

CRS Report for Congress

H.R. 3162: Provisions in the Children's Health and Medicare Protection Act of 2007

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H.R. 3162: Provisions in the Children's Health and Medicare Protection Act of 2007

Summary

On August 1, 2007, the House passed H.R. 3162, the Children's Health and Medicare Protection (CHAMP) Act of 2007. The bill would reauthorize and increase funding levels and state grant distributions for the State Children's Health Insurance Program (SCHIP) and make changes to the Medicare and Medicaid programs. The major SCHIP provisions would provide authorized program appropriations in perpetuity and would make changes to the Medicare and Medicaid programs. Other major SCHIP provisions would provide more options and incentives to states to increase the number of children covered by SCHIP and Medicaid, modify the citizenship verification process, and change minimum benefit requirements.

The bill's Medicare provisions would implement a 0.5% increase in Medicare physician fees for 2008 and 2009 while creating six categories of physician services for which annual updates would be considered separately, establish bonus payments for physicians practicing in counties with low Medicare per capita expenditures, require the Secretary to implement a resource use feedback program for physicians to identify efficient providers, expand a medical home demonstration project, and require the Centers for Medicare and Medicaid Services (CMS) to modify physician payment localities, beginning with California. Other Medicare provisions would reduce payments to Medicare Advantage plans, eliminate Medicare cost-sharing for certain preventive benefits, eliminate the market basket update for FY2008 for Medicare payments for skilled nursing facilities, home health agencies, and long-term care hospitals and reduce the annual update for certain hospitals. It would also establish a bundled payment system for Medicare renal dialysis services and would make a number of changes to the Low-Income Subsidy Program for Medicare Part D, including eliminating cost-sharing requirements for certain full benefit dual eligibles receiving Medicaid-covered long-term care services.

Medicaid provisions in the bill would make changes to rebate payments for certain drugs, prohibit the implementation of the new health opportunity account demonstration authorized under the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), and make other changes. Additional miscellaneous provisions would establish a Center for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality (AHRQ), — funded by public contributions from the Medicare Part A, B, and D trust fund accounts and fees imposed on private health insurance plans, require CMS to develop a plan for the implementation of health information technology under Medicare, and establish a national entity to coordinate development of health care measures.

The Congressional Budget Office (CBO) estimates that H.R. 3162 would result in a net increase of \$25.6 billion in Federal spending between 2008 and 2012. The Joint Committee on Taxation estimates a revenue offset of \$26.9 billion for the same period from increases in the excise tax rate on tobacco-related products, a modification to the definition of roll-your-own tobacco, with an extension of an exemption from fuel excise tax for use in ambulances. This report provides short descriptions of the major provisions contained in H.R. 3162.

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H.R. 3162: Provisions in the Children's Health and Medicare Protection Act of 2007

On July 27, 2007, the House Committee on Ways and Means ordered reported H.R. 3162, the Children's Health and Medicare Protection (CHAMP) Act of 2007. On the same day, the House Committee on Energy and Commerce adjourned without completing the markup. The Committee on Rules discharged the Committee on Energy and Commerce from further consideration of the bill, amended the legislative language, and ordered reported H.R. 3162 on August 1, 2007. The House passed the bill later that day. This report describes provisions in the bill as passed by the House.

The bill would reauthorize and increase funding levels and state grant distributions for the State Children's Health Insurance Program (SCHIP) and make changes to the Medicare and Medicaid programs. The major SCHIP provisions would provide authorized program appropriations in perpetuity and would make changes to the Medicare and Medicaid programs. Other major SCHIP provisions would provide more options and incentives to states to increase the number of children covered by SCHIP and Medicaid, modify the citizenship verification process, and change minimum benefit requirements.

The bill's Medicare provisions would address a number of issues. The bill would make many changes to Medicare physician payments, including implementing a 0.5% increase in Medicare physician fees for 2008 and 2009 while making substantive changes to the calculation of updates to the Medicare physician fee schedule in future years by creating six categories of physician services for which annual updates would be considered separately, establish bonus payments for physicians practicing in counties with low Medicare per capita expenditures, require the Secretary to implement a resource use feedback program for physicians to identify efficient providers, expand a medical home demonstration project, repeal the Physician Assistance and Quality Initiative fund, and require the Centers for Medicare and Medicaid Services (CMS) to modify physician payment localities, beginning with California.

Other Medicare provisions of the bill would reduce payments to Medicare Advantage plans, eliminate Medicare cost-sharing for certain preventive benefits, and repeal the Medicare trigger requirement. In addition, the bill would eliminate the market basket update for FY2008 for Medicare payments for skilled nursing facilities, home health agencies, and long-term care hospitals and reduce the annual update for certain hospitals. It would also establish a bundled payment system for Medicare renal dialysis services and would make a number of changes to the Low-Income Subsidy Program for Medicare Part D, including eliminating cost-sharing requirements for certain full benefit dual eligibles receiving Medicaid-covered long-term care services.

Regarding Medicaid, the bill would make changes to rebate payments for certain drugs, and prohibit the implementation of the new health opportunity account demonstration authorized under the Deficit Reduction Act of 2005 (DRA, P.L. 109-171), among other things.

Additional miscellaneous provisions would establish a Center for Comparative Effectiveness Research within the Agency for Healthcare Research and Quality (AHRQ), — funded by a combination of public contributions from the Medicare Part A, B, and D trust fund accounts and fees imposed on private health insurance plans, require CMS to develop a plan for the implementation of health information technology under Medicare, and establish a national entity to coordinate development of health care measures.

The Congressional Budget Office (CBO) estimates that H.R. 3162 would result in a net increase of \$25.6 billion in Federal spending between 2008 and 2012.¹ The Joint Committee on Taxation estimates a revenue offset of \$26.9 billion for the same period from increases in the excise tax rate on tobacco-related products, a modification to the definition of roll-your-own tobacco, with an extension of an exemption from fuel excise tax for use in ambulances.²

This report provides short descriptions of the major provisions contained in H.R. 3162.

A Brief Description of the Current Programs

H.R. 3162 would make changes to the SCHIP, Medicare, and Medicaid programs, briefly described below. More complete and detailed descriptions are available from CRS.³

SCHIP

SCHIP is authorized under Title XXI of the Social Security Act. In general, this program allows states to cover targeted low-income children with no health insurance in families with income that is above Medicaid eligibility levels. As of July 2006, the highest upper-income eligibility limit under SCHIP had reached 350% of the federal poverty level (FPL) in one state. States may enroll targeted low-income children in an SCHIP-financed expansion of Medicaid, create a new separate state SCHIP program, or devise a combination of both approaches. States choosing the Medicaid

¹ CBO, “Estimated Effect on Direct Spending and Revenues of H.R. 3162, the Children’s Health and Medicare Protection Act, for the Rules Committee,” August 1, 2007.

² The Joint Committee on Taxation estimate for H.R. 3162, as scheduled for consideration by the House on August 1, 2007. [<http://www.house.gov/jct/x-59-07.pdf>]

³ See, for example, CRS Report RL33712, *Medicare: A Primer*, by Jennifer O’Sullivan, April 30, 2007, CRS Report RL33202, *Medicaid: A Primer*, by Elicia J. Herz, January 24, 2007, and CRS Report RL30473, *State Children’s Health Insurance Program (SCHIP): A Brief Overview*, by Elicia J. Herz and Chris L. Peterson, January 30, 2007.

option must provide all mandatory benefits and all optional services covered under the state plan, and must follow the nominal Medicaid cost-sharing rules (with some exceptions). In general, separate state programs must follow certain coverage and benefit options outlined in SCHIP law. While some cost-sharing provisions vary by family income, the total annual aggregate cost-sharing (including premiums, copayments, and other similar charges) for a family may not exceed 5% of total income in a year. Preventive services are exempt from cost-sharing.

In the Balanced Budget Act of 1997, nearly \$40 billion was appropriated for SCHIP for FY1998 to FY2007. Appropriations for FY2007 equaled about \$5.7 billion.⁴ Annual allotments among the states are determined by a formula that is based on a combination of the number of low-income children and low-income uninsured children in the state, and includes a cost factor that represents the average health service industry wages in the state compared to the national average. Like Medicaid, SCHIP is a federal-state matching program. While the Medicaid federal medical assistance percentage (FMAP) ranged from 50% to 75.89% in FY2007, the enhanced SCHIP FMAP ranged from 65% to 83.12% across states.

All states, the District of Columbia, and five territories have SCHIP programs. As of November 2006, 17 use Medicaid expansions, 18 use separate state programs, and 21 use a combination approach. Approximately 6.7 million children were enrolled in SCHIP during FY2006. In addition, 12 states reported enrolling about 700,000 adults in SCHIP through program waivers.

Medicare

Medicare is the nation's health insurance program for persons aged 65 and over and certain disabled persons. In FY2008, the program will cover an estimated 44.6 million persons (37.3 million aged and 7.3 million disabled) at a total cost of \$456.3 billion. Federal costs (after deduction of beneficiary premiums and other offsetting receipts) will total \$389.7 billion. In FY2007, federal Medicare spending will represent approximately 13% of the total federal budget and 3% of GDP. Medicare is an entitlement program, which means that it is required to pay for all covered services provided to eligible persons, so long as specific criteria are met.

Medicare consists of four distinct parts: Part A (Hospital Insurance, or HI); Part B (Supplementary Medical Insurance, or SMI); Part C (Medicare Advantage, or MA); and Part D (the new prescription drug benefit added by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, or MMA). The program is administered by CMS.

⁴ In addition to the original appropriation level of \$5.04 billion this appropriation amount includes supplemental funding up to \$650 million. In some years, there were unspent prior year funds that were available for a state's use. As a result, relying on appropriation amounts alone may not accurately reflect total funds available in any given year.

Medicaid

Medicaid is a means-tested entitlement program that finances the delivery of primary and acute medical services as well as long-term care to more than 63 million people at an estimated cost to the federal and state governments of roughly \$317 billion. Each state designs and administers its own version of Medicaid under broad federal rules. State variability in eligibility, covered services, and how those services are reimbursed and delivered is the rule rather than the exception. In the federal budget, Medicaid is an entitlement program that constitutes a large share of mandatory spending. Federal Medicaid spending is open-ended, with total outlays dependent on the spending levels of state Medicaid programs.

Summary of Provisions in H.R. 3162

Title I — Children’s Health Insurance Program

Section 100. Purpose. The House bill states that the purpose of the title is to provide dependable and stable funding for children’s health insurance under titles XXI (SCHIP) and XIX (Medicaid) of the Social Security Act in order to enroll all six million children who are eligible, but not enrolled, for coverage today through such titles.

Subtitle A — Funding

Section 101. Establishment of new base CHIP allotments. No specific national appropriation amounts would be specified for FY2008 onward. The annual appropriation would be determined automatically as the sum total of the allotments calculated for all the states (including the District of Columbia) and territories and commonwealths. No end year would be specified; the program would receive annual appropriations in perpetuity.

Generally, a state’s FY2008 federal SCHIP allotment would be the greater of (1) its own projection of federal SCHIP expenditures in FY2008, based on the state’s May 2007 submission of projections provided to the Centers for Medicare and Medicaid Services (CMS), and (2) the state’s FY2007 SCHIP allotment multiplied by the allotment increase factor (described below). If the state enacted legislation during 2007 that would expand eligibility or improve benefits (including reduction of out-of-pocket expenditures) in its SCHIP program, the state may use its August 2007 submission of projections instead.

The allotment increase factor would be calculated annually as the product of the following two components: (1) the per capita health care growth factor, and (2) the child population growth factor. The per capita health care growth factor would be equal to 1 plus the percentage increase in the projected per capita amount of National Health Expenditures over the prior year’s. The child population growth factor would be equal to 1.01 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.

Computation of future allotments would depend on the year. For FY2009 and every future odd-numbered fiscal year, a state's federal SCHIP allotment would be equal to the prior year's allotment multiplied by the allotment increase factor. For FY2010 and every future even-numbered fiscal year, a state's federal SCHIP allotment would be "rebased." In these years, the state's allotment would be the prior year's federal SCHIP expenditures multiplied by the allotment increase factor. Beginning with FY2008, the allotment to a territory or commonwealth would be equal to its prior year federal SCHIP expenditures multiplied by the per capita health care growth factor (described above) and by 1.01 plus the percentage increase (if any) in the population of children under 19 years of age in the United States.

A state's allotment as determined above may be increased through a "performance-based shortfall adjustment." To qualify for this adjustment, a state would have to meet the following two requirements: (1) its federal SCHIP expenditures in a fiscal year (beginning with FY2008) exceed the amount of federal SCHIP allotments available to the state in the previous fiscal year (not including any available SCHIP funds redistributed from other states), and (2) its average monthly enrollment of children in SCHIP must have exceeded the target number for the year, which is the prior year's average monthly SCHIP enrollment increased by 1% and by the state's child population growth.

For the states that qualify, the performance-based shortfall adjustment would be added to the state's allotment at the start of the subsequent fiscal year. For example, if a state experienced a shortfall in FY2008, a shortfall adjustment (if the state qualified) would be added to the state's FY2009 allotment. However, the legislation also instructs the Secretary to "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." The adjustment would be calculated as the product of (1) the amount by which the actual average monthly caseload exceeded the target number of enrollees, and (2) the state's projected per capita SCHIP expenditures (state and federal) multiplied by the enhanced FMAP for the state for the fiscal year involved.

Section 102. 2-year initial availability of CHIP allotments. SCHIP allotments through FY2007 are available for three years. SCHIP allotments beginning with FY2008 would be available for two years. Unspent FY2007 allotments and unspent FY2008 allotments would both be available for redistribution in FY2010.

Redistributed funds would be available only for the fiscal year in which they are provided. Redistributed funds that are unspent at the end of the fiscal year may then be used for subsequent redistribution.

Section 103. Redistribution of unused allotments to address State funding shortfalls. Only shortfall states would be eligible to receive redistributed funds, in the amount of their projected shortfall for the fiscal year. If the amounts available for redistribution exceed the amount of applicable shortfalls, the remaining funds would be available for redistribution in the next fiscal year.

A shortfall state would be defined as a state in which its projected federal SCHIP spending for the year exceeds the state's available balances from (1) its own remaining prior-year allotments, (2) the performance-based shortfall adjustment, and (3) the current fiscal year's allotment. If the estimated shortfalls exceed the funds available for redistribution, the amounts to be redistributed to the shortfall states would be reduced proportionally.

Section 104. Extension of option for qualifying States. Under current law, §2105(g) of the Social Security Act permits qualifying states to apply federal SCHIP funds toward the coverage of certain children already enrolled in regular Medicaid (that is, not SCHIP-funded expansions of Medicaid). Specifically, these federal SCHIP funds are used to pay the difference between SCHIP's enhanced FMAP and the Medicaid FMAP that the state is already receiving for these children. Funds under this provision may only be claimed for expenditures occurring after August 15, 2003.

Under current law, qualifying states are limited in the amount they can claim for this purpose to the lesser of the following two amounts:

- 20% of the state's original SCHIP allotment amounts (if available) from FY1998-FY2001 and FY2004-FY2007 (hence the terms "20% allowance" and "20% spending"); and
- the state's available balances of those allotments. If there is no balance, states may not claim Section 2105(g) spending.

The statutory definitions for qualifying states capture most of those that had expanded their upper-income eligibility levels for children in their Medicaid programs to 185% of the federal poverty level or higher prior to the enactment of SCHIP. Based on statutory definitions, 11 states were determined to be qualifying states: Connecticut, Hawaii, Maryland, Minnesota, New Hampshire, New Mexico, Rhode Island, Tennessee, Vermont, Washington and Wisconsin.

Under current law, SCHIP spending under §2105(g) can be used by qualifying states only for Medicaid enrollees (excluding those covered by an SCHIP-funded expansion of Medicaid) who are under age 19 and whose family income exceeds 150% of poverty, to pay the difference between the SCHIP enhanced FMAP and the regular Medicaid FMAP.

In addition to the current-law provisions, qualifying states would be able to use all of any allotment from FY2008 onward for SCHIP spending under §2105(g).

Subtitle B — Improving Enrollment and Retention of Eligible Children

Section 111. CHIP performance bonus payment to offset additional enrollment costs resulting from enrollment and retention efforts. Beginning in FY2008 and ending with FY2013, the provision would establish an additional performance bonus payment to offset Medicaid and SCHIP child

enrollment costs resulting from implementing specified enrollment and retention efforts, and enrolling eligible children above specified target growth percentages.

States that implement at least 4 out of 7 specified enrollment and retention efforts would receive a single bonus payment in a given fiscal year in an amount equal to the weighted sum of the number of enrollees that exceed tiered target enrollment growth levels in Medicaid and SCHIP multiplied by a share of projected Medicaid and SCHIP per capita costs.

For such calculations, costs would be defined as projected average per capita Federal and State Medicaid and SCHIP expenditures for children for the most recent fiscal year, increased by the annual percentage increase in per capita amounts of National Health Expenditures for the respective subsequent fiscal year, and multiplied by a state matching percentage equal to 100% minus each such state's FMAP rate for the fiscal year involved. The bill also requires the Government Accountability Office (GAO) to submit a report for Congress not later than January 1, 2013, regarding the effectiveness of the performance bonus payment program in enrolling and retaining uninsured children in Medicaid and SCHIP.

Section 112. State option to rely on findings from an express lane agency to conduct simplified eligibility determinations. Beginning in January 2008, the provision would allow states the option to rely on a finding made within a state-defined period from an Express Lane Agency to determine whether a child under age 19 (or up to age 21 at state option) has met one or more of the eligibility requirements (e.g., income, assets or resources, citizenship, or other criteria) necessary to determine an individual's initial eligibility, eligibility redetermination, or renewal of eligibility for medical assistance under Medicaid.

