

''(2) At the option of a State, individuals described in this subsection may include individuals who are determined to meet the eligibility requirements referred to in paragraph (1) under the terms, conditions, and procedures applicable to making eligibility determinations for medical assistance under this title under a waiver to provide the benefits described in clause (XV) of the matter following subparagraph (G) of section 1902(a)(10) granted to the State under section 1115 as of January 1, 2007.''.

(3) LIMITATION ON BENEFITS.—Section 1902(a)(10) of the Social Security Act (42 U.S.C. 1396a(a)(10)) is amended in the matter following subparagraph (G)—

(A) by striking ''and (XIV)'' and inserting ''(XIV)''; and

(B) by inserting '', and (XV) the medical assistance made available to an individual described in subsection (ee) shall be limited to family planning services and supplies described in section 1905(a)(4)(C) including medical diagnosis or treatment services that are provided pursuant to a family planning service in a family planning setting provided during the period in which such an individual is eligible'' after ''cervical cancer''.

(4) CONFORMING AMENDMENTS.—Section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)) is amended in the matter preceding paragraph (1)—

(A) in clause (xii), by striking ''or'' at the end;

(B) in clause (xiii), by adding ''or'' at the end; and

(C) by inserting after clause (xiii) the following:

''(xiv) individuals described in section 1902(ee),''.

(b) PRESUMPTIVE ELIGIBILITY.—

(1) IN GENERAL.—Title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) is amended by inserting after section 1920B the following:

''PRESUMPTIVE ELIGIBILITY FOR FAMILY PLANNING SERVICES

''SEC. 1920C. (a) STATE OPTION.—State plan approved under section 1902 may provide for making medical assistance available to an individual described in section 1902(ee) (relating to individuals who meet certain income eligibility standard) during a presumptive eligibility period. In the case of an individual described in section 1902(ee), such medical assistance shall be limited to family planning services and supplies described in 1905(a)(4)(C) and, at the State's option, medical diagnosis or treatment services that are provided in conjunction with a family planning service in a family planning setting provided during the period in which such an individual is eligible.

''(b) DEFINITIONS.—For purposes of this section:

''(1) PRESUMPTIVE ELIGIBILITY PERIOD.—The term 'presumptive eligibility period' means, with respect to an individual described in subsection (a), the period that—

''(A) begins with the date on which a qualified entity determines, on the basis of preliminary information, that the individual is described in section 1902(ee); and

''(B) ends with (and includes) the earlier of—

''(i) the day on which a determination is made with respect to the eligibility of such individual for services under the State plan; or

''(ii) in the case of such an individual who does not file an application by the last day of the month following the month during which the entity makes the determination referred to in subparagraph (A), such last day.

''(2) QUALIFIED ENTITY.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'qualified entity' means any entity that—

''(i) is eligible for payments under a State plan approved under this title; and

''(ii) is determined by the State agency to be capable of making determinations of the type described in paragraph (1)(A).

''(B) RULE OF CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing a State from limiting the classes of entities that may become qualified entities in order to prevent fraud and abuse.

''(c) ADMINISTRATION.—

''(1) IN GENERAL.—The State agency shall provide qualified entities with—

''(A) such forms as are necessary for an application to be made by an individual described in subsection (a) for medical assistance under the State plan; and

''(B) information on how to assist such individuals in completing and filing such forms.

''(2) NOTIFICATION REQUIREMENTS.—A qualified entity that determines under subsection (b)(1)(A) that an individual described in subsection (a) is presumptively eligible for medical assistance under a State plan shall—

''(A) notify the State agency of the determination within 5 working days after the date on which determination is made; and

''(B) inform such individual at the time the determination is made that an application for medical assistance is required to be made by not later than the last day of the month following the month during which the determination is made.

''(3) APPLICATION FOR MEDICAL ASSISTANCE.—In the case of an individual described in subsection (a) who is determined by a qualified entity to be presumptively eligible for medical assistance under a State plan, the individual shall apply for medical assistance by not later than the last day of the month following the month during which the determination is made.

''(d) PAYMENT.—Notwithstanding any other provision of this title, medical assistance that—

''(1) is furnished to an individual described in subsection (a)—

''(A) during a presumptive eligibility period;

''(B) by a entity that is eligible for payments under the State plan; and

''(2) is included in the care and services covered by the State plan, shall be treated as medical assistance provided by such plan for purposes of clause (4) of the first sentence of section 1905(b).''.

(2) CONFORMING AMENDMENTS.—

(A) Section 1902(a)(47) of the Social Security Act (42 U.S.C. 1396a(a)(47)) is amended by inserting before the semicolon at the end the following: ''and provide for making medical assistance available to individuals described in subsection (a) of section 1920C during a presumptive eligibility period in accordance with such section''.

(B) Section 1903(u)(1)(D)(v) of such Act (42 U.S.C. 1396b(u)(1)(D)(v)) is amended—

(i) by striking ''or for'' and inserting ''for''; and

(ii) by inserting before the period the following: '', or for medical assistance provided to an individual described in subsection (a) of section 1920C during a presumptive eligibility period under such section''.

(e) CLARIFICATION OF COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Section 1937(b) of the Social Security Act (42 U.S.C. 1396u-7(b)) is amended by adding at the end the following:

''(5) COVERAGE OF FAMILY PLANNING SERVICES AND SUPPLIES.—Notwithstanding the previous provisions of this section, a State may not provide for medical assistance through enrollment

of an individual with benchmark coverage or benchmark-equivalent coverage under this section unless such coverage includes for any individual described in section 1905(a)(4)(C), medical assistance for family planning services and supplies in accordance with such section.''.

(f) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2007.

SEC. 803. AUTHORITY TO CONTINUE PROVIDING ADULT DAY HEALTH SERVICES APPROVED UNDER A STATE MEDICAID PLAN.

(a) IN GENERAL.—During the period described in subsection (b), the Secretary of Health and Human Services shall not—

(1) withhold, suspend, disallow, or otherwise deny Federal financial participation under section 1903(a) of the Social Security Act (42 U.S.C. 1396b(a)) for the provision of adult day health care services, day activity and health services, or adult medical day care services, as defined under a State Medicaid plan approved during or before 1994, during such period if such services are provided consistent with such definition and the requirements of such plan; or

(2) withdraw Federal approval of any such State plan or part thereof regarding the provision of such services (by regulation or otherwise).

(b) PERIOD DESCRIBED.—The period described in this subsection is the period that begins on November 3, 2005, and ends on March 1, 2009.

SEC. 804. STATE OPTION TO PROTECT COMMUNITY SPOUSES OF INDIVIDUALS WITH DISABILITIES.

Section 1924(h)(1)(A) of the Social Security Act (42 U.S.C. 1396r–5(h)(1)(A)) is amended by striking ''is described in section 1902(a)(10)(A)(ii)(VI)'' and inserting ''is being provided medical assistance for home and community-based services under subsection (c), (d), (e), (i), or (j) of section 1915 or pursuant to section 1115''.

SEC. 805. COUNTY MEDICAID HEALTH INSURING ORGANIZATIONS .

(a) IN GENERAL.—Section 9517(c)(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1396b note), as added by section 4734 of the Omnibus Budget Reconciliation Act of 1990 and as amended by section 704 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, is amended—

(1) in subparagraph (A), by inserting '', in the case of any health insuring organization described in such subparagraph that is operated by a public entity established by Ventura County, and in the case of any health insuring organization described in such subparagraph that is operated by a public entity established by Merced County'' after ''described in subparagraph (B)''; and

(2) in subparagraph (C), by striking ''14 percent'' and inserting ''16 percent''.

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

Subtitle B—Payments

SEC. 811. PAYMENTS FOR PUERTO RICO AND TERRITORIES.

(a) PAYMENT CEILING.—Section 1108(g) of the Social Security Act (42 U.S.C. 1308(g)) is amended—

(1) in paragraph (2), by striking ''paragraph (3)'' and inserting ''paragraphs (3) and (4)''; and

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

''(4) FISCAL YEARS 2009 THROUGH 2012 FOR CERTAIN INSULAR AREAS.—The amounts otherwise determined under this subsection for Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa for fiscal years 2009 through 2012 shall be increased by the following amounts:

''(A) PUERTO RICO.—For Puerto Rico, $250,000,000 for fiscal year 2009, $350,000,000 for fiscal year 2010, $500,000,000 for fiscal year 2011, and $600,000,000 for fiscal year 2012.

''(B) VIRGIN ISLANDS.—For the Virgin Islands, $5,000,000 for each of fiscal years 2009 through 2012.

''(C) GUAM.—For Guam, $5,000,000 for each of fiscal years 2009 through 2012.

''(D) NORTHERN MARIANA ISLANDS.—For the Northern Mariana Islands, $4,000,000 for each of fiscal years 2009 through 2012.

''(E) AMERICAN SAMOA.—For American Samoa, $4,000,000 for each of fiscal years 2009 through 2012.

Such amounts shall not be taken into account in applying paragraph (2) for fiscal years 2009 through 2012 but shall be taken into account in applying such paragraph for fiscal year 2013 and subsequent fiscal years.''.

(b) REMOVAL OF FEDERAL MATCHING PAYMENTS FOR IMPROVING DATA REPORTING SYSTEMS FROM THE OVERALL LIMIT ON PAYMENTS TO TERRITORIES UNDER TITLE XIX.—Such section is further amended by adding at the end the following new paragraph:

''(5) EXCLUSION OF CERTAIN EXPENDITURES FROM PAYMENT LIMITS.—With respect to fiscal year 2008 and each fiscal year thereafter, if Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, or American Samoa qualify for a payment under subparagraph (A)(i) or (B) of section 1903(a)(3) for a calendar quarter of such fiscal year with respect to expenditures for improvements in data reporting systems described in such subparagraph, the limitation on expenditures under title XIX for such commonwealth or territory otherwise determined under subsection (f) and this subsection for such fiscal year shall be determined without regard to payment for such expenditures.''.

SEC. 812. MEDICAID DRUG REBATE.

Paragraph (1)(B)(i) of section 1927(c) of the Social Security Act (42 U.S.C. 1396r-8(c)) is amended—

(1) by striking ''and'' at the end of subclause (IV);

(2) in subclause (V)—

(A) by inserting ''and before January 1, 2008,'' after ''December 31, 1995,''; and

(B) by striking the period at the end and inserting ''; and''; and

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

''(VI) after December 31, 2007, is 22.1 percent.''.

(1) IN GENERAL.—Section 1927(c)(1)(C)(ii)(I) of the Social Security Act (42 U.S.C. 1396r-8(c)(1)(C)(ii)(I)) is amended—

(A) by striking ''and'' before ''rebates''; and

(B) by inserting before the semicolon at the end the following: '', and rebates, discounts, and other price concessions to pharmaceutical benefit managers (PBMs)''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to calendar quarters beginning on or after January 1, 2008.

SEC. 813. ADJUSTMENT IN COMPUTATION OF MEDICAID FMAP TO DISREGARD AN EXTRAORDINARY EMPLOYER PENSION CONTRIBUTION.

(a) IN GENERAL.—Only for purposes of computing the Federal medical assistance percentage under section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)) for a State for a fiscal year (beginning with fiscal year 2006), any significantly disproportionate employer pension contribution described in subsection (b) shall be disregarded in computing the per capita income of such State, but shall not be disregarded in computing the per capita income for the continental United States (and Alaska) and Hawaii.

(b) SIGNIFICANTLY DISPROPORTIONATE EMPLOYER PENSION CONTRIBUTION.—For purposes of subsection (a), a significantly disproportionate employer pension contribution described in this subsection with respect to a State for a fiscal year is an employer contribution towards pensions that is allocated to such State for a period if the aggregate amount so allocated exceeds 25 percent of the total increase in personal income in that State for the period involved.

SEC. 814. MORATORIUM ON CERTAIN PAYMENT RESTRICTIONS.

Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not, prior to the date that is 1 year after the date of enactment of this Act, take any action (through promulgation of regulation, issuance of regulatory guidance, use of federal payment audit procedures, or other administrative action, policy, or practice, including a Medical Assistance Manual transmittal or letter to State Medicaid directors) to restrict coverage or payment under title XIX of the Social Security Act for rehabilitation services, or school-based administration, transportation, or medical services if such restrictions are more restrictive in any aspect than those applied to such coverage or payment as of July 1, 2007.

SEC. 815. TENNESSEE DSH.

The DSH allotments for Tennessee for each fiscal year beginning with fiscal year 2008 under subsection (f)(3) of section 1923 of the Social Security Act (42 U.S.C. 13961396r-4) are deemed to be $30,000,000. The Secretary of Health and Human Services may impose a limitation on the total amount of payments made to hospitals under the TennCare Section 1115 waiver only to the extent that such limitation is necessary to ensure that a hospital does not receive payment in excess of the amounts described in subsection (f) of such section or as necessary to ensure that the waiver remains budget neutral.

SEC. 816. 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 construed 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 Stat÷e other than the State in which the center is located.

SEC. 817. EXTENSION OF SSI WEB-BASED ASSET DEMONSTRATION PROJECT TO THE MEDICAID PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services shall provide for the application to asset eligibility determinations under the Medicaid program under title XIX of the Social Security Act of the automated, secure, web-based asset verification request and response process being applied for determining eligibility for benefits under the Supplemental Security Income (SSI) program under title XVI of such Act under a demonstration project conducted under the authority of section 1631(e)(1)(B)(ii) of such Act (42 U.S.C. 1383(e)(1)(B)(ii)).

(b) LIMITATION.—Such application shall only extend to those States in which such demonstration project is operating and only for the period in which such project is otherwise provided.

(c) RULES OF APPLICATION.—For purposes of carrying out subsection (a), notwithstanding

any other provision of law, information obtained from a financial institution that is used for purposes of eligibility determinations under such demonstration project with respect to the Secretary of Health and Human Services under the SSI program may also be shared and used by States for purposes of eligibility determinations under the Medicaid program. In applying section 1631(e)(1)(B)(ii) of the Social Security Act under this subsection, references to the Commissioner of Social Security and benefits under title XVI of such Act shall be treated as including a reference to a State described in subsection (b) and medical assistance under title XIX of such Act provided by such a State.

Subtitle C—Miscellaneous

SEC. 821. DEMONSTRATION PROJECT FOR EMPLOYER BUY-IN.

Title XXI of the Social Security Act, as amended by section 133(a)(1), is further amended by adding at the end the following new section:

''SEC. 2112. DEMONSTRATION PROJECT FOR EMPLOYER BUY-IN.

''(a) AUTHORITY.—

''(1) IN GENERAL.—The Secretary shall establish a demonstration project under which up to 10 States (each referred to in this section as a 'participating State') that meets the conditions of paragraph (2) may provide, under its State child health plan (notwithstanding section 2102(b)(3)(C)) for a period of 5 years, for child health assistance in relation to family coverage described in subsection (d) for children who would be targeted low-income children but for coverage as beneficiaries under a group health plan as the children of participants by virtue of a qualifying employer's contribution under subsection (b)(2). :

''(2) CONDITIONS.—The conditions described in this paragraph for a State are as follows:

''(A) NO WAITING LISTS.—The State does not impose any waiting list, enrollment cap, or similar limitation on enrollment of targeted low-income children under the State child health plan.

''(B) ELIGIBILITY OF ALL CHILDREN UNDER 200 PERCENT OF POVERTY LINE.—The State is applying an income eligibility level under section 2110(b)(1)(B)(ii)(I) that is at least 200 percent of the poverty line.

''(3) QUALIFYING EMPLOYER DEFINED.—In this section, the term 'qualifying employer' means an employer that has a majority of its workforce composed of full-time workers with family incomes reasonably estimated by the employer (based on wage information available to the employer) at or below 200 percent of the poverty line. In applying the previous sentence, two part-time workers shall be treated as a single full-time worker.

''(b) FUNDING.—A demonstration project under this section in a participating State shall be funded, with respect to assistance provided to children described in subsection (a)(1), consistent with the following:

''(1) LIMITED FAMILY CONTRIBUTION.—The family involved shall be responsible for providing payment towards the premium for such assistance of such amount as the State may specify, except that the limitations on cost-sharing (including premiums) under paragraphs (2) and (3) of section 2103(e) shall apply to all cost-sharing of such family under this section.

''(2) MINIMUM EMPLOYER CONTRIBUTION.—The qualifying employer involved shall be responsible for providing payment to the State child health plan in the State of at least 50 percent of the portion of the cost (as determined by the State) of the family coverage in which the employer is enrolling the family that exceeds the amount of the family contribution under paragraph (1) applied towards such coverage.

''(3) LIMITATION ON FEDERAL FINANCIAL PARTICIPATION.—In no case shall the Federal financial participation under section 2105 with respect to a demonstration project under this section be made for any portion of the costs of family coverage described in subsection (d) (including the costs of administration of such coverage) that are not attributable to children described in subsection (a)(1).

''(c) UNIFORM ELIGIBILITY RULES.—In providing assistance under a demonstration project under this section—

''(1) a State shall establish uniform rules of eligibility for families to participate; and

''(2) a State shall not permit a qualifying employer to select, within those families that meet such eligibility rules, which families may participate.

''(d) TERMS AND CONDITIONS.—The family coverage offered to families of qualifying employers under a demonstration project under this section in a State shall be the same as the coverage and benefits provided under the State child health plan in the State for targeted low-income children with the highest family income level permitted.''.

SEC. 822. DIABETES GRANTS.

Section 2104 of the Social Security Act (42 U.C.C 1397dd), as amended by section 101, is further amended—

(1) in subsection (a)(11), by inserting before the period at the end the following: ''plus for fiscal year 2009 the total of the amount specified in subsection (j)''; and

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

''(j) FUNDING FOR DIABETES GRANTS.—From the amounts appropriated under subsection (a)(11), for fiscal year 2009 from the amounts—

''(1) $150,000,000 is hereby transferred and made available in such fiscal year for grants under section 330B of the Public Health Service Act; and

''(2) $150,000,000 is hereby transferred and made available in such fiscal year for grants under section 330C of such Act.''.

SEC. 823. TECHNICAL CORRECTION.

(a) CORRECTION OF REFERENCE TO CHILDREN IN FOSTER CARE RECEIVING CHILD WELFARE SERVICES.—Section 1937(a)(2)(B)(viii) of the Social Security Act (42 U.S.C. 1396u-7(a)(2)(B) is amended by striking ''aid or assistance is made available under part B of title IV to children in foster care'' and inserting ''child welfare services are made available under part B of title IV on the basis of being a child in foster care''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the amendment made by section 6044(a) of the Deficit Reduction Act of 2005.

TITLE IX—MISCELLANEOUS

SEC. 901. MEDICARE PAYMENT ADVISORY COMMISSION STATUS.

Section 1805(a) of the Social Security Act (42 U.S.C. 1395b-6(a)) is amended by inserting ''as an agency of Congress'' after ''established''.

SEC. 902. REPEAL OF TRIGGER PROVISION.

Subtitle A of title VIII of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) is repealed and the provisions of law amended by such subtitle are restored as if such subtitle had never been enacted.

SEC. 903. REPEAL OF COMPARATIVE COST ADJUSTMENT (CCA) PROGRAM.

Section 1860C–1 of the Social Security Act (42 U.S.C. 1395w-29), as added by section 241(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173), is repealed.

SEC. 904. COMPARATIVE EFFECTIVENESS RESEARCH.

(a) IN GENERAL.—Part A of title XVIII of the Social Security Act is amended by adding at the end the following new section:

''COMPARATIVE EFFECTIVENESS RESEARCH

''SEC. 1822. (a) CENTER FOR COMPARATIVE EFFECTIVENESS RESEARCH ESTABLISHED.—

''(1) IN GENERAL.—The Secretary shall establish within the Agency of Healthcare Research and Quality a Center for Comparative Effectiveness Research (in this section referred to as the 'Center') to conduct, support, and synthesize research (including research conducted or supported under section 1013 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003) with respect to the outcomes, effectiveness, and appropriateness of health care services and procedures in order to identify the manner in which diseases, disorders, and other health conditions can most effectively and appropriately be prevented, diagnosed, treated, and managed clinically.

''(2) DUTIES.—The Center shall—

''(A) conduct, support, and synthesize research relevant to the comparative clinical effectiveness of the full spectrum of health care treatments, including pharmaceuticals, medical devices, medical and surgical procedures, and other medical interventions;

''(B) conduct and support systematic reviews of clinical research, including original research conducted subsequent to the date of the enactment of this section;

''(C) use methodologies such as randomized controlled clinical trials as well as other various types of clinical research, such as observational studies;

''(D) submit to the Comparative Effectiveness Research Commission, the Secretary, and Congress appropriate relevant reports described in subsection (d)(2);

''(E) encourage, as appropriate, the development and use of clinical registries and the development of clinical effectiveness research data networks from electronic health records, post marketing drug and medical device surveillance efforts, and other forms of electronic health data; and

''(F) not later than 180 days after the date of the enactment of this section, develop methodological standards to be used when conducting studies of comparative clinical effectiveness and value (and procedures for use of such standards) in order to help ensure accurate and effective comparisons and update such standards at least biennially.

''(b) OVERSIGHT BY COMPARATIVE EFFECTIVENESS RESEARCH COMMISSION.—

''(1) IN GENERAL.—The Secretary shall establish an independent Comparative Effectiveness Research Commission (in this section referred to as the 'Commission') to oversee and evaluate the activities carried out by the Center under subsection (a) to ensure such activities result in highly credible research and information resulting from such research.

''(2) DUTIES.—The Commission shall—

''(A) determine national priorities for research described in subsection (a) and in making such determinations consult with patients and health care providers and payers;

''(B) monitor the appropriateness of use of the CERTF described in subsection (f) with respect to the timely production of comparative effectiveness research determined to be a national priority under subparagraph (A);

''(C) identify highly credible research methods and standards of evidence for such research to be considered by the Center;

''(D) review and approve the methodological standards (and updates to such standards) developed by the Center under subsection (a)(2)(F);

''(E) enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences shall conduct an evaluation and report on standards of evidence for such research;

''(F) support forums to increase stakeholder awareness and permit stakeholder feedback on the efforts of the Agency of Healthcare Research and Quality to advance methods and standards that promote highly credible research;

''(G) make recommendations for public data access policies of the Center that would allow for access of such data by the public while ensuring the information produced from research involved is timely and credible;

''(H) appoint a clinical perspective advisory panel for each research priority determined under subparagraph (A), which shall frame the specific research inquiry to be examined with respect to such priority to ensure that the information produced from such research is clinically relevant to decisions made by clinicians and patients at the point of care;

''(I) make recommendations for the priority for periodic reviews of previous comparative effectiveness research and studies conducted by the Center under subsection (a);

''(J) routinely review processes of the Center with respect to such research to confirm that the information produced by such research is objective, credible, consistent with standards of evidence established under this section, and developed through a transparent process that includes consultations with appropriate stakeholders;

''(K) at least annually, provide guidance or recommendations to health care providers and consumers for the use of information on the comparative effectiveness of health care services by consumers, providers (as defined for purposes of regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996) and public and private purchasers;

''(L) make recommendations for a strategy to disseminate the findings of research conducted and supported under this section that enables clinicians to improve performance, consumers to make more informed health care decisions, and payers to set medical policies that improve quality and value;

''(M) provide for the public disclosure of relevant reports described in subsection (d)(2); and

''(N) submit to Congress an annual report on the progress of the Center in achieving national priorities determined under subparagraph (A) for the provision of credible comparative effectiveness information produced from such research to all interested parties.

