HR 3162
THE CHILDREN'S HEALTH AND MEDICARE PROTECTION ACT OF 2007
SECTION-BY-SECTION ANALYSIS

TITLE I. CHILDREN'S HEALTH

Subtitle A -- Funding

Sec. 100. Purpose. Establishes the purpose of Title I is to stabilize funding under title XXI and XIX in order to enroll all six million children who are eligible but not enrolled for coverage today.

Sec. 101. Establishment of new base CHIP allotments. Establishes a new State-specific federal allotments for CHIP. Allotments would be the greater of a State's projections for FY08 as reported in May of 2007 or the State's FY 07 allotment increased by child population growth and per capita national health care expenditure growth. For States that experience a shortfall and who have enrolled children who are eligible but not currently enrolled in CHIP, this section also provides a payment equal to the State's average per capita federal expenditure for a child.

Sec. 102. 2-year initial availability of SCHIP allotments. Provides states two years to spend the federal CHIP allotment for any given year.

Sec. 103. Redistribution of unused allotments to address State funding shortfalls. Establishes a system for redistributing any State allotments unspent after two years. The method for redistribution (evenly distributed to the shortfall states) is the same as used for previous shortfall adjustments enacted by Congress.

Sec. 104. Extension of option for qualifying States. Permanently extends the option for "qualifying states" to use a portion of their CHIP allotment for children covered through Medicaid and increases the amount of the allotment that can be spent on such coverage.

Subtitle B—Improving Enrollment of Eligible Children

Sec. 111. SCHIP performance bonus payment to offset additional enrollment costs resulting from outreach, enrollment, and retention efforts. Provides a performance bonus payment for States that enroll children above their baseline and adopt five of seven outreach and enrollment best practices: 12-month continuous eligibility; administrative verification of assets; elimination of the in-person interview requirement; use of a joint application for Medicaid and CHIP; automatic renewal; presumptive eligibility; express lane eligibility. The performance bonus is available for enrollment of children who are currently eligible for CHIP or Medicaid today but are not today enrolled.

Sec. 112. State option to rely on findings from an express lane agency to conduct simplified eligibility determinations. Provides States a new tool for outreach, called Express Lane Eligibility (ELE). States that elect the ELE option could use a finding from an ELE agency to expedite eligibility determinations by CHIP or Medicaid.

Sec. 113. Application of Medicaid outreach procedures to all children and pregnant women. Allows States to apply outreach procedures to all children and pregnant women.

Sec. 114. Encouraging culturally appropriate enrollment and retention practices. Provides additional federal funding for culturally appropriate enrollment and retention activities.

Subtitle C—Coverage

Sec. 121. Ensuring child-centered coverage. Improves CHIP coverage by adding a guaranteed dental benefit for children. It would require parity for mental health coverage under benchmark plans and guarantee access to federally qualified health centers (FQHCs) and rural health centers (RHCs). The FQHC's and RHC's would also be paid under a prospective payment system. The provision also clarifies that school clinic services may be covered under CHIP.

Sec. 122. Improving benchmark coverage options. Ensures that Secretary-approved benchmark coverage is no less protective for children than the coverage offered in other benchmark options. This section also clarifies that the state employee coverage benchmark option is the option most frequently selected by employees seeking family coverage.

Sec. 123. Premium grace period. Grants families a 30-day grace period for premium payment under CHIP before termination of a child's coverage.

Subtitle D—Populations

Sec. 131. Optional coverage of older children under Medicaid and SCHIP. Grants States the option to cover children who otherwise age out of CHIP or Medicaid. States that elected this option could cover children above existing eligibility levels, through age 24.

Sec. 132. Optional coverage of legal immigrants under the Medicaid program and SCHIP. Provides States the option to cover legal immigrant children and legal immigrant pregnant women in CHIP or Medicaid. A State may only cover these individuals in CHIP if the State also elects to cover such individuals in Medicaid.

Sec. 133. State option to expand or add coverage of certain pregnant women under CHIP. Provides a new eligibility option in CHIP for States to cover pregnant women. A State may exercise this option if the State covers pregnant women under Medicaid to 185% of the federal poverty level, covers children in families with incomes up to 200%

of the federal poverty level, and does not impose a waiting list for enrollment of children under CHIP. States that previously covered pregnant women at higher income levels through Medicaid may use up to 30 percent of their CHIP allotment for such coverage. This section also automatically enrolls children born to mothers covered under CHIP or Medicaid in coverage upon birth and allows entities that conduct presumptive eligibility for children to do so for pregnant women.

Subtitle E—Access

Sec. 141. Children's Access Payment and Equity (CAPE) Commission. Creates a new federal Commission, modeled after the Medicare Payment Advisory Commission (MedPAC), to monitor access and quality of care for children under CHIP and Medicaid as well as adequacy of provider payments, including safety net providers.