If a finding from an Express Lane Agency results in a child not being found eligible for Medicaid or SCHIP, the state would be required to determine Medicaid or SCHIP eligibility using its regular procedures and the state would be required to inform the family that they may qualify for lower premium payments if the family's income were directly evaluated for an eligibility determination by the state using its regular policies. States may initiate an eligibility determination (and determine program eligibility) without a program application based on findings from an Express Lane Agency and information from sources other than the child only if the family has affirmatively consented to being enrolled in Medicaid or SCHIP.

Signatures under penalty of perjury would not be required on a Medicaid application form attesting to any element of the application for which eligibility is based on information received from an Express Lane Agency or from another public agency. The provision would authorize federal or state agencies or private entities in possession of potentially pertinent data relevant for the determination of eligibility under Medicaid to share such information with the Medicaid agency for the purposes of child enrollment in Medicaid, and would impose criminal penalties for entities who engage in unauthorized activities with such data.

Section 113. Application of Medicaid outreach procedures to all children and pregnant women. Under current law, a Medicaid state plan must provide for the receipt and initial processing of applications for medical assistance

for low-income pregnant women, infants, and children under age 19 at outstation locations other than Temporary Assistance for Needy Families (TANF) offices such as, disproportionate share hospitals, and Federally-qualified health centers. State eligibility workers assigned to outstation locations perform initial processing of Medicaid applications including taking applications, assisting applicants in completing the application, providing information and referrals, obtaining required documentation to complete processing of the application, assuring that the information contained on the application form is complete, and conducting any necessary interviews.

Effective January 1, 2008, the provision would provide for the receipt and initial processing of applications for medical assistance for children and pregnant women under any provision of this title, and would allow for such application forms to vary across outstation locations.

Section 114. Encouraging culturally appropriate enrollment and retention practices. The federal and state governments share in the costs of both Medicaid and SCHIP, based on formulas defining the federal contribution in federal law. The federal match for administrative expenditures does not vary by state and is generally 50%, but certain administrative functions have a higher federal matching rate.

The provision would permit states to receive Medicaid federal matching payments for translation or interpretation services in connection with the enrollment and use of services by individuals for whom English is not their primary language. Payments for this activity would be matched at 75%.

Section 115. Continuous coverage under SCHIP. States are required to redetermine Medicaid and SCHIP eligibility at least every 12 months with respect to circumstances that may change and affect eligibility. Continuous eligibility allows a child to remain enrolled for a set period of time regardless of whether the child's circumstances change (e.g., the family's income rises above the eligibility threshold), thus making it easier for a child to stay enrolled. Not all states offer it, but among those that do the period of continuous eligibility ranges from 6 months to 12 months.

The provision would require separate SCHIP programs (or SCHIP programs operating under the Section 1115 waiver authority) to implement 12 months of continuous eligibility for targeted low-income children whose annual family income is less than 200% FPL.

Subtitle C — Coverage

Section 121. Ensuring child-centered coverage. The provision would make dental services, and services provided by federally qualified health centers (FQHCs) and rural health clinics (RHCs) required benefits under SCHIP. States would also be required to assure access to these services. The provision would require that payments for FQHC and RHC services provided under SCHIP follow the prospective payment system for such services under Medicaid, which provides adjusted, per-visit cost-based reimbursement for such services. With respect to benchmark-equivalent coverage, the provision would increase the minimum actuarial

value for mental health services from 75% to 100%. Benchmark coverage would also be required to be at least equivalent to the benchmark benefit packages specified in statute. These provisions would apply to coverage provided on or after October 1, 2008.

For the parallel benchmark package option available under Medicaid, as allowed under the Deficit Reduction Act of 2005 (P.L. 109-171), the provision would require coverage of the “Early and Periodic Screening, Diagnosis, and Treatment” (EPSDT) benefit for individuals under age 21, whether such persons are enrolled in benchmark plans, benchmark-equivalent plans, or otherwise. The effective date of this provision would be March 31, 2006 (the date of enactment of the related DRA provisions).

The provision would also add “school-based health center services” to the “clinic services” benefit category in SCHIP statute, and would apply this change to services furnished on or after the date of enactment of this Act.

Section 122. Improving benchmark coverage options. The provision would continue to allow Secretary-approved coverage under both SCHIP and under the DRA option for Medicaid, but only if such coverage is at least equivalent to a benchmark benefit package. The provision would also more explicitly define state employees benchmark coverage for both SCHIP and the DRA option for Medicaid to include the state employee plan that has been selected the most frequently, by employees seeking dependent coverage, among such plans that provide dependent coverage, in either of the previous two years. The provision would apply to health benefits coverage provided on or after October 1, 2008.

Section 123. Premium grace period. States would have to provide SCHIP enrollees with 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 may be terminated. Within seven days after the first day of the grace period, the state would have to provide the individual with notice that failure to make a premium payment within the grace period will result in termination of coverage and that the individual has the right to challenge the proposed termination pursuant to the applicable federal regulations. This provision would be effective for new coverage periods beginning on or after January 1, 2009.

Subtitle D — Populations

Section 131. Optional coverage of children up to age 21 under CHIP. Generally, eligibility for children under Medicaid is limited to persons under the age of 19 (or in some cases, persons under 18 or 21, for example). Under SCHIP, children are defined as individuals under the age of 19. The provision would expand the definition of child under SCHIP to include individuals under age 20 or 21, at state option. The effective date would be January 1, 2008.

Section 132. Optional coverage of legal immigrants under the Medicaid program and CHIP. States may provide full Medicaid coverage to legal immigrants who meet applicable categorical and financial eligibility requirements after such persons have been in the United States for a minimum of five

years. Sponsors can be held liable for the costs of public benefits (such as Medicaid and SCHIP) provided to legal immigrants.

The provision would allow states to cover legal immigrants who are pregnant women and/or children under age 21 (or such higher age as the state has elected) under Medicaid or SCHIP before the five-year bar is met effective upon the date of enactment. Sponsors would not be held liable for the costs associated with providing benefits to such legal immigrants, and the cost of such assistance would not be considered an unreimbursed cost.

Section 133. State option to expand or add coverage of certain pregnant women under CHIP. Currently under SCHIP, states can cover pregnant women ages 19 and older through waiver authority or by providing coverage to unborn children as permitted through regulation. In the latter case, coverage includes prenatal and delivery services only. The provision would allow states to provide optional coverage to pregnant women under SCHIP through a state plan amendment only if (1) the state has established an income eligibility level of at least 185% FPL under Medicaid, but in no case a percentage that is lower than the percentage in effect for certain coverage groups for pregnant women as of July 1, 2007, (2) the state has established an income eligibility level of at least 200% FPL for children under SCHIP or Medicaid, and (3) the state does not impose certain enrollment limitations for children under SCHIP.

For the new group of pregnant women under SCHIP, the lower income limit would exceed 185% FPL (i.e., or the applicable Medicaid threshold, if higher) and the upper income limit could be up to the level for coverage of SCHIP children in the state. Other limitations on eligibility for children under SCHIP would also apply to the new coverage group for pregnant women. States would not be permitted to impose pre-existing condition exclusions or waiting periods, and all cost-sharing incurred by pregnant women under SCHIP would be capped at 5% of annual income, as is the case for SCHIP children. States adopting this new coverage group for pregnant women under SCHIP would receive an adjustment to their annual SCHIP allotments to cover these additional costs. (Different adjustments would apply depending on whether a state did or did not cover pregnant women in SCHIP prior to FY2008 through waiver or regulatory authority.) Pregnancy-related assistance would include all services covered for children under SCHIP (excluding EPSDT), and the period of coverage would be during pregnancy through the end of the month in which the 60-day postpartum period ends.

Additional provisions would: (1) deem infants born to the new group of pregnant women under SCHIP to be eligible for Medicaid or SCHIP, as applicable, up to age one (without regard to whether the infant lives with the mother or whether the mother remains eligible), (2) allow presumptive eligibility determinations for pregnant women and children under SCHIP, and (3) allow entities that make presumptive eligibility determinations for children under Medicaid to make such determinations for pregnant women under SCHIP.

Section 134. Limitation on waiver authority to cover adults. Under current law, Section 1115 of the Social Security Act gives the Secretary of Health and Human Services (HHS) broad authority to modify virtually all aspects of the

Medicaid and SCHIP programs including expanding eligibility to populations who are not otherwise eligible for Medicaid or SCHIP (e.g., childless adults). Approved SCHIP Section 1115 waivers are deemed to be part of a state's SCHIP state plan for purposes of federal reimbursement. Costs associated with waiver programs are subject to each state's enhanced-FMAP. Under SCHIP Section 1115 waivers, states must meet an "allotment neutrality test" where combined federal expenditures for the state's regular SCHIP program and for the state's SCHIP demonstration program are capped at the state's individual SCHIP allotment.

The provision would prohibit the Secretary from allowing federal SCHIP allotments to be used to provide health care services (under the Section 1115 waiver authority) to individuals who are not targeted low-income children or pregnant women (e.g., non-pregnant childless adults or parents of Medicaid or SCHIP eligible children) unless the Secretary determines that no SCHIP-eligible child in the state would be denied SCHIP coverage because of such eligibility. The provision would require states to assure that they have not instituted a waiting list for their SCHIP program, and that they have an outreach program to reach all targeted low-income children in families with annual income less than 200% FPL.

Section 135. No federal funding for illegal aliens. Under the Medicaid program, unauthorized aliens who meet all other program criteria are only eligible for emergency coverage. Under SCHIP, states may opt to cover unauthorized aliens who are pregnant, but covered services must be related to the pregnancy or to conditions that could complicate the pregnancy or threaten the health of the unborn child (who will be a U.S. citizen if he or she is born in the United States). The House bill would specify that nothing in the bill allows federal payment for individuals who are not legal residents.

Section 136. Auditing requirement to enforce citizenship restrictions on eligibility for Medicaid and CHIP benefits. Federal Medicaid law and associated Medicaid Eligibility Quality Control (MEQC) regulations specify an allowable error rate (3%) for erroneous excess payments that are due to eligibility errors, as well as a methodology for determining a state's error rate. Since error rates discovered through MEQC programs were consistently below 3% as of the mid-1990s, states were offered the option to develop alternative ways to identify and reduce erroneous payments. The Improper Payments Information Act of 2002 (IPIA, P.L. 107-300) also requires federal agencies to identify programs that are susceptible to significant improper payments, estimate the amount of overpayments, and report annually to Congress on those figures and on the steps being taken to reduce such payments. To comply with IPIA, a new regulation on Payment Error Rate Measurement (PERM) for Medicaid and SCHIP became effective on October 1, 2006. With respect to these two programs, a subset of states selected for review in a given year are reviewed using a statistically valid random sample of claims and eligibility determinations to determine error rates. States must submit a corrective action plan based on the error rate analysis, and must return overpayments of federal funds.

Under the House bill, each state would be required to audit a statistically based sample of individuals whose Medicaid or SCHIP eligibility is determined under one of the following: (1) optional citizenship documentation rules for children (specified

in section 143 of the bill) or (2) optional coverage rules for legal immigrant pregnant women and children (specified in section 132 of the bill) to demonstrate to the satisfaction of the Secretary that federal Medicaid and SCHIP funds are not unlawfully spent on individuals who are not legal residents. In conducting such audits, a state may rely on MEQC or PERM eligibility reviews. States would be required to remit the federal share of any unlawful expenditures which are identified under the required audit.

Subtitle E — Access

Section 141. Children’s Access, Payment, and Equality Commission. Among many tasks, this new Commission to be established by the provision would review (1) factors affecting expenditures for services in different sectors, payment methodologies, and their relationship to access and quality of care for Medicaid and CHIP beneficiaries, (2) the impact of Medicaid and SCHIP policies on the overall financial stability of safety net providers (e.g., FQHCs, school-based clinics, disproportionate share hospitals), and (3) the extent to which the operation of Medicaid and CHIP ensures access comparable to access under employer-sponsored or other private health insurance.

This Commission would be required to make recommendations to Congress and to submit two annual reports, the first focusing on results of reviews and related policy recommendations and the second examining issues affecting these programs. The Commission would also comment on any reports submitted to Congress by the Secretary of HHS on Medicaid or SCHIP payment policies. The provision requires that the Commission recommendations be voted on by all members, and the voting results be included in each report. Recommendations would be required to consider budget consequences. Certain provisions governing the Medicare Payment Advisory Commission would apply to this new commission (i.e., relating to membership with the addition of Medicaid and CHIP beneficiary representatives, staff and consultants, and powers). The provision would authorize to be appropriated such sums as necessary to carry out the duties of the new Commission.

Section 142. Model of Interstate coordinated enrollment and coverage process. The provision would require the Comptroller General, in consultation with State Medicaid, CHIP directors, and organizations representing program beneficiaries to develop a model process (and report for Congress) for the coordination of enrollment, retention, and coverage of children who frequently change their residency due to migration of families, emergency evacuations, educational needs, etc. The provision would require that such model process be disseminated not later than 18 months after the date of enactment of this Act.

Section 143. Medicaid citizenship documentation requirements. Under current law, noncitizens who apply for full Medicaid benefits have been required since 1986 to present documentation that indicates a “satisfactory immigration status.” Due to recent changes, citizens and nationals also must present documentation that proves citizenship and documents personal identity in order for states to receive federal Medicaid reimbursement for services provided to them. This citizenship documentation requirement was included in the Deficit Reduction Act of 2005 (DRA, P.L. 109-171) and modified by the Tax Relief and Health Care Act of

2006 (P.L. 109-432). Before the DRA, states could accept self-declaration of citizenship for Medicaid, although some chose to require additional supporting evidence. The citizenship documentation requirement is outlined under Section 1903(x) of the Social Security Act and applies to Medicaid eligibility determinations and redeterminations made on or after July 1, 2006. The law specifies documents that are acceptable for this purpose and exempts certain groups from the requirement. It does not apply to SCHIP. However, since some states use the same enrollment procedures for all Medicaid and SCHIP applicants, it is possible that some SCHIP enrollees would be asked to present evidence of citizenship.

The House bill would make Medicaid citizenship documentation for children under age 21 a state option, using criteria that are no more stringent than the existing documentation specified in section 1903(x)(3) of the Social Security Act. Groups that are exempt from the citizenship documentation requirement would remain the same as under current law, except for the inclusion of an additional permanent exemption for children who are deemed eligible for Medicaid coverage by virtue of being born to a woman on Medicaid. The provision would require additional documentation options for federally recognized Indian tribes. It would also specify that states must provide citizens with the same reasonable opportunity to present evidence that is provided under section 1137(d)(4)(A) of the Social Security Act to noncitizens who are required to present evidence of satisfactory immigration status and must not deny medical assistance on the basis of failure to provide such documentation until the individual has had such an opportunity. These changes would be effective as if included in the Deficit Reduction Act of 2005, and states would be allowed to provide retroactive eligibility for certain individuals who had been determined ineligible under previous citizenship documentation rules.

Section 144. Access to dental care for children. The provision would require the Secretary of HHS to develop and implement, through entities that fund or provide perinatal care to CHIP children, a program to deliver oral health education materials that inform new parents about risks for, and prevention of, early childhood caries and the need for a dental visit within a newborn's first year of life. The provision also specifies that states may not prevent a federally qualified health center (FQHC) from entering into contractual relationships with private practice dental providers in the provision of FQHC services under both the Medicaid and CHIP programs. The effective date of these provisions would be January 1, 2008.

The provision would also require that the data states submit on the CMS-416 form for Medicaid, documenting the receipt of EPSDT services in each fiscal year, include parallel information on the receipt of dental services among CHIP children. In addition, each annual CHIP report submitted by states to the Secretary of HHS would be required to include similar information. These data would also be required to include information on such children enrolled in managed care plans, other private health plans, and contracts with such plans under CHIP. These amendments would be effective for annual state CHIP reports submitted for years beginning after the date of enactment of this Act.

Finally, the provision would also require GAO to conduct a study to examine access to dental services by children in under-served areas and 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. The GAO would submit a report to Congress based on the findings of this study not later than one year after the date of enactment of this Act.

Section 145. Prohibiting initiation of new health opportunity account demonstration programs. The Deficit Reduction Act of 2005 allowed the Secretary of HHS to establish no more than 10 demonstration programs within Medicaid for health opportunity accounts (HOAs). HOAs are used to pay (via electronic funds transfers) health care expenses specified by the state. As of July 2007, South Carolina was the only state to receive CMS approval for a Health Opportunity Account Demonstration. The provision would prohibit the Secretary of HHS from approving any new Health Opportunity Account demonstrations as of the date of enactment of this Act.

Subtitle F — Quality and Program Integrity

Section 151. Pediatric health quality measurement program. The Centers for Medicare and Medicaid Services (CMS) and the Agency for Healthcare Research and Quality (AHRQ) are both actively involved in funding and implementing an array of quality improvement initiatives, though only AHRQ has engaged in activities specific to children.

The provision would require the Secretary of HHS to establish a child health care quality measurement program. The purpose would be to develop and implement 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 measures of overall program performance that may be used by public and private sector health care purchasers. Not later than September 30, 2009, the Secretary would be required to publish the recommended measures under this program for years beginning with 2010. In developing and implementing this program, the Secretary would be required to consult with a number of entities. The Secretary would have the option to award grants and contracts to develop, test, validate, update, and disseminate quality measures. The Secretary would also be required to provide technical assistance to states to establish reporting of quality measures under both Medicaid and CHIP.

Not later than January 1, 2009, and annually thereafter, the Secretary would be required to collect, analyze, and make publicly available in an on-line format a complete list of all measures in use by states to measure the quality of medical and dental health services provided to Medicaid and SCHIP children by participating providers, managed care entities, and plan issuers, and other information. Also, not later than January 1, 2010, and every two years thereafter, the Secretary would be required to report to Congress on the quality of health care for children enrolled in Medicaid and SCHIP, and patterns of health care utilization by pediatric characteristics.