''(3) COMPOSITION OF COMMISSION.—

''(A) IN GENERAL.—The members of the Commission shall consist of—

''(i) the Director of the Agency for Healthcare Research and Quality;

''(ii) the Chief Medical Officer of the Centers for Medicare & Medicaid Services; and

''(iii) 15 additional members who shall represent broad constituencies of stakeholders including clinicians, patients, researchers, third-party payers, consumers of Federal and State beneficiary programs.

''(B) QUALIFICATIONS.—

''(i) DIVERSE REPRESENTATION OF PERSPECTIVES.—The members of the Commission shall represent a broad range of perspectives and shall collectively have experience in the following areas:

''(I) Epidemiology.

''(II) Health services research.

''(III) Bioethics.

''(IV) Decision sciences.

''(V) Economics.

''(ii) DIVERSE REPRESENTATION OF HEALTH CARE COMMUNITY.—At least one member shall represent each of the following health care communities:

''(I) Consumers.

''(II) Practicing physicians, including surgeons.

''(III) Employers.

''(IV) Public payers.

''(V) Insurance plans.

''(VI) Clinical researchers who conduct research on behalf of pharmaceutical or device manufacturers.

''(4) APPOINTMENT.—The Comptroller General of the United States, in consultation with the chairs of the committees of jurisdiction of the House of Representatives and the Senate, shall appoint the members of the Commission.

''(5) CHAIRMAN; VICE CHAIRMAN.—The Comptroller General of the United States shall designate a member of the Commission, at the time of appointment of the member, as Chairman and a member as Vice Chairman for that term of appointment, except that in the case of vacancy of the Chairmanship or Vice Chairmanship, the Comptroller General may designate another member for the remainder of that member's term.

''(6) TERMS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), each member of the Commission shall be appointed for a term of 4 years.

''(B) TERMS OF INITIAL APPOINTEES.—Of the members first appointed—

''(i) 8 shall be appointed for a term of 4 years; and

''(ii) 7 shall be appointed for a term of 3 years.

''(7) COORDINATION.—To enhance effectiveness and coordination, the Comptroller General is encouraged, to the greatest extent possible, to seek coordination between the Commission and the National Advisory Council of the Agency for Healthcare Research and Quality.

''(8) CONFLICTS OF INTEREST.—In appointing the members of the Commission or a clinical perspective advisory panel described in paragraph (2)(H), the Comptroller General of the United States or the Commission, respectively, shall take into consideration any financial conflicts of interest.

''(9) COMPENSATION.—While serving on the business of the Commission (including travel-time), a member of the Commission shall be entitled to compensation at the per diem equivalent of the rate provided for level IV of the Executive Schedule under section 5315 of title 5, United States Code; and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the Director of the Commission.

''(10) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

''(11) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Secretary, in consultation with the Comptroller General deems necessary to assure the efficient administration of the Commission, the Commission may—

''(A) employ and fix the compensation of an Executive Director (subject to the approval of the Secretary, in consultation with the Comptroller General) and such other personnel as may be necessary to carry out its duties (without regard to the provisions of title 5, United States Code, governing appointments in the competitive service);

''(B) seek such assistance and support as may be required in the performance of its duties from appropriate Federal departments and agencies;

''(C) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (41 U.S.C. 5));

''(D) make advance, progress, and other payments which relate to the work of the Commission;

''(E) provide transportation and subsistence for persons serving without compensation; and

''(F) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

''(12) POWERS.—

''(A) OBTAINING OFFICIAL DATA.—The Commission may secure directly from any department or agency of the United States information necessary to enable it to carry out this section. Upon request of the Executive Director, the head of that department or agency shall furnish that information to the Commission on an agreed upon schedule.

''(B) DATA COLLECTION.—In order to carry out its functions, the Commission shall—

''(i) utilize existing information, both published and unpublished, where possible, collected and assessed either by its own staff or under other arrangements made in accordance with this section,

''(ii) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate, and

''(iii) adopt procedures allowing any interested party to submit information for the Commission's use in making reports and recommendations.

''(C) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data of the Commission, immediately upon request.

''(D) PERIODIC AUDIT.—The Commission shall be subject to periodic audit by the Comptroller General.

''(c) RESEARCH REQUIREMENTS.—Any research conducted, supported, or synthesized under this section shall meet the following requirements:

''(1) ENSURING TRANSPARENCY, CREDIBILITY, AND ACCESS.—

''(A) The establishment of the agenda and conduct of the research shall be insulated from inappropriate political or stakeholder influence.

''(B) Methods of conducting such research shall be scientifically based.

''(C) All aspects of the prioritization of research, conduct of the research, and development of conclusions based on the research shall be transparent to all stakeholders.

''(D) The process and methods for conducting such research shall be publicly documented and available to all stakeholders.

''(E) Throughout the process of such research, the Center shall provide opportunities for all stakeholders involved to review and provide comment on the methods and findings of such research.

''(2) USE OF CLINICAL PERSPECTIVE ADVISORY PANELS.—The research shall meet a national research priority determined under subsection (b)(2)(A) and shall examine the specific research inquiry framed by the clinical perspective advisory panel for the national research priority.

''(3) STAKEHOLDER INPUT.—The priorities of the research, the research, and the dissemination of the research shall involve the consultation of patients, health care providers, and health care consumer representatives through transparent mechanisms recommended by the Commission.

''(d) PUBLIC ACCESS TO COMPARATIVE EFFECTIVENESS INFORMATION.—

''(1) IN GENERAL.—Not later than 90 days after receipt by the Center or Commission, as applicable, of a relevant report described in paragraph (2) made by the Center, Commission, or clinical perspective advisory panel under this section, appropriate information contained in such report shall be posted on the official public Internet site of the Center and of the Commission, as applicable.

''(2) RELEVANT REPORTS DESCRIBED.—For purposes of this section, a relevant report is each of the following submitted by a grantee or contractor of the Center:

''(A) An interim progress report.

''(B) A draft final comparative effectiveness review.

''(C) A final progress report on new research submitted for publication by a peer review journal.

''(D) Stakeholder comments.

''(E) A final report.

''(3) ACCESS BY CONGRESS AND THE COMMISSION TO THE CENTER'S INFORMATION.—Congress and the Commission shall each have unrestricted access to all deliberations, records, and nonproprietary data of the Center, immediately upon request.

''(e) DISSEMINATION AND INCORPORATION OF COMPARATIVE EFFECTIVENESS INFORMATION.—

''(1) DISSEMINATION.—The Center shall provide for the dissemination of appropriate findings produced by research supported, conducted, or synthesized under this section to health care providers, patients, vendors of health information technology focused on clinical decision support, appropriate professional

associations, and Federal and private health plans.

''(2) INCORPORATION.—The Center shall assist users of health information technology focused on clinical decision support to promote the timely incorporation of the findings described in paragraph (1) into clinical practices and to promote the ease of use of such incorporation.

''(f) REPORTS TO CONGRESS.—

''(1) ANNUAL REPORTS.—Beginning not later than one year after the date of the enactment of this section, the Director of the Agency of Healthcare Research and Quality and the Commission shall submit to Congress an annual report on the activities of the Center and the Commission, as well as the research, conducted under this section.

''(2) RECOMMENDATION FOR FAIR SHARE PER CAPITA AMOUNT FOR ALL-PAYER FINANCING.—Beginning not later than December 31, 2009, the Secretary shall submit to Congress an annual recommendation for a fair share per capita amount described in subsection (c)(1) of section 9511 of the Internal Revenue Code of 1986 for purposes of funding the CERTF under such section.

''(3) ANALYSIS AND REVIEW.—Not later than December 31, 2011, the Secretary, in consultation with the Commission, shall submit to Congress a report on all activities conducted or supported under this section as of such date. Such report shall include an evaluation of the return on investment resulting from such activities, the overall costs of such activities, and an analysis of the backlog of any research proposals approved by the Commission but not funded. Such report shall also address whether Congress should expand the responsibilities of the Center and of the Commission to include studies of the effectiveness of various aspects of the health care delivery system, including health plans and delivery models, such as health plan features, benefit designs and performance, and the ways in which health services are organized, managed, and delivered.

''(g) COORDINATING COUNCIL FOR HEALTH SERVICES RESEARCH.—

''(1) ESTABLISHMENT.—The Secretary shall establish a permanent council (in this section referred to as the 'Council') for the purpose of—

''(A) assisting the offices and agencies of the Department of Health and Human Services, the Department of Veterans Affairs, the Department of Defense, and any other Federal department or agency to coordinate the conduct or support of health services research; and

''(B) advising the President and Congress on—

''(i) the national health services research agenda;

''(ii) strategies with respect to infrastructure needs of health services research; and

''(iii) appropriate organizational expenditures in health services research by relevant Federal departments and agencies.

''(2) MEMBERSHIP.—

''(A) NUMBER AND APPOINTMENT.—The Council shall be composed of 20 members. One member shall be the Director of the Agency for Healthcare Research and Quality. The Director shall appoint the other members not later than 30 days after the enactment of this Act.

''(B) TERMS.—

''(i) IN GENERAL.—Except as provided in clause (ii), each member of the Council shall be appointed for a term of 4 years.

''(ii) TERMS OF INITIAL APPOINTEES.—Of the members first appointed—

''(I) 10 shall be appointed for a term of 4 years; and

''(II) 9 shall be appointed for a term of 3 years.

''(iii) VACANCIES.—Any vacancies shall not affect the power and duties of the Council and shall be filled in the same manner as the original appointment.

''(C) QUALIFICATIONS.—

''(i) IN GENERAL.—The members of the Council shall include one senior official from each of the following agencies:

''(I) The Veterans Health Administration.

''(II) The Department of Defense Military Health Care System.

''(III) The Centers for Disease Control and Prevention.

''(IV) The National Center for Health Statistics.

''(V) The National Institutes of Health.

''(VI) The Center for Medicare & Medicaid Services.

''(VII) The Federal Employees Health Benefits Program.

''(ii) NATIONAL, PHILANTHROPIC FOUNDATIONS.—The members of the Council shall include 4 senior leaders from major national, philanthropic foundations that fund and use health services research.

''(iii) STAKEHOLDERS.—The remaining members of the Council shall be representatives of other stakeholders in health services research, including private purchasers, health plans, hospitals and other health facilities, and health consumer groups.

''(3) ANNUAL REPORT.—The Council shall submit to Congress an annual report on the progress of the implementation of the national health services research agenda.

''(h) FUNDING OF COMPARATIVE EFFECTIVENESS RESEARCH.—For fiscal year 2008 and each subsequent fiscal year, amounts in the Comparative Effectiveness Research Trust Fund (referred to in this section as the 'CERTF') under section 9511 of the Internal Revenue Code of 1986 shall be available to the Secretary to carry out this section.''.

(b) COMPARATIVE EFFECTIVENESS RESEARCH TRUST FUND; FINANCING FOR TRUST FUND.—

(1) ESTABLISHMENT OF TRUST FUND.—

(A) IN GENERAL.—Subchapter A of chapter 98 of the Internal Revenue Code of 1986 (relating to trust fund code) is amended by adding at the end the following new section:

''SEC. 9511. HEALTH CARE COMPARATIVE EFFECTIVENESS RESEARCH TRUST FUND.

''(a) CREATION OF TRUST FUND.—There is established in the Treasury of the United States a trust fund to be known as the 'Health Care Comparative Effectiveness Research Trust Fund' (hereinafter in this section referred to as the 'CERTF'), consisting of such amounts as may be appropriated or credited to such Trust Fund as provided in this section and section 9602(b).

''(b) TRANSFERS TO FUND.—There are hereby appropriated to the Trust Fund the following:

''(1) For fiscal year 2008, $90,000,000.

''(2) For fiscal year 2009, $100,000,000.

''(3) For fiscal year 2010, $110,000,000.

''(4) For each fiscal year beginning with fiscal year 2011—

''(A) an amount equivalent to the net revenues received in the Treasury from the fees imposed under subchapter B of chapter 34 (relating to fees on health insurance and self-insured plans) for such fiscal year; and

''(B) subject to subsection (c)(2), amounts determined by the Secretary of Health and Human Services to be equivalent to the fair share per capita amount computed under subsection (c)(1) for the fiscal year multiplied by the average number of individuals entitled to benefits under part A, or enrolled under part B, of title XVIII of the Social Security Act during such fiscal year.

The amounts appropriated under paragraphs (1), (2), (3), and (4)(B) shall be transferred from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (established under section 1841 of such Act), and from the Medicare Prescription Drug Account within such Trust Fund, in proportion (as estimated by the Secretary) to the total expenditures during such fiscal year that are made under title XVIII of such Act from the respective trust fund or account.

''(c) FAIR SHARE PER CAPITA AMOUNT.—

''(1) COMPUTATION.—

''(A) IN GENERAL.—Subject to subparagraph (B), the fair share per capita amount under this paragraph for a fiscal year (beginning with fiscal year 2011) is an amount computed by the Secretary of Health and Human Services for such fiscal year that, when applied under this section and subchapter B of chapter 34 of the Internal Revenue Code of 1986, will result in revenues to the CERTF of $375,000,000 for the fiscal year.

''(B) ALTERNATIVE COMPUTATION.—

''(i) IN GENERAL.—If the Secretary is unable to compute the fair share per capita amount under subparagraph (A) for a fiscal year, the fair share per capita amount under this paragraph for the fiscal year shall be the default amount determined under clause (ii) for the fiscal year.

''(ii) DEFAULT AMOUNT.—The default amount under this clause for—

''(I) fiscal year 2011 is equal to $2; or

''(II) a subsequent year is equal to the default amount under this clause for the preceeding fiscal year increased by the annual percentage increase in the medical care component of the consumer price index (United States city average) for the 12-month period ending with April of the preceding fiscal year.

Any amount determined under subclause (II) shall be rounded to the nearest penny.

''(2) LIMITATION ON MEDICARE FUNDING.—In no case shall the amount transferred under subsection (b)(4)(B) for any fiscal year exceed $90,000,000.

''(d) EXPENDITURES FROM FUND.—

''(1) IN GENERAL.—Subject to paragraph (2), amounts in the CERTF are available to the Secretary of Health and Human Services for carrying out section 1822 of the Social Security Act.

''(2) ALLOCATION FOR COMMISSION.—Not less than the following amounts in the CERTF for a fiscal year shall be available to carry out the activities of the Comparative Effectiveness Research Commission established under section 1822(b) of the Social Security Act for such fiscal year:

''(A) For fiscal year 2008, $7,000,000.

''(B) For fiscal year 2009, $9,000,000.

''(C) For each fiscal year beginning with 2010, $10,000,000.

Nothing in this paragraph shall be construed as preventing additional amounts in the CERTF from being made available to the Comparative Effectiveness Research Commission for such activities.

''(e) NET REVENUES.—For purposes of this section, the term 'net revenues' means the amount estimated by the Secretary based on the excess of—

''(1) the fees received in the Treasury under subchapter B of chapter 34, over

''(2) the decrease in the tax imposed by chapter 1 resulting from the fees imposed by such subchapter.''.

(B) CLERICAL AMENDMENT.—The table of sections for such subchapter A is amended by adding at the end thereof the following new item:

''Sec. 9511. Health Care Comparative Effectiveness Research Trust Fund.''.

(2) FINANCING FOR FUND FROM FEES ON INSURED AND SELF-INSURED HEALTH PLANS.—

(A) GENERAL RULE.—Chapter 34 of the Internal Revenue Code of 1986 is amended by adding at the end the following new subchapter:

''Subchapter B—Insured and Self-Insured Health Plans

''Sec. 4375. Health insurance.
''Sec. 4376. Self-insured health plans
''Sec. 4377. Definitions and special rules

''SEC. 4375. HEALTH INSURANCE.

''(a) IMPOSITION OF FEE.—There is hereby imposed on each specified health insurance policy for each policy year a fee equal to the fair share per capita amount determined under section 9511(c)(1) multiplied by the average number of lives covered under the policy.

''(b) LIABILITY FOR FEE.—The fee imposed by subsection (a) shall be paid by the issuer of the policy.

''(c) SPECIFIED HEALTH INSURANCE POLICY.—For purposes of this section—

''(1) IN GENERAL.—Except as otherwise provided in this section, the term 'specified health insurance policy' means any accident or health insurance policy issued with respect to individuals residing in the United States.

''(2) EXEMPTION OF CERTAIN POLICIES.—The term 'specified health insurance policy' does not include any insurance policy if substantially all of its coverage is of excepted benefits described in section 9832(c).

''(A) liabilities incurred under workers' compensation laws,

''(B) tort liabilities,

''(C) liabilities relating to ownership or use of property,

''(D) credit insurance,

''(E) medicare supplemental coverage, or

''(F) such other similar liabilities as the Secretary may specify by regulations.

''(3) TREATMENT OF PREPAID HEALTH COVERAGE ARRANGEMENTS.—

''(A) IN GENERAL.—In the case of any arrangement described in subparagraph (B)—

''(i) such arrangement shall be treated as a specified health insurance policy, and

''(ii) the person referred to in such subparagraph shall be treated as the issuer.

''(B) DESCRIPTION OF ARRANGEMENTS.—An arrangement is described in this subparagraph if under such arrangement fixed payments or premiums are received as consideration for any person's agreement to provide or arrange for the provision of accident or health coverage to residents of the United States, regardless of how such coverage is provided or arranged to be provided.

''SEC. 4376. SELF-INSURED HEALTH PLANS.

''(a) IMPOSITION OF FEE.—In the case of any applicable self-insured health plan for each plan year, there is hereby imposed a fee equal to the fair share per capita amount determined under section 9511(c)(1) multiplied by the average number of lives covered under the plan.

''(b) LIABILITY FOR FEE.—

''(1) IN GENERAL.—The fee imposed by subsection (a) shall be paid by the plan sponsor.

''(2) PLAN SPONSOR.—For purposes of paragraph (1) the term 'plan sponsor' means—

''(A) the employer in the case of a plan established or maintained by a single employer,

''(B) the employee organization in the case of a plan established or maintained by an employee organization,

''(C) in the case of—

''(i) a plan established or maintained by 2 or more employers or jointly by 1 or more employers and 1 or more employee organizations,

''(ii) a multiple employer welfare arrangement, or

''(iii) a voluntary employees' beneficiary association described in section 501(c)(9),

the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan, or

''(D) the cooperative or association described in subsection (c)(2)(F) in the case of a plan established or maintained by such a cooperative or association.

''(c) APPLICABLE SELF-INSURED HEALTH PLAN.—For purposes of this section, the term 'applicable self-insured health plan' means any plan for providing accident or health coverage if—

''(1) any portion of such coverage is provided other than through an insurance policy, and

''(2) such plan is established or maintained—

''(A) by one or more employers for the benefit of their employees or former employees,

''(B) by one or more employee organizations for the benefit of their members or former members,

''(C) jointly by 1 or more employers and 1 or more employee organizations for the benefit of employees or former employees,

''(D) by a voluntary employees' beneficiary association described in section 501(c)(9),

''(E) by any organization described in section 501(c)(6), or

''(F) in the case of a plan not described in the preceding subparagraphs, by a multiple employer welfare arrangement (as defined in section 3(40) of Employee Retirement Income Security Act of 1974), a rural electric cooperative (as defined in section 3(40)(B)(iv) of such Act), or a rural telephone cooperative association (as defined in section 3(40)(B)(v) of such Act).

''SEC. 4377. DEFINITIONS AND SPECIAL RULES.

''(a) DEFINITIONS.—For purposes of this subchapter—

''(1) ACCIDENT AND HEALTH COVERAGE.—The term 'accident and health coverage' means any coverage which, if provided by an insurance policy, would cause such policy to be a specified health insurance policy (as defined in section 4375(c)).

''(2) INSURANCE POLICY.—The term 'insurance policy' means any policy or other instrument whereby a contract of insurance is issued, renewed, or extended.

''(3) UNITED STATES.—The term 'United States' includes any possession of the United States.

''(b) TREATMENT OF GOVERNMENTAL ENTITIES.—

''(1) IN GENERAL.—For purposes of this subchapter—

''(A) the term 'person' includes any governmental entity, and

''(B) notwithstanding any other law or rule of law, governmental entities shall not be exempt from the fees imposed by this subchapter except as provided in paragraph (2).

''(2) TREATMENT OF EXEMPT GOVERNMENTAL PROGRAMS.—In the case of an exempt governmental program, no fee shall be imposed under section 4375 or section 4376 on any covered life under such program.

''(3) EXEMPT GOVERNMENTAL PROGRAM DEFINED.—For purposes of this subchapter, the term 'exempt governmental program' means—

''(A) any insurance program established under title XVIII of the Social Security Act,

''(B) the medical assistance program established by title XIX or XXI of the Social Security Act,

''(C) any program established by Federal law for providing medical care (other than through insurance policies) to individuals (or the spouses and dependents thereof) by reason of such individuals being—

''(i) members of the Armed Forces of the United States, or

''(ii) veterans, and

''(D) any program established by Federal law for providing medical care (other than through insurance policies) to members of Indian tribes (as defined in section 4(d) of the Indian Health Care Improvement Act).

''(c) TREATMENT AS TAX.—For purposes of subtitle F, the fees imposed by this subchapter shall be treated as if they were taxes.

''(d) NO COVER OVER TO POSSESSIONS.—Notwithstanding any other provision of law, no amount collected under this subchapter shall be covered over to any possession of the United States.''

(B) CLERICAL AMENDMENTS.—

(i) Chapter 34 of such Code is amended by striking the chapter heading and inserting the following:

''CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES

''SUBCHAPTER A. POLICIES ISSUED BY FOREIGN INSURERS

''SUBCHAPTER B. INSURED AND SELF-INSURED HEALTH PLANS

''Subchapter A—Policies Issued By Foreign Insurers''.

(ii) The table of chapters for subtitle D of such Code is amended by striking the item relating to chapter 34 and inserting the following new item:

''CHAPTER 34—TAXES ON CERTAIN INSURANCE POLICIES''.

(C) EFFECTIVE DATE.—The amendments made by this subsection shall apply with respect to policies and plans for portions of policy or plan years beginning on or after October 1, 2010.

SEC. 905. IMPLEMENTATION OF HEALTH INFORMATION TECHNOLOGY (IT) UNDER MEDICARE.

(a) IN GENERAL.—Not later than January 1, 2010, the Secretary of Health and Human Services shall submit to Congress a report that includes—

(1) a plan to develop and implement a health information technology (health IT) system for all health care providers under the Medicare program that meets the specifications described in subsection (b); and

(2) an analysis of the impact, feasibility, and costs associated with the use of health information technology in medically underserved communities.

(b) PLAN SPECIFICATION.—The specifications described in this subsection, with respect to a health information technology system described in subsection (a), are the following:

(1) The system protects the privacy and security of individually identifiable health information.

(2) The system maintains and provides permitted access to health information in an electronic format (such as through computerized patient records or a clinical data repository).

(3) The system utilizes interface software that allows for interoperability.

(4) The system includes clinical decision support.

(5) The system incorporates e-prescribing and computerized physician order entry.

(6) The system incorporates patient tracking and reminders.

(7) The system utilizes technology that is open source (if available) or technology that has been developed by the government.

The report shall include an analysis of the financial and administrative resources necessary to develop such system and recommendations regarding the level of subsidies needed for all such health care providers to adopt the system.

SEC. 906. DEVELOPMENT, REPORTING, AND USE OF HEALTH CARE MEASURES.

(a) 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:

''DEVELOPMENT, REPORTING, AND USE OF HEALTH CARE MEASURES

''SEC. 1890. (a) FOSTERING DEVELOPMENT OF HEALTH CARE MEASURES.—The Secretary shall designate, and have in effect an arrangement with, a single organization (such as the National Quality Forum) that meets the requirements described in subsection (c), under which such organization provides the Secretary with advice on, and recommendations with respect to, the key elements and priorities of a national system for establishing health care measures. The arrangement shall be effective beginning no sooner than January 1, 2008, and no later than September 30, 2008.