Sec. 142. Model of Interstate coordinated enrollment and coverage process. Directs the Government Accountability Office (GAO) to work with stakeholders to develop model practices to facilitate enrollment of children who live in families that move frequently around the United States.

Sec. 143. Medicaid citizenship documentation requirements. Amends the requirements for documenting citizenship and identity to allow individuals a reasonable period of time to gather necessary information, allow newborns to meet requirements more easily, and allow additional tribal membership documents to be used as satisfactory evidence of citizenship or nationality. This section also allows states the option of returning to pre-July 1, 2006 documentation requirements for children, so long as the State submits to an audit of a sample of cases to demonstrate compliance.

Sec. 144. GAO study of access to dental services for children. Provides for a study by the Government Accountability Office on access to dental services in underserved areas.

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

Subtitle F—Quality and Program Integrity

Sec. 151. Pediatric health quality measurement program. Establishes a pediatric health care quality measurement program to develop and implement measures of pediatric clinical quality and measures of overall program quality. These measures will specifically examine disparities in care based on age, race, ethnicity, and geography.

Sec. 152. Application of certain managed care quality safeguards to CHIP. Applies managed care quality protections such as the quality assurance standards, protections against fraud and abuse, and the "prudent layperson" standard for access to emergency care to managed care organizations in CHIP.

Sec. 153. Updated Federal Evaluation of CHIP. Provides for a new federal evaluation of the CHIP program in 2010, modeled after the initial evaluation completed in 2005.

Sec. 154. References to title XXI. Repeals section 704 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999.

Sec. 155. Reliance on law; exception for State legislation. Allows for good-faith implementation of provisions by States prior to CMS regulatory action and allows flexibility in effective dates for States which need legislation to comply with the provisions of this title or title VIII.

TITLE II: MEDICARE BENEFICIARY IMPROVEMENTS

Subtitle A – Improvements in Benefits

Sec. 201. Coverage and waiver of cost-sharing for preventive services. Effective January 1, 2008, allows the Secretary of Health and Human Services to add new benefits for preventive items and services, including mental health services, that are reasonable and necessary for the prevention or early detection of an illness or disability. Requires the Secretary to take into account evidence-based recommendations of the United States Preventive Services Task Force and other appropriate organizations when creating new benefits. Eliminates co-insurance for and exempts from deductible current preventive benefits and future preventive benefits added through this process. Requires new preventive benefits to be included as part of the initial "Welcome to Medicare" physical.

Sec. 202. Waiver of deductible for colorectal cancer screening tests regardless of coding, subsequent diagnosis, or ancillary tissue removal. Effective January 1, 2008, clarifies that the deductible is waived for a screening colonoscopy even if a diagnosis is established as a result of a test or tissue is removed during the procedure.

Sec. 203. Parity for mental health coinsurance. Reduces coinsurance for outpatient mental health services by five percentage points annually from 50 percent to 20 percent by 2012.

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

Sec. 211. Improving assets tests for Medicare Savings Program and Low-Income Subsidy program. Increases the amount of allowable resources to $17,000 for an individual and $34,000 for a couple in order to qualify for assistance with Medicare Part B and D costs. Starting in 2010, the limit is increased annually by $1,000 per individual and $2,000 per couple.

Sec. 212. Making QI program permanent and expanding eligibility. Makes permanent the Qualified Individual (QI) program that provides assistance with premiums for certain low-income beneficiaries, which otherwise expires on September 30, 2007. Raises the QI income level to 150% of the federal poverty level, or $15,315 for an individual in 2007.

Sec. 213. Eliminating barriers to enrollment. Provides for administrative verification of income and resources for individuals under the Low-Income Subsidy (LIS) program as well as automatic renewal without the need to reapply. Directs the Secretary of Health and Human Services to take all reasonable steps to encourage States to adopt these enrollment simplifications in the Medicare Savings Programs (MSP).

Directs the Commissioner of Social Security to provide applications for MSP and LIS to individuals applying for Medicare benefits and to provide assistance in completing such applications at the request of the beneficiary. Requires the Commissioner to forward completed MSP applications to States for eligibility determinations. Requires the Secretary of Health and Human Services to translate the existing simplified MSP form into at least the ten languages most often used by individuals applying for benefits under title II or title XVIII. Allows the Commissioner of Social Security to obtain data from IRS to identify beneficiaries potentially eligible for the LIS.

Sec. 214. Eliminating application of estate recovery. Eliminates the requirement that States recover costs from the estate of individuals receiving assistance with Part B costs beginning in 2008.