Section 152. Application of certain managed care quality safeguards to CHIP. A number of sections of the Social Security Act apply to states under title XXI (SCHIP) in the same manner as they apply to a state under title XIX (Medicaid). These include the following: section 1902(a)(4)(C) (relating to

conflict of interest standards); paragraphs (2), (16), and (17) of section 1903(i) (relating to limitations on payment); section 1903(w) (relating to limitations on provider taxes and donations); and section 1920A (relating to presumptive eligibility for children). The House bill would add subsections (a)(4), (a)(5), (b), (c), (d), and (e) of section 1932 (relating to requirements for managed care) to the list of title XIX provisions that apply under title XXI. It would apply to contract years for health plans beginning on or after July 1, 2008.

Section 153. Updated federal evaluation of CHIP. Under prior law, the Secretary was required to conduct an independent evaluation of 10 states with approved CHIP plans, and to submit a report on that study to Congress by December 31, 2001. Ten million dollars was appropriated for this purpose in FY2000 and was available for expenditure through FY2002. The 10 states chosen for the evaluation were to be ones that utilized diverse approaches to providing CHIP coverage, represented various geographic areas (including a mix of rural and urban areas), and contained a significant portion of uninsured children. (The 10 states ultimately chosen for the evaluation were California, Colorado, Florida, Illinois, Louisiana, Missouri, New Jersey, New York, North Carolina and Texas.)

In addition to the information states were required to provide to the Secretary in their own evaluations by March 31, 2000, the federal evaluation of the 10 states was to include the following matters: (1) surveys of the target population (enrollees, disenrollees, and individuals eligible for but not enrolled in CHIP); (2) an evaluation of effective and ineffective outreach and enrollment practices, and identification of enrollment barriers and key elements of effective outreach and enrollment practices, including practices that have successfully enrolled hard-to-reach populations; (3) an evaluation of the extent to which state Medicaid eligibility practices and procedures are a barrier to the enrollment of children, and the extent to which coordination (or lack of coordination) between Medicaid and CHIP affects enrollment; (4) an assessment of the effect of cost-sharing on utilization, enrollment, and coverage retention; and (5) an evaluation of disenrollment or other retention issues, such as switching to private coverage, failure to pay premiums, or barriers in the recertification process.

As before, directly or through contracts or interagency agreements, the provision would require the Secretary to conduct an independent evaluation of 10 states with approved CHIP plans. The new evaluation would be submitted to Congress by December 31, 2010. Ten million dollars would be appropriated for this purpose in FY2009 and made available for expenditure through FY2011. The current-law language for the types of states to be chosen and the matters included in the evaluation would also apply to this new evaluation.

Section 154. Access to records for IG and GAO audits. Every third fiscal year (beginning with FY2000), the Secretary (through the Inspector General of the Department of Health and Human Services) must audit a sample from among the states with an approved SCHIP state plan that does not, as part of such plan, provide health benefits coverage under Medicaid. The Comptroller General of the United States must monitor these audits and, not later than March 1 of each fiscal year after a fiscal year in which an audit is conducted, submit a report to Congress on the results of the audit conducted during the prior fiscal year. Under the House bill, for

the purpose of evaluating and auditing the SCHIP program, the Secretary, the Office of Inspector General, and the Comptroller General would have access to any books, accounts, records, correspondence, and other documents that are related to the expenditure of federal SCHIP funds and that are in the possession, custody, or control of states, political subdivisions of states, or their grantees or contractors.

Section 155. References to XXI. The provision would repeal the section in P.L. 106-113 that directed the Secretary of HHS or any other federal officer or employee, with respect to references to the program under Title XXI, in any publication or official communication to use the term “SCHIP” instead of “CHIP” and to use the term “State children’s health insurance program” instead of “children’s health insurance program.” Thus, for official publication and communication purposes, the provision would reinstate “CHIP” and “children’s health insurance program,” as applicable, when referencing Title XXI.

Section 156. Reliance on law; exception for state legislation. This provision states that with respect to amendments made by title I or title VIII of the House bill that become effective as of a date, the following would apply: (1) that such amendments are effective as of such date whether or not regulations implementing such amendments have been issued, and (2) that federal financial participation for medical or child health assistance furnished under Medicaid or SCHIP 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 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. The provision also provides a grace period for states that require state legislation in order to meet certain requirements imposed by the House bill.

Title II — Medicare Beneficiary Improvements

Subtitle A — Improvements in Benefits

Section 201. Coverage and Waiver of Cost-Sharing for Preventive Services. Medicare Part B generally pays 80% of the approved amount for covered services in excess of the annual deductible (\$131 in 2007). The beneficiary is liable for the remaining 20%. The deductible and/or coinsurance are waived for certain services, primarily preventive services. The provision would add a new category of additional preventive services (including mental health services) that the Secretary determined to be reasonable and necessary for the prevention or early detection of an illness or disability. No coinsurance would apply for such services or for services provided in a hospital outpatient department or for sigmoidoscopies and colonoscopies. The deductible would be waived for all preventive services. All preventive services, including the new additional preventive services category, would be included within the definition of the initial preventive physical exam. The provision would apply to services furnished on or after January 1, 2008.

Section 202. Waiver of Deductible for Colorectal Cancer Screening Tests Regardless of Coding, Subsequent Diagnosis, or Ancillary Tissue Removal. The Medicare Part B deductible does not apply to colorectal cancer screening tests. Effective January 1, 2008, the provision would specify that the waiver of the deductible would apply regardless of the coding, subsequent diagnosis, or the removal of tissue or other matter or procedure performed in connection with and as a result of the screening test.

Section 203. Parity for Mental Health Coinsurance. Medicare Part B generally pays 80% of the approved amount (generally a fee schedule or other predetermined amount) for covered services in excess of the annual deductible. However, it pays 62 ½% of covered expenses incurred in connection with the treatment of mental, psychoneurotic, and personality disorders of a person who is not a hospital inpatient. As a result it generally pays 50% rather than 80% of Medicare's recognized amount. The provision would eliminate the limitation effective January 1, 2008.

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

Section 211. Improving Assets Tests for Medicare Savings Program and Low-Income Subsidy Program. The law includes assets tests for determining eligibility for both the low-income subsidy (LIS) assistance program for Part D drug benefits and the Medicare Savings Program (MSP). In 2007, the maximum LIS level is \$10,210 for an individual and \$20,410 for a couple (increased in future years by the percentage increase in the CPI). The maximum MSP level is \$4,000 for an individual and \$6,000 for a couple. The provision would increase the maximum resources levels, effective January 1, 2009, to \$17,000 for an individual and \$34,000 for a couple. In subsequent years, it would be the previous year's level increased by the consumer price index.

Section 212. Making QI-1 Program Permanent and Expanding Eligibility. Certain low-income individuals are eligible to have their Medicare Part B premiums paid for by Medicaid under the Medicare Savings Program (MSP). One eligible group is Qualifying Individuals (QI-1s). These persons have incomes between 120% and 135% of poverty. Federal spending under the QI-I program is subject to annual limits. The program is currently slated to terminate September 30, 2007. The provision would make the program permanent, eliminate the current federal funding limitation, provide 100% federal matching for payments under the program, and increase the income standard to 150% of poverty, effective January 1, 2008.

Section 213. Eliminating Barriers to Enrollment. Effective January 1, 2009, the provision would permit applicants for the low-income subsidy (LIS) program to qualify on the basis of self-certification of income and resources. Matters attested to in the application would be subject to appropriate verification without a requirement for additional documentation except in unusual circumstances. These persons would continue to remain eligible without the need for any annual or periodic application until they notified a federal or state official of a change in circumstances.

The provision would require the Secretary to take all reasonable steps to encourage states to provide, under the MSP program, for administrative verification of income and automatic reenrollment. The provision would extend the outreach requirements currently applicable for the Commissioner of Social Security. It would require the Secretary to translate the model application form into at least 10 languages and to make such translated forms available to the states and to the Commissioner of Social Security. For two years the Commissioner of Social Security would be allowed to obtain information from the IRS to identify persons potentially eligible for LIS.

Section 214. Eliminating Application of Estate Recovery. Medicaid law requires states to recover, from the estate of the beneficiary, amounts paid by the program for certain long-term care, related services, and other services at state option. Effective January 1, 2008, the provision would exempt from estate recovery any Medicaid payments for premiums, deductibles, and coinsurance made on behalf of an individual eligible under the Medicare Savings Program.

Section 215. Elimination of Part D Cost-Sharing for Certain Non-Institutionalized Full-Benefit Dual Eligible Individuals. Full benefit dual eligibles who are residents of a medical institution or nursing facility have no Part D cost-sharing. Effective January 1, 2009, the provision would extend the cost-sharing exemption to persons who would otherwise require institutional care paid for by Medicaid except for the fact that they are receiving care under a home- and community-based care waiver.

Section 216. Exemptions From Income and Resources For Determination of Eligibility for Low-Income Subsidy. The definitions of income and assets used for making eligibility determinations for low-income subsidies generally follow that used for determining eligibility under the Medicare Savings program. Certain items are excluded from the calculations. Effective January 1, 2009, the provision would exclude support and maintenance furnished in kind from the definition of income. It would also exclude the following from the definition of resources: (1) any part of the value of any life insurance policy; and (2) any balance in any pension or retirement plan.

Section 217. Cost-Sharing Protections for Low-Income Subsidy Eligible Individuals. Non-institutionalized persons who are low-income subsidy individuals are required to pay nominal cost-sharing charges. The provision would limit aggregate cost-sharing in a year to 5% of income, effective January 1, 2009.

Section 218. Intelligent Assignment in Enrollment. The law requires automatic enrollment for full benefit dual eligibles who failed to enroll in a Part D plan. Individuals are enrolled with the plan in the region that has a premium not exceeding the premium subsidy amount. If more than one such plan is available, enrollment among these plans is made on a random basis. The provision would specify that for enrollments effected on or after November 15, 2009, no Part D full benefit dual eligible individual could be enrolled in a plan unless one of the following apply: (1) the formulary covered 95% of the 100 most commonly prescribed generic covered Part D drugs and 95% of the 100 most commonly prescribed brand name covered Part D drugs for the Medicare population; (2) the plan had a network of pharmacies that substantially exceeded the minimum requirements for plans in the

state and that provided access in areas where lower income individuals resided; (3) the plan (except for a new plan) had an above average score on quality ratings made by the Secretary; (4) the total cost of providing coverage under the plan (consistent with the new requirements) was among the lowest 25th percentile of prescription plans under Part D in the state.

Subtitle C — Part D Beneficiary Improvements

Section 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. Beneficiaries enrolled in prescription drug plans under Part D are required to incur a certain level in out-of-pocket costs in connection with the purchase of covered drugs before catastrophic coverage begins. Costs are treated as incurred, and thus treated as true out-of-pocket (TROOP) costs only if they are paid by the individual (or by another family member on behalf of the individual), paid on behalf of a low-income individual under the subsidy provisions, or under a state pharmaceutical assistance program. Any costs for which the individual is reimbursed by insurance or otherwise do not count toward the TROOP amount. Beginning January 1, 2009, the provision would count toward TROOP costs paid by the Indian Health Service, Indian tribe or tribal organization or an urban Indian organization and costs paid under an AIDS Drug Assistance Program under Part B of Title XXVI of the Public Health Service Act.

Section 222. Permitting Mid-Year Changes in Enrollment for Formulary Changes Adversely Impacting an Enrollee. Part D plans can change their formularies at the beginning of a year; during the year, plans can make changes only after giving notice. CMS policy specifies that plans should make formulary changes (such as removing drugs from the formulary, moving drugs to a less preferred tier status, or adding utilization management requirements) during the year only if enrollees currently taking the affected drugs are exempted from the change for the remainder of the plan year. The provision would establish a special open enrollment period, beginning January 1, 2009, for an individual to change plans during a period (other than during the annual open enrollment period) if the formulary of their existing plan materially changed (other than at the end of the contract year) such as to reduce coverage or change the cost-sharing of the drug.

Section 223. Removal of Exclusion of Benzodiazepines From Required Coverage Under the Medicare Prescription Drug Program. The provision would remove, effective January 1, 2013, the existing exclusion of benzodiazepines from those drugs that prescription drug plans are required to include in their formularies.

Section 224. Permitting Updating Drug Compendia under Part D Using Part B Update Process. The provision would permit the Secretary to update drug compendia used under Part D using a process similar to that used for Part B.

Section 225. Codification of Special Protections for Six Protected Drug Classifications. Part D plans are required to include in their formularies drugs within each therapeutic category and class of covered Part D drugs, although not necessarily all drugs within such categories and classes. CMS has required plans to cover all or substantially all drugs in the following six classes: anticonvulsants, antineoplastics, antiretrovirals, antidepressants, antipsychotics, and immunosuppressives. The provision would codify this requirement effective January 1, 2009. A plan sponsor would only be permitted to use prior authorization or step therapy for the initiation of medications within one of these classifications if approved by the Secretary. However, such prior authorization or step therapy could not be used in the case of antiretrovirals or in the case of individuals already stabilized on a drug treatment regimen.

Section 226. Elimination of Medicare Part D Late Enrollment Penalties Paid by Low-Income Subsidy-Eligible Individuals. A late enrollment penalty is assessed on persons who go for 63 days or longer after the close of their initial Part D enrollment period without creditable coverage and subsequently enroll in Part D. CMS waived this penalty for 2006 and 2007 for persons deemed eligible for a low-income subsidy after the close of their initial enrollment period. The provision would eliminate the late enrollment penalties for low-income subsidy eligible individuals, beginning January 2008.

Section 227. Special Enrollment Period for Low-Income Subsidy Eligible Individuals. CMS established special enrollment periods for 2006 and 2007 for persons determined eligible for a low-income subsidy outside of the annual open enrollment period. The provision would establish, beginning January 1, 2008, a special 90- day enrollment period for such persons beginning on the date the individual received notification that they were subsidy eligible. The Secretary would be required to provide for a facilitated enrollment in a plan for persons deemed low income subsidy eligible but who failed to enroll in a plan.

Subtitle D — Reducing Health Disparities

Section 231. Medicare Data on Race, Ethnicity, and Primary Language. The provision would require the Secretary to collect and annually analyze data on race, ethnicity and the primary language of Medicare applicants and beneficiaries to be used in analyses related to health disparities. The Secretary would report the results of these analyses annually to the Director of the Office for Civil Rights and the appropriate committees of Congress. The Secretary would be required to develop and implement a plan to improve the collection, analysis, and reporting of racial, ethnic, and primary language data within the Medicare program. In consultation with the National Committee on Vital Health Statistics, the Office of Minority Health, and other public and private entities, the Secretary would be required to make recommendations on racial, ethnic, and primary language data collection, awareness, quality, analysis, access, and use. Within one year of the enactment of the Act, the Director of the Office of Minority Health, in consultation with the Office for Civil Rights of the Department of HHS, would be required to develop and disseminate Standards for the Classification of Federal Data on Preferred Written and Spoken Language. The Secretary would be allowed to provide direct or

indirect technical assistance to enable a Medicare health care provider or plan to comply with racial, ethnic, and primary language data collection. The Secretary, acting through the Director of the Agency for Health Care Research and Quality (AHRQ) and the Administrator of the Centers for Medicare and Medicaid Services (CMS) would be required to (1) identify appropriate quality assurance mechanisms to monitor for health disparities under Medicare, (2) specify the measures that should be monitored, (3) develop new quality measures for 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. Not later than two years after the date of enactment, and biennially thereafter, the Secretary would 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 Medicare program. An applicant or recipient of assistance could not be denied or otherwise adversely affected because of the failure of the applicant or recipient to provide data. The data collected for these purposes would be protected under the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The Secretary would also ensure that the data is protected from all inappropriate internal use by any entity. The provision authorizes to be appropriated such sums as may be necessary for FY2008 to 2012.

Section 232. Ensuring effective communication by the CMS. The provision would require the Secretary to conduct a study examining ways that Medicare should pay for language services, using the results from the demonstration program described in Section 233. In considering payment methods, the Secretary could vary the types of service providers, available delivery methods, and costs for providing language services. The Secretary would be required to submit a report on the study to the appropriate committees of Congress within one year of the expiration of the demonstration program. If a Medicare Part C organization failed substantially to provide language services to limited English proficient beneficiaries enrolled in the plan, then the Secretary would be allowed to place sanctions on the organization.

Section 233. Demonstration to promote access for Medicare beneficiaries with limited English proficiency by providing reimbursement for culturally and linguistically appropriate services. The provision would require the Secretary, acting through the CMS, to award 24 three-year demonstration grants to eligible Medicare service providers within one year of the enactment of the Act. The purpose of the demonstrations would be to improve communication between Medicare service 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. Each three-year grant must be less than or equal to \$500,000. Only service providers under Medicare Part A, B, C, or D would be eligible for the grants. To the extent feasible, the Secretary would be required to award the grants to an equal number of service providers under each part of Medicare (Parts A, B, C, and D), such that 6 providers, sponsors, or organizations under each of the 4 parts would receive grants. The Secretary would be required to ensure that variation exists among grantees, giving priority consideration to applicants that have developed partnerships with community organizations or with agencies with experience in language access.

A grantee would be allowed to use the grant funds to pay for the provision of competent language and translation services to Medicare beneficiaries who are limited English proficient. Grantees who are also Medicare Part C organizations or Part D sponsors would be required to ensure that their network providers, including physicians and pharmacies, receive at least 50% of the grant funds to pay for the provision of competent language services to Medicare beneficiaries who are limited English proficient. The limited English proficient beneficiaries would not be required to pay cost-sharing or co-pays for language services provided through the demonstration.