''(b) DUTIES.—The duties of the organization designated under subsection (a) (in this title referred to as the 'designated organization') shall, in accordance with subsection (d), include—

''(1) establishing and managing an integrated national strategy and process for setting priorities and goals in establishing health care measures;

''(2) coordinating the development and specifications of such measures;

''(3) establishing standards for the development and testing of such measures;

''(4) endorsing national consensus health care measures; and

''(5) advancing the use of electronic health records for automating the collection, aggregation, and transmission of measurement information.

''(c) REQUIREMENTS DESCRIBED.—For purposes of subsection (a), the requirements described in this subsection, with respect to an organization, are the following:

''(1) PRIVATE NONPROFIT.—The organization is a private nonprofit entity governed by a board and an individual designated as president and chief executive officer.

''(2) BOARD MEMBERSHIP.—The members of the board of the organization include representatives of—

''(A) health care providers or groups representing such providers;

''(B) health plans or groups representing health plans;

''(C) groups representing health care consumers;

''(D) health care purchasers and employers or groups representing such purchasers or employers; and

''(E) health care practitioners or groups representing practitioners.

''(3) OTHER MEMBERSHIP REQUIREMENTS.—The membership of the organization is representative of individuals with 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 arrangement described in subsection (a), the organization conducts its business in an open and transparent manner and provides the opportunity for public comment.

''(5) VOLUNTARY CONSENSUS STANDARDS SETTING ORGANIZATION.—The organization 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 organization has at least 7 years experience in establishing national consensus standards.

''(d) REQUIREMENTS FOR HEALTH CARE MEASURES.—In carrying out its duties under subsection (b), the designated organization shall ensure the following:

''(1) MEASURES.—The designated organization shall ensure that the measures established or endorsed under subsection (b) are evidence-based, reliable, and valid; and include—

''(A) measures of clinical processes and outcomes, patient experience, efficiency, and equity;

''(B) measures to assess effectiveness, timeliness, patient self-management, patient centeredness, and safety; and

''(C) measures of under use and over use.

''(2) PRIORITIES.—

''(A) IN GENERAL.—The designated organization shall ensure that priority is given to establishing and endorsing—

''(i) measures with the greatest potential impact for improving the effectiveness and efficiency of health care;

''(ii) measures that may be rapidly implemented by group health plans, health insurance issuers, physicians, hospitals, nursing homes, long-term care providers, and other providers;

''(iii) measures which may inform health care decisions made by consumers and patients; and

''(iv) measures that apply to multiple services furnished by different providers during an episode of care.

''(B) ANNUAL REPORT ON PRIORITIES; SECRETARIAL PUBLICATION AND COMMENT.—

''(i) ANNUAL REPORT.—The designated organization shall issue and submit to the Secretary a report by March 31 of each year (beginning with 2009) on the organization's recommendations for priorities and goals in establishing and endorsing health care measures under this section over the next five years.

''(ii) SECRETARIAL REVIEW AND COMMENT.—After receipt of the report under clause (i) for a year, the Secretary shall publish the report in the Federal Register, including any comments of the Secretary on the priorities and goals set forth in the report.

''(3) RISK ADJUSTMENT.—The designated organization, in consultation with health care measure developers and other stakeholders, shall establish procedures to assure that health care measures established and endorsed under this section account for differences in patient health status, patient characteristics, and geographic location, as appropriate.

''(4) MAINTENANCE.—The designated organization, in consultation with owners and developers of health care measures, shall require the owners or developers of such measures to update and enhance such measures, including the development of more accurate and precise specifications, and retire existing outdated measures. Such updating shall occur not more often than once during each 12-month period, except in the case of emergent circumstances requiring a more immediate update to a measure.

''(e) USE OF HEALTH CARE MEASURES; REPORTING.—

''(1) USE OF MEASURES.—For purposes of activities authorized or required under this title, the Secretary shall select from health care measures—

''(A) recommended by multi-stakeholder groups; and

''(B) endorsed by the designated organization under subsection (b)(4).

''(2) REPORTING.—The Secretary shall implement procedures, consistent with generally accepted standards, to enable the Department of Health and Human Services to accept the electronic submission of data for purposes of—

''(A) effectiveness measurement using the health care measures developed pursuant to this section; and

''(B) reporting to the Secretary measures used to make value-based payments under this title.

''(f) CONTRACTS.—The Secretary, acting through the Agency for Healthcare Research and Quality, may contract with organizations to support the development and testing of health care measures meeting the standards established by the designated organization.

''(g) DISSEMINATION OF INFORMATION.—In order to make information on health care measures available to health care consumers, health professionals, public health officials, oversight organizations, researchers, and other appropriate individuals and entities, the Secretary shall work with multi-stakeholder groups to provide for the dissemination of information developed pursuant to this title.

''(h) FUNDING.—For purposes of carrying out subsections (a), (b), (c), and (d), including for expenses incurred for the arrangement under subsection (a) with the designated organization, there is payable from the Federal Hospital Insurance Trust Fund (established under section 1817) and the Federal Supplementary Medical Insurance Trust Fund (established under section 1841)—

''(1) for fiscal year 2008, $15,000,000, multiplied by the ratio of the total number of months in the year to the number of months (and portions of months) of such year during which the arrangement under subsection (a) is effective; and

''(2) for each of the fiscal years, 2009 through 2012, $15,000,000.''.

SEC. 907. IMPROVEMENTS TO THE MEDIGAP PROGRAM.

(a) IMPLEMENTATION OF NAIC RECOMMENDATIONS.—The Secretary of Health and Human Services shall provide, under subsections (p)(1)(E) of section 1882 of the Social Security Act (42 U.S.C. 1395s), for implementation of the changes in the NAIC model law and regulations recommended by the National Association of Insurance Commissioners in its Model #651 (''Model Regulation to Implement the NAIC Medicare Supplement Insurance Minimum Standards Model Act'') on March 11, 2007, as modified to reflect the changes made under this Act. In carrying out the previous sentence, the benefit packages classified as ''K'' and ''L'' shall be eliminated and such NAIC recommendations shall be treated as having been adopted by such Association as of January 1, 2008.

(b) REQUIRED OFFERING OF A RANGE OF POLICIES.—

(1) IN GENERAL.—Subsection (o) of such section is amended by adding at the end the following new paragraph:

''(4) In addition to the requirement of paragraph (2), the issuer of the policy must make available to the individual at least medicare supplemental policies with benefit packages classified as 'C' or 'F'.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to medicare supplemental policies issued on or after January 1, 2008.

(c) REMOVAL OF NEW BENEFIT PACKAGES.—Such section is further amended—

(1) in subsection (o)(1), by striking ''(p), (v), and (w)'' and inserting ''(p) and (v)'';

(2) in subsection (v)(3)(A)(i), by striking ''or a benefit package described in subparagraph (A) or (B) of subsection (w)(2)''; and

(3) in subsection (w)—

(A) by striking ''POLICIES'' and all that follows through ''The Secretary'' and inserting ''POLICIES.—The Secretary'';

(B) by striking the second sentence; and

(C) by striking paragraph (2) .

SEC. 908. IMPLEMENTATION FUNDING.

For purposes of implementing the provisions of this Act (other than title X), the Secretary of Health and Human Services 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 $40,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for fiscal year 2008.

SEC. 909. ACCESS TO DATA ON PRESCRIPTION DRUG PLANS AND MEDICARE ADVANTAGE PLANS.

(a) IN GENERAL.—Section 1875 of the Social Security Act (42 U.S.C. 1395ll) is amended—

(1) in the heading, by inserting ''TO CONGRESS; PROVIDING INFORMATION TO CONGRESSIONAL SUPPORT AGENCIES'' after ''AND RECOMMENDATIONS''; and

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

''(c) PROVIDING INFORMATION TO CONGRESSIONAL SUPPORT AGENCIES.—

''(1) IN GENERAL.—Notwithstanding any provision under part D that limits the use of prescription drug data collected under such part, upon the request of a Congressional support agency, the Secretary shall provide such agency with information submitted to, or compiled by, the Secretary under part D (subject to the restriction on disclosure under paragraph (2)), including—

''(A) only with respect to Congressional support agencies that make official baseline spending projections, conduct oversight studies mandated by Congress, or make official recommendations on the program under this title to Congress—

''(i) aggregate negotiated prices for drugs covered under prescription drug plans and MA-PD plans;

''(ii) negotiated rebates, discounts, and other price concessions by drug and by contract or plan (as reported under section 1860D-2(d)(2));

''(iii) bid information (described in section 1860D-11(b)(2)(C)) submitted by such plans;

''(iv) data or a representative sample of data regarding drug claims and other data submitted under section 1860D-15(c)(1)(C) (as determined necessary and appropriate by the Congressional support agency to carry out the legislatively mandated duties of the agency);

''(v) the amount of reinsurance payments paid under section 1860D-15(a)(2), provided at the plan level; and

''(vi) the amount of any adjustments of payments made under subparagraph (B) or (C) of section 1860D-15(e)(2), provided at the plan level aggregate negotiated prices for drugs covered under prescription drug plans and MA-PD plans; and

''(B) access to drug event data submitted by such plans under section 1860D-15(d)(2)(A), except, with respect to data that reveals prices negotiated with drug manufacturers, such data shall only be available to Congressional support agencies that make official baseline spending projections, conduct oversight studies mandated by Congress, or make official recommendations on the program under this title to Congress.

''(2) RESTRICTION ON DATA DISCLOSURE.—

''(A) IN GENERAL.—Data provided to a Congressional support agency under this subsection shall not be disclosed, reported, or released in identifiable form.

''(B) IDENTIFIABLE FORM.—For purposes of subparagraph (A), the term 'identifiable form' means any representation of information that permits identification of a specific prescription drug plan, MA-PD plan, pharmacy benefit manager, drug manufacturer, drug wholesaler, or individual enrolled in a prescription drug plan or an MA-PD plan under part D.

''(3) TIMING.—The Secretary shall release data under this subsection in a timeframe that enables Congressional support agencies to complete congressional requests.

''(4) USE OF THE DATA PROVIDED.—Data provided to a Congressional support agency under this subsection shall only be used by such agency for carrying out the functions and activities of the agency mandated by Congress.

''(5) CONFIDENTIALITY.—The Secretary shall establish safeguards to protect the confidentiality of data released under this subsection. Such safeguards shall not provide for greater disclosure than is permitted under any of the following:

''(A) The Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

''(B) Sections 552 or 552a of title 5, United States Code, with regard to the privacy of individually identifiable beneficiary health information.

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

''(A) CONGRESSIONAL SUPPORT AGENCY.—The term 'Congressional support agency' means—

''(i) the Medicare Payment Advisory Commission;

''(ii) the Government Accountability Office; and

''(iii) the Congressional Budget Office.

''(B) MA-PD PLAN.—The term 'MA-PD plan' has the meaning given such term in section 1860D-1(a)(3)(C).

''(C) PRESCRIPTION DRUG PLAN.—The term 'prescription drug plan' has the meaning given such term in section 1860D-41(a)(14).''.

(b) CONFORMING AMENDMENT.—Section 1805(b)(2) of the Social Security Act (42 U.S.C. 1395b-6(b)(2)) is amended by adding at the end the following new subparagraph:

''(D) PART D.—Specifically, the Commission shall review payment policies with respect to the Voluntary Prescription Drug Benefit Program under part D, including—

''(i) the factors affecting expenditures;

''(ii) payment methodologies; and

''(iii) their relationship to access and quality of care for Medicare beneficiaries.''.

SEC. 910. ABSTINENCE EDUCATION.

Section 510 of the Social Security Act (42 U.S.C. 710) is amended to read as follows:

''SEC. 510. SEPARATE PROGRAM FOR ABSTINENCE EDUCATION.

''(a) IN GENERAL.—For the purpose described in subsection (b), the Secretary shall, for fiscal year 2008 and fiscal year 2009, allot to each State which has transmitted an application for the fiscal year under section 505(a) an amount equal to the product of—

''(1) the amount appropriated in subsection (d) for the fiscal year; and

''(2) the percentage determined for the State under section 502(c)(1)(B)(ii).

''(b) PURPOSE OF ALLOTMENT.—

''(1) PURPOSE.—The purpose of an allotment under subsection (a) to a State is to enable the State to provide abstinence education, and where appropriate, mentoring, counseling, and adult supervision to promote abstinence from sexual activity, with a focus on those groups which are most likely to bear children out-of-wedlock.

''(2) DEFINITION; STATE OPTION.—For purposes of this section, the term 'abstinence education' has, at the option of each State receiving an allotment under subsection (a), the meaning given such term in subparagraph (A), or the meaning given such term in subparagraph (B), as follows:

''(A) Such term means a medically and scientifically accurate educational or motivational program which—

''(i) has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;

''(ii) teaches abstinence from sexual activity outside marriage as the expected standard for all school age children;

''(iii) teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;

''(iv) teaches that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;

''(v) teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;

''(vi) teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;

''(vii) teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and

''(viii) teaches the importance of attaining self-sufficiency before engaging in sexual activity.

''(B) Such term means a medically and scientifically accurate educational or motivational program which promotes abstinence and educates those who are currently sexually active or at risk of sexual activity about additional methods to prevent unintended pregnancy or reduce other health risks.

''(3) CERTAIN REQUIREMENTS.—

''(A) LIMITATION REGARDING INACCURATE INFORMATION.—None of the funds made available under this section may be used to provide abstinence education that includes information that is medically and scientifically inaccurate. For purposes of this section, the term 'medically and scientifically inaccurate' means information that is unsupported or contradicted by a preponderance of peer-reviewed research by leading medical, psychological, psychiatric, and public health publications, organizations and agencies.

''(B) EFFECTIVENESS REGARDING CERTAIN MATTERS.—None of the funds made available under this section may be used for a program unless the program is based on a model that has been demonstrated to be effective in preventing unintended pregnancy, or in reducing the transmission of a sexually transmitted disease, including the human immunodeficiency virus. The preceding sentence does not apply to any program that was approved and funded under this section on or before September 30, 2007.

''(c) APPLICABILITY OF CERTAIN SECTIONS.—

''(1) REQUIREMENTS.—Sections 503, 507, and 508 apply to allotments under subsection (a) to the same extent and in the same manner as such sections apply to allotments under section 502(c).

''(2) DISCRETION OF SECRETARY.—Sections 505 and 506 apply to allotments under subsection (a) to the extent determined by the Secretary to be appropriate.

''(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of allotments under subsection (a), there is authorized to be appropriated $50,000,000 for each of fiscal years 2008 and 2009.''.

TITLE X—REVENUES

SEC. 1001. INCREASE IN RATE OF EXCISE TAXES ON TOBACCO PRODUCTS AND CIGARETTE PAPERS AND TUBES.

(a) SMALL CIGARETTES.—Paragraph (1) of section 5701(b) of the Internal Revenue Code of 1986 is amended by striking ''$19.50 per thousand ($17 per thousand on cigarettes removed during 2000 or 2001)'' and inserting ''$42 per thousand''.

(b) LARGE CIGARETTES.—Paragraph (2) of section 5701(b) of such Code is amended by striking ''$40.95 per thousand ($35.70 per thousand on cigarettes removed during 2000 or 2001)'' and inserting ''$88.20 per thousand''.

(c) SMALL CIGARS.—Paragraph (1) of section 5701(a) of such Code is amended by striking ''$1.828 cents per thousand ($1.594 cents per thousand on cigars removed during 2000 or 2001)'' and inserting ''$42 per thousand''.

(d) LARGE CIGARS.—Paragraph (2) of section 5701(a) of such Code is amended—

(1) by striking ''20.719 percent (18.063 percent on cigars removed during 2000 or 2001)'' and inserting 40 percent (33 percent on cigars removed after December 31, 2007, and before October 1, 2013).

(2) by striking ''$48.75 per thousand ($42.50 per thousand on cigars removed during 2000 or 2001)'' and inserting ''$1 per cigar''.

(e) CIGARETTE PAPERS.—Subsection (c) of section 5701 of such Code is amended by striking ''1.22 cents (1.06 cents on cigarette papers removed during 2000 or 2001)'' and inserting ''2.63 cents''.

(f) CIGARETTE TUBES.—Subsection (d) of section 5701 of such Code is amended by striking ''2.44 cents (2.13 cents on cigarette tubes removed during 2000 or 2001)'' and inserting ''5.26 cents''.

(g) SNUFF.—Paragraph (1) of section 5701(e) of such Code is amended by striking ''58.5 cents (51 cents on snuff removed during 2000 or 2001)'' and inserting ''$1.26''.

(h) CHEWING TOBACCO.—Paragraph (2) of section 5701(e) of such Code is amended by striking ''19.5 cents (17 cents on chewing tobacco removed during 2000 or 2001)'' and inserting ''42 cents''.

(i) PIPE TOBACCO.—Subsection (f) of section 5701 of such Code is amended by striking ''$1.0969 cents (95.67 cents on pipe tobacco removed during 2000 or 2001)'' and inserting ''$2.36''.

(j) ROLL-YOUR-OWN TOBACCO.—

(1) IN GENERAL.—Subsection (g) of section 5701 of such Code is amended by striking ''$1.0969 cents (95.67 cents on roll-your-own tobacco removed during 2000 or 2001)'' and inserting ''$7.4667''.

(2) INCLUSION OF CIGAR TOBACCO.—Subsection (o) of section 5702 of such Code is amended by inserting ''or cigars, or for use as wrappers for making cigars'' before the period at the end.

(k) EFFECTIVE DATE.—The amendments made by this section shall apply to articles removed after December 31, 2007.

(l) FLOOR STOCKS TAXES.—

(1) IMPOSITION OF TAX.—On cigarettes manufactured in or imported into the United States which are removed before January 1, 2008, and held on such date for sale by any person, there is hereby imposed a tax in an amount equal to the excess of—

(A) the tax which would be imposed under section 5701 of the Internal Revenue Code of 1986 on the article if the article had been removed on such date, over

(B) the prior tax (if any) imposed under section 5701 of such Code on such article.

(2) AUTHORITY TO EXEMPT CIGARETTES HELD IN VENDING MACHINES.—To the extent provided in regulations prescribed by the Secretary, no tax shall be imposed by paragraph (1) on cigarettes held for retail sale on January 1, 2008, by any person in any vending machine. If the Secretary provides such a benefit with respect to any person, the Secretary may reduce the $500 amount in paragraph (3) with respect to such person.

(3) CREDIT AGAINST TAX.—Each person shall be allowed as a credit against the taxes imposed by paragraph (1) an amount equal to $500. Such credit shall not exceed the amount of taxes imposed by paragraph (1) for which such person is liable.

(4) LIABILITY FOR TAX AND METHOD OF PAYMENT.—

(A) LIABILITY FOR TAX.—A person holding cigarettes on January 1, 2008, to which any tax imposed by paragraph (1) applies shall be liable for such tax.

(B) METHOD OF PAYMENT.—The tax imposed by paragraph (1) shall be paid in such manner as the Secretary shall prescribe by regulations.

(C) TIME FOR PAYMENT.—The tax imposed by paragraph (1) shall be paid on or before April 14, 2008.

(5) ARTICLES IN FOREIGN TRADE ZONES.—- Notwithstanding the Act of June 18, 1934 (48 Stat. 998, 19 U.S.C. 81a) and any other provision of law, any article which is located in a foreign trade zone on January 1, 2008, shall be subject to the tax imposed by paragraph (1) if—

(A) internal revenue taxes have been determined, or customs duties liquidated, with respect to such article before such date pursuant to a request made under the 1st proviso of section 3(a) of such Act, or

(B) such article is held on such date under the supervision of a customs officer pursuant to the 2d proviso of such section 3(a).

(6) DEFINITIONS.—For purposes of this subsection—

(A) IN GENERAL.—Terms used in this subsection which are also used in section 5702 of the Internal Revenue Code of 1986 shall have the respective meanings such terms have in such section.

(B) SECRETARY.—The term ''Secretary'' means the Secretary of the Treasury or the Secretary's delegate.

(7) CONTROLLED GROUPS.—Rules similar to the rules of section 5061(e)(3) of such Code shall apply for purposes of this subsection.

(8) OTHER LAWS APPLICABLE.—All provisions of law, including penalties, applicable with respect to the taxes imposed by section 5701 of such Code shall, insofar as applicable and not inconsistent with the provisions of this subsection, apply to the floor stocks taxes imposed by paragraph (1), to the same extent as if such taxes were imposed by such section 5701. The Secretary may treat any person who bore the ultimate burden of the tax imposed by paragraph (1) as the person to whom a credit or refund under such provisions may be allowed or made.

SEC. 1002. EXEMPTION FOR EMERGENCY MEDICAL SERVICES TRANSPORTATION.

(a) IN GENERAL.—Subsection (l) of section 4041 of the Internal Revenue Code of 1986 is amended to read as follows:

''(l) EXEMPTION FOR CERTAIN USES.—

''(1) CERTAIN AIRCRAFT.—No tax shall be imposed under this section on any liquid sold for use in, or used in, a helicopter or a fixed-wing aircraft for purposes of providing transportation with respect to which the requirements of subsection (f) or (g) of section 4261 are met.

''(2) EMERGENCY MEDICAL SERVICES.—No tax shall be imposed under this section on any liquid sold for use in, or used in, any ambulance for purposes of providing transportation for emergency medical services. The preceding sentence shall not apply to any liquid used after December 31, 2012.''.

(b) FUELS NOT USED FOR TAXABLE PURPOSES.—Section 6427 of such Code is amended by inserting after subsection (e) the following new subsection:

''(f) USE TO PROVIDE EMERGENCY MEDICAL SERVICES.—Except as provided in subsection (k), if any fuel on which tax was imposed by section 4081 or 4041 is used in an ambulance for a purpose described in section 4041(l)(2), the Secretary shall pay (without interest) to the ultimate purchaser of such fuel an amount equal to the aggregate amount of the tax imposed on such fuel. The preceding sentence shall not apply to any liquid used after December 31, 2012.''.

(c) TIME FOR FILING CLAIMS; PERIOD COVERED.—Paragraphs (1) and (2)(A) of section 6427(i) of such Code are each amended by inserting ''(f),'' after ''(d),''.

(d) CONFORMING AMENDMENT.—Section 6427(d) of such Code is amended by striking ''4041(l)'' and inserting ''4041(l)(1)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to fuel used in transportation provided in quarters beginning after the date of the enactment of this Act.

The SPEAKER pro tempore. Debate shall not exceed 2 hours, with 1 hour equally divided and controlled by the chairman and ranking minority member of the Committee on Ways and Means and 1 hour equally divided and controlled by the chairman and ranking minority member of the Committee on Energy and Commerce.

The gentleman from New York (Mr. RANGEL), the gentleman from Louisiana (Mr. MCCRERY), the gentleman from Michigan (Mr. DINGELL) and the gentleman from Texas (Mr. BARTON) each will control 30 minutes.

The Chair recognizes the gentleman from New York.

Mr. RANGEL. Mr. Speaker, I rise in support of this great piece of legislation that this august body has the privilege of supporting.

There may be some concerns in the House, some with merit, about procedure, but we on the Ways and Means Committee are so proud of the work that has been done by the subcommittee, led by Mr. STARK, working with Mr. CAMP, that we had 15 hearings on what was involved in this bill and a half a dozen sessions where we just talked with the professionals to make certain that not only did we support the great work that had been done by the Dean of our House in terms of education, in terms of Energy and Commerce and the SCHIP bill, but so at the same time we could preserve the benefits that are provided to our senior citizens through medical programs.