Sec. 215. Elimination of part D cost-sharing for certain non-institutionalized full-benefit dual eligible individuals. Ensures that dual eligible beneficiaries receiving care through a home- and community-based care waiver are treated the same with respect to cost sharing under Part D as beneficiaries who are in nursing homes. This ensures the lowest income Medicare beneficiaries can choose to receive care in the least restrictive community setting without penalty.

Sec. 216. Exemptions from income and resources for determination of eligibility for low-income subsidy. Exempts the balance of a pension and retirement plan and the value of a life insurance policy from LIS resource determinations. It also exempts in kind support and maintenance (e.g., assistance provided by a family member or church) from LIS income determinations. The protections begin in 2009.

Sec. 217. Cost-sharing protections for low-income subsidy-eligible individuals. Caps out-of-pocket spending under Part D to 2.5 percent of income annually for the lowest income Medicare beneficiaries ($15, 315). These protections begin in 2009.

Sec. 218. Intelligent assignment in enrollment. Ensures the lowest income Medicare beneficiaries who are automatically assigned to a Part D plan, are assigned to a plan that: (1) covers 95 percent of the 100 brand drugs most commonly used by Medicare beneficiaries; (2) covers 95 percent of the 100 generic drugs most commonly used by Medicare beneficiaries; (3) provides pharmacy access that exceeds minimum standards, including access in areas where low income beneficiaries reside; and (4) has a total cost among the lowest 25th percentile of plans where the beneficiary resides. This provision takes effect in 2009.

Subtitle C —Part D Beneficiary Improvements

Sec. 221. Including costs incurred by AIDS drug assistance programs and Indian Health Service in providing prescription drugs toward the annual out of pocket threshold under Part D. Allows costs for Part D prescription medicines paid by the Indian Health Service (IH S) or an AIDS Drug Assistance Program (ADAP) to count toward a beneficiary's total out-of-pocket Part D spending beginning in 2009 for purposes of filling the donut hole.

Sec. 222. Permitting mid-year changes in enrollment for formulary changes adversely impact an enrollee. Allows a beneficiary to change to a new plan if their plan has a mid-year material change in the formulary that reduces access to their prescribed drug (unless such change was required for safety reasons). This provision takes effect in 2009.

Sec. 223. Removal of exclusion of benzodiazepines from required coverage under the Medicare prescription drug program. Allows Part D plans to cover benzodiazepines, which are commonly used by individuals with mental illness. This provision takes effect in 2009.

Sec. 224. Permitting updating drug compendia under part D using part B update process. Allows the Secretary to update compendia used under Part D using a process similar to the one in place under Part B.

Sec. 225. Codification of special protections for six protected drug classifications. Codifies the Secretary's guidance relating to coverage of the "six protected classes" of drugs under Part D, anti-convulsants, anti-neoplastics, anti-retrovirals, anti-depressants, anti-psychotics, and immunosuppressants. It also clarifies that plans may only use prior-authorization or step therapy when approved by the Secretary.

Sec. 226. Elimination of Medicare part D late enrollment penalties paid by low-income subsidy-eligible individuals for periods. Eliminates the Part D late enrollment penalty for low-income subsidy eligible individuals to ensure Part D coverage is available without penalty.

Sec. 227. Special enrollment period for subsidy eligible individuals. Provides for a special enrollment period for LIS subsidy-eligible individuals, allowing up to 90 days after notification of LIS status, to select a Part D plan or Medicare Advantage plan that covers prescription drugs. This provision takes effect in 2008.

Subtitle D—Reducing Health Disparities

Sec. 231. Medicare data on race, ethnicity, and primary language. Requires the Secretary to collect, analyze, and report data on race, ethnicity, and primary language of Medicare beneficiaries.

Sec. 232. Ensuring effective communication in Medicare. Requires the Secretary to conduct a study on Medicare payments for language services, and provides for additional enforcement.

Sec. 233. Demonstration to promote access for Medicare beneficiaries with limited English proficiency by providing Medicare reimbursement for culturally and linguistically appropriate services. Requires CMS to conduct a demonstration of the effect of Medicare reimbursement for culturally and linguistically appropriate services.

Sec. 234. Demonstration to improve care to previously uninsured. Requires CMS to conduct a demonstration to improve outreach to and support for Medicare beneficiaries who were previously uninsured.

Sec. 235. Office of the Inspector General report on compliance with and enforcement of national standards on culturally and linguistically appropriate services (CLAS) in Medicare. Requires the Office of the Inspector General to study and report on the extent to which Medicare providers are complying with CLAS standards, and the extent to which non-compliance is being enforced.

Sec. 236. IOM Report on impact of language access services. Requires the Institute of Medicine to conduct a study and issue a report on the effect of language access services on access to and quality of care.

Sec. 237. Definitions. Defines terms used in this section.