Payments to grantees would be required to be calculated based on the estimated number of limited English proficient Medicare beneficiaries in a grantee's service area. Payments would be contingent on grantees reporting their costs of providing language services and utilizing competent bilingual staff, or competent interpretation or translation services. Grantees would be required to provide, at the conclusion of each grant year, reports to the Secretary.

The Secretary would be required to conduct an evaluation of the demonstration program and submit a report to the appropriate committees of Congress within one year after completion of the program. There would be authorized to be appropriated \$10,000,000 for each fiscal year of the demonstration.

Section 234. Demonstration to improve care to previously uninsured. The provision would require the Secretary to establish, within one year of the date of enactment of the provision, a two-year demonstration project to determine the greatest needs and most effective methods of outreach to Medicare beneficiaries who were previously uninsured. The demonstration would be required to include at least 10 sites, as well as state health insurance assistance programs, community health centers, and other service providers under Medicare Parts A, B, and C. The Secretary would be required to conduct an evaluation of the demonstration, and submit a report to Congress within one year of the completion of the project.

Section 235. Office of the Inspector General report on compliance with and enforcement of national standards on Culturally and Linguistically Appropriate Services (CLAS) in Medicare. This provision would require the Inspector General of the Department of HHS to prepare and publish a report, within two years of the date of enactment of the Act, that examines the extent to which Medicare providers and plans are complying with the Office of 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. The report must also describe the costs or savings related to the provision of language services and recommend ways of improving compliance with and enforcement of Culturally and Linguistically Appropriate Services (CLAS) Standards. Within one year of the report's publication date, the Department of HHS would be required to implement any changes resulting from any deficiencies identified in the report.

Section 236. IOM report on impact of language access services.

This provision would require the Institute of Medicine to prepare and publish a report, within three years, on the impact of language access services on the health and health care of limited English proficient populations.

Section 237. Definitions. The provision defines the terms bilingual, competent interpreter services, competent translation services, effective communication, interpreting/interpretation, health care services, health care-related services, language access, language services, limited English proficient, Medicare program, and service provider.

Title III — Physicians' Service Payment Reform

Section 301. Establishment of Separate Target Growth Rates for Service Categories. Medicare pays for services of physicians and certain nonphysician practitioners on the basis of a fee schedule. With a few exceptions, most physicians' services are considered together in the calculation of the fee schedules, related expenditure targets and annual updates. In some instances, special rules apply to the calculation of Medicare fees for some services including anesthesia, radiology, and nuclear medicine. The Medicare physician fee schedule assigns relative values to services that reflect physician work (i.e., the time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The relative values are adjusted for geographic variations in costs. The adjusted relative values are then converted into a dollar payment amount by a conversion factor. The single conversion factor for 2007 is \$37.8975, the same level as in 2005 and 2006.

The physician fee schedule places a limit on payment per service but not on overall volume of services. The formula for calculating the annual update to the conversion factor responds to changes in volume. If the overall volume of services increases, the update is lower; if the overall volume is reduced, the update is higher. The intent of the formula is to place a restraint on overall increases in Medicare spending for physicians' services.

Several factors enter into the current calculation of the annual update (and increase or decrease) of Medicare physician fees. These include (1) the Medicare economic index (MEI), which measures inflation in the inputs needed to produce physicians' services; (2) the sustainable growth rate (SGR), which is essentially a target for Medicare spending growth for physicians' services; and (3) an adjustment that modifies the update, which would otherwise be allowed by the MEI, to bring spending in line with the SGR target. The SGR target is not a limit on expenditures. Rather, the fee schedule update reflects the success or failure in meeting the target. If expenditures exceed the target, the update for a future year is reduced. This is what occurred for 2002. Fee reductions were also slated to occur in subsequent years; however, legislation has prevented this from occurring through 2007. Most recently, the Tax Relief and Health Care Act of 2006 (TRHCA, P.L.109-432) kept the 2007 conversion factor at the 2006 level.

The performance adjustment factor sets the conversion factor at a level so that projected spending for the year will meet allowed spending by the end of the year. Current law restrictions prevent the adjustment factor from being less than minus 7% or more than plus 3%. Under the current update formula, a reduction in the conversion factor will occur for the next several years. In the absence of legislation, payment rates will be reduced by about 10% in 2008 and around 5% annually for at least several years thereafter. The 2008 estimate reflects the fact that TRHCA specified that the 2007 override of the statutory formula was to be treated as if it did not occur. Therefore, the starting base for the calculation is 5% below the actual 2007 conversion factor. Further, for the six-month period from July 1, 2007 to December 31, 2007, physicians who voluntarily report certain quality measures that meet the reporting criteria can receive bonus payments of 1.5%.

The provision would create six new categories of physicians' services beginning January 1, 2008: (1) evaluation and management services for primary care and for preventive services; (2) evaluation and management services not included in (1); (3) imaging services and diagnostic tests (other than clinical diagnostic laboratory tests); (4) major procedures; (5) anesthesia services; and (6) minor procedures and any other physicians' services not described above. The provision would eliminate the single conversion factor currently applied to all physician services and establish a separate conversion factor for each of the six newly created service categories.

Beginning with 2008, the conversion factors would be computed and updated separately for each of the six service categories, as would be the target growth rate and the allocation of the cumulative adjustment component, or overhang. However, in the calculation of the target growth rate, the rate would be increased by 2.5% for the primary and preventive health care category. The provision would establish a floor for updates equal to 0.5% for 2008 and 2009. However, the restriction on the update adjustment factor for 2010 and 2011 would be changed from -7% to -14%, and for 2013 and each succeeding year the update conversion factor for each of the service categories would be 0%.

Section 302. Improving accuracy of relative values under the Medicare physician fee schedule. Medicare pays for services of physicians and certain nonphysician practitioners on the basis of a fee schedule. The fee schedule assigns relative values to services that reflect physician work (i.e., the time, skill, and intensity it takes to provide the service), practice expenses, and malpractice costs. The work relative value units (RVUs) incorporated in the initial fee schedule were developed after extensive input from the physician community. Refinements in existing values and establishment of values for new services have been included in the annual fee schedule updates. This refinement and update process is based in part on recommendations made by the American Medical Association/ Specialty Society Relative Value Update Committee (RUC) which receives input from over 100 specialty societies.

Traditionally, the five-year review has led to more increases in work RVUs than decreases. MedPAC and other observers have stated that more attention needs to be given to overvalued services in order to maintain the integrity of the fee schedule. The most recent five-year review resulted in significant increases in values for

evaluation and management services; however, the impact was reduced by the budget neutrality adjustment.

This provision would require the Secretary to establish an expert panel to identify misvalued physicians' services. The panel would conduct data analysis to identify physicians' services for which the relative value is potentially misvalued, particularly those which are overvalued, and assess whether those misvalued services warrant review through existing processes. The panel would also advise the Secretary as part of the periodic review (not less than every five years) and adjustments in relative values.

The Secretary would consult with the expert panel and would also perform the following: (1) in conjunction with the RUC five-year review, conduct a five-year review of physicians' 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; (2) identify new services to determine if they are likely to experience a reduction in value over time and forward a list of the services identified to the RUC for review in the next five-year review cycle; and (3) for physicians' services that are otherwise unreviewed by the RUC, periodically review a sample of relative value units within different types of services to ensure the accuracy of the relative values contained in the Medicare physician fee schedule.

The provision would give the Secretary the authority to reduce the work component for services with accelerated volume growth without using the RUC process beginning January 1, 2009. In consultation with the expert panel described above, the Secretary would be able to reduce the work value units for a particular physicians' service if the annual rate of growth in expenditures for the service provided under Medicare for 2006 or a subsequent year exceeds the average annual rate of growth in expenditures for all Medicare physicians' services by more than 10 percentage points. The Secretary would take into account clinical evidence supporting or refuting the merits of such accelerated growth. The Secretary would also be granted the authority to adjust payments for efficiency gains for new procedures. The Secretary may apply a methodology, based on supporting evidence, under which there is imposed a reduction over a period of years in specified 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.

Section 303. Physician feedback mechanism on practice patterns.

Both MedPAC and GAO have recently recommended providing information to physicians on their resource use. MedPAC asserts that physicians would be able to assess their practice styles, evaluate whether they tend to use more resources than their peers or what evidence-based research (if available) recommends, and revise practice styles as appropriate. MedPAC notes that in certain instances, the private sector use of feedback has led to a small downward trend in resource use. According to MedPAC, Medicare has the potential to be more successful since it is the single largest purchaser of health care and therefore its reports should command more attention. MedPAC states that using the results for physician education would provide CMS and physicians with experience with the measurement tool and allow for refinements. With more experience and confidence in the approach, physician

feedback on resource use could be used for payment purposes or to create other incentives.

In an April 2007 report (Focus on Physician Practice Patterns Can Lead to Greater Program Efficiency), GAO explored linking physician compensation to efficiency - defined as providing and ordering a level of services sufficient to meet a patient's needs but not excessive given a patient's health status. The analysis focused on generalists, namely physicians who defined their specialty as general practice, internal medicine, or family practice. The report categorized physicians who treated a disproportionate share of overly expensive patients as outlier generalists. The report found outlier generalist physicians in all twelve metropolitan areas studied. GAO found that Medicare patients who saw outlier generalists were more likely to have been hospitalized, more likely to have been hospitalized multiple times, and more likely to have used home health services. They were however, less likely to have been admitted to a skilled nursing home.

The GAO report noted that certain public and private health care purchasers routinely evaluate physicians in their networks using measures of efficiency and other factors. It noted that the purchasers it studied linked their evaluation results to a range of incentives, from steering patients toward the most efficient providers to excluding physicians from the provider's network because of inefficient practice patterns. GAO noted that while CMS has the tools available to evaluate physician practices it may not have the flexibility that other purchasers have to link physician profiling results to a range of incentives to encourage efficiency.

The provision would require the Secretary of Health and Human Services to develop and implement a mechanism to measure resource use on a per capita and an episode basis by June 1, 2008. This activity is meant to provide feedback to physicians who participate in the Medicare program on how their practice patterns compare to physicians generally, both in the same locality as well as nationally. This feedback would not be subject to disclosure under the Freedom of Information Act.

Section 304. Payments for Efficient Physicians. MMA provided for an additional 5% in payments for certain physicians in scarcity areas for the period January 1, 2005 through December 31, 2007. The Secretary was required to calculate, separately for practicing primary care physicians and specialists, the ratios of such physicians to Medicare beneficiaries in the county, rank each county (or equivalent area) according to its ratio for primary care and specialists separately, and then identify those scarcity areas with the lowest ratios which collectively represented 20% of the total Medicare beneficiary population in those areas. The list of counties was to be revised no less often than once every three years unless there were no new data. The listing of counties appeared in Appendix I and Appendix J of the 2005 physician fee schedule update.

This provision would create incentive payments under the Medicare program for physicians practicing in areas identified as an efficient area. From January 1, 2009 through December 31, 2010, physicians practicing in counties or equivalent areas that are in the lowest fifth percentile based on per capita spending for Medicare Part A and Part B, standardized to eliminate the effect of geographic adjustments in payment rates, would receive an amount equal to 5% of the Medicare payment

amount. For each year, the Secretary would identify and post low volume areas as part of the proposed and final rule to implement the annual physician fee schedule. The Secretary would post the list of counties identified on the CMS website.

Section 305. Recommendations on refining the physician fee schedule. The provision would modify the physician fee schedule by requiring the Secretary to analyze and recommend ways to consolidate coding for procedures and to increase use of bundled payments. No later than December 31, 2008, the Secretary of Health and Human Services would be required to complete an analysis of those procedures under the Medicare physician fee schedule for which there is no global payment methodology being applied for which a bundled payment methodology would be appropriate, and submit a report on such analysis and recommendations on increasing the use of bundled payments under the Medicare physician fee schedule.

Section 306. Improved and Expanded Medical Home Demonstration Project. Advocates of the advanced medical home concept propose a vision of health care focused on physician-guided, patient-centered care through the promotion of continuous care relationships and the delivery of care in a variety of settings according to the needs of the patient and skills of the medical provider. In theory, the advanced medical home model emphasizes patient-centered, physician-guided, cost-efficient, longitudinal care over episodic, illness-oriented, complaint-based care. The personal physician would coordinate and facilitate care and provide guidance, insight, and advice to help the patients. In most cases, primary care physicians, with their office care team, would be best suited to provide principal care and be a patient's care coordinator, or personal physician, in the advanced medical home model. However, a medical specialist with his or her office care team could also fulfill the role of personal physician. Proponents of this model claim that a personal physician would be able to coordinate and facilitate the care of patients and would be directly accountable to each patient, in contrast to a "gatekeeper" who is sometimes viewed as an impediment, restricting patient access to services.

Section 204 of the Tax Relief and Health Care Act of 2006 mandated a Medicare medical home demonstration project. The demonstration is to be conducted in up to 8 states to provide targeted, accessible, continuous and coordinated family-centered care to Medicare beneficiaries who are deemed to be high need (with multiple chronic or prolonged illnesses that require regular medical monitoring, advising or treatment.) CMS anticipates selecting a contractor to provide assistance in the design of the Medical Home Demonstration by September, 2007. Implementation is expected by late September, 2008.

The provision would require the Secretary to establish an expanded medical home Medicare demonstration project ("expanded project"), which would supersede the project initiated under section 204 of the Tax Relief and Health Care Act of 2006. The expanded project's purposes would be as follows: (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.

Under the expanded Medicare medical home project, the Secretary would provide a monthly medical home care management fee payment to the personal physician of each participating beneficiary. In determining the amount of the fee, the Secretary would consider the operating expenses, the added value services, a risk adjustment, a HIT adjustment, and a performance-based payment.

The expanded project would be funded through monies for the original demonstration as well as \$500,000,000 of additional funds from the Federal Supplementary Medical Insurance Trust Fund (Part B). This would include the payments of the monthly medical home care management fees described above, reductions in coinsurance for participating beneficiaries, and funds for the design, implementation, and evaluation of the expanded project. The Secretary would monitor the expenditures under the expanded project and could terminate the project early so that expenditures would not exceed the amount of funding provided for the project. The Secretary would provide and submit to Congress an annual report on the project and an evaluation of the project, by a date specified by the Secretary. The Secretary would also provide for an evaluation of the expanded project and would 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.

Section 307. Repeal of Physician Assistance and Quality Initiative Fund. The provision would repeal the Physician Assistance and Quality Initiative Fund established by TRHCA. TRHCA authorized \$1.35 billion for 2008 for the fund, which is to be available to the Secretary for physician payment and quality improvement initiatives.

Section 308. Adjustment to Medicare Payment Localities. Medicare payments to physicians vary according to geographic areas called Medicare payment localities or fee schedule geographic areas. There are currently 89 localities; some are statewide, while others are substate areas. Medicare makes a separate geographic adjustment to each component of the physician fee schedule: a work adjustment, a practice expense adjustment, and a malpractice adjustment. These adjustments are intended to reflect the variation in the costs of providing services in different parts of the country. These three components are weighted and then added together to produce an indexed relative value unit for the service for the locality. The payment locality structure for the current Medicare's physician fee schedule was established in 1996 and took effect January 1, 1997. The objective was to ensure that the localities had relatively homogenous resource costs. Currently, there are 89 separate payment localities of which 34 are statewide.

MMA made temporary changes to the geographic adjusters. From 2004 - 2006, the geographic adjustment for the work component of the fee schedule was increased to 1.000 in any area where the multiplier would otherwise be less. The Tax Relief and Health Care Act of 2006 extended the provision for an additional year, through 2007. MMA further directed the GAO to conduct a study of the geographic adjusters. A GAO report issued in March 2005 concluded that all three adjusters were valid in their fundamental design, and appropriately reflected broad patterns of geographic differences in running a practice. The report made several recommendations for improving the data and methods used to construct the data. CMS has stated that any changes must be made in a budget-neutral fashion for the

state. Thus, if higher geographic practice cost indices (and thus payments) are applied in one part of the state, they must be offset by lower indices (and payments) in other parts of the state.

Two counties in California (Santa Cruz and Sonoma) are assigned to a larger payment locality (“rest of California”), but in the years since the payment localities were initially established, the cost and expenditure measures used to calculate geographic adjusters for Medicare physician payment have increased more quickly in those areas than in the “rest of California” payment locality. In the July 12, 2007, proposed rule for the 2008 physician fee schedule (*72 Federal Register* 38122, July 12, 2007), CMS proposed three options for addressing the situation.

The provision would require the Secretary to revise the fee schedule areas for California using the county-based geographic adjustment factor as specified in option 3 (table 9) in the proposed rule for Medicare physician services beginning January 1, 2008. This approach would group counties within a state into localities based on similarity of GAFs even if the counties were not geographically contiguous and would reduce the number of payment localities in California from 9 to 6, each based on counties or aggregates of counties, with the resulting localities reflecting similar geographic adjustment factors (GAFs). CMS claims that this option would be the most administratively burdensome option to implement because of the significant systems changes and provider education that would be required to reconfigure the California localities in this manner. It would also place a greater burden on practicing physicians who are more likely to experience a change in his or her practice’s locality. The county-by-county impact of this option is detailed in table 9, *72 Federal Register* 38141 (July 12, 2007). In the transition from the existing payment localities to the new payment localities, for services provided January 1, 2009, through December 31, 2010, the new GAF would apply unless there is a loss, in which case the old GAF would apply. In other words, the higher of the two GAFs as calculated under the existing or the new methodology would apply.