Mr. STARK did one great job at making certain that we worked with the administration, tried to find out where the abuses were and, where we could, we were able to raise $15 billion so that the poorest of our seniors would have the ability to receive health care enhanced.

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Of course, those who live in rural areas and who for years have not be able to receive the type of access to health care, we found $5 billion to do it.

I am not thoroughly convinced as to what PAYGO is going to mean in the future, but it is the rules of our party. It seems now that it makes some sense. But when you say that you have to enlarge this program so that an additional 6 million people, kids, that are already on the program, adding 5 million people to it, nobody, Republican or Democrat, liberal or conservative, does not believe that these children should be entitled to health care.

It is not just the right and moral thing to do. But in terms of being fiscally responsible, everyone would tell you that having a kid in the family exposed to preventive care actually costs less money than just ignoring the care of our children. I could go even further in saying that, even kids that go to school, if they are not well, they can't learn. And God knows we have millions of people in the street that had health impediments, that they thought they were educational impediments, and they are out there. I personally believe that a stronger country is a healthier country and a well-educated country.

Now, it is true when you have these PAYGO rules and you don't want to raise taxes that you have to find the money. And so it is a great deal of empathy that I have for our poor cigarette smokers, because I used to be one; and, two, I just don't like the idea of regressive taxes where the poor are penalized. But I am learning to live with it in such a sense that these cigarette smokers, these addicts, they hate themselves for smoking. And I have stretched it to the point that when I talk with them and tell them what we are about to do, after they finish coughing and spitting, they said, ''I have got to stop this smoking.'' Then, when you look at the little kids, this is the one thing that an increase in prices sharply reduces, it is kids going to smoke.

So, I am trying to get myself to think that maybe I am doing it for the tobacco companies, because they advertise they don't want kids to smoke, and we are going to help them by increasing the price of cigarettes, which one thing is abundantly clear, it will stop a lot of children from smoking.

Mr. Speaker, I am going to yield the rest of my time to the gentleman from California, PETE STARK, who has done such a fantastic job in finding out where the problems were and bringing to this floor not only a great child insurance bill, but also improving Medicare, increasing the benefits of our seniors who are poor and help into rural areas.

While we may have a lot of procedural differences, and I understand that, I just hope that whether you are Republican or Democrat that you feel comfortable being able to say that there may be some pain for cigarette smokers who really are costing us a lot of money with these lung transplants and whatnot. But that is painful enough.

So you may have some problem with your smokers. But just think about 11 million children and their families that love them so much and a country that wants them healthy, and I am certain that at the end of the day that the kids

are going to win, we will have a better health care delivery system, and you will feel very, very comfortable in talking about the procedural differences that you differed with. But, in your heart, you would know that every major advocate for children and health and hospitals and doctors have signed up saying, ''do the right thing.'' I personally believe that that is what you are going to do today.

Mr. Speaker, I yield the balance of my time to the gentleman from California, PETE STARK, the chairman of the Subcommittee on Health, and I thank him publicly, and the staff, for the fantastic job that they have done in having hearings and letting all Members have a better understanding of the problem, but, better than that, in being able to bring a solution to this floor today.

The SPEAKER pro tempore. Without objection, the gentleman from California will manage the remainder of the time for the Ways and Means Committee majority.

There was no objection.

Mr. BARTON of Texas. Mr. Speaker, I ask unanimous consent that there be one 1 hour of additional debate, equally divided between the majority and the minority, and within each of those subsegments, equally divided between the Ways and Means Committee and the Energy and Commerce Committee.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

Mr. STARK. Mr. Speaker, I object.

The SPEAKER pro tempore. Objection is heard. The time will remain the same.

Mr. DINGELL. Mr. Speaker, I hope that my good friend from California will not object.

Mr. BARTON of Texas. Mr. Speaker, I would repeat that unanimous consent request.

Mr. DINGELL. Mr. Speaker, I would hope my good friend would not object.

Mr. STARK. Mr. Speaker, I reserve the right to object. I may discuss it at a later point, but at this time, I must object.

The SPEAKER pro tempore. The gentleman from California reserves the right to object.

Mr. BARTON of Texas. Mr. Speaker, does that mean we discuss the reservation now?

Mr. DINGELL. Mr. Speaker, reserving the right to object.

Mr. STARK. Mr. Speaker, I object.

The SPEAKER pro tempore. The gentleman from California has reserved the right to object.

Mr. STARK. Mr. Speaker, I object.

The SPEAKER pro tempore. Now he objects. The gentleman from California objects.

Does the gentleman from California rise to object?

Mr. STARK. Yes, Mr. Speaker, I object.

The SPEAKER pro tempore. Objection is heard.

Mr. RANGEL. Mr. Speaker, may I be recognized to respond?

The SPEAKER pro tempore. For what purpose does the gentleman from New York rise?

Mr. RANGEL. Mr. Speaker, it appears as though the decision for extra time should be one that our leadership should have decided on. It just seems to me that since our leader has not been conferred with, that if you just reserve the opportunity, that in a very short while we will be able to discuss this.

Mr. BARTON of Texas. Mr. Speaker, if the gentleman will yield, we have, just from the Energy and Commerce Committee on the minority side, a request for 25 speakers, plus several of our leadership. So if this unanimous consent request were to be agreed to, it would give each committee on both sides of the aisle an additional 15 minutes. I am sure there are many Members on the majority side, as on the minority, that wish to speak. I will offer it later on if you want to check on it.

Mr. RANGEL. Well, Mr. Speaker, the minority somehow manages to find time to speak on this and many other subjects. But I am saying that under normal conditions, you would think that your leadership would have discussed this issue with ours so that at some times the Members would know exactly what to expect.

Now, I don't see any reason why this should not be agreed upon, but I just don't think Members can come to the floor by unanimous consent and ask for an hour or 2 hours or 3 hours. We don't even know whether or not the minority intends to follow any other procedures that could kind of take away floor time in terms of debates and exchanges. Just based on some of the things that I've seen from your committee, it appears to me that we have to find out what you want to do with that hour.

Mr. BARTON of Texas. Mr. Speaker, if the gentleman will yield, the gentleman has every right to be suspicious of the ranking member of the Energy and Commerce Committee. I am a devious fellow and I reserve all my options. But on this one, we were shooting straight and dealing off the top of the deck.

The SPEAKER pro tempore. The gentleman from California has objected. Does the gentleman stand to object, or does he withdraw his objection?

Mr. STARK. I object.

The SPEAKER pro tempore. Objection is heard.

Mr. DINGELL. Mr. Speaker, I am going to make the same unanimous consent request, and then I will withdraw it. But first I want to make an observation here for the benefit of all of my colleagues and friends.

This is a very important piece of legislation. I am not going to defend the behavior of any Member here, and I am not going to criticize the behavior of any Member, but I am going to make an observation that I think is important.

This is a very important piece of legislation. Twelve million of our kids are going to have their health insurance increased or not depending on how we conduct ourselves today. I want to have a broad exposition. If you look at the time that we have to give to Members who wish to be heard on this, we are talking about a minute or 30 seconds, hardly enough time for any Member to adequately make a position on something which is important to him and to the kids.

I think that we have a chance to do a great deal of good for our young people. I don't think that it is excessive to say we are going to give enough time so that this matter can be properly discussed, nor do I think there is any benefit in denying our Members the time to do this and denying the Members a chance to be heard.

Now, I am going to withdraw this.

The SPEAKER pro tempore. The gentleman withdraws his request. Members may engage in debate by using their time.

Mr. DINGELL. Mr. Speaker, I have asked unanimous consent and I reserved the right to object.

The SPEAKER pro tempore. The gentleman cannot reserve the right to object on his own request. The gentleman reiterates a unanimous consent request.

Is there objection?

Mr. WAXMAN. Mr. Speaker, I reserve the right to object.

The SPEAKER pro tempore. The gentleman from California.

Mr. WAXMAN. Mr. Speaker and my colleagues, for goodwill, I would see it a wise course of action to give additional time, since the minority requests it, but I wouldn't be prepared to give them that time now.

The reason we are starting so late today on this bill is because we have been interrupted with procedural votes to delay us from debating this issue. In our own committee, the Energy and Commerce Committee, the gentleman from Texas said he had a lot of people from our committee who wanted to speak on the issue. They wouldn't let us debate any single issue of merit. They made us read the bill, to frustrate the committee from meeting at all.

Let's renew this request for additional time later as a reward for good behavior, if we can see some good behavior. But right now, to this point, I haven't seen a lot of good behavior from the other side.

The SPEAKER pro tempore. Does the gentleman object or does he withdraw his reservation of the right to object?

Mr. WAXMAN. I object.

The SPEAKER pro tempore. Objection is heard.

Mr. BARTON of Texas. Mr. Speaker, I proudly stand for the First Amendment rights of even the Members of the minority, and I also stand for honoring the rules and the procedures developed over 200 years in the most Democratic body the free world has ever known, the House of Representatives.

With that, I yield 1 minute to the distinguished minority leader from the great State of Ohio (Mr. BOEHNER).

Mr. BOEHNER. Mr. Speaker, let me thank my colleague for yielding.

Mr. Speaker and my colleagues, the State Children's Health Insurance Program was created 10 years ago by a Republican Congress, along with our Democrat colleagues and a Democrat President. It clearly was a very bipartisan process from the beginning, and as we reauthorize this important program that Republicans, Democrats, the White House, everyone supports, I am saddened that we are here today with a very partisan bill done in a very partisan way.

I thought in this reauthorization process, I know on our side, Mr. BARTON, Mr. MCCRERY, their respective committees, wanted to work with our Democrat colleagues to develop a bill that we could all vote for. But that process never even got started. While there may have been some hearings in the Ways and Means Committee on this bill, there were no hearings in the Energy and Commerce Committee. We were presented with a 488-page bill the night before the markup. Now we have brought this to the floor without a markup in committee, no amendments allowed to be offered by the minority and a limited time for debate. This saddens me and disappoints me. It did not have to be this way.

The result of this flawed process is a bill that expands government-run health care beyond anything that any one of us could have imagined over the last 10 years. I really do believe that Republicans and Democrats can work together to reauthorize this program in a way that will receive bipartisan support.

Last November, the American people sent us a message here in Congress, but I don't think that message was, ''I want you to cut my Medicare and I want you to raise taxes. I did not want you to raise my taxes.''

When you look at the bill that we have before us, we have $193 billion worth of cuts to Medicare, a program to provide health insurance for our seniors. We are going to cut this $193 billion over 10 years, and we are going to raise tobacco taxes, which affects the poorest of America's citizens, and lay more of this tax burden on their backs.

□ 1430

In my district alone, some 14,267 seniors are going to have their Medicare costs increased, and about 73 percent of that number are likely to lose their Medicare Advantage Program altogether.

That is not what the voters sent us here to do; and, believe me, the seniors in my district who take advantage of this very valuable program don't want to lose their benefits which will result from the passage of this bill.

And so I say to my colleagues, we have a flawed bill on the floor today; and the flawed bill is the result of a flawed process. As I said last night to all of my colleagues, we represent nearly half of the American people. We have a right to be heard. We have a right to participate. And through the process over the last couple of weeks we have been denied the right to be involved in the process, denied the right today to be involved in trying to amend the bill to a point where we can have a bipartisan product to send to the other body. I am disappointed by that.

Later today, Republicans will offer a motion to recommit this bill, the only option that we have. And that motion to recommit will do this: It will reauthorize the SCHIP program for 1 year. There will be no Medicare cuts involved in this program, no benefits will go to illegal immigrants, and we will see to that in the motion to recommit.

Fourthly, it will have a sense of the Congress that this bill should go back to the committee and, over the course of the next year, have the Republicans and Democrats on the respective committees work together to produce a bipartisan product that the President can sign into law. I think that is a responsible course of action, given what we have dealt with here over the last couple of weeks.

I would ask my colleagues to reject the underlying bill and vote for the motion to recommit.

Mr. DINGELL. Mr. Speaker, I yield myself 3 minutes.

(Mr. DINGELL asked and was given permission to revise and extend his remarks.)

Mr. DINGELL. Mr. Speaker, the Children's Health and Medicare Protection Act, the CHAMP Act, is a good piece of legislation. It expands and improves a most successful program, bipartisan in character, created in 1997. That program has cut the rate of uninsured children by a full third. Some States have been able to ensure as many as 60 percent of the children who previously had no health insurance.

This bill is about taking care of our kids. It is about taking care of the future of the country. Today, 6 million of our youngsters get their health care through the program. With this legislation, an additional 5 million previously uninsured children will be able to see doctors, receive immunizations, and get dental and mental health coverage.

The bill requires that children receive priority in coverage. It allows States to cover pregnant women, recognizing that healthy moms make for healthy babies. I am certain my Republican colleagues on Energy and Commerce understood this point, because our clerk read this bill to them. As I am sure all of us there will recall, all some 486 pages were to be read.

The CHAMP Act does not allow one thin dime to be spent on illegal aliens. You will find this prohibition in section 135 of the bill. Nor does it create a government-run health insurance system. Coverage under CHIP and Medicaid are provided primarily through private health insurance. All but two States use some form of managed care for their programs. Nothing here will change that, and the newly covered children will be exactly the same kind of child in the same situation that every one of the children now covered happens to be.

The CHAMP Act also covers and secures Medicare for the future. This past Monday marked the 42nd anniversary of President Johnson signing that wonderful piece of legislation into law. I was there.

The CHAMP Act shores up the Medicare trust fund, improves benefits for seniors, protects their ability to choose their own doctors, and these reforms effectively provide low-income seniors on Medicare with an additional $1,200 in benefits.

The CHAMP Act is an act of fiscal responsibility. Seniors in traditional Medicare will pay approximately three-quarters of a billion dollars in excess premiums to cover the overpayments now being made to HMOs, a great injustice. The things that my Republican colleagues are complaining about are that we stop that evil practice. The CHAMP Act also adds 3 years to the life of the trust fund by stopping these overpayments which are accelerating the insolvency of the Medicare trust fund.

I know that President Bush has pledged to veto counterpart legislation in the Senate that is much more modest in its ambitions.

I include the rest of my speech for the RECORD and urge my Republican colleagues to read it. It is an excellent speech.

The legislation before us accomplishes two critical goals. It will provide health care to as many as 12 million children. And it will allow our elderly to continue seeing their own doctors.

The CHAMP Act—the Children's Health and Medicare Protection Act—improves a most successful program created with bipartisan support in 1997. That program has cut the rate of low-income uninsured children by one-third. Some States have been able to insure as many as 60 percent of their children who previously had no health insurance.

Today, six million children get their health care through this program. With this legislation, five million previously uninsured children will be able to see doctors, receive immunizations, get dental care, and other coverage.

This legislation requires that children receive priority in coverage. It allows States to cover pregnant women, recognizing that healthy moms make for healthy babies.

While I am certain that my Republican colleagues on the Committee on Energy and Commerce understand this point—because our wonderful clerk read the bill to them—I will restate it for others listening:

The CHAMP Act does not allow one Federal dime to be spent on illegal aliens. You will find this prohibition in section 135 of the bill.

Nor does the bill create a ''government run'' health care system. Coverage under CHIP and Medicaid are provided primarily through private insurance—all but two States use some form of managed care for their programs. Nothing here would change that. And the newly covered children are exactly the same as those now covered.

The CHAMP Act also secures Medicare for the future. This past Monday marked the 42nd anniversary of President Johnson signing Medicare into law. The CHAMP Act shores up the Medicare trust fund, improves benefits for seniors, and protects their ability to choose their own doctors. These reforms will effectively provide low-income seniors on Medicare with an additional $1,200 in their pockets.

The CHAMP Act is an act of fiscal responsibility. This year, seniors in traditional Medicare will pay nearly three-quarters of a billion dollars in excess premiums to finance overpayments to HMOs. Those overpayments will accelerate the insolvency of the Medicare trust fund. The CHAMP Act adds three years to the life of the Trust Fund.

I am well aware that President Bush has pledged to veto counterpart legislation in the Senate that is much more modest in its ambitions, and I have received my own veto letter from the Secretary of the Department of Health and Human Services. They stand on one side of the debate.

Let's look at who stands on the other side: 12 million children. The American Medical Association. The American Academy of Pediatrics. The National Rural Health Association. The National Council on Aging. The AARP. The Federation of American Hospitals. The March of Dimes. The Children's Defense Fund. The NAACP. The National Governors Association, including the Governors of New York, Michigan, California, Illinois, and Maryland, and the Catholic Health Association—which notes that ''the most important pro-life thing the Congress can do right now is ensure that the State Children's Health Insurance Program is reauthorized.''

A vote against this bill is a vote to deprive six million children of healthcare. A vote against this bill is a vote to continue the plunder of the Medicare Trust Fund by bloated private interests. A vote against this bill is a vote to deny seniors in Medicare additional benefits.

I urge all of my colleagues to stand up for what's right for children, seniors, people with disabilities, and taxpayers: support the speedy passage of the CHAMP Act.

Mr. BARTON of Texas. Mr. Speaker, I yield myself 2 minutes.

To follow up on our distinguished minority leader, I want to say what the Republicans are for in this debate before we talk about some of the flaws in the pending bill.

We are for authorization of the SCHIP legislation. We are for covering low-income and near-low-income children so they have health care benefits.

We are for making sure that the States that are out of funding receive additional funds beginning October, 2007.

So we want to reauthorize the SCHIP program. We do believe that it should be maintained as a block grant program and not become an entitlement program. We believe it should be reauthorized for a specific period of time, not become an open-ended entitlement.

We believe that SCHIP payments should be restricted to citizens of the United States and legal residents who have been here at least 5 years. We do not believe SCHIP payments should be allowed for illegal aliens who have come into this country without the proper documentation. So we are for reauthorization of SCHIP. We are for covering our low-income and near-low-income children.

We disagree with our friends on the majority side on the number of individuals that we are talking about. We believe that children below 200 percent of poverty that do not have health insurance or health coverage today are in the neighborhood of 700,000, not 7 million.

But we do understand that if you raise the level to 400 percent, if you allow States to self-certify above that level so there really is no income test, we do understand if you do that, almost every child in America, 78 million children, could be eligible for some sort of SCHIP assistance under the majority Democratic plan. But if you restrict it to low-income and near-low-income children below 200 percent of poverty, we believe that the Republican substitute, which was not made in order by the Rules Committee at 2 a.m. this morning, solves that.

Mr. STARK. Mr. Speaker, I yield myself such time as I may consume.

Much has been said by the distinguished chairman of the Energy and Commerce Committee, by the distinguished chairman of the Ways and Means Committee on how this bill helps Americans. Five million kids will receive medical coverage insurance that they don't now have. Seniors will receive preventative care with no copayments. They will receive mental health care at parity. Rural benefits will be extended to the rural communities that need assistance for access to their population. Low-income seniors will receive assistance in paying for their co-pays and their premiums.

This bill is fully funded over 10 years, something my Republican colleagues never did in the past. I want to remind my colleagues that there are many myths being floated around here today. It is important to note that 83 of my Republican friends in 1997 voted for an identical bill. The bill that they voted on has the exact same income eligibility that was passed in 1997. The minority leader, the ranking member of the Ways and Means Committee, the ranking member of the Health Subcommittee on the Ways and Means Committee, all voted for this and included a cigarette tax to pay for it.

And I might added that the reductions that they put in their Medicare bill were five times greater than the adjustments we made in the bill today. It included an increase in the Federal tobacco tax.

Now I don't know what has changed. Maybe they have learned to hate children in the interim, but nothing has changed in the eligibility. It is the same bill. If it was good for you, then it is better now. And it does a fair thing.

The public is sick of radical ranting. They want health care for kids and seniors, and the way to get that is to support the bill before us today.

Mr. Speaker, I reserve the balance of my time.

Mr. BARTON of Texas. Mr. Speaker, I yield 2 minutes to the ranking member of the Health Subcommittee on the Energy and Commerce Committee, the gentleman from Georgia (Mr. DEAL).

Mr. DEAL of Georgia. Mr. Speaker, this is a program that started 10 years ago with a $40 billion Federal authorization of expenditures. The current bill before us would spend $128.7 billion over the next 10 years. When added with the State money, that is over $255 billion in taxpayer money over the next 10 years. That is over a quarter of a trillion dollars. And what do you get for it?

CBO says you will cover 600,000 more eligible children, 600,000 children. You would be better off to give each one of them $80,000 in cash, and they would probably get better results.

In 1996, we had an immigration bill that provided that if you wanted to bring somebody and sponsor somebody to come into this country legally, you would have to say they would not go on the public rolls of Medicaid and other programs for 5 years. This bill removes that. CBO says that alone will cost $2.2 billion, and we let sponsors off the hook and we put them on the public payroll.

If we have a bill like the Senate was considering that would make 20 million illegals legal, that cost alone would be $140 billion a year. What it does, too, is it says, in the area of immigration, we are going to spend $400 billion paying for translators, not just to serve people but to enroll them in the program. That is $400 million.

Now they can say this does not open it up to illegal immigrants just by saying that. CBO says it will cost $2 billion because they think that is the cost that it is. What they are saying is just sign an affidavit that says you are legally in this country. I have speeders who would just like to sign an affidavit saying they have a driver's license. I have taxpayers who would like on April 15 to sign an affidavit saying they didn't have any taxable income; just take my word for it. And if you believe just signing an affidavit is a deterrent to people illegally in the country, then you also believe we can just put a sign at the Mexican border saying, if you don't have permission, just don't come in.

This is a ridiculous piece of legislation. It will undermine the purposes of the original bill.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the gentleman from Michigan (Mr. STUPAK).

Mr. STUPAK. Mr. Speaker, I want to congratulate Mr. DINGELL and Mr. PALLONE on crafting a well-balanced bill and for all of the hard work you and your staff have spent on the CHAMP Act.

The State Children's Health Initiative Program was enacted with bipartisan support a decade ago to reduce the number of low-income, uninsured

children by expanding eligibility levels and simplifying application procedures.

In 2006, SCHIP provided insurance to 6.7 million children. In Michigan, roughly 118,000 children are enrolled in SCHIP. Eighty-six percent of these SCHIP children are of working parents who are unable to afford private health insurance for their children.

SCHIP is vitally important to children living in our country's rural areas. Of the 50 counties with the highest rates of uninsured children, 44 are rural counties.

This legislation commits $50 billion to reauthorize and improve the SCHIP program to protect and continue coverage for 6 million children. In addition, this legislation ensures coverage for an additional 5 million children that are eligible but currently uninsured.

I am also very pleased to see the rural investments in the CHAMP Act which maintains Congress's commitment to rural America by extending a number of provisions that, if left to expire, would negatively affect rural beneficiaries' access to Medicare health services.

The CHAMP Act provides health care for children, expands preventive Medicare medicine for our seniors and helps make health care more affordable, available and accessible in rural America.

Mr. Speaker, I urge my colleagues to vote in favor of this legislation.

Mr. BARTON of Texas. Mr. Speaker, I yield 2 minutes to the distinguished former Speaker of the House and currently the ranking member of the Energy and Air Quality Subcommittee of the Energy and Commerce Committee, the gentleman from the great State of Illinois (Mr. HASTERT).

Mr. HASTERT. Mr. Speaker, I stand somewhat chagrined that we bring this bill to the floor of this great House, the floor that deliberates on the issues that take care of the needs of people, but this bill comes under a charade, a charade that we are going to help the poorest and most disadvantaged children.

□ 1445

The SCHIP program that we put in place 10 years ago started to do that, and we can't expand that, but this bill covers people up to four times of poverty. That is a family of four earning $82,000 a year.

What it does is say if you go out into the private sector and you continue to buy health care for you and your family, you're going to pay a tax, and that tax will fund other people, not just children, but expand the amount of adults covered by SCHIP, which is supposed to be for children.