TITLE III -- MEDICARE PHYSICIAN PAYMENT REFORM

Sec. 301. Establishment of separate target growth rates for service categories. Provides for a 0.5 percent update in 2008 and 2009. Replaces the Sustainable Growth Rate (SGR) methodology with a system of separate updates for six categories of physician services within the Medicare fee schedule: Primary and Preventive Services, Other Evaluation and Management Services, Major Procedures, Anesthesia Services, Imaging Services, Minor Procedures and Other Services. Primary Care and Preventive Services Category annual allowed growth would equal growth in the gross domestic product (GDP) plus 3 percent; annual allowed growth for other service categories would equal the GDP growth. Future fee schedule updates would take into consideration the prior "overhang" of accumulated excess expenditures under the SGR system, but would not incorporate growth of expenditures for clinical diagnostic laboratory tests or drugs and would include national coverage determinations as allowed growth. Requires the Secretary to annually report growth of expenditures for clinical diagnostic laboratory tests or drugs in the physician fee schedule proposed rule, including analysis of reasons for such growth and recommendations for addressing it.

Sec. 302. Improving accuracy of relative values under the Medicare Physician Fee Schedule. Establishes an expert panel to identify physicians' services for which the relative value is potentially misvalued. The Secretary would also identify physician services growing at an unusually high annual rate and would have the authority to reduce the work value of specific physician services after consultation with the expert panel and consideration of evidence supporting the clinical appropriateness of the observed rapid growth.

Sec. 303. Physician Feedback mechanism on practice patterns. Requires the Secretary to implement a system of confidential feedback to physicians in the Medicare program on how their practice patterns compare to other physicians both in the same locality as well as nationally.

Sec. 304. Payments for efficient physicians. Provides a 5 percent bonus for Medicare physicians practicing in counties in the lowest 5th percentile of per capita spending.

Sec. 305. Recommendations on refining the Physician Fee Schedule. Requires GAO to conduct an analysis of codes paid under the Medicare physician fee schedule to determine whether the codes for procedures that are commonly furnished together should be combined and/or payments adjusted; GAO would also analyze the Medicare physician fee schedule to identify opportunities for increased use of ''bundled'' payment methodologies.

Sec. 306. Improved and expanded Medical Home Demonstration Project. Initiates a nationwide project involving up to 500 medical practices, especially those serving communities whose populations are at higher risk for health disparities. The Secretary would certify practices to be eligible for payment for "Medical Home" services, actively managing and coordinating care for participating beneficiaries. The Secretary would also certify practices using robust health information technology (HIT) in their medical home model, and would conduct a separate study of the additional costs and benefits of the "HIT enhanced medical home."

Sec. 307. Repeal of Physician Assistance and Quality Initiative Fund. Repeals the bonus fund for the Physician Assistance and Quality Initiative, but allows the program to continue on a voluntary basis.

Sec. 308. Adjustment to Medicare payment localities. Requires CMS to revise payment localities in California by January 1, 2008, and in multi-locality states by January 1, 2011. Provides for transition funding for counties in California that would otherwise experience losses as a result of the revised localities.

Sec. 309. Payment for Imaging Services. Establishes an accreditation process for facilities that provide diagnostic imaging services and requires that a facility be accredited in order to receive reimbursement for imaging services from Medicare. Requires CMS to increase their assumption on the amount of time imaging equipment is in use from 50 percent to 75 percent. Requires a 50 percent reduction in the technical component for imaging services involving contiguous body parts. Requires CMS to assume that the interest rate for capital purchases reflects the prevailing rate in the market, but in no case higher than 11 percent. Disallows global billing.

Sec. 310. Repeal of Physicians Advisory Council. Repeals the Practicing Physicians Advisory Council.

TITLE IV – MEDICARE ADVANTAGE REFORMS

Subtitle A – Payment Reform

Sec. 401. Equalizing payments between Medicare Advantage plans and fee-for-service Medicare. Phases-out overpayments to MA plans over four years to 100% FFS in 2011. The phase-out of payments in excess of 100% FFS would be a blend of the current county benchmarks adjusted for the applicable year and 100% of county FFS costs in the projected year. In 2009, the benchmarks would be a blend of 2/3 current benchmark and 1/3 100% FFS in the county; in 2010, the blend would be 1/3 current benchmark and 2/3 100% FFS. In 2011, and subsequent years, all MA benchmarks would be set at 100% FFS costs in the county.

Provides that MA plans that indicate in their bids that they cannot provide Medicare Part A and Part B services for less than 106% of FFS costs in 2009 and 103% in 2010 may not enroll new beneficiaries in those years.

Eliminates the remaining authority for spending from the regional PPO stabilization fund in 2012 and 2013.