No later than January 1, 2011, the Secretary would review and make revisions to fee schedule areas in all states where there is more than one Medicare physician payment fee schedule area. The Secretary may revise the fee schedule areas in these states using the same methodology used for California. Any such revisions would be made effective concurrently with the application of the periodic (3-year) review of geographic adjustment factors required by law for 2011.

Section 309. Payment for Imaging Services. The provision would establish an accreditation process for facilities that provide diagnostic imaging services; the process would be modeled on that used for mammography facilities under Section 354 of the Public Health Service Act. Effective January 1, 2010, imaging services could only be paid for if provided in accredited facilities, except that this limitation would 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. (The provision would apply to ultrasound services on January 1, 2012.) Effective January 1, 2008, The provision would require separate billing for the technical component and professional component of imaging services. It would require CMS to increase the assumption regarding the time equipment is in use from 50% to 75%. It would also require CMS

to assume the interest rate for capital purchases reflects the prevailing rate, but in no case higher than 11%.

Section 310. Reducing Frequency of Meetings of the Practicing Physicians Advisory Council. The provision would modify the frequency of meetings of the Physicians Advisory Council, as established under Section 1868(a) of the Social Security Act, from quarterly to once each year (“and at such other times as the Secretary may specify”). The Council’s duties are to discuss certain proposed changes in regulations and carrier manual instructions related to physician services identified by the Secretary. The council members are appointed by the Secretary, based upon nominations submitted by medical organizations representing physicians. The Council is composed of 15 physicians, each of whom has submitted at least 250 Medicare claims for physicians’ services in the previous year. At least 11 of the members of the Council are doctors of medicine or osteopathy (not doctors of dentistry or dental surgery, podiatry, optometry, or chiropractic) and the members of the Council include both physicians participating in Medicare as well as nonparticipating physicians and physicians practicing in rural areas and underserved urban areas.

Title IV — Medicare Advantage Reforms

Subtitle A — Payment Reform

Section 401. Equalizing payments between Medicare Advantage Plans and fee-for-service Medicare. The provision would phase-in Medicare Advantage benchmarks equal to per capita fee-for-service (FFS) spending in each county; this would result in decreased MA benchmarks in some areas. Plans bidding a specified percent above per capita FFS would not be allowed to enroll new enrollees. The calculation of per capita FFS would be altered to exclude costs attributable to indirect medical education. The stabilization fund would be repealed.

Subtitle B — Beneficiary Protections

Section 411. NAIC development of marketing, advertising, and related protections. Currently, MA plans are required to conform to fair marketing standards. This provision would request the National Association of Insurance Commissioners (NAIC), in consultation with a working group of MA plan representatives, consumer groups, beneficiaries, and others, to develop new marketing and advertising standards for Medicare Part C and Prescription Drug Plans (PDPs). Model regulations would be required to address the sales and advertising techniques used by plans, beneficiary education, training by sales agents and brokers, and agent and broker commissions. Plans would be required to comply with the new marketing standards by January 1, 2011. In addition, the provision would double the penalties for violations of the new marketing standards and expand the state’s role in oversight of MA plans. The Secretary would be required to publicly disclose all MA plan violations. The provision would also increase funding for the State Health Insurance Assistance Program (SHIPs), which provides community-based counseling and outreach assistance to beneficiaries on Medicare-related issues.

Section 412. Limitation on out-of-pocket costs for individual health services. All MA plans can impose cost sharing on Medicare beneficiaries that is equal to the cost sharing required under traditional Medicare or equal to an actuarially equivalent level of cost sharing under traditional Medicare. Beginning January 1, 2009 this provision would prohibit plans from imposing cost sharing amounts that were greater than the cost sharing amounts for the same service in FFS Medicare. Additionally, beginning January 1, 2008, cost-sharing amounts for dual eligibles and Qualified Medicare Beneficiaries (QMBs) would be required to be at a minimum equivalent to the cost sharing amounts imposed under a state's Medicaid program.

Section 413. MA plan enrollment modifications. This provision would provide continuous open enrollment to full benefit dual-eligibles and qualified Medicare beneficiaries (QMBs). Specified Low-Income Beneficiaries (SLMBs) would be eligible to participate in special election periods and change their enrollment in a MA plan outside of the annual coordinated election period. Beneficiaries that disenroll from MA plans would have two years instead of one to re-enroll in their previous Medigap plan. Further, the Secretary would be prohibited from enrolling Medicaid-eligible individuals as dual-eligibles or QMBs in a MA plan without explicit permission from the beneficiary.

Section 414. Information for beneficiaries on MA plan administrative costs. This provision would require MA plans to submit certain financial information to the Secretary, including the plan's medical loss ratio, adjusted per enrollee payment amount, average risk score, and other data elements. Beginning in 2009, the Secretary would be required to publicly report this data. By 2010, the data submitted related to a plan's medical loss ratio, would be based on standardized definitions and data elements developed by the Secretary in consultation with the National Association of Health Insurance Commissioners (NAIC), MA plan representatives, and experts on health plan accounting systems. Plans that did not have a minimum medical loss ratio of at least 0.85 would face a reduced benchmark amount the following year, limits on new enrollment after three consecutive years, and termination from the Medicare program after five years. The provision would also require MedPAC to conduct a study on the feasibility of providing for different medical loss ratios for different types of MA plans.

Subtitle C — Quality and Other Provisions

Section 421. Requiring all MA plans to meet equal standards. The provision would require Medicare Part C private fee-for-service plans and medical savings accounts to submit the same performance measure information as preferred provider plans in 2009 and the same performance measure information as other Part C plans starting in 2010. The Secretary's authority to waive or modify requirements for Part C plans sponsored by employers and unions would be limited beginning in January 2009.

Section 422. Development of new quality reporting measures on racial disparities. The Secretary would be required to develop quality measures that measure disparities in the amount and quality of health services provided to racial and ethnic minorities. Plans would be required to submit data on the new

measures. The Secretary would be required to submit a report to Congress based on this data.

Section 423. Strengthening Audit Authority. The audits of Medicare Part C plans that the Secretary currently conducts would be expanded to include information on risk adjustment. The Secretary would be authorized to pursue financial recoveries necessary to address deficiencies identified in the audit or other activities. These provision would apply to Medicare Part D plans as well.

Section 424. Improving risk adjustment for MA plans. No later than one year after enactment, the Secretary would be required to submit a report to Congress that evaluated the adequacy of risk adjustment under Medicare Part C.

Section 425. Eliminating special treatment for private fee-for-service plans. In 2009, this provision would eliminate a provider's ability to bill enrollees in private FFS plans more than the fee schedule amount. The Secretary would have the authority to review and negotiate the bid amounts from private FFS plans in the same manner as with all other Part C plans.

Section 426. Renaming of Medicare Advantage program. The Medicare Advantage program would be renamed the Medicare Part C program.

Subtitle D — Extension of Authorities

Section 431. Extension and revision of authority for special needs plans (SNPs). The authority to limit SNP enrollment to only special needs beneficiaries would be extended from January 1, 2009 to January 1, 2012. As of January 1, 2009, the definition of SNPs would be changed to include MA plans in which at least 90% of enrollees were institutionalized, dually-eligible, or had one of six specific chronic conditions as indicated by MA risk-adjustment data. Chronic care SNPs would have to meet additional requirements such as having an average risk score of 1.35 or greater and maintaining a sufficient network of providers. The Secretary would be required to develop new quality measures appropriate for all types of SNPs. Effective January 1, 2009, the provision would repeal the special authority granted to the Secretary by Section 231 of MMA to designate MA plans that disproportionately serve special needs individuals as SNPs.

Section 432. Extension and revision of authority for Medicare reasonable cost contracts. The provision would extend for three additional years - from January 1, 2008 to January 1, 2011 - the length of time a cost-based plan could continue operating in an area where either 2 local or 2 regional Medicare Advantage plans had entered. Any reasonable cost plan contract that was extended or renewed on or after enactment would be required to comply with substantially similar requirements as other Medicare Part C organizations.

Title V — Provisions Relating to Medicare Part A

Section 501. Inpatient Hospital Payment Updates. Medicare increases hospital payments each year. The legislation would establish that acute care hospitals

paid under Medicare's inpatient prospective payment system (IPPS) would receive a smaller payment update. Instead of the hospital market basket (MB), hospitals would receive the MB minus 0.25 percentage points as their payment update. Other hospitals, including cancer hospitals, that are paid on the basis of reasonable costs subject to certain limits or hospital-specific target amounts, would also receive a smaller payment increase. Target amounts for certain IPPS exempt hospitals would be increased by the MB minus 0.25 percentage points in FY2008.

Section 502. Payment for Inpatient Rehabilitation Facility (IRF) Services. Starting January 1, 2002, payments to inpatient rehabilitation facilities (IRFs) are made under a discharge-based prospective payment system where one payment covers capital and operating costs. Each year, the per discharge payment amount is increased by an update factor based on the increase in the market basket index. The provision would establish the IRF update factor at 1% in FY2008, starting for discharges on January 1, 2008. The IRF compliance threshold (that determines if a facility is an IRF or an acute care hospital) would be established as no greater than the 60% compliance rate that became effective for cost reporting periods beginning July 1, 2006; comorbidities would be included as qualifying conditions.

The provision would create a special payment rule for patients in IRFs admitted for three applicable medical conditions: unilateral knee replacement, unilateral hip replacement, and unilateral hip fracture. Instead of the IRF standardized amount, starting October 1, 2008, discharges with applicable medical conditions would be paid based on a modified standardized amount, generally based on the SNF payment rate. These provisions would apply until the Secretary implements an integrated, site-neutral payment methodology for post acute care. These provisions would not be subject to administrative or judicial review. For discharges from April 1, 2008 through September 30, 2008, the standardized payment amount would be \$9,507 for unilateral knee replacements; \$10,398 for unilateral hip replacements; and \$10,958 for unilateral hip fractures.

Not later than one year after this legislation is enacted, the Secretary, in consultation with interested parties, would submit a report to appropriate Congressional committees on the IRF compliance criteria and beneficiary access to IRF care among other issues.

Section 503. Long-Term Care Hospitals. A long-term care hospital (LTCH) is an acute care general hospital that has a Medicare inpatient average length of stay greater than 25 days. Since 2002, LTCHs have been paid under their own prospective payment system (PPS). This provision would establish 1886(m) of the Social Security Act (SSA) entitled "Prospective Payment for Long-Term Care Hospitals." The base rate for LTCH's rate year (RY) 2008 would be the same as that used for discharges in the previous rate year, starting January 1, 2008. This legislation would also establish section 1861(ccc) in the SSA that would define an LTCH as an institution which qualifies as one of the following: 1) the institution 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 LTCH services; 2) the institution has a Medicare inpatient

average length of stay greater than 25 days; 3) the institution satisfies Medicare's hospital definition; or 4) the institution meets certain facility criteria.

An LTCH would be required to have a patient review process prior to admission and other established procedures to ensure the patient's continued need for LTCH care. Other LTCH staffing and care requirements, including patient criteria, would be imposed, starting for discharges occurring on January 1, 2008. If rehabilitation services are not included as one of the patient criteria, then the Secretary would be required to approve distinct part rehabilitation units in certain LTCHs (those classified as such by October 1, 2004 with specified accreditation). The one-year waiting period applicable to the conversion of hospital beds into distinct-part IRFs would not apply. The above provisions would apply to discharges on or after January 1, 2008.

No later than one year from enactment, the Secretary would be required to submit a report to the appropriate Congressional committees that contained recommendations regarding the promulgation of national LTCH facility and patient criteria. Starting October 1, 2007, the Secretary would be required to contract with one or more appropriate Medicare administrative contractors to review the medical necessity of LTCH admissions and continued LTCH stays. The reviews would be funded by the aggregate overpayments recouped by the Secretary from LTCHs for medically unnecessary care.

The Secretary would impose a four-year moratorium on the certification of new LTCHs and satellite facilities as well as LTCH beds and satellite facility beds. The moratorium would not apply to an LTCH hospital, satellite facility or additional beds that are under development (according to criteria specified in the legislation) as of the enactment date. Certain exceptions to the moratorium would be established. There would be no administrative or judicial review of these exceptions.

Certain LTCH payment policies would be precluded for specific periods. CMS limits the proportion of patients who can be admitted to an LTCH from an acute care hospital during a cost reporting period and be paid under the LTCH-PPS. Under this policy (referred to as the "25% rule"), after the threshold is reached, the LTCH is paid the lesser of the LTCH PPS rate or the acute hospital IPPS rate. During a five-year period beginning with enactment, the existing 25% rule would not apply to freestanding LTCHs or certain LTCH hospitals-with-hospital (or HwHs) referred to as "grandfathered LTCHs" that have been considered to be freestanding. The existing 50% threshold would be increased to 75% for applicable LTCHs (HwHs or satellite facilities) in rural areas or LTCHs that are co-located with an urban single or MSA dominant hospital. For other HwHs or satellite facilities, the admission threshold from a co-located hospital would be established at 50%. Also, the Secretary would not be able to apply the new short-stay outlier policy during a five-year period. The Secretary would not be able to make the one-time prospective adjustment to LTCH prospective payments during a five-year moratorium period. These changes would apply to discharges starting October 1, 2007 and before October 1, 2012.

As established by the Balanced Budget Act of 1997 (BBA), there is one "subclause II" long term care hospital identified in 1886(d)(1)(B)(iv)(II) of the Social Security Act (SSA). A separate classification for this hospital as a long-stay cancer

hospital would be created in Section 1886(d)(1)(B)(vi) of the SSA. Starting for cost reporting periods after the date of enactment, Medicare payments to this hospital would be based on the rates in effect for the cost reporting period for the hospital during FY2001 increased by the applicable update factor. This hospital would include satellite or remote site locations that met the applicable Medicare provider based regulations and other applicable state licensure and certification requirements.

Section 504. Increasing the DSH Adjustment Cap. Medicare will increase its payments to hospitals that qualify for a disproportionate share hospital (DSH) adjustment. Small urban hospitals and many rural hospitals have their DSH adjustment capped at 12%. The provision would raise the DSH adjustment cap for these hospitals to 16% for discharges occurring in FY2008 and to 18% for discharges in FY2009. For discharges starting October 1, 2009, the DSH adjustment cap would revert to 12%. The DSH adjustment formula for hospitals in Puerto Rico would change.

Section 505. PPS-Exempt Cancer Hospitals. Certain specialty hospitals were exempt from IPPS. Historically, they were paid on a reasonable cost basis, subject to TEFRA payment limitations which establishes a ceiling or target amount that serves as an upper limit on operating costs. Children's and cancer hospitals are still paid on a reasonable cost basis, subject to TEFRA limits. Psychiatric hospitals, inpatient rehabilitation, and long-term care hospitals have separate prospective payment systems.

A hospital receiving reasonable cost reimbursement during cost reporting periods before October 1, 1999 would be able to request a new target amount. Beginning during FY2008, the target amount would be based on the five most recent settled cost reporting periods prior to the enactment of this clause. This recalculation (or re-basing) would not apply to long-term care hospitals.

Presently there are 11 freestanding IPPS exempt cancer hospitals. Other cancer hospitals (exempt from IPPS) would be established starting for cost reporting periods on or after January 1, 2006. Certain hospitals would have this IPPS exempt classification apply to cost reporting periods beginning on or after January 1, 2006. One would take effect on January 1, 2008. Other provisions would apply.

No later than March 1, 2009, MedPAC would be required to evaluate the following: (1) measures of payment adequacy and Medicare margins for PPS-exempt cancer hospitals; (2) margin information for PPS cancer hospitals that were previously affiliated with another hospital; and (3) payment adequacy for cancer discharges paid for under Medicare's IPPS.

Section 506. Skilled Nursing Facility Payment Update. Skilled Nursing Facilities (SNFs) are paid through a prospective payment system (PPS) which is composed of a daily ("per-diem") urban or rural base payment amount that is then adjusted for case mix and area wages. The urban and rural federal per diem payment rates are increased annually by an update factor that is determined, in part, by the projected increase in the SNF market basket (MB) index, a measure of the changes in the costs of goods and services purchased by SNFs. The provision would eliminate

the MB update for FY2008, effective for payments for days on or after January 1, 2008.

Section 507. Revocation of Unique Deeming Authority of the Joint Commission for the Accreditation of Healthcare Organizations. In order to receive Medicare payments, healthcare providers and suppliers must meet certain conditions of participation established by the Secretary. A hospital is deemed to have met these conditions of participation if it has been accredited by the Joint Commission of Healthcare Organizations (JCAHO). This provision would revoke the unique authority granted the Joint Commission of Healthcare Organizations (JCAHO) to accredit hospitals for participation in Medicare. Hospitals, like other Medicare provider entities, would be accredited by national accrediting organizations approved by the Secretary. The Secretary would have the authority to recognize JCAHO as a national accreditation body. The provision would take effect 18 months after the enactment date.

Section 508. Treatment of Medicare Hospital Reclassifications. Under IPPS, a hospital (or group of hospitals) can increase its Medicare payments through administrative reclassification (by the Medicare Geographic Classification Review Board or MGCRB) to a different area with a higher wage index value. These reclassifications are budget neutral. Other hospitals have been reclassified by legislation. Section 508 of MMA provided \$900 million for a one-time, three-year geographic reclassification of certain hospitals who were otherwise unable to qualify for administrative reclassification to areas with higher wage index values. These reclassifications were extended from March 31, 2006, to September 30, 2007, by the Tax Relief and Health Care Act of 2006. This extension was exempt from any budget neutrality requirements.

The provision would extend the Section 508 reclassifications until September 30, 2009. Hospitals that were reclassified through the Secretary's authority to make exceptions and adjustments during the FY2005 rulemaking process would have their reclassification extended until September 30, 2009. A hospital that has been reclassified under Section 508 (as extended) would not prevent the group reclassification of otherwise eligible hospitals.