In the State of Illinois, my State, 60 percent of the people on SCHIP are adults, not children; 40 percent are covered by children. If we want to cover children, let's change it so we cover children. This bill doesn't do that. This bill expands what we do for adults, adults that should be able to be paying their own way in American society.

What this bill does is open the doors for all other types of people to be able to be involved in government-paid health care, and that's the bottom line. It's government-paid health care. It's Hillary care all over again.

And what we do is take, at the cost of seniors who get Medicare Advantage, who get choices of their own health care plans, we take it away. We wipe it out, and we give it to people who are illegal aliens and aliens. And don't kid yourself, it's going to happen.

So, if we want to take health care on the backs and take it away from seniors and give it to people who haven't made their way in this country, who haven't got their citizenship, then this bill does it. It's a bad bill for a bad time, and it's coming under the false pretences of trying to do something for children.

Vote ''no.''

Mr. Speaker, it's unfortunate that today we are considering legislation which was rushed through the House without proper consideration in the Energy and Commerce Committee. There were no legislative hearings held by the Subcommittee or full committee on a bill that could cost taxpayers over $300 billion. That is simply unacceptable and the American people have the right to know what this bill is really about.

This Congress has the opportunity to correct flaws in SCHIP and bring spending in the program under control. Rather than return the focus back to our most vulnerable children, the CHAMP Act would greatly expand coverage.

First, it changes law to now define a child as someone as old as 21. It also expands coverage to more adults, and families with incomes upwards of 400 percent of the poverty line. This equates to an annual salary of over $82,000.

We are sending the message to families across the country—drop your children from your private insurance—the American taxpayer will foot the bill.

Furthermore, at a time when Americans look to Congress to secure our borders and enforce our existing immigration laws, the Democrat leadership, through the CHAMP Act, is taking leaps in the opposite direction by opening the door to free health insurance for illegal aliens.

It does so by removing language from the Deficit Reduction Act requiring proof of citizenship to receive SCHIP and Medicaid. This will make it nearly impossible for the Federal Government to prevent illegal immigrants from accessing these programs.

The American people are getting a clear message today from the new majority. They want your tax dollars to provide incentives to those who choose to break our laws and enter this country illegally.

And our Democrat colleagues would pay for this reckless expansion of SCHIP by cutting Medicare Advantage plans and significantly raising premiums on seniors.

Millions of seniors depend on Medicare Advantage plans to provide the benefits they need and services they can't otherwise get with traditional Medicare. Especially our seniors in rural and underserved communities. The CHAMP Act will immediately eliminate these enhanced benefits and choices so many have come to rely on.

Our Democrat friends are once again attempting to empower the Government to ration healthcare in this country. This will take choices out of every American's hands when it comes to their well-being and leaves the decisions to a government-run managed care system.

Instead, we should be encouraging the participation of private plans regardless if it is for children, families, or seniors. This creates competition in the marketplace, which we know lowers out-of-pocket costs while expanding benefits for the insured.

I believe, given the opportunity to properly debate and offer amendments, we could ensure coverage to our most vulnerable children in a fiscally responsible way without raising taxes and sacrificing Medicare services for our seniors. Unfortunately Republicans were denied that right today. I urge my colleagues to vote "no" on the CHAMP Act.

Mr. STARK. Mr. Speaker, I just remind the former Speaker that he voted for the same benefits in 1997, and nothing has changed since then.

I yield 1 minute to the gentleman from Michigan (Mr. LEVIN), who remembers what happened in 1997.

(Mr. LEVIN asked and was given permission to revise and extend his remarks.)

Mr. LEVIN. Mr. Speaker, some issues are complicated. This one is quite simple. It's kids and more benefits for seniors.

Five million more kids. I just wonder how many on the minority side are going to stand up and say no to 5 million kids, including kids where you live. Benefits for seniors are improved. And then we hear there will be benefits for illegal aliens, illegal immigrants? It's false. It's a lie.

This does not go to illegal immigrants. I did read the bill, and I also read the minds of the American people.

I also read the minds of the American people. They want the children of America covered by health insurance, and the Republicans have failed to do it in their years here.

We're going to do it today for the 5 million kids in the United States of America. That's what this is all about.

I rise in strong support of the Children's Health and Medicare Improvement Act of 2007. This legislation re-authorizes the State Children's Health Insurance Program and improves Medicare for all beneficiaries.

Some of the issues we debate in Congress are complicated. This issue is quite simple. It is about kids getting health care and seniors getting better Medicare benefits. The American people want the children of America covered by health msurance.

The current health insurance program covers 6 million children nationwide, including 55,000 kids in my home State of Michigan. But when two-thirds of the 9 million uninsured kids in America are eligible, but not participating, we need to extend the reach of the program. Extending this program means giving States the resources they need to reach out and cover these 6 million kids.

This important legislation not only allows more kids to have health insurance, but it also

makes long-needed improvements to the Medicare program. Improvements include ensuring physician access for Medicare beneficiaries, lowering the cost of mental health care for seniors, eliminating co-pays and deductibles for preventative services like mammograms and colonoscopy screenings, and expanding programs that help low-income seniors pay for their health care and prescriptions.

The Republicans reject this bill because it does not fit their rigid ideology. This bill is about a program that works and kids that need health care.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from Nashville, Tennessee (Mrs. BLACKBURN), a member of the committee.

Mrs. BLACKBURN. Mr. Speaker, I support the original intent of SCHIP to cover our low-income children at 200 percent of the Federal poverty level; yet the bill before us really strays from that, and we all know it.

And we're debating this under a lockdown rule because the Rules Committee refused to allow Republican amendments to this bill, and I will tell you, I found that 1 a.m. meeting for the Rules Committee informative and entertaining in an unfortunate sense.

The debate on this, as my colleague said, is pretty simple: Who will manage and control the health care sector that comprises one-seventh of our Nation's economy. That's what this is about today. Are individual Americans going to have the freedom to make those choices or are those Americans going to be relegated to being a faceless file on a bureaucrat's desk with that bureaucrat making those life-and-death decisions? Our future health care system is going to be shaped by the way we answer those questions on this floor today.

Under this Democrat bill, there will be billions spent to enroll children into SCHIP.

I encourage my colleagues to oppose this bill.

Mr. DINGELL. Mr. Speaker, my good Republican friends will be discussing process, and we want to discuss kids and the future of the country.

For that purpose, I yield 2 minutes to the distinguished chairman of the subcommittee, my friend, Mr. PALLONE of New Jersey.

Mr. PALLONE. Mr. Speaker, there shouldn't be any doubt here today about what the Republicans are trying to do. They are trying to destroy the SCHIP program.

We spent 18 hours in our committee where they wouldn't let the bill come up. The substitute that they had in the committee would put so many barriers in the program that, in effect, the program would die.

Don't believe them. They don't want to provide the additional funds. They know that this expires on September 30, and it will if we don't do something today; that there will be a million kids that will automatically not have their health insurance.

We're not changing any of the eligibility today. It's they that want to change the eligibility.

The fact of the matter is CBO tells us, and I have it right here, that this bill would cover another 5 million children who are currently uninsured.

Now, my colleagues on the other side know that the States have run out of money. Georgia ran out of money in March. They came to us and begged us for more money. States ran out each month of money. We had to put money in the supplemental appropriations bill because the States ran out of money.

We need a lot more money to make sure that these 5 million kids are covered. They want to stop that. They're not proposing to cover any additional kids. They want to cut that.

There's no illegal aliens covered in this bill. There never were. There's no language in here that says that.

This is not an entitlement. It's a block grant set up by Newt Gingrich. Newt Gingrich was the guy who set it up as a block grant, giving the States flexibility. The States want flexibility. Some of them want to go a little higher. Well, it's George Bush, the President of the United States, that granted the waiver so they could have some adults or kids at higher incomes.

Who are you kidding? This is a Republican program, but you are now walking away from it. You don't want to fund it. You want to deny eligibility. You want to kill the program. That's what you're all about here today.

And don't let anybody kid you. Eighteen hours we had to listen while the bill was being read. Today, they want to delay. They're kidding no one saying that they want an SCHIP program. Don't believe what they say. It's simply not true.

You vote for this bill today to expand this program to provide more kids, not more eligibility. And if you don't, this will die and those kids are not going to have health insurance.

We have health insurance for our kids as Members of Congress. That's okay for our own kids but not for the rest of these poor kids.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. All Members are reminded to direct their comments to the Chair.

Mr. BARTON of Texas. Mr. Speaker, page 76 and 77, section 143 of the original committee print repeals the requirement for documentation presentation for children covered under SCHIP.

With that, I yield 1 minute to the gentleman from Michigan, a member of the committee, Mr. ROGERS.

Mr. ROGERS of Michigan. Mr. Speaker, a letter recently from the NAACP says: We strongly support maintaining adequate funding for the Medicare Advantage program that serves as a critical funding for accessing health care services, particularly for low-income and minority Medicare beneficiaries.

Talk about what's in the bill. Don't use children as your shield. This is the single largest cut to Medicare in the program's history. Absolutely, it is, and let me tell you what you are cutting. Read the bill.

You're cutting stroke victims from inpatient rehab. You're cutting doctors. You're cutting oxygen equipment and wheelchair services to seniors. You're cutting seniors' home health care, cutting hospital payments, cutting skilled nursing care for the sickest seniors in nursing homes. You're cutting dialysis services for kidney cancer patients. You're cutting imaging services for cancer and cardiac patients.

The list goes on. You're telling seniors once we slash the Medicare Advantage payments, we're going to push you on to part B, and guess what, your premiums are going up. We can work this out.

This was a Republican-generated idea when it started, SCHIP, to include those 200 percent or below of children in poverty, and I will tell you that there's not one thing that helps those kids under 200 percent of poverty, and you will get more of illegal immigrants at the expense of seniors. This is a bad bill.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The time has expired. Would the gentleman please refrain from talking on.

The gentleman from California.

Mr. STARK. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Washington (Mr. MCDERMOTT), a member of the Ways and Means Committee. Pending that, I would like to point out that he understands that in 1997 the Republican bill had five times greater reduction in Medicare spending than this bill does today, which 83 Members of the Republican party who are still in Congress voted for at that time.

(Mr. MCDERMOTT asked and was given permission to revise and extend his remarks.)

Mr. MCDERMOTT. Mr. Speaker, the debate comes down to this: Do you favor big tobacco or children? Do you favor big tobacco and insurance company profits or seniors? We come down on the side of children and seniors, and that's what this bill is all about.

You've heard over and over and over again there is no change of eligibility, but you insist on saying the same untruth because you want to make a point in the press. That is wrong. There are not any illegal aliens going to get in here. What we took out was what you put in. The fact is that we took out your requirement that people bring in papers when their kid is sick and dying, and you're saying to a parent, now you've got to prove you're a citizen before we'll take care of your kid.

That's what you're doing. You've taken your clothes off in public. You don't want to take care of children.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. All Members are reminded to please address their remarks to the Chair.

The gentleman from Texas.

Mr. BARTON of Texas. Mr. Speaker, I'd like to point out CBO scores this as $1.9 billion. So somebody is not telling the truth on the floor.

I yield 1 minute to a distinguished member of the committee, Mr. BURGESS of Texas.

Mr. BURGESS. Mr. Speaker, I thank the chairman. One minute is scarcely enough time to discuss what we need to discuss today. So I would, just like the chairman of the full committee, put my entire statement into the RECORD.

Mr. Speaker, I want to confine my comments today to issues that surround issues for physician reimbursement. I had two amendments last night in Rules Committee that were not made in order that would have vastly improved physician reimbursement. Instead, we have language in the Democratic underlying bill that provides a small uptick for the next 2 years, then you fall off the cliff, and then you're frozen for the next 10 years. Hardly measures that will encourage people to go into the practice of medicine in the future.

I also want to reference section 651, the whole hospital exemption. Mr. Speaker, I would just point out that in the Rules Committee it was made in order that several hospitals would actually be grandfathered out or carved out of that exemption, and most of these hospitals lie in Democratic districts. I have a letter from 75 constituents, physicians back in my home State of Texas, who strongly object to the whole hospital exemption in this bill, and I will submit that for the RECORD as well.

The Democratic party is prepared to take its first step toward cradle to grave government involvement in the lives of all Americans. The 40-plus page SCHIP bill that was unveiled to this committee in the wee hours of last Wednesday represents legislative malpractice. We shouldn't be surprised because we've been here before. A handful of Democratic staff, working behind closed doors, without any input from the real world have produced just what we should expect: a bloated and complicated proposal that grows the size of government, diminishes state fiscal accountability and an individual's personal responsibility, and likely erodes the independent practice of medicine.

I doubt anybody in this body, Republican or Democrat, really understands what is in this proposal. We've not had one legislative hearing on this bill and haven't even taken this bill through regular order in the Energy and Commerce Committee. As a member of the Health Subcommittee of that panel, I'm disappointed in that fact because the subcommittee has shown an ability to come together and work out partisan differences. I haven't spoken with Chairman PALLONE, but I imagine he shares that sentiment to some degree.

Just recently, Republicans and Democrats came together to report out a bill that improves drug safety and FDA review of new drugs and devices. We worked through our differences and produced superior legislation. But all that bipartisan comity has been thrown out the window. Any rationalization of how we can vote on this bill and report to our constituents that we conducted an in-depth review of this legislation would be farcical at best, especially when we have learned that the Rules Committee plans to report out a completely different measure in the dark and early hours this coming Wednesday.

Kids need a safety net, but the safety net shouldn't apply to those that can and should help themselves. Taking money from taxpayers to give it to families that have the resources to purchase health insurance for their children is irresponsible. And if affordable options don't exist for these families, well forget it, because this bill doesn't lift a finger to reform an insurance market burdened by regulation and lack of choice.

On immigration, this bill all but ensures that states like mine and other border states will be saddled with more cost as it rewards those that illegally enter our country. The debate on illegal immigration is often ruled by emotion but the provisions in this bill relating to immigrant health care are equally suited—this bill makes little to no effort to understand this dynamic and only serves to pour gasoline on an inferno.

On Medicare, this bill misses the mark widely. This bill would make a bad investment in an attempt to fix Medicare physician payment and in doing so, members will find themselves in the position of spending billions more in the future to fix the problem again.

We shouldn't fool ourselves that this is realistic policy making. For those members about to head home and face their constituents at coffees, lunches, and town halls they should be wary of what Speaker PELOSI is force feeding this body.

BAYLOR MEDICAL CENTER AT FRISCO,
Frisco, TX, August 1, 2007.

Hon. MICHAEL C. BURGESS, MD,
U.S. Congressman,
Washington, DC.

DEAR CONGRESSMAN BURGESS: We are physicians that practice at Baylor Medical Center at Frisco. Today, we are writing to express our deep concern about the language in the S–CHIP bill (CHAMP Act) once again attempting to prohibit physicians from owning or investing in any hospital. While this legislation contains many important and generous provisions, such as the reauthorization of SCHIP and the SGR fix, Section 651 virtually eliminates physician owned hospitals for no reason other than the enmity of certain competitors.

Much has been written about the negative effect this ownership has had on our community hospitals where we also practice. Many of the large hospital systems claim they are being harmed by physician-owned specialty hospitals in their communities. Yet none of them has provided any factual data to support their claim that they are unable to provide ''essential services'' as a result of specialty hospitals. In fact each of the last 6 years the American Hospital Association has reported a 6% increase in profits in their member hospitals. And many of their arguments (e.g. ''specialty hospitals typically do not provide emergency care'') simply is not accurate.

The benefits of the physician ownership model are so convincing that a growing number of not-for-profit healthcare systems, including some of the largest members of the American Hospital Association, have embraced the concept of physician ownership.

MedPAC, CMS, and GAO have all studied this issue. Not one of them has concluded that physician owned hospitals represent a threat to the community hospitals where they exist. To the contrary, some have concluded that the overall increase in quality of care greatly benefits the communities in which they exist.

We believe that a major part of our success is due to the fact that individual physicians are partners in the ownership in the facility. As any business owner, we take pride in our facility and have worked hard to make sure the quality of medical care remains high. And frankly, we are much more aware of the costs and how to better deliver care more cost effectively. Through disclosure policies our patients are aware of the physician ownership and our surveys reveal very high patient satisfaction.

The best way to manage health care costs is to encourage physicians to become involved in the development of new models for the delivery of surgical and other health services. Maintaining the status quo by giving acute care hospitals protection from market forces will only lead to higher health care costs for us all.

When voting, please consider carefully the decision you will be asked to make regarding physician ownership, it will not only affect your constituents' rights as a patient to have the most convenient cost effective care, it will affect the delivery of health care for generations to come.

Sincere regards,

Benton Ellis, MD; James Gill, MD; David Layden, MD; James Montgomery, MD; Mark Allen, MD; Dawn Bankston, MD; F. Alan Barber, MD; Richard Bowman, MD; Dale Burleson, MD; Cameron Carmody, MD; John Schweers, MD; William Cobb, MD; Stephen Courtney, MD; A. Joe Cribbins, MD; Bruce Douthit, MD; Dennis Eisenberg, MD; Berry Fleming, MD; Richard Guyer, MD; Lloyd Haggard, MD; Stephen Hamn, MD; Andrea Ku, MD; Briant Herzog, MD; Stephen Hochschuler, MD; James Hudguns, MD; Fawzia Jaffee, MD; Warrett Kennard, MD; Adam Kouyoumjian, DO; Jimmy Laferney, MD; Stephen Lieman, MD; Samuel Lifshitz, MD; Earl Lund, MD; Gary Mashigian, DPM; Mark McQuaid, MD; William Mitchell, MD; Dr. Keith Matheny; William Montgomery, MD; John Moore, MD; Mickey Morgan, MD; William Mulchin, MD; John Peloza, MD; Ralph Rashbaum, MD; Jon Ricks, MD; Alfred Rodriguez, MD; Vince Rogenes, MD; David Rogers, MD; Ivan Rovner, MD; Michael Schwartz, MD; James Smrekar, MD; Robert Taylor, DPM; Ewen Tseng, MD; Gary Webb, MD; Stanley Whisenant, MD; Michael Wierschem, MD; Kathryn White, MD; Kathryn Wood, MD; Iddriss Yusufali, MD; Roger Skiles, MD; Scott Fitzgerald, MD; Leonard Bays, MD; Donald Mackenzie, MD; Lloyd Haggard, MD; David Holder, MD; Joe Hughes, MD; David Perkins; Robert Purnell, MD; Eddie Pybatt, MD; Elaine Allen, MD; Steven Michelsen, DO.

AMENDMENT TO H.R. 3162

This amendment would modify Title III of H.R. 3162 that addresses Medicare physician reimbursement. While H.R. 3162 provides temporary relief to address scheduled Medicare physician payment cuts, it does nothing to address the problem in the long-term, and would in fact exacerbate the problem in the long-term. The amendment does the following:

1. Reset to 2007 the base year for application of the Sustainable Growth Rate (SGR), and eliminates the Sustainable Growth Rate in 2010. The practical effect of this on Medicare physician payment would provide physicians with over a 1 percentage increase in 2008 and

2009, and stable and sustainable growth rate in payment from 2010 and into the future.

2. Makes available incentive payments for increased quality reporting and implementation of health information technology.

3. Provides annual reports to physicians on billing patterns under Medicare.

4. Provides an annual report to Medicare beneficiaries on annual Medicare expenditures.

5. Mandates a study on whether quality reporting requirements on health care disparities.

AMENDMENT TO H.R. 3162, AS REPORTED [BY THE COMMITTEE ON WAYS AND MEANS] OFFERED BY MR. BURGESS OF TEXAS

(CHAMP amendment)

Strike sections 301, 302, 303, 304, and 307, and insert the following sections (and redesignate sections 305 and 306 accordingly):

SEC. 301. RESETTING TO 2007 THE BASE YEAR FOR APPLICATION OF SUSTAINABLE GROWTH RATE FORMULA; ELIMINATION OF SUSTAINABLE GROWTH RATE FORMULA IN 2010.

(a) IN GENERAL.—Section 1848(d)(4) of the Social Security Act (42 U.S.C. 1395w–4(d)(4)) is amended—

(1) in paragraph (4)—

(A) in subparagraph (B), by striking ''subparagraph (D)'' and inserting ''subparagraphs (D) and (G)''; and

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

''(G) REBASING TO 2007 FOR UPDATE ADJUSTMENTS BEGINNING WITH 2008.—In determining the update adjustment factor under subparagraph (B) for 2008 and 2009—

''(i) the allowed expenditures for 2007 shall be equal to the amount of the actual expenditures for physicians' services during 2007;

''(ii) subparagraph (B)(ii) shall not apply to 2008; and

''(iii) the reference in subparagraph (B)(ii)(I) to 'April 1, 1996' shall be treated, beginning with 2009, as a reference to 'January 1, 2007'.''; and

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

''(8) UPDATING BEGINNING WITH 2010.—The update to the single conversion factor for each year beginning with 2010 shall be the percentage increase in the MEI (as defined in section 1842(i)(3)) for that year.''.

(b) CONFORMING SUNSET.—Section 1848(f)(1)(B) of such Act is amended by inserting ''(ending with 2008)'' after ''each succeeding year''.

SEC. 302. QUALITY INCENTIVES.

(a) EXTENSION OF CURRENT QUALITY REPORTING SYSTEM AND TRANSITIONAL BONUS INCENTIVE PAYMENTS FOR 2008 AND 2009.—

(1) EXTENSION OF QUALITY REPORTING SYSTEM THROUGH 2009.—Section 1848(k) of the Social Security Act (42 U.S.C. 1395w(k)) is amended—

(A) in the heading of paragraph (2)(B), by inserting ''AND 2009'' after ''2008''; and

(B) in paragraphs (2)(B) and (4), by inserting ''and 2009'' after ''2008'' each place it appears.

(2) EXTENSION OF AND INCREASE IN BONUS PAYMENTS FOR 2008 AND 2009.—Section 101(c) of the Medicare Improvement and Extension Act of 2006 (division B of Public Law 109–432) is amended—

(A) in the heading, by inserting '', 2008, AND 2009'' after ''2007'';

(B) in paragraph (1), by inserting ''(or 3 percent in the case of reporting periods beginning after December 31, 2007)'' after ''1.5 percent'';

(C) in paragraph (4), by striking ''single consolidated payment.'' and inserting ''single consolidated payment for each reporting period. Such payment shall be made for a reporting period within 30 days after the date that required information has been submitted with respect to claims for such period.''; and

(D) in paragraph (6)(C), by striking ''the period beginning on July 1, 2007, and ending on December 31, 2007'' and inserting ''each of the five consecutive 6-month periods beginning on July 1, 2007, and ending on December 31, 2009''.

(b) ESTABLISHMENT OF NEW QUALITY INCENTIVE SYSTEM EFFECTIVE IN 2010.—

(1) IN GENERAL.—Section 1848 of the Social Security Act (42 U.S.C. 1395w) is amended by striking subsection (k) and inserting the following:

''(k) PHYSICIAN QUALITY INCENTIVE SYSTEM.—

''(1) IN GENERAL.—The Secretary shall establish a reporting system (in this subsection referred to as the 'Physician Quality Incentive System' or 'System') for quality measures relating to physicians' services that focuses on disease-specific high cost conditions. Not later than January 1, 2010, the Secretary shall—

''(A) identify the 10 health conditions that have the highest proportion of spending under this part, due in part to a gap in patient care, and for which reporting measures are feasible; and

''(B) adopt reporting measures on these conditions, based on measures developed by the Physician Consortium of the American Medical Association.

''(2) ADD-ON PAYMENT.—

''(A) IN GENERAL.—The Secretary shall provide, in a form and manner specified by the Secretary, for a bonus or other add-on payment for physicians that submit information required on the conditions identified under paragraph (1).