Subtitle B – Beneficiary Protections

Sec. 411. NAIC development of marketing, advertising and related protections. Requests the National Association of Insurance Commissioners (NAIC) to develop model marketing, advertising and related beneficiary protections for MA and Part D plans. Requires the model regulations to include standards for marketing activities, ensure appropriate beneficiary education, set standards for training and certification, limit agent and broker commissions and conduct market conduct surveys. Increases penalties for violations of these protections.

The NAIC would consult with a working group of representatives of MA plan representatives, consumer groups, Medicare beneficiaries, and State Heath Insurance Programs. Provides for the NAIC to promulgate model regulations 12 months from date of enactment.

Expands the role of state oversight of agents, brokers and MA plans. The model marketing regulations would be a condition of all plan contracts. Requires the Secretary to publicly disclose MA plan violations of the marketing and enrollment standards.

Increases funding to State Health Insurance Assistance Programs (SHIPs).

Sec. 412. Limitation on out-of-pocket costs for individual services. Limits out-of-pocket costs in MA plans for any service to no more than the amount of cost-sharing for

the same service in FFS Medicare. Limits out-of-pocket costs in MA plans for Medicaid beneficiaries to the amount of cost-sharing for the same service in Medicaid in the State.

Sec. 413. MA plan enrollment modifications. Revises MA plan enrollment practices to provide continuous open enrollment for full Medicaid dual eligibles and Qualified Medicare Beneficiaries (people with incomes up to 100% of poverty). Provides special election periods to additional beneficiaries with special health needs. Extends the period that Medicare beneficiaries may return to their previous Medigap plan to 24 months. Prohibits auto-enrollment of Medicaid beneficiaries into a MA plan.

Sec. 414. Information for beneficiaries on plan administrative costs and services. Provides for each MA plan Medicare Loss Ratio and other information, to be publicly reported in September of each year prior to the fall MA plan open enrollment period. The MLR information would use data currently submitted as part of the MA bid process. Standardized data elements and definitions for the calculation of the MLR would be developed for implementation in 2010. Plans that do not have a minimum MLR of .85 beginning in 2010 would face benchmark reductions, limits on new enrollment and, after year 5 years, exclusion from the MA program. Provides for additional MA program information to be routinely published.

Subtitle C – Quality and Other Provisions

Sec. 421. Requiring all MA plans to meet equal standards. Equalizes the playing field across types of MA plans by requiring PFFS and PPO plans to report the same data reported by Coordinated Care Plans for HEDIS, CAHPS and HOS quality measures beginning in 2010.

Requires employer plans to have 90% of their members in counties where the MA plan firm has a plan available to local residents. The MA provisions of the CHAMP Act could not be waived for employer plans.

Sec. 422. Developing new quality reporting measures on racial disparities. New HEDIS measures to assess disparities in the amount and quantity of health services provided to racial and ethnic minorities would be developed. HHS would return to its previous practice of issuing biennial reports on disparities in MA plan services to minorities.

Sec. 423. Strengthening audit authority. Audits would be required for risk adjustment data in a manner similar to audits of other MA plan data. Provides HHS the authority necessary to address deficiencies identified in MA plan audits.

Sec. 424. Improving risk adjustment for MA plans. The adequacy of the MA risk adjustment system with a focus on its accuracy in predicting the costs of enrollees with multiple chronic diseases would be analyzed by HHS and a report to Congress submitted within one year.

Sec. 425. Eliminating special treatment of private fee-for-service plans. Special features of the MA program for PFFS plans would be eliminated. Hospitals, physician

and other providers would not be permitted to extra-bill PFFS plan members by 15%; HHS would review PFFS plan bids in a fashion similar to other MA plans.

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

Subtitle D – Extension of Medicare Advantage Authorities

Sec. 431. Extension and revision of authority for Special Needs Plans. The authority for MA SNPs would be revised and extended for 3 years through 2011. SNPs would continue to be paid the same manner and amounts as other MA plans.
The authority for dual Medicare-Medicaid SNPs would be revised to require that dual-SNP plans have: 90% enrollees that are full-dual eligible or QMB Medicaid beneficiaries; an agreement with a State Medicaid agency regarding cooperation on the coordination of the financing of care and, beginning in 2011, a contract with the State Medicaid agency for capitation payments for supplemental Medicaid benefits.

The authority for institutional SNPs would be revised to require that institutional-SNP plans have: 90% enrollees that are residents of long-term care facilities; contracts with long-term care facilities sufficient to meet the needs of its enrollees; and an agreement with a State Medicaid agency regarding cooperation on the coordination care.

All SNPs would report data for new HEDIS measures especially developed for quality of care for SNP beneficiaries. Plans that were part of State demonstrations in 2004 would not be required to meet the new requirements for SNP plans.

The authority for chronic disease SNPs is not extended and would expire in at the end of 2009. All MA plans would continue to be required to have a chronic care improvement program. Chronic disease plans may continue to operate as regular MA plans.