Special treatment was established for other hospitals or groups of hospitals for a three-year period starting October 1, 2008 as follows:

- Hospitals located in Putnam County, TN, with a reclassified wage index that would expire on September 30, 2007, would have such reclassification extended through September 30, 2008;
- Any hospital in Orange County, NY, that received a Section 508 reclassification would be reclassified into New York-White Plains-Wayne NY-NJ urban area;
- The large urban area of New York, NY, would include hospitals required by state law to have a single governance structure if certain requirements are met;
- The large urban area of Buffalo-Niagara Falls, NY, would include Chautaugua County, NY. There would be no reduction in the hospital wage index for Erie County, NY, or any adjoining county

as a result of this provision except for that associated with the budget neutrality requirements associated with a MGCRB reclassification;

- A hospital in Burlington County, NJ, would be reclassified into the New York-White Plains NY-NJ urban area if certain criteria are met;
- A hospital that is located in a core-based statistical area with certain characteristics would be reclassified to a urban area that is within the same state and is adjacent to the area where the hospital is located with an average hourly wage that is closest to, but does not exceed its own average hourly wage. This provision would apply to hospitals in Orange County, NY, that were described above;
- Albany, Schenectady, and Rensselaer counties are deemed to be part of the Hartford, CT, urban area;
- Cumberland County, TN, is deemed to be part of the Nashville-Davidson-Murfreesboro urban area;
- Hospitals that are colocated in Marinette, WI, and Meominee, MI, are deemed to be located in Chicago, IL;
- A hospital in Massachusetts or Clinton County, NY, that is reclassified into an area that uses the higher rural wage index would receive the rural wage index;
- A hospital in Toledo, OH, and one in Adrian, MI, would treated as if they are located in Ann Arbor, MI.
- A hospital in Columbia County, NY, with less than 250 beds is deemed to be in the New York-White Plains-Wayne, NY-NY urban area.

Generally, these reclassifications would be treated as MGCRB decisions and would be subject to budget neutrality requirements.

Section 509. Medicare Critical Access Hospital Designations.

Critical access hospitals (CAHs) are limited-service facilities that are located more than 35 miles from another hospital or 15 miles in certain circumstances; offer 24-hour emergency care; have no more than 25 acute care inpatient beds and have a 96-hour average length of stay. Until January 1, 2006, states could waive the CAH mileage requirements and designate an entity as a necessary provider of health care and qualify as a CAH. The State of Minnesota would be able to designate one hospital in Cass County, MN, as a necessary provider of health care on or after January 1, 2006. A hospital in the county seat of Butler, AL, with a 32-mile drive would be deemed to meet the CAH mileage requirement. These provisions would apply to cost reporting periods beginning on or after enactment date.

Title VI — Other Provisions Relating to Medicare Part B

Subtitle A — Payment and Coverage Improvements

Section 601. Payment for Therapy Services. The law places an annual per beneficiary payment limit on outpatient physical therapy services and speech language pathology services. A second annual per beneficiary payment limit applies to outpatient occupational therapy services. A temporary exceptions process applies

for certain specified conditions or complex situations. The provision would extend the exceptions process for two years, through 2009. It would also require the Secretary to conduct a study on refined and alternative payment systems for therapy services.

Section 602. Medicare Separate Definition of Outpatient Speech Language Pathology Services. The provision would permit, effective January 1, 2008, speech language pathologists practicing independently to bill Part B subject to the same conditions applicable to physical and occupational therapists in independent practice.

Section 603. Increased Reimbursement Rate for Certified Nurse Midwives. The provision would remove the current law provision which specifies that the fee schedule amount for a service furnished by a certified nurse midwife can in no case exceed 65% of the fee schedule amount for the same service performed by a physician.

Section 604. Adjustment in Outpatient Hospital Fee Schedule Increase Factor. Each year, the hospital outpatient department conversion factor is increased by an amount that is loosely based on increases in the hospital market basket index. Under this provision, Medicare's increase in hospital outpatient department payments for services furnished in 2008 would be established as the market basket increase reduced by 0.25 percentage points.

Section 605. Exception to 60-Day Limit on Medicare Reciprocal Billing Arrangements in Case of Physicians Ordered to Active Duty in the Armed Forces. Medicare payment may be made to a physician for services furnished by a second physician to patients of the first physician provided certain conditions are met. The services cannot be provided by the second physician for more than 60 days. The provision would permit reciprocal billing over a longer period in cases where the first physician has been called or ordered to active duty as a member of a reserve component of the Armed Forces.

Section 606. Excluding clinical social worker services from coverage under the Medicare skilled nursing facility prospective payment system and consolidated payment. Skilled Nursing Facilities (SNFs) are paid through a prospective payment system (PPS) that is composed of a daily ("per-diem") urban or rural base payment and is adjusted for case mix and area wages. The PPS provides a bundled payment for services provided to the beneficiary that day. Services provided to residents by certain types of providers, such as physicians, are excluded from the bundled payment. The provision would exclude clinical social worker services from the SNF PPS; to be effective for items and services furnished on or after January 2008.

Section 607. Coverage of Marriage and Family Therapists and Mental Health Counselor Services. The provision would add coverage, effective January 1, 2008, for state-licensed or certified marriage and family therapists and mental health counselors. Payment would equal the lesser of 80% of the actual charge for the service or 75% of the amount paid to a psychologist for such services.

Section 608. Rental and Purchase of Power-Driven Wheelchairs.

On or after January 1, 2008, the provision would eliminate the option to purchase a power-driven wheelchair with a lump sum payment. The provision would not apply to the Durable Medical Equipment Competitive Acquisition Program.

Section 609. Rental and Purchase of Oxygen Equipment.

The provision would require the Secretary to conduct a study on oxygen services and equipment provided to beneficiaries. The provision would reduce the length of time that Medicare rented oxygen equipment from 36 months to 18 months, but would exempt oxygen generating portable equipment and equipment offered through the DME Competitive Acquisition Program.

Section 610. Adjustment for Medicare Mental Health Services.

The provision would provide for a temporary increase of 5% over the amount otherwise payable for certain specified mental health services for the period beginning January 1, 2008, and ending December 31 of the year before the effective date of the first five year review of relative values conducted after January 1, 2008.

Section 611. Extension of Brachytherapy Special Rule.

MMA required Medicare's outpatient prospective payment system to make separate payments for specified brachytherapy sources. As mandated by TRHCA, until January 1, 2008, this separate payment will be made using hospitals' charges adjusted to their costs. The provision would extend cost reimbursement for brachytherapy services until January 1, 2009.

Section 612. Payment for Part B Drugs.

Payments for most Part B drugs are based on an average sales price (ASP) payment methodology. Alternatively, drugs can be provided through the competitive acquisition program (CAP); each year, each physician is given the opportunity either to receive payment using the ASP methodology or to obtain drugs and biologicals through the CAP. The provision would require the Secretary to use consistent volume weighting in the computation of the ASP. The provision would modify the CAP program as follows: permit continuous open enrollment and selection of a CAP vendor; specify that an election and selection would continue to be effective without the need for any periodic reelection or reapplication or selection; specify that vendors would not be prevented from delivering drugs to a satellite office designated by the prescribing physician or allowing a physician to transport drugs to the site of administration consistent with state law; and require the Secretary to conduct an outreach and education program on the CAP. The provision would also establish, beginning January 1, 2008, a special rule for the payment calculation for inhalation drugs furnished through items of durable medical equipment to specify that the payment for both single source and multiple source drugs would be the lower of the current or historic level.

Subtitle B — Extension of Medicare Rural Access Protections**Section 621. 2-Year Extension of Floor on Medicare Work Geographic Adjustment.**

Current law includes a temporary provision under which the value of any work geographic index under the physician fee schedule that is below 1.00 is increased to 1.00 for services furnished on or after January 1, 2004,

and before January 1, 2008. The provision would extend the floor through December 31, 2009.

Section 622. 2-Year Extension of Special Treatment of Certain Physician Pathology Services Under Medicare. The provision would extend through December 31, 2009, the temporary provision that allows independent laboratories providing services to hospitals to continue to bill directly for such services. The provision is limited to labs that had agreements with hospitals on July 22, 1999, to bill directly for the technical component of pathology services.

Section 623. 2-Year Extension of Medicare Reasonable Cost Payments for Certain Clinical Diagnostic Laboratory Tests Furnished to Hospital Patients in Certain Rural Areas. Generally, hospitals that provide clinical diagnostic laboratory services under Part B are reimbursed using a fee schedule. Hospitals with under 50 beds in qualified rural areas (certain rural areas with low population densities) receive 100% of reasonable cost reimbursement for the clinical diagnostic laboratories covered under Part B that are provided as outpatient hospital services. Reasonable cost reimbursement for laboratory services provided by these hospitals will end July 1, 2007. This provision would extend reasonable cost reimbursement for clinical laboratory services provided by qualified rural hospitals until July 1, 2009.

Section 624. 2-Year Extension of Medicare Incentive Payment Program for Physician Scarcity Areas. Current law provides a 5% bonus payment for certain physicians in scarcity areas for the period January 1, 2005, through December 31, 2007. The provision would extend the add-on payments through December 31, 2009. During 2008 and 2009, the Secretary would be required to use the primary care scarcity areas and specialty care scarcity areas that the Secretary was using on December 31, 2007.

Section 625. 2-Year Extension of Medicare Increase Payments for Ground Ambulance Services in Rural Areas. Ambulance services are paid on the basis of a national fee schedule, which is being phased-in. For the period July 2004 through December 2006, the law provided for a temporary increase in payments for ground ambulance services. The increase was 2% in rural areas and 1% in other areas. The provision would reinstate the bonus payments for rural areas for 2008 and 2009.

Section 626. Extending Hold Harmless for Small Rural Hospitals under the HOPD Prospective Payment System. Small rural hospitals (with no more than 100 beds) that are not sole community hospitals can receive additional Medicare payments if their outpatient payments under the prospective payment system are less than under the prior reimbursement system. For calendar year (CY) 2006, these hospitals will receive 95% of the difference between payments under the prospective payment system and those that would have been made under the prior reimbursement system. The hospitals will receive 90% of the difference in CY2007 and 85% of the difference in CY2008. The provision would establish that these small rural hospitals would receive 90% of the payment difference for service furnished after CY2006.

Subtitle C — End Stage Renal Disease Program

Section 631. Chronic Kidney Disease Demonstration Projects. The Secretary, acting through the Director of the National Institutes of Health (NIH), would be required to establish demonstration projects to do the following: (1) increase public and medical community awareness about the causal factors, prevention, diagnosis, and treatment of chronic kidney disease; (2) increase screening and use of prevention techniques for chronic kidney disease for Medicare beneficiaries and the general public; and, (3) enhance surveillance systems and expand research to better assess the prevalence and incidence of chronic kidney disease, building on work of the Centers for Disease Control and Prevention (CDC). The Secretary would be required to conduct an evaluation of the demonstration projects. Within 12 months after completion of the projects, the Secretary would be required to submit a report to Congress including the evaluation and recommendations for appropriate legislative and administrative action.

Section 632. Medicare Coverage of Kidney Disease Patient Education Services. Medicare coverage would be expanded to include coverage for kidney disease education services, defined as education services that are (1) furnished to an individual with stage IV chronic kidney disease who, according to accepted clinical guidelines identified by the Secretary, would require dialysis or a kidney transplant; (2) furnished, upon the referral of the physician managing the individual's kidney condition, by a qualified person; (3) designed to provide comprehensive information regarding the management of co-morbidities (including delaying the need for dialysis), prevention of uremic complications, and options for renal replacement therapy; (4) designed to ensure that individuals have the opportunity to actively participate in the choice of therapy; and (5) tailored to meet the needs of the individual involved. Qualified person would mean a physician, physician assistant, nurse practitioner, or clinical nurse specialist who provides services that are paid under the Medicare fee-schedule, but would not include a renal dialysis facility. The Secretary would be required to set standards for the content of the educational services, after consulting with physicians and others as required by statute, excluding to the extent possible those who have received industry funding from a drug or biological manufacturer or dialysis facility. The Secretary would be required to monitor and to promulgate regulations to carry out this education, to ensure that beneficiaries entitled to these services received them in a timely manner to maximize the benefit of the services. Individuals would be eligible for no more than 6 sessions of kidney disease education services.

No later than September 1, 2010, GAO would be required to submit a report to Congress on the following: (1) the number of Medicare beneficiaries who are eligible for kidney disease education services and who received the services; (2) the extent to which there is a sufficient number of physicians and eligible providers to furnish these services and whether or not renal dialysis facilities and their employees should be included as an eligible entity to furnish such services; and, (3) recommendations for facilities and their employees to structure education services that are objective, unbiased and provide options and alternative locations for renal replacement therapy and management of co-morbidities that may delay the need for dialysis. These provisions would be effective January 1, 2009.

Section 633. Required Training for Patient Care Dialysis Technicians. A provider of services or a renal dialysis facility could not use an individual as a patient care dialysis technician for more than 12 months during 2009, or at any time thereafter, unless the individual completed a training program in chronic kidney failure dialysis care and treatment and was certified by a nationally recognized certification entity for dialysis technicians. An exception would be made for those who were enrolled in a training program and those who had performed such services for at least five years. Individuals who had not provided services for which they were paid, for 24 consecutive months since their last training, would be required to complete a new training program or be required to become recertified. Providers of services or renal dialysis facilities would be required to provide regular performance review and in-service education to assure competency of individuals who perform dialysis-related services.

Section 634. MedPAC Report on Treatment Modalities for Patients with Kidney Failure. No later than March 1, 2009, the Medicare Payment Advisory Commission (MedPAC) would be required to submit a report to the Secretary and to Congress evaluating the barriers to increasing the number of Medicare ESRD beneficiaries electing home dialysis services. The report would include the following: (1) a review of Medicare home dialysis demonstration projects initiated before the date of enactment of this Act, including recommendations for future demonstrations or changes to the Medicare program to test models that could improve access to home dialysis; (2) a comparison of current costs and payments between Medicare home dialysis and in-center and hospital dialysis; (3) an analysis of the adequacy of Medicare reimbursement for patient training for home dialysis and recommendations for ensuring appropriate payments for home dialysis training; (4) 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; (5) an evaluation of patient education services and how they impact patients' treatment choices; and (6) recommendations for implementing incentives to encourage patients to use home dialysis or other Medicare treatment modalities.

Section 635. Adjustment for Erythropoietin Stimulating Agents (ESAs). The payment amount for erythropoietin furnished by a large dialysis facility during 2008 or 2009 to a patient with ESRD would be changed from the average sales price (ASP) + 6% to the lesser of \$8.75 per 1,000 units (rounded to the nearest 100 units) or 102% of the ASP for such drug or biological. The payment amounts for darbepoetin alfa furnished by a large dialysis facility during 2008 or 2009 to a patient with ESRD would be changed from the ASP + 6% to the lesser of \$2.92 per microgram or 102% of the ASP for such drug or biological. A large dialysis facility would be defined as one that was owned or managed by a corporate entity that as of July 24, 2007, owned or managed 300 or more such providers or facilities and included a successor to such a corporate entity. This provision would not affect the amount of a drug add-on payment.

Section 636. Site Neutral Composite Rate. Beginning January 1, 2008, the payment for providers of dialysis services furnished by hospital-based facilities would be the same as the rate for such services furnished by renal dialysis facilities that are not hospital based, except that in applying the geographic index to

hospital-based facilities, the labor share would be based on the labor share otherwise applied for such facilities. Adjustments would no longer be made to the composite rate for hospital-based dialysis facilities to reflect higher overhead costs.

Section 637. Development of ESRD Bundling System and Quality Incentive Payments. Beginning January 1, 2010, the Secretary would implement a bundled payment system under which a single payment would be made for Medicare renal dialysis services, ensuring that the estimated total payment for 2010 for Medicare renal dialysis services would equal 96% of payments that would have been made if the bundled payment system had not been implemented. The term “renal dialysis services” would include as follows: (1) items and services which were included in the composite rate as of December 31, 2009; (2) erythropoietin stimulating agents (ESAs) furnished to patients with ESRD; (3) certain other drugs, biologicals, and diagnostic laboratory tests; and (4) home dialysis training. The term “renal dialysis services” would not include vaccines. The Secretary could determine payments on the basis of services furnished during a week, month, or another unit. The payment system would include adjustments for case mix, high cost outliers, and other appropriate measures. The Secretary could phase-in the payment system, for providers and facilities that had pediatric patients, low volume of services, operated in rural areas and were not large. The phase-in would be required to be fully implemented for services furnished on or after January 1, 2013. The Secretary would annually increase the bundled payment amounts by the same increase that would have applied to the drug-add on adjustment required under current law.

In addition to the bundled payment amount, providers and facilities would receive an additional amount if they met the specified performance standard for the period, and beginning in 2009, the specified reporting requirements. The four periods would be July 1, 2008 to December 31, 2008, CY2009, CY2010, and a multi-month period in 2011, as specified by the Secretary. Total bonus payments would be limited to \$50 million for 2008, \$100 million for 2009, \$150 million for 2010, and \$200 million for 2011.

The Secretary would provide an annual written notification to each individual receiving dialysis services that informs the individual of relevant quality measures, compares the scores and measures with average local and national scores and measures, and provides information on how to access additional information on quality of other providers and facilities, along with web-based information.

No later than January 1, 2013, the Secretary would submit a report to Congress on the implementation of the bundled payment system and the quality initiative. No later than January 1, 2015, the Secretary would be required to submit a report to Congress including an update on aspects of the bundled payment system discussed in the previous report and a comparison of the result of the bundled payment system during the two-year period beginning on January 1, 2013, and the result of such payment system during the previous two-year period.