''(B) AMOUNT.—Such a bonus or add-on payment shall be equal to 1.0 percent of the payment amount otherwise computed under this section.

''(C) TIMELY PAYMENTS.—Such a payment shall be made, with respect to information submitted for a month, by not later than 30 days after the date the information is submitted for such month.

''(D) DEDUCTIBLE AND COINSURANCE NOT APPLICABLE.—Such payment shall not be subject to the deductible or coinsurance otherwise applicable to physicians' services under this part.

''(E) USE OF REGISTRY.—In carrying out subparagraph (A), the Secretary shall allow the submission of the required information through an appropriate medical registry identified by the Secretary.

''(3) MONITORING.—The Secretary shall monitor and report to Congress on an annual basis physician participation in the Physician Quality Incentive System, administrative burden encountered by participants, barriers to participation, as well as savings accrued to the Medicare program due to quality care improvements based on measures established under the Physician Quality Incentive System.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to payment for physicians' services for services furnished in years beginning with 2010.

SEC. 303. HEALTH INFORMATION TECHNOLOGY (HIT) PAYMENT INCENTIVE.

Section 1848 of the Social Security Act is amended by adding at the end the following new subsection:

''(m) HEALTH INFORMATION TECHNOLOGY PAYMENT INCENTIVES.—

''(1) STANDARDS.—Not later than January 1, 2008, the Secretary shall create standards for the certification of health information technology used in the furnishing of physicians' services.

''(2) ADD-ON PAYMENT.—The Secretary shall provide for a bonus or other add-on payment for physicians that implement a health information technology system that is certified under paragraph (1). Such a bonus shall be equal to 3.0 percent of the payment amount otherwise computed under this section, except that—

''(A) in no case may total of such bonus and the bonus provided under subsection (k)(2) exceed 6 percent of such payment amount; and

''(B) such payments with respect to a physician shall only apply to physicians' services furnished during a period of 36 consecutive months beginning with the first day of the first month after the date of such certification.

The bonus payment under this paragraph shall not be subject to the deductible or coinsurance otherwise applicable to physicians' services under this part.''.

SEC. 304. INFORMATION FOR PHYSICIANS ON MEDICARE BILLINGS.

(a) IN GENERAL.—Section 1848 of the Social Security Act, as amended by section 201, is further amended by adding at the end the following new subsection:

''(n) ANNUAL REPORTING OF INFORMATION TO PHYSICIANS.—

''(1) IN GENERAL.—The Secretary shall annually report to each physician information on total billings by the physician (including laboratory tests and other items and services ordered by the physician) under this title. Such information shall be provided in a comparative format by code, weighting for practice size, number of Medicare patients treated, and relative number of Medicare beneficiaries in the geographical area.

''(2) CONFIDENTIALITY.—Information reported under paragraph (1) is confidential and shall not be disclosed to other than the physician to whom the information relates.''.

(b) EFFECTIVE DATE.—The Secretary of Health and Human Services shall first provide for reporting of information under the amendment made by subsection (a) for billings during 2007.

SEC. 305. INFORMATION FOR BENEFICIARIES ON MEDICARE EXPENDITURES.

(a) IN GENERAL.—Section 1804 of the Social Security Act is amended by adding at the end the following new subsection:

''(d) ANNUAL REPORT ON INDIVIDUAL RESOURCE UTILIZATION.—The Secretary shall provide for the reporting, on an annual basis, to each individual entitled to benefits under part A or enrolled under part B, on the amount of payments made to or on behalf of the individual under this title during the year involved. Such information shall be provided in a format that compares such amount with the average per capita expenditures in the region or area involved.''.

(b) EFFECTIVE DATE.—The Secretary of Health and Human Services shall first provide for reporting of information under the amendment made by subsection (a) for payments made during 2007.

SEC. 306. COLLECTION OF DATA ON MEDICARE SAVINGS FROM PHYSICIANS' SERVICES DIVERSION.

(a) IN GENERAL.—The Secretary of Health and Human Services shall collect data on annual savings in expenditures in the Medicare program due to physicians' services that resulted in hospital or in-patient diversion.

(b) REPORT.—The Secretary shall transmit to Congress annually a summary of the data collected under subsection (a).

SEC. 307. STUDY OF REPORTING REQUIREMENTS ON HEALTH CARE DISPARITIES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall provide for a study of health care disparities in high-risk health

condition areas and minority communities about the impact reporting requirements may have on physician penetration in such communities.

(b) REPORT.—The Secretary shall provide for the completion of the study by not later than January 1, 2011, and shall submit to Congress a report on the study upon its completion.

''(m) HEALTH INFORMATION TECHNOLOGY PAYMENT INCENTIVES.—

''(1) STANDARDS.—Not later than January 1, 2008, the Secretary shall create standards for the certification of health information technology used in the furnishing of physicians' services.

''(2) ADD-ON PAYMENT.—The Secretary shall provide for a bonus or other add-on payment for physicians that implement a health information technology system that is certified under paragraph (1). Such a bonus shall be equal to 3.0 percent of the payment amount otherwise computed under this section, except that—

''(A) in no case may total of such bonus and the bonus provided under subsection (k)(2) exceed 6 percent of such payment amount; and

''(B) such payments with respect to a physician shall only apply to physicians' services furnished during a period of 36 consecutive months beginning with the first day of the first month after the date of such certification.

The bonus payment under this paragraph shall not be subject to the deductible or coinsurance otherwise applicable to physicians' services under this part.''.

AMENDMENT TO H.R. 3162

This amendment would modify section 704 of H.R. 3162 that would require the Secretary of HHS to develop a plan to implement for never events. Never events, pursuant to H.R. 3162, are defined as an event involving the delivery of (or failure to deliver) physician services in which there is an error in medical care that is clearly identifiable, usually preventable, and serious in consequences to patients and that indicates a deficiency in the safety and process controls of the services furnished with respect to the physician, hospital, or ambulatory surgical center involved. This amendment would ensure that the identification of a never event is confidential in nature, as it applies to patient work product under Section 922 of the Public Health Service Act.

NEVER EVENTS

This amendment would ensure that the identification of never events as required by CHAMP does not lead to frivolous lawsuits against physicians.

While I may not agree with how ''never events'' are defined by this bill, I agree that physicians should be able to operate in an environment that supports improvement of processes and outcomes and not a punitive legal environment.

Under the bill, ''never events'' are defined as an event involving the delivery of (or failure to deliver) physician services in which there is an error in medical care that is clearly identifiable, usually preventable, and serious in consequences to patients and that indicates a deficiency in the safety and process controls of the services furnished with respect to the physician, hospital, or ambulatory surgical center involved.

This simple amendment ensures that identification of these ''never events'' would not be used in a legal proceeding and would be considered patient work product as they are under other areas of federal law.

AMENDMENT TO H.R. 3162, AS REPORTED [BY THE COMMITTEE ON WAYS AND MEANS]

OFFERED BY MR. BURGESS OF TEXAS

(CHAMP Amendment)

Amend section 704 (relating to never events plan) by redesignating subsection (d) as subsection (e) and inserting after subsection (c) the following:

(d) LIABILITY PROTECTION.—

(1) IN GENERAL.—Section 922 of the Public Health Service Act (42 U.S.C. 299b–22) (relating to liability and confidentiality protections) shall apply to never event information under this section in the same manner as it applies to patient work product under such section 922.

(2) NEVER EVENT INFORMATION DEFINED.—For purposes of this subsection the term ''never event information'' means information required to be provided by a hospital, ambulatory surgical center, or physician under the never events plan with respect to a determination to reduce or deny payment under title XVIII of the Social Security Act for services furnished by the hospital, ambulatory surgical center, or physician, respectively, on the basis of the finding of a never event.

AMENDMENT TO H.R. 3162

This amendment would prohibit the Secretary of Health and Human Services from approving future State waivers that would cover adults other than pregnant adults under the State Children's Health Insurance Program. This amendment would also terminate existing State waivers that cover adults other than pregnant adults under a State's Children's Health Insurance Program. SCHIP is designed to cover uninsured children, and taxpayer funds used to cover adults cannot achieve that goal. This amendment would save State and Federal Governments hundreds of millions of dollars that could be used to cover more uninsured children.

ADULTS

Since Congress enacted SCHIP in 1997, States have been successful in making affordable health insurance available to millions of low-income children.

Prior to the enactment of SCHIP, low-income families that made too much money to be eligible for Medicaid coverage found it difficult to find affordable coverage for their children. Several million children were left without health coverage for important preventative health services, forcing their families to seek care in emergency departments and lacking vital continuity of care.

With the Federal and State partnership that is the cornerstone of SCHIP, needy families were able to obtain health coverage for their children that was previously just out of reach.

Unfortunately some States have extended coverage to adults under their SCHIP program, taking limited dollars away from the needs of the children the program was intended to meet. One dollar a State spends on an adult is $1 not spent on a needy child. This amendment would eliminate this inequitable development that needs to be stopped dead in its tracks.

My bill would prohibit States from spending even a single SCHIP dollar on anyone but a child or a pregnant woman. Currently, 14 States extend SCHIP coverage to adults and four of those States cover more adults than children in their programs.

We can debate coverage of adults and affordable options and States can take this responsibility upon their shoulders as well. But we shouldn't spend a dollar dedicated to a child on an adult. It does a disservice to the very needy children we're trying to provide coverage to.

AMENDMENT TO H.R. 3162, AS REPORTED [BY THE COMMITTEE ON WAYS AND MEANS]

OFFERED BY MR. BURGESS OF TEXAS

(CHAMP amendment)

At the end of subtitle D of title I add the following new section:

SEC. _____. PROHIBITION OF SECTION 1115 WAIVERS FOR COVERAGE OF NONPREGNANT ADULTS UNDER SCHIP.

(a) IN GENERAL.—Section 2107(f) of the Social Security Act (42 U.S.C. 1397gg) is amended, as added by section 6102(a) of the Deficit Reduction Act of 2005 (Public law 109–171) is amended—

(1) in the first sentence, by striking ''childless''; and

(2) by striking the second sentence.

(b) CONFORMING AMENDMENTS.—Section 2105(c)(1) of the Social Security Act (42 U.S.C. 1397ee(c)(1)) is amended—

(1) in the first sentence, by striking ''childless''; and

(2) by striking the second sentence.

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

(d) TERMINATION OF FUNDING OF COVERAGE UNDER CURRENT WAIVERS.—In the case of any waiver, experimental, pilot, or demonstration project that would allow funds made available under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) to be used to provide child health assistance or other health benefits coverage to an adult (other than pregnant adult) that is approved as of the date of the enactment of this Act, on and after such date the Secretary of Health and Human Services shall not extend or renew such a waiver or project in a manner that permits funds under the waiver or project to be used for such purpose and shall otherwise take such action as is necessary to prevent the use of funds under the waiver or project to be used for such purpose on and after January 1, 2008.

AMENDMENT TO H.R. 3162

This amendment would require a State submitting a SCHIP waiver request to the Secretary of Health and Human Services to certify that children in that state have access to an adequate level of pediatricians, pediatric specialists and pediatric sub-specialists for targeted low-income children covered under the State's child health plan.

The State must include a survey conducted by the American Academy of Pediatrics, a state professional medical society, or other qualified organization and the Secretary may not approve a waiver application unless the survey is included in the State's submission.

ACCESS

This amendment would ensure that as states seek to expand their CHIP programs, that an adequate number of pediatricians, pediatric specialists and sub-specialists are available to meet increased demand by new patients.

To quote the American Academy of Pediatrics Workforce Committee, ''an appropriate pediatrician workforce is essential to attain the optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults. To fully realize such a workforce requires careful examination of the needs of children and the consequences of policies that influence the pediatrician workforce.''

This amendment would attempt to achieve this goal, by requiring adequate access to

these medical professionals as a condition approval of a waiver submission.

The amendment would require the American Academy of Pediatrics or other state medical society to survey and certify that the state's children have access to a sufficient number of pediatricians and specialists, should a state request a waiver from federal SCHIP requirements.

States have a variety of policy options to ensure that an adequate physician workforce is available in the state and this amendment would encourage those states to exercise those options.

The growth of the number of pediatricians per child has been positive over the past decade.

We should ensure that this momentum is sustained and this amendment will do just that.

I think this is an amendment that should have broad bipartisan support because its goal is ensuring access to needed medical professionals for our children.

More broadly, in the coming years this country will face a physician workforce shortage and this committee and this Congress needs to begin addressing this now.

I look forward to working with the members of this committee on this very broad and complicated issue, but this amendment would be a good first step.

AMENDMENT TO H.R. 3162, AS REPORTED [BY THE COMMITTEE ON WAYS AND MEANS]

Offered by Mr. Burgess of Texas

(CHAMP amendment)

Add at the end of subtitle E of title I the following new section:

SEC. _____. LIMITATION ON APPROVAL OF SCHIP WAIVERS.

The Secretary of Health and Human Services shall not approve any application submitted by a State for a waiver of any provision of title XXI of the Social Security Act unless—

(1) the State has certified that there is access to an adequate level of pediatricians, pediatric specialists and pediatric sub-specialists for targeted low-income children covered under the State child health plan under such title; and

(2) the State includes in such application the results of a survey, that may be conducted by the American Academy of Pediatrics, a State professional medical society, or other qualified organization, that establishes that such an adequate level exists on a per capita child basis.

Mr. DINGELL. Mr. Speaker, I yield to the distinguished gentleman from Virginia (Mr. MORAN) for purposes of a unanimous consent request.

Mr. MORAN of Virginia. Mr. Speaker, I ask unanimous consent to insert a statement for the RECORD refuting the fact that this has anything to do with undocumented children. The fact is that the current provision prohibits undocumented children from getting health care, but if we don't pass it, it will deny tens of thousands of children who are legally eligible.

Mr. BURGESS. I object.

The SPEAKER pro tempore. Objection is heard.

PARLIAMENTARY INQUIRY

Mr. BARTON of Texas. Mr. Speaker, parliamentary inquiry, where are we?

The SPEAKER pro tempore. Objection has been heard. The gentleman objected. It's for the gentleman from Michigan to yield time.

Mr. BARTON of Texas. So Mr. DINGELL controls the time?

The SPEAKER pro tempore. That's correct.

Mr. DINGELL. Mr. Speaker, I yield to the distinguished gentlewoman from California (Ms. ESHOO) 1 minute.

Ms. ESHOO. Mr. Speaker, I thank the distinguished chairman of the Energy and Commerce Committee.

Mr. Speaker, today is one of the most exciting days since I've come to the Congress, having been elected first in 1992. I think today is a day of history, a day of history for the children of our country, because the fact is that there are nearly 9 million American children without guaranteed access to health care in our Nation today. I think that is a national shame.

Today, we correct that. We build on a successful bipartisan program of Republican and Democratic Governors, of leaders in the Congress past, of a program that has worked.

It has not been riddled by fraud, and what we do today very simply is add 5 million American children in the rolls of health care. It is private insurance for almost all of the States.

We also strengthen Medicare. I would suggest that my friends on this side of the aisle are on the wrong side of history.

□ 1500

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the distinguished gentleman of the committee from the great State of Florida (Mr. STEARNS).

(Mr. STEARNS asked and was given permission to revise and extend his remarks.)

Mr. STEARNS. Mr. Speaker, I would say to the gentlelady from California who said this is a great day in history, it was a great day in history when, in 1997, the Republicans, who had the majority, initiated and started this program. The Democrats are saying this is a great day, what a great day, when the Republicans started the SCHIP program.

Now, this bill, you have heard it all before. Obviously, it creates a new entitlement, crowds out private insurance with government coverage, offers perverse incentives to States; and, my friends, it contains a huge tax increase, with more on the way. Lastly, it punishes Medicare beneficiaries. This is very troubling, particularly in Florida. We have so many seniors that actually use Medicare Advantage.

The fact that they are going to eliminate this program to pay for this is really outrageous. It will disproportionately harm racial minorities and rural senior citizens by taking funds away from Medicare Advantage, a successful, lower-cost option for health care for seniors and use it to enroll and federally insure adult men and women who have the ability to work and receive health care from their employers in the open market.

Mr. STARK. Mr. Speaker, I yield to the distinguished member of the Ways and Means Committee, a member of the Health Subcommittee, the gentleman from Georgia (Mr. LEWIS).

Pending that, I would explain that he knows that the NAACP, in a letter of endorsement, has said that this legislation fills a much-needed gap that currently exists in health care services for some of the most vulnerable citizens, low-income children, seniors and the disabled.

Mr. LEWIS of Georgia. Mr. Speaker, health care is a basic human right. It is unacceptable to see a young child die because his family could not afford for him to see a dentist. This should never, ever, happen in the United States of America. It is wrong. It must not be tolerated any longer, and today we said ''no more''.

This bill would give 6 million children access to health care. For our seniors who rely on Medicare, this bill helps our low-income seniors and makes prevention more affordable.

I applaud the work of Chairman RANGEL and Chairman STARK for making these important improvements. I am proud to have worked on this bill to help those who suffer from chronic kidney disease and end-stage renal disease receive the highest quality care and to take the first of many steps towards preventing these terrible diseases.

Until we can make health care right for every American, we have a moral mission, a mission and a mandate to start with the most vulnerable among us, our children and our seniors. We can do no less. Vote ''yes'' on the CHAMP Act. Do it now. Do it today.

Mr. BARTON of Texas. Mr. Speaker, could I inquire of the time remaining on each side on this part of the bill?

The SPEAKER pro tempore. The gentleman from Texas has 18 minutes remaining, and the gentleman from Michigan has 22½ minutes remaining.

The gentleman from California has 19 minutes remaining, and the gentleman from Louisiana has 30 minutes remaining.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to a distinguished member of the committee from the great State of Illinois (Mr. SHIMKUS), the winning pitcher on the congressional baseball team.

(Mr. SHIMKUS asked and was given permission to revise and extend his remarks.)

Mr. SHIMKUS. Mr. Speaker, under the current Illinois SCHIP program, it covers up to 200 percent of poverty, $41,300 in annual income for a family of four; 26,830, or 31 percent of all families with children under the age of 18, in my district are already eligible for either Medicaid or SCHIP.

In this bill, Democrats have opposed cutting at least $194 billion in Medicare spending. Specifically, the Democrats have proposed cutting Medicare spending for 6,070 seniors in my district who

are currently enrolled in Medicare Advantage. Payments for hospital inpatient care will be cut $2.7 billion; inpatient rehabilitation services, $6.6 billion; skilled nursing facilities, a $6.5 billion cut; certain drugs, $1.9 billion in cuts; home health care, $7.2 billion; end-stage renal disease cut by $3.6 billion; motorized wheelchair and oxygen cuts.

Mr. STARK. Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Texas (Mr. GENE GREEN).

(Mr. GENE GREEN of Texas asked and was given permission to revise and extend his remarks.)

Mr. GENE GREEN of Texas. Mr. Speaker, I rise in strong support of the Children's Health and Medicare Protection Act.

This is the best piece of legislation since 1997 when the children's health care was created, but this time we will cover 5 million more children if we vote ''yes'' today for this bill.

I want to particularly thank the committee, although we didn't get to have a markup in ours because the Republican minority refused to let us even have votes on our amendments, so we have to have it on the floor today. We have to have that discussion. I am just glad they included that it would cover 12 months of insurability for our children, because some States have made 6 months the way to cut children off of health care.

Let me say one other thing. I have heard, particularly last night, I think it was insulting to say that this bill takes money away from seniors to give to illegal alien children. You ought to be ashamed of yourself. That's just outrageous. When you look at the bill and actually current law that we don't change, it prohibits undocumented children from getting any assistance.

Now the States are going to be the ones that have to prove that. If the States can't do it, they have to pay for it. It is just outrageous that you throw out the ''illegals'' every time you don't have any other argument.

I am particularly proud of the SCHIP provisions in this legislation, which would provide much-needed health insurance coverage to low-income children in need.

Currently, the SCHIP program provides coverage to 6 million low-income American children.

Unfortunately, an additional 6 million children are eligible for SCHIP benefits, yet remain uninsured.

This legislation would reach about 5 million of those children by putting in place a more efficient funding formula based on projected enrollment and providing states with incentives to find eligible children and get them enrolled.

I am particularly thankful for the committee's support of our language to ensure that children in SCHIP get 12 months of continuous eligibility.

This provision is critical to ensuring that eligible SCHIP children remain in the program and are not dropped due to cumbersome bureaucratic requirements imposed on families whose primary focus is on making ends meet.

A recent Health Affairs article underscores the importance of continuous eligibility in addressing retention problems in SCHIP.

Of the policy options suggested, the authors state that ''[f]irst and foremost, the renewal process should be simplified as much as possible, by reducing the frequency of renewal to once a year.''

This bill does just that.

For many states, this bill reaffirms the compassionate and effective policies currently in place.

But for a state like mine, this bill will ensure that the State of Texas does right by Texas children and doesn't use the flexibility inherent in the program to kick them off the rolls on a budgetary whim.

I encourage my colleagues to stand up for low-income children and pass this important legislation.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. All Members are reminded to please address their remarks through the Chair.

Mr. BARTON of Texas. Mr. Speaker, the CBO baseline score shows that Medicare cuts total $157 billion over the 10-year period.

Mr. Speaker, I yield 1 minute to the gentleman from Staten Island, a member of the committee, Mr. FOSSELLA.

Mr. FOSSELLA. Mr. Speaker, Mr. Addison Good is an 80 year-old retired cook from Staten Island. He survives on a very limited income of Social Security and a small pension. Through every step of his hip operations, his Medicare Advantage plan paid for the services and drugs that he needed. He switched to a new plan that provides even better benefits at lower cost. He says he does not know how he would get the care he needs without his Medicare Advantage.

Let me say up front, we will consider Mr. Addison Good as we consider the legislation; and I support the SCHIP program, I support its reauthorization, I support expanding access to health care for low-income children.

I do not support this ill-conceived plan that pits parents against their grandchildren. Make no mistake, the bill cuts Medicare by more than $190 billion. In my district alone, it will reduce funds for Medicare Advantage by $58 million for the 38,000 enrollees in just the first year.

The real-world impact of slashing $58 million in Medicare in Staten Island, Brooklyn, for seniors enrolled in this program could result in the following: either denied access to the program altogether, to lose health care benefits like hearing, vision and dental services or have to pay more out of pocket. We should not gut Medicare or punish seniors to achieve a Democratic goal.

Mr. STARK. Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, we reserve the balance of our time.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to another member of the committee, Mr. SULLIVAN of Oklahoma.

Mr. SULLIVAN. Mr. Speaker, it's really astounding that there is nothing in this bill that stops States from covering illegal immigrations in this bill. People have come up to me and said, you know, the Democrats, the people in the Senate wanted to allow illegal aliens to get free Social Security benefits. Now they want to give free health care, and that's wrong.

There is nothing in this bill that prevents adults, States from covering adults, giving them health care. There's nothing in this bill that prevents States from even covering the children of the Members of Congress in this bill.

I think this is a bill that should not happen. I rise today in strong opposition to it.

One of my problems is that it eliminates the 5-year waiting period for immigrants who deserve to be eligible for Medicare and SCHIP. Congress wisely created this waiting period, and eliminating this waiting period will exacerbate our current immigration problems and further endanger government health care programs. By repealing this current law, millions of citizens will be eligible for Medicaid and SCHIP immediately.

Had this bill been brought to the committee, the proper thing, I had an amendment that would have saved taxpayers $2.2 billion having this waiting period.

I urge my colleagues to vote ''no.''

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to another distinguished member of the Energy and Commerce Committee, the gentleman from California (Mr. RADANOVICH).