Sec. 432. Extension and revision of authority for Medicare reasonable cost contract plans. The authority for MA cost plans would be revised and extended for 3 years through 2011. Cost plans would continue to be paid under the current cost reimbursement system.

Provisions that currently apply to MA risk plans and would now apply to cost plans include: approved marketing materials and application forms; a quality program; grievance mechanisms; and coverage determinations.

TITLE V -- MEDICARE PART A

Sec. 501. Inpatient hospital payment updates. Provides for 0.25% market basket reduction for fiscal year 2008.

Sec. 502. Payments for inpatient rehabilitation facility (IRF) services. Provides a one percent increase in rates for fiscal year 2008. Permanently freezes implementation of the "75 percent" rule at 60 percent. Reduces rates for hip and knee replacements and hip fractures. Directs research on outcomes, costs, and other factors needed to evaluate the value of services provided.

Sec. 503. Payments and coverage for long term care hospitals.

- Creates specific patient and facility criteria to clearly define long-term care hospitals (LTCHs) and the patients who belong there and directs the Secretary to develop additional criteria as recommended by MedPAC;
- Expands the current medical necessity review of LTCH admissions and continued stays to ensure that clinically appropriate patients are admitted;
- Imposes a 4 year moratorium on the development of new LTCHs and expansion of existing LTCHs to address concerns about growth;
- Prevents the current "25% Rule" pertaining to hospital referrals from being extended to freestanding and grandfathered LTCHs;
- Freezes the "25% Rule" at its current level for co-located, rural or MSA dominant LTCHs;
- Protects patient access by limiting a regulation on short stay outliers;
- Prevents imposition of a one-time budget neutrality adjustment.
- Freezes payment rates for long term care hospitals for rate year 2008.

Sec. 504. Increasing the disproportionate share (DSH) adjustment cap for rural hospitals. Raises the DSH cap for rural and small urban facilities to 16 percent in 2008 and 18 percent in 2009.

Sec. 505. PPS-exempt cancer hospitals. Provides the Secretary the authority to rebase PPS-exempt cancer hospitals.

Sec. 506. Skilled nursing facility update. Freezes payments to skilled nursing facilities for fiscal year 2008.

Sec. 507. Revocation of deeming authority of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Repeals JCAHO's unique statutory protection, effective 18 months after date of enactment.

TITLE VI -- OTHER PROVISIONS RELATING TO MEDICARE PART B

SUBTITLE A -- Payment and Coverage Improvements

Sec. 601. Payment for therapy services. Provides a two-year extension of the exceptions process for the Medicare therapy caps and requires that HHS conduct a study to develop an alternative or refined payment system for the future.

Sec. 602. Medicare separate definition of outpatient speech-language pathology services. Allows speech-language pathologists in private practice to bill Medicare directly for their services. Change does not allow for direct access to speech language pathology services (services will still require a physician's referral).

Sec. 603. Increased reimbursement rate for certified nurse-midwives. Increases reimbursement for certified nurse-midwife services from 65% to 100% of the physician fee schedule.

Sec. 604. Adjustment in outpatient fee schedule increase factor. Provides for a .25 reduction in the hospital outpatient market basket for FY 2008.

Sec. 605. Exception to 60-day limit on Medicare substitute billing arrangements in case of physicians ordered to active duty in the Armed Forces. Provides an exception to Medicare's 60-day leave of absence limitation for physicians who are on active duty in the Armed Forces Reserve or Guard.

Sec. 606. Excluding clinical social workers from coverage under the Medicare skilled nursing facility prospective payment system and consolidated payment. Removes clinical social workers from the skilled nursing facility consolidated billing which allows them to bill for clinical treatment for nursing home residents in nursing homes as do psychologists and psychiatrists.

Sec. 607. Coverage of marriage and family therapists and mental health counselors: Adds state-licensed or certified marriage and family therapists and mental health counselors as Medicare providers and pays them at the same rate as social workers.

Sec. 608. Rental and purchase of power-driven wheelchairs. Prohibits immediate purchase of power-driven wheelchairs.

Sec. 609. Rental and purchase of oxygen equipment. Reduces the length of time period for the rental of oxygen equipment from 36 months to 13 months. Requires CMS to conduct a study to assess the costs associated with provision of equipment versus service and to report whether those payments should be divided to assure appropriate reimbursement for each component.

Sec. 610. Adjustment for certain Medicare mental health services. Provides a temporary payment adjustment for certain mental health services to offset an unanticipated disparate reduction for those services as a result of the last relative value unit review.

Sec. 611. Extension of brachytherapy special rule. Extends for one year the current "charges adjusted to cost" methodology for reimbursing brachytherapy in the hospital outpatient department.