Section 638. MedPAC Report on ESRD Bundling System. No later than March 1, 2012, MedPAC would be required to submit a report to Congress on the implementation of the ESRD bundling payment system, including an analysis of the following: (1) the overall adequacy of the payment for all such services; (2) a

comparison of the adequacy of payment for services furnished by (a) a large dialysis facility (one that was owned or managed by a corporate entity that as of July 24, 2007, owned or managed 300 or more such providers or facilities and included a successor to such a corporate entity), (b) a provider or facility that is not large, (c) a hospital-based facility, (d) a free-standing facility, (e) a facility in an urban area, and (f) a facility in a rural area; (3) the financial status of providers and facilities, including access to capital, return on equity, and return on capital; (4) the adequacy of payment under the bundling payment system and the adequacy of quality improvement payments, in ensuring that Medicare payments for such services are consistent with costs for such services; and (5) any recommendations for modifying the payment system.

Section 639. OIG Study and Report on Erythropoietin. No later than January 1, 2009, the Inspector General of the Department of Health and Human Services would be required to conduct a study and submit a report to Congress with recommendations on dosing guidelines, standards, protocols, and algorithms for ESAs recommended or used at large dialysis facilities (facilities owned or managed by a corporate entity that as of July 24, 2007, owned or managed 300 or more such providers or facilities and included a successor to such a corporate entity) and those that are not large. The study would examine these guidelines, standards, protocols, and algorithms for the following: (1) the consistency with the labeling of the Food and Drug Administration; (2) the extent of which physicians sign standing orders for ESAs that are consistent with providers or facilities; (3) the extent to which the prescribing decisions of physicians for ESAs are independent of these measures or recommendations of an anemia management nurse or other appropriate employee of the provider or facility; and (4) the role of the medical director and the financial relationship between the medical director hired by a provider or facility.

Subtitle D — Miscellaneous

Sec. 651. Limitation on Exception to the Prohibition of Certain Physician Referrals for Hospitals. Physicians are generally prohibited from referring Medicare patients for certain services to facilities in which they (or their immediate family members) have financial interests. However, among other exceptions, physicians are not prohibited from referring patients to whole hospitals in which they have ownership or investment interests. Providers that furnish substantially all of its designated health services to individuals residing in rural areas are exempt as well. Only hospitals meeting certain requirements would be exempt from the prohibition on self-referral. Hospitals with a Medicare provider agreement on July 24, 2007, and no increase in the number of operating rooms and beds after the date of enactment that meet other specified requirements would be exempt from this self-referral ban. These requirements would address conflicts of interest, bona fide investments and proportional returns, and patient safety. Rural providers that meet the requirements no later than 18 months after the date of enactment would retain an exception to the requirements. For the purposes of this subsection, a physician owner would be defined as a physician (or an immediate family member of such a physician) with a direct or indirect ownership interest in the hospital.

The Secretary would be required to establish policies and procedures to ensure compliance with these requirements, beginning on their effective date. The

enforcement efforts would be able to include unannounced site reviews of hospitals. Beginning no later than 18 months from the date of enactment, the Secretary would be required to conduct audits to determine if hospitals violate the above requirements.

Title VII — Provisions Relating to Medicare Parts A and B

Section 701. Home Health Payment Update for 2008. Home health agencies (HHAs) are paid under a prospective payment system that is based on 60-day episodes of care for beneficiaries with unlimited episodes of care in a year. The base payment is increased annually by an update factor that is determined, in part, by the projected increase in the home health market basket (MB) index. Starting in 2007, HHAs are required to submit health care quality data to the Secretary. HHAs that do not submit these data will receive an update of the MB minus two percentage points. The provision would eliminate the MB update for home health payments for 2008. HHAs would still be subject to the data quality provision.

Section 702. 2-Year extension of temporary Medicare payment increase for home health services furnished in rural areas. MMA provided for a one-year 5% additional payment for home health (HH) services furnished in rural areas for episodes and visits ending on or after April 1, 2004, and before April 1, 2005. DRA extended the payments for rural HH episodes or visits beginning on or after January 1, 2006, and before January 1, 2007. The provision would renew these additional payments for episodes and visits beginning on or after January 1, 2008, and before January 1, 2010.

Section 703. Extension off Medicare Secondary Payer for beneficiaries with End Stage Renal Disease for Large Group Plans. Medicare entitlement based on ESRD usually begins with the third month after the month in which the beneficiary starts a regular course of dialysis, referred to as the three-month waiting period. In addition to the waiting period, for individuals whose Medicare eligibility is based solely on ESRD, any group health plan coverage they receive through their employer or their spouse's employer is the primary payer for the first 30 months of ESRD benefit eligibility, referred to as the 30-month coordination period and Medicare is the secondary payer (MSP). After 30 months, Medicare becomes the primary insurer. Beginning January 1, 2008, the coordination period for ESRD MSP would be extended from 30 months to 42 months, but only for those individuals who receive group coverage through a large group health plan. A large group health plan is a plan offered by an employer that normally employed at least 100 employees on a typical business day during the preceding calendar year. This also applies to certain smaller plans that are part of a multiple or multi-employer plan.

Section 704. Plan for Medicare Payment Adjustment for Never Events. According to the National Quality Forum (NQF) “never events” are errors in medical care that are clearly identifiable, preventable, and serious in their consequences for patients, and indicate a real problem in the safety and credibility of a health care facility.

TRHCA directs the OIG to report to Congress on the following: 1) the incidence of never events (those listed and endorsed as serious reportable events by the National Quality Forum or NQF as of November 16, 2006) for Medicare beneficiaries; 2) the extent to which the Medicare program paid, denied payment, or recouped payment for services furnished in connection with such events, and the extent to which beneficiaries paid for them; and 3) the administrative processes of CMS to detect such events and to deny or recoup payments for related services. The OIG was appropriated \$3 million to carry out this section; these funds are available until January 1, 2010.

The Secretary would be required to develop a plan to reduce or eliminate payments for hospital based never events beginning in FY2010. A hospital based never event would be defined as an event involving the delivery (or failure to deliver) physician services, inpatient or outpatient hospital services, ambulatory surgery center 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 for such services. No later than June 1, 2008, the Secretary would submit a report to Congress on this plan, including relevant recommendations.

Section 705. Reinstatement of Residency Slots. Medicare pays for the direct and indirect graduate medical education expenses in teaching hospitals with approved physician training programs. BBA generally capped the total number of allopathic and osteopathic residents reimbursed under Medicare at the level that existed for the cost reporting period ending in calendar year 1996. The limit does not include dental or podiatry residents. Rural hospitals, and hospitals that established new training programs before August 5, 1997, will be partially exempt from the cap. Also, MMA provided for the redistribution of unused residency slots to other teaching hospitals. Other exceptions apply to hospitals with new programs established after that date.

If one or more hospitals with approved medical residency training programs as of January 1, 2000, closes, the Secretary would increase the otherwise applicable resident limit of qualifying hospitals in the same metropolitan area. The receiving hospitals would have to meet certain criteria. In no event would the resident limit for any hospital be increased above 50. In no event would the total of all residency positions added by this provision exceed 10. This provision would be effective for cost reporting periods beginning on or after July 1, 2005.

A hospital with a dual accredited osteopathic and allopathic family practice program that had its resident limit adjusted under the MMA redistribution provisions would receive an adjustment if such reduction was determined using a cost report that was subsequently revised between September 1, 2006, and September 15, 2006. This revision would have resulted in a higher resident level than that which served as the basis for the MMA redistribution calculation. The resident adjustment would be effective as if it were included in MMA and would apply to portions of cost reporting periods occurring on or after July 1, 2005.

A hospital in Peoria County, IL, with more than 500 beds would have its resident limit increased by 2.

Section 706. Studies Relating to Home Health. The provision would require the Medicare Payment Advisory Commission (MedPAC) to conduct a study of Medicare home health (HH) beneficiaries to determine the impact that remote monitoring equipment and related services have on the following: (1) improving health outcomes for persons with chronic conditions; (2) the percentage of inpatient hospital and emergency room visits; and (3) the estimated reduction in aggregate Part A and B Medicare expenditures. It would also study the percentage of Medicare beneficiaries utilizing remote monitoring equipment and variation in utilization across geographic regions and sizes of HH agencies. The provision would require HH agencies to submit relevant data as a condition of participation in Medicare, beginning no later than January 1, 2008. By June 1, 2010, MedPAC would report its findings to Congress and provide recommendations on how Congress may enact HH reimbursement policies that would appropriately increase the use of remote monitoring equipment and other services for persons with chronic conditions.

Section 707. Rural Home Health Quality Demonstration Projects. No later than 180 days after enactment, the Secretary would make grants to certain states for two-year demonstration projects to assist home health agencies in serving Medicare beneficiaries while reducing costs through the use of telemonitoring and other telehealth technologies, health information technologies, and telecommunications technologies, among others. These technologies would be intended to reduce costs and the need for inpatient hospital services and health center visits and address safety, effectiveness, patient or community-centeredness, among others. The Secretary would submit a report to Congress with its findings no later than one year after the project's completion. Out of the funds of the Treasury not otherwise appropriated, the provision would appropriate \$3 million for FY2008, to remain available until expended.

Title VIII — Medicaid

Subtitle A — Protecting Existing Coverage

Section 801. Modernizing transitional Medicaid. States are required to continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in their income. This continuation is called transitional medical assistance (TMA). Federal law permanently requires four months of TMA for families who lose Medicaid eligibility due to increased child or spousal support collections, as well as those who lose eligibility due to an increase in earned income or hours of employment. Congress expanded work-related TMA under section 1925 of the Social Security Act in 1988, requiring states to provide TMA to families who lose Medicaid for work-related reasons for at least six, and up to 12 months. Since 2001, work-related TMA requirements under section 1925 have been funded by a series of short-term extensions, most recently through September 30, 2007.

The House bill would extend work-related TMA under section 1925 through September 30, 2011. States could opt to treat any reference to a 6-month period (or 6 months) as a reference to a 12-month period (or 12 months) for purposes of the initial eligibility period for work-related TMA, in which case the additional 6-month

extension would not apply. States could opt to waive the requirement that a family have received Medicaid in at least three of the last six months in order to qualify. They would be required to collect and submit to the Secretary of HHS (and make publicly available) information on average monthly enrollment and participation rates for adults and children under work-related TMA, and on the number and percentage of children who become ineligible for work-related TMA and whose eligibility is continued under another Medicaid eligibility category or who are enrolled in SCHIP. Except for the four-year extension of work-related TMA, which would be effective October 1, 2007, the provision would be effective upon enactment.

Section 802. Family planning services. State Medicaid programs must offer family planning services and supplies to categorically needy individuals of childbearing age, including minors considered to be sexually active. Family planning services must be available to eligible pregnant women through the 60th day following the end of the pregnancy. Coverage of the medically needy other than pregnant women may include family planning. States receive a 90% federal matching rate for expenditures attributable to the offering, arranging, and furnishing of family planning services and supplies.

The provision would provide states with the option to extend family planning services and supplies to women who are not pregnant and 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. States could opt to include individuals who are determined to meet these eligibility requirements under the terms, conditions, and procedures applicable to a Medicaid family planning waiver granted to the state under section 1115 of the Social Security Act as of January 1, 2007.

Federal financial participation (at the 90% federal Medicaid match rate) for medical assistance made available to such individuals would be limited to family planning services and supplies including medical diagnosis or treatment services that are provided pursuant to a family planning service in a family planning setting and only for the duration of the woman's eligibility under this state option.

States would be permitted to extend such Medicaid family planning services and supplies to women who are determined eligible for Medicaid because they meet the eligibility requirements of this provision during a period of presumptive eligibility. Finally, the provision would prohibit the enrollment of such individuals in a Medicaid benchmark and benchmark-equivalent state plan option, unless such coverage includes medical assistance for family planning services and supplies.

Section 803. Authority to continue providing adult day health services approved under a State Medicaid plan. Adult day care programs provide health and social services in a group setting on a part-time basis to certain frail older persons and other persons with physical, emotional, or mental impairments. Generally, states that cover adult day care under Medicaid do so under home and community-based waivers, the Program for All-Inclusive Care for the Elderly (PACE), or section 1115 waiver authority. Some states cover adult day care under their Medicaid state plans even though Medicaid law does not list adult day

care as a mandatory or optional benefit. There have been concerns that CMS may not continue to allow adult day care to be offered under a state's Medicaid plan without the use of a waiver. The provision would require the Secretary to provide for federal financial participation for adult day health care services, as defined under a state Medicaid plan, approved during or before 1994. The provision would be effective beginning November 3, 2005, and ending on March 1, 2009.

Section 804. State option to protect community spouses of individuals with disabilities. Although Medicaid law grants states the option to apply spousal impoverishment rules to the counting of income and assets for a married person who applies to Medicaid as a medically needy individual under section 1915(c) and (d) home and community-based waivers, states may not apply spousal impoverishment rules to the eligibility determination for medically needy for 1915(e) waivers. In addition, states may not apply spousal impoverishment rules to the post-eligibility treatment of income for medically needy persons enrolled in 1915(c), (d), and (e) waivers. Neither eligibility nor post-eligibility spousal impoverishment rules are applied to persons receiving section 1915(i) or 1915(j) benefits unless these persons qualify for Medicaid through an eligibility group for which spousal impoverishment rules apply. The provision would amend Medicaid law to allow states to apply spousal impoverishment rules to medically needy applicants and their spouses during the eligibility and post-eligibility determination of income process for applicants of HCBS waivers authorized under sections 1915(c), (d), or (e) as well as section 1115 of the Social Security Act. It would also apply to medically needy individuals who are receiving benefits under sections 1915(i) and (j).

Section 805. County Medicaid health insuring organizations. In general, Medicaid managed care organizations (MCOs) are subject to contracting requirements described in section 1903(m)(2)(A) of the Social Security Act. However, certain county-operated managed care plans in California that serve Medicaid beneficiaries, which are referred to as “county organized health systems” or “health insuring organizations” (HIOs), are exempt from these contracting requirements. The Consolidated Omnibus Budget Reconciliation Act of 1985 (P.L. 99-272) grandfathered the 1903(m)(2)(A) exemption for HIOs operating before January 1, 1986. In addition, the Omnibus Budget Reconciliation Act of 1990 (P.L. 101-508) provided an exemption for up to three county-operated HIOs in California that became operational on or after January 1, 1986, provided that certain requirements were met. For example, the three entities could enroll no more than 10% of all Medicaid beneficiaries in California, later raised to 14% by the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (incorporated by reference in P.L. 106-554). The House bill would add an exemption for HIOs operated by Ventura County and Merced County, and would raise the allowable percentage of beneficiaries to 16%. The provision would be effective upon enactment.

Subtitle B — Payments

Section 811. Payments for Puerto Rico and the territories. In the 50 states and the District of Columbia, Medicaid is an individual entitlement. There are no limits on the federal payments for Medicaid as long as the state is able to

contribute its share of the matching funds. In contrast, Medicaid programs in the territories are subject to spending caps. For FY1999 and subsequent fiscal years, these caps are increased by the percentage change in the medical care component of the Consumer Price Index (CPI-U) for all Urban Consumers (as published by the Bureau of Labor Statistics). The Deficit Reduction Act of 2005 increased the federal Medicaid cap in Puerto Rico by \$12 million in each of FY2006 and FY2007. For the Virgin Islands and Guam, the federal Medicaid caps were increased by \$2.5 million in FY2006, and by \$5.0 million in FY2007. For the Northern Marianas, the federal Medicaid cap was increased by \$1.0 million in FY2006, and by \$2.0 million in FY2007. For American Samoa, the federal Medicaid cap was increased by \$2.0 million in FY2006, and by \$4.0 million in FY2007. For FY2008 and subsequent fiscal years, the total annual cap on federal funding for the Medicaid programs in the insular areas is calculated by increasing the FY2007 ceiling for inflation.

The federal Medicaid matching rate, which determines the federal share of most Medicaid expenditures, is statutorily set at 50% in the territories (an enhanced match is also available for certain administrative costs). Therefore, the federal government generally pays 50% of the cost of Medicaid items and services in the territories up to the spending caps.

The provision would increase the territory Medicaid caps by the following amounts:

- For Puerto Rico, \$250,000,000 for FY2009; \$350,000,000 for FY2010; \$500,000,000 for FY2011; and \$600,000,000 for FY2012.
- For the Virgin Islands, \$5,000,000 for each of fiscal years 2009 through 2012.
- For Guam, \$5,000,000 for each of fiscal years 2009 through 2012.
- For the Northern Mariana Islands, \$4,000,000 for each of fiscal years 2009 through 2012.
- For American Samoa, \$4,000,000 for each of fiscal years 2009 through 2012.

For years after FY2008, if a territory qualifies for the enhanced federal match (90% or 75%) that is available under Medicaid for improvements in data reporting systems, such reimbursement would not count towards its spending cap.

Section 812. Medicaid Drug Rebate. Pharmaceutical manufacturers that wish to have their products available to Medicaid beneficiaries must enter into “rebate agreements” under which they agree to provide state Medicaid programs with the rebates for drugs provided to Medicaid beneficiaries. Rebates for single source drugs (generally, those still under patent) and “innovator” multiple source drugs (drugs originally marketed under a patent or original new drug application (NDA) but for which generic competition now exists) are calculated to be equal to the greater of 15.1% of the average manufacturer’s price (AMP) or the difference between the AMP and the best price. Additional rebates are required if the weighted average prices for all of a given manufacturer’s single source and innovator multiple source drugs rise faster than inflation. For non-innovator multiple source drugs, rebates are equal to 11% of the AMP.

The provision would increase the rebate percentage for the basic rebate for single source and innovator multiple source drugs to 22.1% of the AMP or the difference between the AMP and the best price. The higher rebate percentage would become effective after December 31, 2007.