Mr. RADANOVICH. I thought I would use my time to talk about the Ag approps bill. Just kidding.

Mr. Speaker, we must ensure that all children who qualify for the SCHIP program are taken care of, but I have grave concerns about the SCHIP reauthorization bill, which doesn't target low-income kids but does increase mandatory spending by almost $130 billion over 10 years. This is not the way to provide coverage for anybody.

I am particularly concerned that the CHAMP bill defines children as up to the age of 25. I am not aware of any other Federal program that defines the term ''children'' this broadly, and I certainly don't think that my constituents could agree that governments should be using health care funds intended for low-income children to cover a 25-year-old.

This is not what SCHIP is supposed to be about. I don't believe that the creation of a new entitlement program costing hundreds of billions of dollars is in the best interests of our children. Are we going to encourage people and make it easier for them to take advantage of the private health care market, or are we going to have the government grabbing for control of all health care services?

This legislation certainly indicates where our majority is trying to go. These are not procedural differences but major philosophical differences.

Under this bill, Donald Trump's daughter, Ivanka, will be enrolled in the SCHIP program.

Mr. BARTON of Texas. Mr. Speaker, might I inquire as to the time?

The SPEAKER pro tempore. The gentleman from Texas has 14 minutes remaining, the gentleman from Michigan has 21½ minutes remaining, the gentleman from California has 19 minutes remaining, and the gentleman from Louisiana has 30 minutes remaining.

Mr. BARTON of Texas. Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, our problem is a simple one, and I say this with respect and affection to my colleague. Our Republican colleagues have chosen to allocate time with two committees on this side and one committee on that side. The end result is that there is one committee on the Republican side which is not using its time. In order to balance out the time use, Mr. STARK and I are reserving our time at this time.

Mr. BARTON of Texas. Mr. Speaker, the gentleman from Texas is in a quandary. I am not aware we were able to determine anything for the other side. I don't know why they are allocating their time.

Mr. Speaker, I reserve the balance of my time.

Mr. STARK. Mr. Speaker, it was just my intent to accommodate my friends in the minority who have been asking for all this extra time, but I guess if they have lost their speakers, they really don't need any.

Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. THOMPSON), a member of the Health Subcommittee of the Ways and Means Committee, who recognizes that the American Medical Association has, in their endorsement, has said that this legislation addresses two of the AMA's highest priorities, providing health insurance coverage for low-income coverage and protecting seniors' access to care by preventing drastic cuts in the Medicare funding for physician services.

Mr. THOMPSON of California. Mr. Speaker, keeping kids healthy today means that the government will inherit a healthier Medicare population tomorrow. Investing in our children is both common sense and it's cost-effective.

It was very difficult to watch the former majority allow the national debt to grow to record heights. Today, I am proud that the new Democratic leadership has said no to deficit spending.

The CHAMP Act is emblematic of that shift. It is completely paid for. The CHAMP Act guarantees that both eligible children and Medicare seniors can access qualify health care.

Make no mistake. Without this legislation, 5 million new kids won't be able to get health care, and millions more already in the program will see their benefits cut.

Without this legislation, physicians will take the biggest rate cut in the history of the Medicare program.

Without this legislation, Medicare benefits that are critical to rural communities will expire.

Today, with the passage of the CHAMP Act, Congress has taken an historic step. So be a champion for kids, be a champion for seniors and be a champion for common sense.

Vote ''aye'' on the CHAMP Act.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to the distinguished leader of the Republican Study Committee, Mr. HENSARLING of Texas.

□ 1515

Mr. HENSARLING. Mr. Speaker, today the Democrat majority in Congress will no doubt ram through a bill representing the single largest step in Washington-controlled, bureaucratized, rationed, socialized health care, and they will do this under the guise of insuring needy children who are already insured under Medicaid or are already insured under the SCHIP program, which we could reauthorize. And they do this by turning SCHIP into a new entitlement, threatening to bankrupt the very children they claim to be helping. They do this by cutting Medicare, hastening the bankruptcy of the Medicare trust fund. They do this by cutting Medicare Advantage plan, threatening the health care choices of millions of our seniors. They do this by increasing taxes on working Americans.

This is a threat to our children's fiscal health, it is a threat to our Nation's and children's physical health. It should be rejected.

Mr. BARTON of Texas. Mr. Speaker, I renew my unanimous consent for 1 additional hour of time equally divided between the majority and the minority.

Ms. DEGETTE. I object.

The SPEAKER pro tempore. Objection is heard.

Does the gentleman from Texas wish to yield time?

Mr. BARTON of Texas. Who objected, Mr. Speaker?

The gentleman has to be on his feet to object.

The SPEAKER pro tempore. The gentlewoman from Colorado has objected. She is on her feet.

Mr. BARTON of Texas. I reserve the balance of my time.

Mr. STARK. I reserve the balance of my time.

Mr. DINGELL. I reserve the balance of my time.

Mr. Speaker, it would appear at this time that many of the difficulties that confront us could be addressed by the appearance of our good friends on the minority side of the Ways and Means.

Mr. BARTON of Texas. Mr. Speaker, I move that the House do now adjourn.

The SPEAKER pro tempore. Pursuant to House Resolution 594, the previous question is ordered to final passage without such an intervening motion.

A motion to adjourn may not be entertained.

Mr. BARTON of Texas. Parliamentary inquiry. I thought a motion to adjourn was in order at any time.

The SPEAKER pro tempore. Pursuant to House Resolution 594, the previous question is ordered to final passage without intervening motion other than recommittal. As such, a motion to adjourn may not be entertained.

Mr. BARTON of Texas. Parliamentary inquiry. What is House Resolution 594? Is that the closed rule?

The SPEAKER pro tempore. The rule for consideration of this bill.

Mr. BARTON of Texas. Then I suggest the absence of a quorum, Mr. Speaker.

The SPEAKER pro tempore. That may not be entertained unless the Chair is putting the question, in accord with clause 7 of rule XX.

Mr. BARTON of Texas. Then I yield 1 minute to a member of the committee, Mr. TERRY of Nebraska.

Mr. TERRY. Mr. Speaker, first of all, I want to state that I believe that we should cover our low-income uninsured children, and I do believe we should make efforts to get them all in. If it was just that, we would be all in agreement. But that is not before us today. And I do believe that part of this attacks health insurance as we know it today.

Number one, they defund Medicare Advantage, which is where people can opt out of Medicare and actually go into a managed program by a health insurance company. So they defund that, attacking that.

Next is, for the first time, they are going to place a tax on health insurance policies, driving up the costs, so making it more unaffordable so more people drop out.

Then probably just as egregious as the other, an amendment that was denied, a Republican amendment, that says if there is a child that is eligible by the requirements but already insured can't drop that insurance or their insurer can't drop them, forcing them to go into the State-run free health insurance. That was denied.

So what we see here is a step-by-step process of making health insurance companies less effective and nationalizing health care.

Mr. BARTON of Texas. I reserve the balance of my time.

Mr. STARK. I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield to the distinguished gentlewoman from California (Ms. HARMAN) for purposes of a unanimous consent request.

(Ms. HARMAN asked and was given permission to revise and extend her remarks.)

Ms. HARMAN. Mr. Speaker, I rise in strong support of this bill and commend Chairman DINGELL for his enormous work.

Regardless of the business before the House, for the past two weeks, a drumbeat of dire predictions has been maintained on this floor about the so-called terrorism gap—the failure of Democrats to fix the Foreign Intelligence Surveillance Act, or FISA, to permit

our intelligence agencies to intercept foreign-to-foreign communications related to international terrorism. The argument is specious on its face. Democrats are just as committed as our colleagues on the other side of the aisle to preventing another terrorist attack on the United States.

As a member of the Gang of Eight from 2002–2006, I am very familiar with FISA and our Terrorist Surveillance Program. While I agree that some technical adjustments are appropriate, the core principle of FISA and the 4th Amendment—that individualized court warrants are required if the communications of a U.S. person are involved—must be preserved.

But my question is, in the context of the CHAMP Act now before us: where is the outrage for the 5 million American kids who have no health insurance and no prospect of getting it unless we pass this bill?

What is the real objective of Members who continue to clutter an essential debate on improving health outcomes for our neediest children with alarmist exchanges on the surveillance of potential terrorists? Perhaps it is to jam Democrats and score partisan points before the August recess instead of reaching out to the most vulnerable among us.

The CHAMP Act reaches out by providing insurance to 11 million children, covering mental health and dental benefits, and by allowing States to cover pregnant women and family planning.

It reauthorizes Title V abstinence education, but requires that it be medically and scientifically accurate, as well as proven effective. I expect every Member agrees that no Federal program should use taxpayer dollars to give inaccurate information to young people.

The CHAMP Act makes improvements to the Medicare program, too, providing our most vulnerable seniors with better coverage for cost-saving preventive care and by making it easier to apply for benefits.

Let me bring the issue close to home. The Venice Family Clinic, located in my congressional district, is the largest free clinic in the Nation. They know something about reaching out to the most vulnerable in our communities.

Clinic staff told me today about an 8-year-old boy and his younger brother. Both of them are on the waiting list for SCHIP because the program is maxed-out—and their working mother doesn't earn enough to buy health insurance.

This child suffers epileptic seizures every couple of weeks. He worries constantly about when the next one will occur, when and if he will be able to see a doctor or have access to medication that could help him. These are not things an 8-year-old in a country as rich as ours should be worrying about.

Expanding SCHIP will cover these children. It will change their lives, and the lives of 11 million other low income American kids.

FISA can, should and will be fixed—and we can fix health insurance for kids, too. Every child deserves the health insurance that my four children and one grandchild have. And I have two more grandchildren on the way. Hopefully, the CHAMP Act will be law before they are born early next year.

Mr. DINGELL. Mr. Speaker, I reserve the balance of my time.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to another distinguished member of the Energy and Commerce Committee, Mr. PITTS of Pennsylvania.

Mr. PITTS. Mr. Speaker, I would like to focus on one important failure of this legislation that I think the prolifers on the other side of the aisle would be interested in.

Since 2002, the present administration has granted the States the option of providing SCHIP coverage to the child before birth, the unborn child, prenatal care and other health services for the unborn child and the pregnant mother. Unfortunately, the bill offered today would override current regulation and extend coverage in the name of the pregnant woman only. My amendment to codify the words ''unborn child'' was disallowed, not made in order last night.

Protecting only the pregnant woman could lead to a greater number of abortions. It would make the woman eligible for all publicly-funded services, including State-funded elective abortions. In States with Medicaid expansion programs, this could increase the number of women eligible for free abortions, thus promoting more abortions of unborn children in the name of children's health. This bill's language essentially classifies the pregnant woman herself. It does not make sense.

Mr. BARTON of Texas. Mr. Speaker, I reserve the balance of my time.

Mr. STARK. Mr. Speaker, I ask unanimous consent that the time allotted to the minority members of the Ways and Means Committee be forfeited.

Mr. BARTON of Texas. I object to that.

The SPEAKER pro tempore. Objection is heard.

Mr. STARK. I reserve the balance of my time.

The SPEAKER pro tempore. The gentleman from Michigan? Does anybody wish to yield time?

Mr. DOGGETT. Mr. Speaker, could you give us a time report? How much time remains for each?

The SPEAKER pro tempore. The gentleman from Louisiana has 30 minutes; the gentleman from California has 17½ minutes; the gentleman from Texas has 11 minutes; the gentleman from Michigan has 21½ minutes.

Mr. DOGGETT. How much does the gentleman from Louisiana have?

The SPEAKER pro tempore. 30 minutes.

Mr. DOGGETT. None of it has been used.

PARLIAMENTARY INQUIRY

Mr. LINDER. Mr. Speaker, I have a parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state his inquiry.

Mr. LINDER. Would you tell us how much time they have combined, the two committees and our two committees combined, left?

The SPEAKER pro tempore. The gentleman from Michigan has 21½ minutes remaining; the gentleman from California has 17½ minutes remaining; the gentleman from Louisiana has 30 minutes remaining; and the gentleman from Texas has 11 minutes remaining.

Mr. BARTON of Texas. Mr. Speaker, I ask unanimous consent to proceed out of order and engage in a colloquy with Mr. STARK and Mr. DINGELL for purposes of trying to understand what is going on.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

Mr. STARK. I object.

The SPEAKER pro tempore. Objection is heard.

Mr. STARK. Mr. Speaker, I ask unanimous consent to insert in the RECORD a letter from the Catholic Health Association of the United States, which in part states that: We believe the most important pro-life thing that Congress can do right now is to ensure that the State Children's Health Insurance Program is reauthorized.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

Mr. BARTON of Texas. Reserving the right to object, Mr. Speaker, I will not object if the gentleman from California will explain to me why we are fighting over what was in a pre-agreed-upon time arrangement. We have got six or seven speakers from the Energy and Commerce Committee. We are simply trying to do it in a balanced way. The gentleman from California has 17 minutes; the gentleman from Michigan has, I believe, 21 minutes. We just wish that the time go down in a balanced way. I don't understand why that should be a problem.

The SPEAKER pro tempore. The gentleman from Texas will suspend.

The Chair will clarify. The gentleman from Michigan has 21½ minutes remaining; the gentleman from California has 17½ minutes remaining; the gentleman from Louisiana has 30 minutes remaining; and the gentleman from Texas has 11 minutes remaining.

Mr. BARTON of Texas. I yield to my friend from California to explain to me why they don't want to use some of their time right now.

Mr. STARK. I am happy to respond. You are a couple minutes ahead of us, and of course I am dying to hear what my colleagues on the Republican side of the Ways and Means have to say.

Mr. BARTON of Texas. Reclaiming my reservation, my understanding was that the Energy and Commerce Committee was going to go first, and then the Ways and Means Committee was going to go in the second hour. That is why Mr. MCCRERY is reserving his 30 minutes.

Mr. STARK. If the gentleman would yield.

Mr. BARTON of Texas. I would be happy to yield.

Mr. STARK. I think you have just touched on a misunderstanding. We had been led to believe that we would be rotating around among the various committees, and so that now we are kind of out of balance. Our understanding is that we would rotate back and forth between Energy and Commerce and Ways and Means for the full time. I apologize to the gentleman if we misled. Our concern was that we

would be out of balance in the time between the two committees.

The SPEAKER pro tempore. The Chair will clarify that the gentlemen from California and from Michigan have a combined total of 39 minutes remaining; the gentlemen from Louisiana and from Texas have a total of 41 minutes remaining.

Mr. BARTON of Texas. I withdraw my reservation on the gentleman's unanimous consent request.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

Mr. PRICE of Georgia. Reserving the right to object, Mr. Speaker, it is apparent that that was the letter that was requested to be inserted earlier, and the gentleman himself objected to it.

Mr. STARK. Mr. Speaker, I withdraw my unanimous consent request.

The SPEAKER pro tempore. The request is withdrawn.

Does the gentleman from Texas wish to yield time?

Mr. BARTON of Texas. Mr. Speaker, I yield 2 minutes to the gentleman from Arizona, a distinguished member of the committee, Mr. SHADEGG.

Mr. SHADEGG. I thank the gentleman for yielding, and I really wish this debate was about what my colleagues on the other side want to make it about. I wish this bill was a debate about the uninsured children of the near poor or the working poor. I wish it was a debate like we had 10 years ago about insuring children too well off to get Medicaid but not well enough to buy insurance. But that is not what it is about. It is about cutting Medicare to provide health care services to middle- and upper middle-income children and to provide health care services to adults.

And when you hear SCHIP, children, you don't expect that. When you think it is to go to the uninsured, you don't expect that.

The median income in America, listen carefully, is $45,000. This bill will extend SCHIP benefits to families earning $60,000 and up to $80,000. That means it does not provide money for health insurance to the poor or the near poor or the working poor. We are all for that. That is why we initiated the program. We just don't think it ought to go to upper middle-income Americans.

And let's see what the program has done. Sixty-one percent of the children who are in the SCHIP program today had private health insurance before the program was created. They dropped their private health insurance to take SCHIP. Is that what generous, compassionate Americans want to do for the poor? I don't think so. They dropped their private insurance to take SCHIP.

CBO says that the Democrats' billions of dollars larger program will produce one person dropping private insurance for every one person who gets SCHIP insurance. Speaker after speaker on the other side has said this will insure 5 million more children.

□ 1530

What they don't tell you is that 5 million children, according to SCHIP, will drop their private insurance. Obviously, what they want is to take people off of private insurance and put them on SCHIP. That's not what the American people understand when they understand that that is supposed to be a bill about the children of the working poor.

I urge my colleagues to oppose this bill. It's a fraud.

Mr. STARK. Mr. Speaker, I yield to the gentleman from Rhode Island (Mr. KENNEDY) for a unanimous consent request.

(Mr. KENNEDY asked and was given permission to revise and extend his remarks.)

Mr. KENNEDY. Mr. Speaker, I rise in support of this legislation that raises parity for mental health for Medicare enrollees from 50 percent to 80 percent and for SCHIP from 75 percent to 100 percent, an additional $3 billion in this bill for mental health care. That's why we ought to support it.

Mr. STARK. Mr. Speaker, I reserve the balance of my time.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to another distinguished member of the committee, the ranking member of the Veterans Affairs Committee, the gentleman from Indiana (Mr. BUYER).

Mr. BUYER. Mr. Speaker, I don't consider this a high-water mark for Congress in the 15 years I've been here. I don't consider it a high-water mark because I'm very disappointed in us, in how we have conducted ourselves with regard to our process, in how we have treated ourselves to each other, the lack of intolerance with regard to how we view each others' opinions. I don't think this is a high-water mark. A lot of this is taking place at the committee levels, and I have to reiterate my disappointment.

We can battle it out. The democratic process is never meant to be pretty and easy. It's a difficult process, but it's exactly what it was meant to do so we wouldn't have capricious actions, that we wouldn't have power centralized and imperialistic from the top down. And that's what kind of happened here, and I'm very bothered by it.

There is no ''time of the essence.'' Yes, this is a program that we came together in a bipartisan fashion and passed almost 10 years ago to care for children, poor and impoverished and to take care of them; and we've done that.

We can extend that existing program and work together in a bipartisan fashion, if that's what this was really about. But it's not.

Mr. BARTON of Texas. Mr. Speaker, in addition to myself, I only have one additional speaker that's currently on the floor. I would encourage my friend from Michigan, if he has any speakers, to use some of his time at this point in time.

The SPEAKER pro tempore. The gentleman from Michigan has 21½ minutes remaining. Does he wish to yield any time?

Mr. DINGELL. The gentleman from Michigan will continue to reserve.

Mr. STARK. I continue to reserve, Mr. Speaker.

Mr. BARTON of Texas. I reserve.

The SPEAKER pro tempore. The gentleman from Louisiana has 30 minutes remaining. The gentleman from Texas has 8 minutes remaining. So 38 minutes total on the minority side, 39 minutes total on the majority side.

Mr. DINGELL. Mr. Speaker, out of a surcease of good will for my Republican colleagues, at this time I yield 1 minute to the distinguished gentlewoman from Colorado (Ms. DEGETTE).

Ms. DEGETTE. Mr. Speaker, children who receive well-child care begin their lives healthy and ready to learn in school; and this care is cheaper and more humane than reliance on the emergency room.

Because of SCHIP, 6 million children of the working poor get the care they need for a healthy start to their lives. Despite the success, our work is not complete. Six million uninsured children are still eligible for SCHIP but not currently enrolled. The CHAMP Act will build on the strong bipartisan foundation of SCHIP and insure these remaining children.

Those on the other side of the aisle will put forth a proposal in the motion to recommit that not only fails to cover these 6 million remaining children, but it will result in current beneficiaries losing coverage.

We are halfway to covering the uninsured children in this country, and the Republicans want to pack up and go home. Thank goodness they weren't in charge of the mission to the moon. Neil Armstrong would have gone halfway to the moon and been ordered back to earth. Mission accomplished.

Mr. Speaker, halfway is not mission accomplished. Vote ''yes'' for kids, vote ''yes'' on this bill.

Mr. BARTON of Texas. Mr. Speaker, I yield 1 minute to a distinguished member of the committee, Mr. WALDEN of the great State of Oregon.

Mr. WALDEN of Oregon. Mr. Speaker, I agree that the SCHIP program is a good program, as it was created in a bipartisan manner many years ago. Its extension would be a good thing. But what we have before us today on the floor is not, because it robs from senior citizens in my district and elsewhere to provide extraordinary and expanded coverage of health care to people who may already have it, as well as much higher income levels. Eighty to one hundred thousand dollars you could be making, your kids could be eligible for your current health insurance from your employer, and this program, as proposed by the Democrats, would actually take those off, or potentially could take those kids off, as well as take away the Medicare choice that seniors in my district, some 31,798 seniors in my district run the potential of losing the choice they have for Medicare.

I was at a town meeting in the eastern part of my district about 2 weeks ago; and a woman said, please, Congressman, don't let them take away my Medicare. And that's what's happening today. And it's unfortunate the process has been so usurped that we didn't have time other than 1 minute to talk about it.

The SPEAKER pro tempore. The gentleman from Michigan has 20½ minutes remaining. The gentleman from California has 17½ minutes remaining, for a total of 38 minutes. The gentleman from Louisiana has a total of 30 minutes remaining. The gentleman from Texas has 7 minutes remaining.

Mr. DINGELL. Mr. Speaker, I would yield 1 minute at this time to the distinguished gentlewoman from California, my dear friend, Mrs. CAPPS.

Mrs. CAPPS. Mr. Speaker, this bill is the reason I came to Congress, to continue my work for children's health. It's a blight on our Nation that millions of children in hardworking families still have no access to health care, and today we can undo that wrong. Through this fiscally responsible bill we ensure that millions more eligible children will be able to get primary care, manage life-threatening illnesses, improve their school attendance and grow into healthy, productive adults. And how fitting that at the same time we will improve Medicare for seniors.

I wish to submit for the RECORD the piece by Ron Brownstein in today's L.A. Times where he calls the Bush and Republican arguments against this bill as not much more than stealing health care from babies.

We do have a choice today. We can continue to ignore the health of millions of babies and children, or we can take the high moral ground and pass this bill which will provide health care to those who need it most.

I want to commend Chairmen DINGELL, PALLONE, RANGEL, AND STARK for all the hard work they and the committee staff have done. I urge my colleagues to vote ''yes'' on the CHAMP Act. Do something positive today for America's children.

[From the Los Angeles Times, Aug. 1, 2007]

STEALING HEALTHCARE FROM BABIES

(By Ronald Brownstein)

Does President Bush really believe what he's saying about the effort from congressional Democrats and some leading Senate Republicans to provide health coverage for millions of uninsured children? He's portraying it as the first step on a slippery slope toward ''government-run healthcare,'' as if senior senators in both parties were conspiring with Michael Moore to import Cuban doctors to inoculate and indoctrinate American children.

In fact, Congress is moving responsibly to remove a blot on the nation: the 8 million children without health insurance. It is doing so by expanding the State Children's Health Insurance Program, or SCHIP, a state-federal partnership that the Republican Congress and President Clinton created in 1997 to cover kids in working-poor families. Final votes on the House and Senate floors could come this week.

Bush, seemingly determined to provoke every possible confrontation with congressional Democrats, has pledged to veto the bills. And with the GOP congressional leadership, he is fighting the proposals with a swarm of misleading and hypocritical arguments.

Bush complains that expanding the program costs too much. But cost was no object when Bush and congressional Republicans sought to court seniors by creating the Medicare prescription drug benefit in 2003.

Under the bipartisan Senate bill, Washington would spend about $56 billion over the next five years to cover almost half of the nation's uninsured children. Over the same period, the Medicare entitlement that Bush signed (after more than four-fifths of House and Senate Republicans voted for it) will cost nearly $330 billion. Is social spending affordable only when it benefits constituencies Republicans prize in elections?