Sec. 612. Payment for part B drugs. Requires CMS to adjust its Average Sales Price (ASP) calculation to appropriately weight ASPs based on actual sales volume. Improves the Competitive Acquisition Program (CAP) by allowing physicians to continually enroll in the program, permitting contractors to deliver drugs directly to the site of administration, improving CMS outreach, and requiring CMS to rebid the CAP contracts in 2009. Eliminates the recent reimbursement increase for generic albuterol by removing the drug from a bundled ASP reimbursement with brand name levalbuterol.

SUBTITLE B – Extension of Medicare Rural Access Protections

Sec. 621. 2-year extension of floor on Medicare work geographic adjustment. Extends for two years the work geographic floor of 1.0 for any locality for which such index was below 1.0.

Sec. 622. 2-year extension of special treatment of certain physician pathology services under Medicare. Extend for two years the provision that allows independent laboratories providing services to hospitals that utilized independent laboratories prior to the CMS November 1999 final physician fee schedule rule to continue to bill Medicare directly for the physician pathology services they provide to hospitals.

Sec. 623. 2-year extension of Medicare reasonable costs payments for certain clinical diagnostic laboratory tests furnished to hospital patients in certain rural areas. Provides reasonable cost reimbursement for clinical lab tests performed by rural hospitals as part of their outpatient services (i.e. for area patients receiving care at home or in nursing homes) through 2010.

Sec. 624. 2-year extension of Medicare incentive payment program for physician scarcity areas. Extend provision which automatically qualifies physicians practicing in counties ranked in the bottom 20th percentile nationwide for a 5 percent bonus payment through 2010.

Sec. 626. 2-year extension of temporary Medicare payment increase for ambulance services in rural areas. Increases payments by 2 percent for rural ground ambulance services through 2010.

Sec. 627 Extending hold harmless for small-hospitals under the HOPD prospective payment system. Extends for two years the provision for hospitals with less than 100 beds harmless that provides a 90 percent "hold harmless" from the Medicare outpatient prospective payment system (PPS).

SUBTITLE C – END STAGE RENAL DISEASE PROGRAM

Sec. 631. Chronic kidney disease demonstration projects. Creates demonstration projects to test ways to increase public and medical awareness of factors that lead to chronic kidney disease, increasing screening and prevention, and enhance surveillance systems.

Sec. 632. Medicare coverage of kidney disease patient education services. Provides up to six patient education sessions for pre-dialysis (Chronic Kidney Disease Stage 4) Medicare beneficiaries.

Sec. 633. Requiring training for patient care dialysis technicians. Requires training and certification for patient care dialysis technicians.

Sec. 634. MedPAC report on treatment modalities for patients with kidney disease. Mandates a report by the Medicare Payment Advisory Commission on Medicare payment adequacy and recommendations for home dialysis.

Sec. 635. Adjustment for erythropoietin stimulating agents (ESAs). Adjusts payments for ESAs for large dialysis organzations.

Sec. 636. Site neutral composite rate. Creates a site-neutral composite rate for dialysis services.

Sec. 637. Development of ESRD bundling system and quality incentive payments. Starting in 2010, creates a bundled payment for dialysis and related drugs and services, with certain requirements to ensure appropriate anemia management. Allows for a four year phase-in for certain providers. Provides quality incentive payments for dialysis providers for 2008 through 2011.

Sec. 638. MedPAC report on ESRD bundling system. Mandates a report by the Medicare Payment Advisory Commission on payment adequacy under a bundled payment system.

Sec. 639. OIG Study and report on erythropoietin. Mandates a report by the HHS Office of the Inspector General on anemia management dosing guidelines and the extent to which such guidelines are consistent with the Food and Drug Administration's label for anemia management drugs.

SUBTITLE D -- MISCELLANEOUS

Sec. 651. Limitation on exception to the prohibition on certain physician referrals to hospitals. Eliminates the whole hospital exception so that physicians cannot self refer to hospitals in which they have ownership. Applies to all hospitals – not just specialty hospitals. Grandfathers hospitals that were in operation with Medicare provider agreements as of the date of introduction of the bill. Requires grandfathered hospitals to meet standards within 18 months of enactment that include: preventing growth,

requiring disclosure of ownership, limiting physician ownership to an aggregate of no more than 40% of the facility and no more than 2% individually, and disclosing to patients if they fail to have 24 hour physician coverage .

TITLE VII -- MEDICARE PARTS A and B

Sec. 701. Home health payment update for 2008. Provides zero update for home health services for FY 2008.

Sec. 702. 2-year extension of temporary Medicare payment increase for home health services furnished in rural areas. Extends for two years a 5% add-on payment for rural home health services.

Sec. 703. Extension of Medicare secondary payer for beneficiaries with end state renal disease for large group plans. Extends Medicare Secondary Payer to 42 months for beneficiaries with health insurance coverage from large employers (100+ employees).

Sec. 704. Plan for Medicare payment adjustments for never events. Requires HHS to develop a plan to identify steps needed to implement a system to prohibit Medicare payment for so-called "never events" or mistake procedures.

Sec. 705. Treatment of Medicare hospital reclassifications. Extends for two years the provisions of the Medicare Modernization Act of 2003 relating to wage index reclassifications.

Title VIII - MEDICAID

Subtitle A – Protecting and Extending Existing Coverage.

Sec. 801. Modernizing transitional Medicaid. Extends the Transitional Medical Assistance program (TMA) through Fiscal Year 2009, provides States the option to provide twelve months of continuous eligibility for families transitioning from welfare to work, [allows states the option to provide TMA to families who spent fewer than three months receiving TANF-related medical assistance], and enhances reporting on enrollment and participation under TMA.

Sec. 802. Family planning services. Allows states to offer family planning services without a waiver.

Sec. 803. Authority to continue providing adult day health services approved under a State Medicaid plan. Allows states to continue providing adult day health services under their state plan.

Sec. 804. State option to protect community spouses of individuals with disabilities. Clarifies States' ability to allow individuals with disabilities to remain in the community for care under home and community based care waivers.

Sec. 805. County Medicaid health insuring organizations. Amends section 9517©(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985 as amended by section 704 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 to increase the applicable percentage to 16.

Subtitle B – Payments

Sec. 811. Payments for Puerto Rico and territories. Increases the federal funding cap for Puerto Rico and the U.S. Territories. Allows for the first time federal matching payments for improvements in data reporting systems for the Commonwealth of Puerto Rico and the U.S. Territories. These payments would not be counted against the funding limitation otherwise in effect for these areas.

Sec. 812. Medicaid drug rebate. Increases the applicable rebate on drugs by 5 percentage points.

Sec. 813. Adjustment in computation of Medicaid FMAP to disregard an extraordinary employer pension contribution. Exempts extraordinary employer pension contributions from the calculation of personal income for the purposes of establishing a State's federal medical assistance percentage.

Sec. 814. Moratorium on certain payment restrictions. Protects access to care for children with disabilities who receive health care services in schools and children with disabilities who require rehabilitation services.

Sec. 815. Tennessee DSH. Provides a permanent allotment of disproportionate share hospital funding under section 1923 of $30 million.

Sec. 816. Clarification permitting regional medical center to participate in other States' Medicaid financing mechanism. Clarifies a regional medical center's eligibility to receive funds from a center located in another state.

Subtitle C – Miscellaneous

Sec. 821. SCHIP demonstration project for employer buy-in of family coverage.

Sec. 822. Diabetes grants. Extends diabetes grant funding until 2009.

Sec. 823. Technical correction. Makes a technical correction to provisions enacted in the Deficit Reduction Act.

TITLE XI -- MISCELLENEOUS

Sec. 901. Medicare Payment Advisory Commission status. Clarifies that MedPAC is a Congressional support agency.

Sec. 902. Repeal of trigger provision. Repeals provision created in the Medicare Modernization Act of 2003 to limit the amount of general revenues used to finance Medicare.

Sec. 903. Repeal of comparative cost adjustment program. Repeals the premium support demonstration created in the Medicare Modernization Act.

Sec. 904. Comparative effectiveness research. Establishes within the Agency of Healthcare Research and Quality a Center for Comparative Effectiveness Research to conduct research on the outcomes, effectiveness, and appropriateness of health care services. Also establishes an independent Comparative Effectiveness Research Commission to set priorities and ensure credibility for the Center's work. It also establishes a Comparative Effectiveness Research Trust Fund, initially funded through the Medicare trust fund, to support the work of the Center and the Commission.

Sec. 905. Implementation of health information technology (IT) under Medicare. Requires CMS to develop a plan to implement a health information technology system for Medicare.

Sec. 906. Development, Reporting, and use of health care measures. Requires the Secretary to designate a single national entity to coordinate development of health care measures

Sec. 907. Improvements to the Medigap Program. Directs the Secretary to implement the changes in the model law and regulations as recommended by the National Association of Insurance Commissioners in March 2007. Requires plans to offer guaranteed issue policies, and eliminates the only two statutorily mandated plans.

TITLE X -- REVENUES

Sec. 1001. Increase in rate of excise taxes on tobacco products and cigarette papers and tubes. Increases the per pack cigarette excise tax by $0.45 and generally increases other tobacco products by a proportionate percentage. Equalizes the rate on small cigars and small cigarettes, increases the cap on large cigars to $1.00 a cigar, and expands the definition of roll-your-own tobacco. Imposes a tax on floor stocks.

Sec. 1002. Exemption for emergency medical services transportation. Exempts from fuel excise taxes any liquid used by ambulances to provide emergency medical services.