Section 813. Adjustment in computation of Medicaid FMAP to disregard an extraordinary employer pension contribution. The federal medical assistance percentage (FMAP) is the rate at which states are reimbursed for most Medicaid service expenditures. It is based on a formula that provides higher reimbursement to states with lower per capita incomes relative to the national average (and vice versa). When state FMAPs are calculated by HHS for the upcoming fiscal year, the state and U.S. per capita income amounts used in the formula are equal to the average of the three most recent calendar years of data on per capita personal income available from the Department of Commerce's Bureau of Economic Analysis (BEA). BEA revises its most recent estimates of state per capita personal income on an annual basis to incorporate revised and newly available source data on population and income. It also undertakes a comprehensive data revision every few years that may result in upward and downward revisions to each of the component parts of personal income, one of which is employer contributions for employee pension and insurance funds. In describing its 2003 comprehensive revision, BEA reported that upward revisions to employer contributions for pensions beginning with 1989 were the result of methodological improvements and more complete source data.

Under the House bill, for purposes of computing Medicaid FMAPs beginning with FY2006, any significantly disproportionate employer pension contribution would be disregarded in computing state per capita income, but not U.S. per capita income. A significantly disproportionate employer pension contribution would be defined as an employer contribution towards pensions that is allocated to a state for a period if the aggregate amount so allocated exceeds 25% of the total increase in personal income in that state for the period involved.

Section 814. Moratorium on certain payment restrictions. For one year after the date of enactment of this Act, the provision would prohibit the Secretary of HHS from taking any action through regulation, official guidance, use of federal payment audit procedures, or other administrative action, policy or practice to restrict Medicaid coverage or payments 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.

Section 815. Tennessee DSH. When establishing hospital payment rates, state Medicaid programs are required to recognize the situation of hospitals that provide a disproportionate share of care to low-income patients with special needs. Such "disproportionate share (DSH) payments" are subject to statewide allotment caps. Allotments for the state of Tennessee, however, are equal to zero. This is because the state has, in the past, operated its state Medicaid program under the provisions of a research and demonstration waiver. The requirement to make disproportionate share payments is one of the provisions that have been waived by the state under the conditions of their research and demonstration waiver. The

provision would set a DSH allotment for the state of Tennessee for fiscal years beginning with 2008 to be equal to \$30 million for each year. In addition, the provision would allow the Secretary of HHS to limit the total amount of payments made to hospitals under Tennessee's research and demonstration waiver authorized under Section 1115 of the Social Security Act only to the extent that such limitation is necessary to ensure that a hospital does not receive a payment in excess of Tennessee's annual state DSH allotment or is necessary to ensure that the spending under waiver remains budget neutral.

Section 816. Clarification treatment of regional medical center. The states and federal government share in the cost of the Medicaid program. Sometimes states fund their share of program costs by using funds transferred from certain health care institutional providers that are publicly-owned or are governmental providers. Such "inter-governmental transfers" of certified public expenditures made by those types of health care providers to fund the non-federal share of a state's Medicaid expenditures are allowable but only when transferred to the state in which the facility is located. The provision would establish that funds transferred from the Regional Medical Center of Memphis, a hospital in a tri-state region that provides a significant amount of uncompensated care to individuals in all three states, can be used to fund a state other than Tennessee's share of Medicaid costs if the Secretary determines that the use of such funds is proper and in the interest of the Medicaid program.

Section 817. Extension of SSI web-based asset demonstration project to the Medicaid program. The Social Security Administration (SSA) is piloting (in certain field offices) a financial account verification system that uses an electronic asset verification system to help confirm that individuals who apply for Supplemental Security Income (SSI) benefits are eligible. The process permits automated paperless transmission of asset verification requests between SSA field offices and financial institutions. Part of this pilot involved a comprehensive study to measure the value of such a system for SSI applicants as well as recipients already on the payment rolls. This study identified a small percentage (about 5 percent) of applicants and recipients who were overpaid based on this financial account verification system.

Under the House bill, the Secretary of HHS would be required to provide for application of the SSI pilot to asset eligibility determinations under the Medicaid program. This application would only extend to states in which the SSI pilot is operating and only for the period in which the pilot is otherwise provided. For purposes of applying the SSI pilot to Medicaid, information obtained from a financial institution that is used for purposes of SSI eligibility determinations could also be shared and used by states for purposes of Medicaid eligibility determinations.

Subtitle C — Miscellaneous

Section 821. Demonstration project for employer buy-in. An enrollee buy-in program is a program under which the family of a child that does not qualify for the SCHIP program (usually due to excess income) can enroll their children into the SCHIP program by paying for most or all of the cost of coverage. Under current law, states may not receive federal matching funds for the services provided to these children, or for the costs of administering the buy-in program.

The bill allows the Secretary of Health and Human Services to establish a five-year demonstration project under which up to 10 states would be permitted to provide SCHIP child health assistance to children (and their families) who would be targeted low-income children but for coverage as beneficiaries under a group health plan as allowed under this provision. To qualify, states must have an SCHIP income eligibility that is at least 200% FPL. Under the demonstrations, SCHIP federal financial participation would be permitted only for such costs attributable to eligible children.

The bill requires coverage and benefits under a demonstration project to be the same as the coverage and benefits provided under the state's SCHIP plan for targeted low-income children with the highest family income level provided.

Covered families would be responsible for payments towards the premium for such assistance in an amount specified by the state as long as no cost sharing is imposed on benefits for preventive services, and SCHIP rules related to income-related limitations on cost sharing are applied. Qualifying providers would be responsible for providing payment in an amount that is equal to at least 50% of the portion of the cost of the family coverage that exceeds the amount of the family's cost sharing contribution.

Qualifying employers would be defined as an employer with a majority of its workforce that is composed of full time workers (where two, part time workers are treated as a single full-time worker) with family incomes reasonably estimated by the employer (based on wage information) at or below 200% FPL.

Section 822. Diabetes grants. As specified in Section 330B of the Public Health Service Act, the Secretary, directly or through grants, must provide for research into the prevention and cure of Type I diabetes. Appropriations are set at \$150 million per year during the period FY2004 through FY2008. As specified in Section 330C of the Public Health Service Act, the Secretary must make grants for providing services for the prevention and treatment of diabetes among American Indian and Alaska Natives. Appropriations are set at \$150 million per year during the period FY2004 through FY2008. As a part of the appropriation for SCHIP under this bill, for each of these two diabetes grant programs, the provision would provide \$150 million for FY2009.

Section 823. Technical correction. The Deficit Reduction Act of 2005 (DRA; P.L. 109-171) gave states the option to provide Medicaid to state-specified groups through enrollment in benchmark and benchmark-equivalent coverage which is nearly identical to plans available under SCHIP. DRA identifies a number of groups as exempt from mandatory enrollment in benchmark or benchmark-equivalent plans. These exempted groups may be enrolled in such plans on a voluntary basis. One such exempted group is children in foster care receiving child welfare services under Part B of title IV of the Social Security Act and children receiving foster care or adoption assistance under Part E of such title. The provision would make a correction to the reference to children in foster care receiving child welfare services in the DRA; this change would be effective as if included in DRA (i.e., March 31, 2006).

Title IX — Miscellaneous

Section 901. Medicare Payment Advisory Commission Status. The Medicare Payment Advisory Commission (MedPAC) is an independent federal body established by the Balanced Budget Act of 1997 to advise the U.S. Congress on issues affecting the Medicare program. The Commission's statutory mandate is to (1) advise the Congress on payments to private health plans participating in Medicare and providers in Medicare's traditional fee-for-service program, and (2) analyze access to care, quality of care, and other issues affecting Medicare. The provision would establish MedPAC as an agency of Congress.

Section 902. Repeal of Trigger Provision. The provision in MMA that requires the annual report of the Hospital Insurance (HI) and Supplementary Medical Insurance (SMI) trustees' to include an expanded analysis of Medicare expenditures and revenues would be repealed. Specifically, the provision requires that a determination must be made as to whether or not general revenue financing will exceed 45% of total Medicare outlays within the next seven years. General revenues financing is defined as total Medicare outlays minus dedicated financing sources (i.e., HI payroll taxes; income from taxation of Social Security benefits; state transfers for prescription drug benefits; premiums paid under Parts A, B, and D; and any gifts received by the trust funds).

Section 903. Repeal of Comparative Cost Adjustment (CCA) Program. The requirement for a six-year program that will begin in 2010 to examine comparative cost adjustment (CCA) in designated CCA areas would be repealed. Specifically this program requires that payments to local MA plans in CCA areas would, in part, be based on competitive bids (similar to payments for regional MA plans), and Part B premiums for individuals enrolled in traditional Medicare may be adjusted, either up or down. This program would be phased-in and there is also a 5% annual limit on the adjustment, so that the amount of the adjustment to the beneficiary's premium for a year can not exceed 5% of the amount of the monthly Part B premium, in non-CCA areas.

Section 904. Comparative Effectiveness Research. There are few provisions in current Medicare statutes that address comparative clinical effectiveness research. Section 1013 of MMA authorizes the Agency for Healthcare Research and Quality (AHRQ) to conduct and support evidence syntheses and research to meet the priorities and requests for scientific evidence and information identified by the Medicare, Medicaid and SCHIP programs. This includes developing information with respect to (1) outcomes, comparative clinical effectiveness, and appropriateness of health care items and services, including prescription drugs, and (2) strategies for improving the efficiency and effectiveness of such programs, including the ways in which such items and services are organized, managed, and delivered under such programs. To carry out Section 1013, MMA authorized \$50 million for FY2004, and "such sums as may be necessary for each fiscal year thereafter." Congress has appropriated \$15 million a year for AHRQ's comparative effectiveness endeavors under MMA section 1013.

The provision would establish a Center for Comparative Effectiveness Research ("Center") within the Agency for Healthcare Research and Quality, which would

“conduct, support, and synthesize research 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.” These activities would include the research conducted or supported under section 1013 of MMA. An independent Comparative Effectiveness Research Commission (“Commission”), established by the Secretary, would have oversight responsibility over the Center and would evaluate the Center’s activities to ensure that highly credible research and information result from such research.

The comparative effectiveness research activities would be funded by both private and public contributions. The provision would alter the tax code to allow for the collection of the fair share per capita amount from health insurance and self-insured plans. Beginning with FY2011, the fair share per capita amount would be an amount that would result in revenues of \$375,000,000 for the fiscal year. Alternatively, if the Secretary is unable to compute the fair share per capita amount, the fair share per capita amount would be the default amount, which for FY2013 would equal \$2, and in subsequent years would be increased by the annual percentage increase in the medical care component of the consumer price index.

For the public contribution, a Comparative Effectiveness Research Trust Fund (“CERTF”) would be created in the Treasury of the United States and at least the following amounts would be appropriated for the first three years: (1) for FY2008, \$90 million; (2) for FY2009, \$100 million; and (3) for FY2010, \$110 million. The amounts appropriated would be transferred from the Federal Hospital Insurance Trust Fund (Part A), from the Federal Supplementary Medical Insurance Trust Fund (Part B), and from the Medicare Prescription Drug Account (Part D), in proportion (as estimated by the Secretary) to the total Medicare expenditures during such fiscal year from the respective trust fund or account. In no case would the amount transferred, resulting from the calculation of the fair share per capita amount multiplied by the average number of Medicare beneficiaries for fiscal years beginning 2011, exceed \$90,000,000.

Funds in the CERTF would be available to the Secretary for comparative effectiveness research activities as established by this provision. For the oversight activities of the Comparative Effectiveness Research Commission, at least \$7 million would be available for FY2008, at least \$9 million for FY2009, and at least \$10 million for each fiscal year beginning with 2010.

Section 905. Implementation of Health Information Technology (IT) Under Medicare. While the quality, safety, and efficiency benefits of the widespread adoption of health information technology (HIT) systems have been lauded by many, there are currently no requirements for the implementation of an HIT system that meets a common set of criteria under the Medicare program, particularly in physicians’ offices. However, a few initiatives do address the adoption of HIT among providers in the Medicare program. The Physician Quality Reporting Initiative, implemented as part of the Tax Relief and Health Care Act of 2006, includes structural quality measures addressing the adoption of health information technology systems. CMS has a few demonstration projects in place to examine the impact of HIT on providers and beneficiaries, including the Doctor’s

Office Quality - Information Technology project and the VistA-Office Electronic Health Record project.

The provision would require the Secretary to submit a report to Congress by January 10, 2010, that would include a plan to develop and implement a health information technology system for all health care providers under the Medicare program. This plan would meet the following specifications: (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; and (7) the system utilizes technology that is open source (if available) or technology that has been developed by the government. The report would include recommendations regarding the level of subsidies needed for all such health care providers to adopt the system. The Secretary's report to Congress would also include an analysis of the impact feasibility and cost associated with the use of health information technology in medically underserved communities.

Section 906. Development, Reporting, and Use of Health Care Measures. The provision would foster efforts to develop, report, and use health care measures in the Medicare program under the auspices of a single entity. No earlier than January 1, 2008, and no later than September 30, 2008, the Secretary would designate a single organization (such as the National Quality Forum) that would provide 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 designated organization's duties would include the following: (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.

The Secretary, acting through the Agency for Healthcare Research and Quality, would be able to contract with organizations to support the development and testing of health care measures meeting the standards established by the designated organization. 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 would work with multi-stakeholder groups to provide for the dissemination of effectiveness information developed pursuant to this title.

Funding for the activities specified in this provision, including for expenses incurred for the arrangement with the designated organization, would come from both the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (Medicare Part A and Part B trust funds) in the amount

of \$15 million for FY2008, pro-rated to reflect the portion of the year the designated organization is performing the duties described above, and \$15 million for fiscal years 2009 through 2012.

Section 907. Improvements to the Medigap Program. Many Medicare beneficiaries have individually purchased health insurance policies, commonly referred to as “Medigap” policies. Beneficiaries with Medigap insurance typically have coverage for Medicare’s deductibles and coinsurance; they may also have coverage for some items and services not covered by Medicare. Individuals generally select from one of 10 standardized plans (Plan “A” through Plan “J,” though not all 10 plans are offered in all states). The law incorporates by reference, as part of the statutory requirements, certain minimum standards established by the National Association of Insurance Commissioners (NAIC) and provides for modification where appropriate to reflect program changes. MMA added two new standardized plan types, Plan “K” and Plan “L” which, unlike the other standardized plans, eliminated first-dollar coverage for most Medicare cost-sharing and included an annual out-of-pocket limit on such charges. The provision would require the Secretary to accept modifications recommended by the NAIC in March 2007, as further modified by this section. Policy issuers would be required to offer, in addition to the core package, at least policies classified as “C” or “F.” The provision would eliminate benefit packages “K” and “L.” It would apply to policies issued on or after January 1, 2008.

Section 908. Implementation Funding. This provision would require the Secretary to transfer \$40,000,000 from the Medicare Supplementary Medical Insurance Trust Fund to the Centers for Medicare and Medicaid Services program management account for the purposes of administering the provisions of this bill. The funds would be available for FY2008.

Section 909. Access to Data on Prescription Drug Plans and Medicare Advantage Plans. The provision would allow Congressional support agencies access to some of the prescription drug data collected by the Secretary under Part D. Data to be made available would include the following: (1) aggregate negotiated prices for drugs covered under prescription drug plans and MA-PD plans; (2) negotiated rebates, discounts, and other price concessions by drug and by contract or plan; (3) bid information submitted by the plans; (4) data or a representative sample of data regarding drug claims and other data regarding drug claims submitted by PDP sponsors and MA organizations that can be linked at the individual level to part A and part B data; (5) the amount of reinsurance payments to plans; (6) the adjustments to plan payments because of the risk corridor; and (7) drug event data.

Congressional support agencies would not disclose, report, or release the data in identifiable form, that is, any representation that permits identification of a specific PDP, MA-PD plan, pharmacy benefit manager, drug manufacturer, drug wholesaler, or individual enrolled in a Medicare Part D prescription drug plan or MA-PD plan. They would be required to implement safeguards specified by the Secretary to protect against unauthorized disclosure of the data, and would be prohibited from disclosing the data where such disclosure by the Secretary would be prohibited under applicable federal law. Congressional support agencies would only use the data for the functions and activities of the agency as mandated by Congress. This provision

defines Congressional support agencies as the Medicare Payment Advisory Commission (MedPAC), the Government Accountability Office (GAO) and the Congressional Budget Office (CBO).

Section 910. Abstinence Education⁵. P.L. 104-193, the 1996 welfare reform law, provided \$250 million in federal funds specifically for an abstinence education program (\$50 million per year for each of five years, FY1998-FY2002). This program is referred to as the Title V Abstinence Education block grant. Funds must be requested by states when they solicit Title V Maternal and Child Health (MCH) block grant funds and must be used exclusively for teaching abstinence. To receive federal funds, a state must match every \$4 in federal funds with \$3 in state funds. This means that if maximum federal funding is provided, funding for Title V Abstinence Education must total at least \$87.5 million annually. Although the Title V Abstinence Education block grant has not yet been reauthorized, the latest temporary extension, contained in P.L. 110-48 (S. 1701), continues funding for the Title V Abstinence Education block grant through September 30, 2007.

The House bill would do the following: (1) reauthorize the Title V Abstinence Education block grant at \$50 million per year for each of two years (FY2008 and FY2009), (2) require that states only fund programs that are medically and scientifically accurate, (3) allow states to provide funding for both abstinence-only education and abstinence-plus education programs, and (4) require that states only fund programs that are based on a model that has been demonstrated to be effective in preventing unintended pregnancy, or in reducing the transmission of sexually transmitted diseases, including HIV/AIDS.

⁵ This description was prepared by Carmen Solomon-Fears of the Children and Families section of the Domestic Social Policy Division at CRS.