Next, Bush complains that the SCHIP expansion would require ''a huge tax increase.'' Actually, both the House and Senate plans would raise taxes just on tobacco. And the sponsors are increasing taxes only because they have committed to the novel notion of paying for their program. When Bush and the Republican Congress created the expensive Medicare drug benefit, they did not provide any new revenue to fund it. They just billed the cost to the next generation through higher federal deficits. Now Bush is condemning Democrats for displaying more responsibility.

Bush also disparages the SCHIP expansion as an attempt ''to encourage people to transfer from the private sector to government healthcare plans.'' But studies have found that three-fourths of children covered under the current program receive their care through private insurance plans that contract with the states, notes Edwin Park of the liberal Center on Budget and Policy Priorities. In that way, the program is no different than Bush's prescription drug plan: The government pays for services delivered by private insurance companies.

Bush's argument that the SCHIP changes will unacceptably ''crowd out'' private insurance is misleading in another respect. It's true, as Bush charges, that if the program is expanded, some eligible families would shift their children into it from private coverage, hoping to save money or improve care. The Congressional Budget Office estimates that children making such a switch would account for about one-third of the 6 million kids expected to enroll in the expanded SCHIP program under the Senate plan, and hence one-third of the added cost.

But as CBO Director Peter Orszag notes, all efforts to expand coverage for the uninsured inevitably spill some benefits on those who already have insurance. And the Senate SCHIP plan, by limiting that spillover to one-third of its cost, is actually more efficient than most alternatives for expanding coverage.

Bush, for instance, wants to reduce the number of uninsured by providing new tax incentives for buying coverage. But the Lewin Group, an independent consulting firm, recently calculated that 80 percent of the benefits from Bush's plan would flow to people who already have insurance. Such numbers help explain why Orszag recently said that, dollar for dollar, expanding SCHIP ''is pretty much as efficient as you can possibly get'' to insure more kids.

Bush's most outrageous argument is that expanding SCHIP ''empower[s] bureaucrats.'' In reality, covering more children would empower parents like Sheila Miguel of Sun Valley, Calif.

Miguel used to spend hours in emergency rooms trying to obtain asthma medicine for her daughter, Chelsea, but since enrolling her in a SCHIP-funded program, Miguel can take her to reliably scheduled clinic visits.

Bush says he wants ''to put more power'' over healthcare ''in the hands of individuals.'' By freeing Miguel's family from the worry and drudgery of repeated emergency room visits, that's exactly what SCHIP does.

Few of the lower-income working families that rely on this program have the time to follow this week's legislative struggle, much less analyze how it serves the White House's apparent strategy of embroiling congressional Democrats in unrelenting conflicts with Bush that alienate swing voters. In that political skirmishing, these families have been reduced to collateral damage. They deserve something better from a president who once called himself a ''compassionate conservative.''

Mr. BARTON of Texas. I would like to yield 2 minutes to the distinguished Republican whip and a member of the committee who is on leave, Mr. BLUNT of Missouri.

Mr. BLUNT. Mr. Speaker, I'm thankful to the former chairman and the ranking member for yielding to me on this bill.

It seems to me that what we have here is a bill that has not benefited from the process of hearings. Most of our friends in the majority today, I assume, will vote for this bill. Most of our friends on our side are going to vote against this bill, and I believe that during the month of August the voters will have the hearings that we should have had in advance. I believe what we'll find out is this bill has needless problems in it in the name of expanding SCHIP.

My good friend, Ms. DEGETTE, mentioned the moon mission. It does seem to me that, in this bill now, the moon is the limit. The original bill said 200 percent of poverty, with some flexibility to the States. We're in favor of extending these guidelines.

The original proposal, as we understood it from the majority, was 400 percent of poverty. Families who made 80, $85,000 would get free health insurance for their children. I don't think that limit is there any more. I believe it's up to the States under this bill. If you made 1,000 times the poverty rate and your State wanted to insure you, they could do that and your initial payment from the Federal Government would be 95 cents on every dollar.

We're going to offer a recommital today that extends the current SCHIP program; that gives us the time to talk about it and ways that make it better; that reinstates the current law on immigrants, where, if you come to this country, you have to have a sponsor, and you can't participate in programs like this for the first 5 years. That's been one of the workable parts of our immigration policy.

We would propose we don't have self-verification, where people who are here illegally just can walk up and sign up and say I'm legally here.

We'll have a doctor fix. We'll do something about the therapy caps. And, in my district, 21,033 people who would lose their choice of Medicare don't lose their choice of Medicare. Restricting Medicare benefits to pay for children's health care is not the right thing.

Mr. STARK. I reserve the balance of my time.

Mr. BARTON of Texas. I'm going to try one more time here.

Mr. Speaker, I ask unanimous consent that there be 1 hour of additional time allotted on the pending legislation, equally divided between the majority and the minority, and, within that, equally divided between the Ways and Means Committee and the Energy and Commerce Committee.

Mr. STARK. Reserving the right to object.

The SPEAKER pro tempore. The gentleman reserves the right to object.

Mr. DINGELL. And I make a similar reservation.

Mr. STARK. If I could inquire of the distinguished gentleman from Texas, it's my understanding that this unanimous consent request has been negotiated between the majority and minority leadership.

Mr. BARTON of Texas. We share the same understanding.

Mr. STARK. And as part of it that we would proceed expeditiously to use the debate, move to passage, and without intervening stalling motions.

Mr. BARTON of Texas. We have the same understanding.

Mr. STARK. Then I withdraw my reservation.

Mr. DINGELL. I have no objection.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas?

There was no objection.

Mr. BARTON of Texas. Hallelujah.

Mr. Speaker, at this point in time, I reserve my time.

Mr. STARK. Mr. Speaker, with this new-found wealth of time, I'm happy to yield 1 minute to the senior member of the Health Ways and Means Subcommittee, the gentleman from Texas (Mr. DOGGETT), who understands that the Lance Armstrong Foundation has urged a vote in favor of 3162, a legislation scored as a key vote for people affected by cancer; and Mr. Armstrong is a constituent of Mr. DOGGETT.

Mr. DOGGETT. Surely if Lance Armstrong can overcome mountains in France, we can overcome the mountains of obstructionism and of excuses to provide our children and our seniors the health coverage that they need.

By including significant portions of two Medicare bills that I filed, today's legislation supports grandparents as well as grandchildren. All seniors would get preventive care, and many of the 3.3 million poor seniors not receiving any help today would get the extra help for which they qualify.

Today, those seniors most in need are often least aware that help exists. We must identify and notify those entitled to extra help with prescription drugs and simplify the application process.

We also ensure that drug coverage is not lost by our seniors who saved a small nest egg or receive help and groceries from their children—behavior that we ought to encourage, not punish.

□ 1545

Importantly, we mandate that patients suffering from cancer, AIDS, and mental illness receive access to life-saving medications. Without this protection, vulnerable patients are held hostage by "cost cutting decisions" by private insurance companies.

While Lance inspires us to live strong, we can "vote strong" and improve the lives of children, seniors, and Americans fighting to get well again. Approve this important legislation.

Mr. BARTON of Texas. Mr. Speaker, could I inquire as to how much time there is remaining?

The SPEAKER pro tempore. The gentleman from Michigan has 34½ minutes remaining; the gentleman from California has 31½ minutes remaining; the gentleman from Texas has 20 minutes remaining; and the gentleman from Louisiana has 45 minutes remaining.

Mr. BARTON of Texas. Mr. Speaker, I yield 2½ minutes to a distinguished member from the great State of Georgia, Dr. GINGREY.

Mr. GINGREY. Mr. Speaker, I thank the gentleman for yielding.

Mr. Speaker, I want to talk about policy and process.

This is a situation where in the process the voices on both sides of the aisle have literally been shut down by bringing forward one of the most important pieces of legislation, I think, that I have had to discuss in the 4½ years that I have been a Member of this Congress. To say to the 11 position Members, almost equally divided between the Democrats and the Republicans, that we don't want to hear your voice, we don't want to hear some amendments that you might want to proffer because you have spent maybe 30 years, in my case maybe 25 years, 250 years in the aggregate of these 11 physicians' practicing medicine, no one being able to bring meaningful amendments to this issue.

The other side has talked many times about the Republican former majority running up this massive debt and borrowing money from the Chinese. I am going to tell you something. This might be a time, Mr. Speaker, where the new majority should borrow this $75 billion massive expansion of the SCHIP program from the Chinese rather than getting the money off the backs of our Medicare recipients under Medicare Advantage, 8 million of whom choose that option, and many of those are the lowest income; and also encouraging 22 million people to become addicted to smoking so they could raise this revenue. The chairman says it is a modest increase in tax on a pack of cigarettes. Indeed, Mr. Speaker, it doubles the tax on a pack of cigarettes.

So we have a better idea. I am opposed to this bill in its present form, and I support the Republican motion to recommit, which is the Barton-Deal bill, which says, look, we will cover children that are slipping through the cracks. The CBO estimates, Mr. Speaker, that 600,000 children have fallen through the cracks. They are in that group 100 to 200 percent of the Federal poverty level. Under the Barton-Deal plan, we can cover them and we will do that. We don't need to increase the funding by $50 billion and start covering children who already have health insurance because their families make more than $100,000 a year.

Mr. DINGELL. Mr. Speaker, at this time, I yield 2 minutes to the distinguished gentleman from Maine (Mr. ALLEN).

Mr. ALLEN. Mr. Speaker, there are 11 million reasons to vote for this bill, and each is a child in a working-class family who will grow up healthier and stronger as a result of its passage.

Every dollar we invest in the SCHIP program saves money over time. The children we cover are far less likely to require more expensive health care later on, far more likely to be better achievers in school and much better prepared to become productive adults.

SCHIP today provides health care to 6 million children. This bill will cover an additional 5 million children who qualify for SCHIP but today lack coverage.

Maine has developed one of the best SCHIP programs in the Nation. This bill offers States the flexibility to tailor outreach efforts to their specific needs and capacities. Failure to pass this legislation would mean the loss of health coverage for millions of children. But every child should have access to quality, affordable health care.

I am proud of the comparative effectiveness research provision in this bill. It will reduce health care costs and improve quality for all Americans. It does that by providing doctors and their patients with valid evidence-based information on how different treatments for particular medical conditions compare to one another. This data can help doctors and their patients determine whether or not new or high-priced drugs, devices, and other medical treatments provide better clinical outcomes.

This is a critically important piece of legislation. It helps our kids. It preserves Medicare for our seniors. It makes sure our physicians and other providers are adequately reimbursed. I urge my colleagues to support this legislation.

Mr. BARTON of Texas. Mr. Speaker, I yield 1½ minutes to the gentleman from Georgia, Dr. PRICE.

(Mr. PRICE of Georgia asked and was given permission to revise and extend his remarks.)

Mr. PRICE of Georgia. Mr. Speaker, I appreciate the opportunity.

I have in my hand here a letter from the American Association for Homecare, Coalition for Pulmonary Fibrosis, the COPD Alert, the Council for Quality Respiratory Care, and the National Emphysema/COPD Association asking us not to vote for this bill that would enact cuts in their programs.

As a physician, I understand the negative consequences of greater governmental involvement in health care.

This bill will cut Medicare benefits. It will tax every single American with private health insurance.

Now, why would they do this? Why would they pass a bill like this? The answer, Mr. Speaker, is because they can. But their motives are laid bare. Their motives are laid today.

The true desire of those on the left is to gradually and enticingly move all Americans to Washington-controlled bureaucratic health care. Read the bill. Read the bill. It's right there.

It's not what we ought to be doing. It's not what Americans want. I urge my colleagues to oppose this bill.

Mr. STARK. Mr. Speaker, I would like to yield 1 minute to the distinguished gentleman from California, a member of the Ways and Means Committee (Mr. BECERRA). Pending that, I would point out that he is well aware that the National Hispanic Medical Association has endorsed the bill, and I would like to submit their endorsing letter into the RECORD.

NHMA, NATIONAL HISPANIC
MEDICAL ASSOCIATION,
Washington, DC, July 25, 2007.

Hon. JOHN DINGELL,
Chairman, House Committee on Energy and Commerce, House of Representatives, Washington, DC.

DEAR CHAIRMAN DINGELL: On behalf of the National Hispanic Medical Association (NHMA), a non-profit association representing 36,000 licensed Hispanic physicians in the United States, we write to express our strong support for the Children's Health and Medicare Protection Act, H.R. 3162, which will allow the State Children's Health Insurance Program (SCHIP), Medicare, and Medicaid to expand enrollment of Hispanic children and elderly. Since one in five Hispanic children are currently uninsured and only 10 percent of Hispanics eligible for Medicare are enrolled, these programs are vital to increasing access to health care.

The mission of NHMA is to improve the health of Hispanics and other underserved populations. We support the SCHIP section that allows states to cover legal immigrant children and legal immigrant pregnant women, covers dental care and mental health care, provides state performance bonuses if they can demonstrate that they have enrolled new children who are currently eligible, but not enrolled, and creates the Children's Access, Payment and Equity Commission, that will examine issues of health disparities. We support the Medicare section that calls for reducing health disparities through demonstrations for language services reimbursement and targeted outreach, new quality data relating to disparities, expands the Low Income Subsidy and Medicare Savings Programs, and mandates a report on Culturally and Linguistically Appropriate Standards use by providers. We do not support total elimination of Medicare Advantage with a Hispanic enrollment of 21 percent receiving comprehensive care management and with Puerto Rico covering dual eligibles. Finally, we support the Medicaid section that increases funds for transition to work, disabilities, family planning, adult day care and Puerto Rico.

In summary, the National Hispanic Medical Association supports the Children's Health and Medicare Protection Act, H.R. 3161, because it will increase access to health insurance for Hispanics and will, thus, improve the health of all Americans.

Sincerely,

ELENA RIOS, M.D., M.S.P.H.,
President and CEO.

Mr. BECERRA. Mr. Speaker, I thank the gentleman for yielding.

The CHAMP Act is a victory for children's health, it is a victory for seniors' health, and it is a victory for American taxpayers who expect us to be fiscally responsible.

Why shouldn't 11 million American children from working families in this country have the same access to health care that the children of every single Member of Congress has? The taxpayers pay our salary and they make it possible for us to get health care benefits. Why shouldn't 11 million American children who live with parents who are working day to day have the same access?

Like our victory this year in increasing the minimum wage for America's workers, expanding health care coverage to 5 million children is long overdue.

My colleagues on the Republican side of the aisle voted a few years ago to add a prescription drug benefit under Medicare that costs about eight times as much as the benefit we would offer to the 11 million children would cost. Why not do it for our kids?

We are doing this in a way that is fiscally responsible. The CHAMP Act will not add a single cent to the Federal deficit that the Bush administration has created.

This is sound policy. Let's vote for the CHAMP Act for our kids and our seniors.

Mr. BARTON of Texas. Mr. Speaker, I would like to yield 1 minute to the distinguished gentleman from the great State of Nebraska (Mr. FORTENBERRY).

Mr. FORTENBERRY. Mr. Speaker, everyone agrees that children deserve proper health care. The SCHIP program is an important program that provides health insurance for over 6.6 million of America's neediest children. I supported its renewal, but I believe it must be done responsibly.

This legislation overreaches. It cuts Medicare and also allows some adults to claim health care coverage meant for children. Good public policy should not pit the children against their grandparents.

This 465-page bill makes sweeping changes to American health care and tax policies. It needs thorough, thoughtful, and deliberate analysis, and time has not been provided for adequate examination. The SCHIP bill could have clear bipartisan support, I believe, but instead it contains a labyrinth of provisions, some of which hurts seniors. Mr. Speaker, I believe this Congress can do better.

Mr. DINGELL. Mr. Speaker, I yield at this time 1 minute to my very dear friend, the gentleman from New Jersey (Mr. ANDREWS).

(Mr. ANDREWS asked and was given permission to revise and extend his remarks.)

Mr. ANDREWS. Mr. Speaker, somewhere in America right now an 8-year-old girl comes home to her mother and father and says she has a numbness and ache in her right arm, and they worry about it, wondering whether it is just a strain from playing on the playground or whether she has a serious disease of her nervous system. But they can't send her to the pediatrician because they do not have enough money left in the family budget this week and they have no health insurance.

The question before the House is whether or not to provide health insurance for that family and that little girl. Yes or no?

The bill says ''yes.'' It pays for it responsibly by a modest increase in the cigarette tax and by eliminating subsidies to health insurance companies. You can say whatever you want, but the question comes down to that: yes or no? It is time we voted ''yes'' for that little girl and her family, voted ''yes'' on this bill.

Mr. BARTON of Texas. Mr. Speaker, I want to yield 1 minute to the Member of Congress with the largest number of Social Security recipients, the gentlewoman from the great State of Florida (Ms. GINNY BROWN-WAITE).

Ms. GINNY BROWN-WAITE of Florida. Mr. Speaker, I rise today on behalf of the 43,000 senior citizens living in my congressional district who will lose their Medicare benefits if the bill before us today becomes law.

Everyone in this Chamber wants to extend SCHIP because it has helped many children, but not at the expense of their grandparents. Let me repeat: 43,000 of my constituents, 693,000 Floridians, and 8.3 million seniors nationwide will be pushed off of Medicare plans in favor of other priorities.

Today we are seeing the biggest raid on the Medicare trust fund seniors have ever seen, with no regard to those who rely on Medicare Advantage for their only access in many rural areas to health care benefits.

Some of the specific cuts that are in this bill are a 43 percent cut to patients who rent lifesaving oxygen equipment, a $7.2 billion cut for home health services, a $6.5 billion cut for skilled nursing facilities.

Mr. Speaker, cutting the only health care program many of my constituents use would be unconscionable.

The SPEAKER pro tempore. The gentleman from Michigan has a total of 31½ minutes remaining, and the gentleman from California has 30 minutes remaining, for an aggregate total of 61½ minutes. The gentleman from Texas has 14 minutes, and the gentleman from Louisiana has 45 minutes, for an aggregate total of 59 minutes.

Mr. DINGELL. Mr. Speaker, I continue to reserve the balance of my time.

Mr. STARK. Mr. Speaker, I continue to reserve the balance of my time.

Mr. BARTON of Texas. Mr. Speaker, I respectfully reserve the balance of my time at this time.

□ 1600

Mr. DINGELL. Mr. Speaker, I note that Mr. MCCRERY has time remaining.

He is a very valuable Member of this body, and I'm sure he would make very good use of the time that's available to him, and I would suggest that the business of the House could be expedited by having Mr. MCCRERY proceed to yield time to members of the Ways and Means Committee on the minority side.

Mr. BARTON of Texas. Mr. Speaker, I just wish to make an observation that the tradition of normal procedure is to alternate between majority and minority. We just had a minority speaker. It should be the opportunity of the majority to tell their side of the story.

The SPEAKER pro tempore. The Chair notes that it was an alternation between two committees on one side and two committees on the other side of the House.

The gentleman from Michigan has 31½ minutes remaining, the gentleman from California has 30½ minutes remaining, for an aggregate of 61½ minutes.

The gentleman from Texas has 14 minutes remaining, the gentleman from Louisiana continues to have his full 45 minutes remaining, for an aggregate of 59 minutes.

Mr. DINGELL. Mr. Speaker, I would then yield, with the understanding that the Democrats want to give the choice of the doctor, while our good Republican friends want to give a choice of HMOs.

With that, I yield 2 minutes to the distinguished gentleman from New York (Mr. ENGEL).

Mr. ENGEL. I thank the gentleman.

Mr. Speaker, the reauthorization of State Children's Health Insurance is unquestionably one of the most important bills we will pass this year. This bill will protect six million kids currently covered by SCHIP and provide coverage for an additional five million children.

This bill provides aggressive outreach to enroll children by simplifying enrollment procedures and awarding States bonuses for finding more children. This is important since two-thirds of the uninsured children in our Nation are actually eligible but not enrolled in Medicaid or SCHIP.

What is the response of our Republican friends? Block the bill from coming up in our committee; create phony issues because they're against insuring children. Illegal amnesty? Give me a break. No hearings? We've had seven hearings on this bill. Eligible for private insurance? 93.5 percent of the children we cover in this bill would have no private insurance without this bill.

What is the President's response? Under the President's plan, this program would see its funding cut from last year; and, worse, the amount allocated for its reauthorization would be less than half of the amount required to maintain coverage for current beneficiaries.

He says he will veto this bill because it covers too many children. This is unconscionable. Sixty-one national advocacy groups devoted to improving children's health request that we fund the SCHIP program at 60 billion additional dollars. The President countered with $4.8 billion. Clearly, there is a disconnect.

We are proud that, despite budgetary constraints, we will be able to reauthorize our SCHIP program at $50 billion. I am proud that we will be covering 11 million low-income children under this reauthorization, and I know our Nation will be better off for it.

This is an amazing feat. Passing bills like this is why we should all feel honored to be Members of Congress. I'm sorry that my Republican friends just continue to say no. We say yes, yes to 11 million children, yes to saying that our children ought to be insured, yes to saying that America's children need our help. Pass this bill. It is good for all our children.

Mr. BARTON of Texas. Mr. Speaker, I wish to yield 2 minutes to the distinguished gentleman from Georgia (Mr. DEAL), ranking member of the Health Subcommittee.

Mr. DEAL of Georgia. I thank the gentleman for yielding.

Mr. Speaker, we've heard a lot of opinions today about the effects of this bill; and opinions are, of course, of different perspectives on the bill. But there is an agency that we all rely on, supposedly, to give us the facts, and that is the Congressional Budget Office.

Now, there has been an argument about whether or not this bill, in its reforms, will go back to a system that would allow illegal immigrants to be covered. Now, we can say that it doesn't, but CBO says that, by changing that provision back to the way it used to be, that over the next 5 years it will cost $800 million and over the next 10 years it will cost $1.9 billion.

Now, CBO is simply saying that if you make it easier for illegals to enter the program, that's the price tag. They wouldn't say that if they didn't have some basis for coming up with those numbers. They didn't just pull them out of the air.

The other part deals with legal immigrants. We have had a policy in this country that if someone wants to bring a family member, a friend, or sponsor somebody to come in and we give that person coming in legal status, that they are not eligible to participate in our social programs, such as Medicaid, for the first 5 years. Their sponsor signs an affidavit that they will be personally responsible for that.

This bill removes that waiting time. So when you bring someone in, they can immediately sign up for the Medicaid rolls. Now, CBO says that that will cost $900 million over the next 5 years and $2.2 billion over the next 10 years. Now, the truth of the matter is that this bill gives incentives to States to allow this to happen.

I urge a ''no'' vote.

CONFERENCE REPORT ON H.R. 2272, AMERICA COMPETES ACT

Mr. GORDON of Tennessee submitted the following conference report and statement on the bill (H.R. 2272) to invest in innovation through research and development, and to improve the competitiveness of the United States:

CONFERENCE REPORT (H. REPT. 110–289)

The committee of conference on the disagreeing votes of the two Houses on the amendment of the Senate to the bill (H.R. 2272), to invest in innovation through research and development, and to improve the competitiveness of the United States, having met, after full and free conference, have agreed to recommend and do recommend to their respective Houses as follows:

That the House recede from its disagreement to the amendment of the Senate and agree to the same with an amendment as follows:

In lieu of the matter proposed to be inserted by the Senate amendment, insert the following:

SECTION 1. SHORT TITLE.

This Act may be cited as the ''America COMPETES Act'' or the ''America Creating Opportunities to Meaningfully Promote Excellence in Technology, Education, and Science Act''.

SEC. 2. TABLE OF CONTENTS.

The table of contents of this Act is as follows: