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Summary of S. 3101 and S. 3118: Bills to Amend Medicare, Medicaid, and Other Provisions in the Social Security Act

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Hinda Chaikind, Coordinator
Jennifer O'Sullivan, Sibyl Tilson, Paulette C. Morgan,
Holly Stockdale, Jim Hahn, Gretchen A. Jacobson,
Richard Rimkunas, Evelyne P. Baumrucker, April Grady,
Jean Hearne, Elicia J. Herz, Julie Stone, Gene Falk,
and Emilie Stoltzfus
Domestic Social Policy Division

Prepared for Members and
Committees of Congress

Summary of S. 3101 and S. 3118: Bills to Amend Medicare, Medicaid, and Other Provisions in the Social Security Act

Summary

On June 6, 2008, Senator Baucus, Chairman of the Senate Finance Committee, introduced S. 3101, designed to avert the Medicare reduction in payments to physicians, which would otherwise occur by law beginning on July 1, 2008, and make other changes. The bill would freeze physicians fees at the current level until January 2009. In January, 2009 fees would increase by 1.1%. In 2010, fees would revert back to current law levels, resulting in a 21% reduction to physician payments, according to the Congressional Budget Office (CBO). CBO estimates that the physician payment provision would cost $9.9 billion. In total, the provisions in S. 3101 that increase spending would cost $19.8 billion over the five-year period (2008-2013). Other provisions in the bill would offset these costs, so that there would be no change in direct spending over either the 5- or 10-year budget window. The main source for these offsets comes from reductions in spending for (1) the Medicare Advantage program and (2) the physician assistance and quality initiative (PAQI) Fund.

The bill was not considered by the full Senate Finance Committee but rather went directly to the Senate Floor, where a cloture vote was held. The cloture motion did not pass, and it is unclear what future action will occur.

Senator Grassley, Ranking Member of the Senate Finance Committee, offered an alternative to S. 3101, titled "Preserving Access to Medicare Act of 2008" (S. 3118, introduced on June 11, 2008). This bill was also designed to avert the Medicare reduction in payments to physicians, which would otherwise occur beginning on July 1, 2008, and make other changes. Like S. 3101, the Grassley bill would freeze physicians fees at the current level until January 2009. In January, 2009 fees would increase by 1.1%. Similarly, in 2010, fees would revert back to current law levels. Other provisions in the bill would offset these costs and others in the bill, so that there would be no change in direct spending over either the 5- or 10-year budget window. The main source for these offsets comes from reductions in spending for (1) the Medicare Advantage program and (2) Medicaid and TANF provisions.

This report provides a brief summary of (1) S. 3101 as introduced, including amendments made by the Chairman (Medicare Improvements for Patients and Providers Act of 2008, version GOEO8452), and (2) the provisions in Senator Grassley's alternative (Preserving Access to Medicare Act of 2008, version GOEO8440).

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Summary of S. 3101 and S. 3118: Bills to Amend Medicare, Medicaid, and Other Provisions in the Social Security Act

Introduction

On June 6, 2008, Senator Baucus, Chairman of the Senate Finance Committee, introduced S. 3101, designed to avert the Medicare reduction in payments to physicians, which would otherwise occur by law beginning on July 1, 2008, and make other changes. The bill would freeze physicians fees at the current level until January 2009. In January, 2009 fees would increase by 1.1%. In 2010 fees would revert back to current law levels, resulting in a 21% reduction to physician payments[1], according to the Congressional Budget Office (CBO).[2] CBO estimates that the physician payment provision would cost $9.9 billion over the FY2008-2010 period. In total, the provisions in S. 3101 that increase spending, would cost $19.8 billion over the five-year period (2008-2013). The bill makes additional changes to the Medicare program. For instance it expands preventive services, modifies the asset tests associated with the Medicare Savings Program, affects sales and marketing activities surrounding the Medicare advantage and prescription drug plans, and extends a number of expiring Medicare and Medicaid provisions. Other provisions in the bill would offset these costs, so that there would be essentially no change in direct spending over either the 5- or 10-year budget window. The main source for these offsets comes from reductions in spending for (1) the Medicare Advantage program, and (2) the physician assistance and quality initiative (PAQI) Fund.

The bill was not considered by the full Senate Finance Committee but rather went directly to the Senate Floor where a cloture vote was held. The cloture motion did not pass and it is unclear what future action will occur. The White House indicated in a Statement of Administration Policy that it would veto S. 3101 in its current form.[3]

Senator Grassley, Ranking Member of the Senate Finance Committee, offered an alternative to S. 3101, titled " Preserving Access to Medicare Act of 2008" (S.

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[1] For a further explanation of how physicians are paid under Medicare and why this reduction would occur, see CRS Report RL31199, *Medicare: Payments to Physicians*, by Jennifer O'Sullivan.

[2] The CBO cost estimate is available at [http://www.cbo.gov/ftpdocs/93xx/doc9379/s3101Baucus.pdf]

[3] See [http://www.whitehouse.gov/omb/legislative/sap/110-2/saps3101-s.pdf].

3118, introduced on June 11, 2008). Like the Baucus bill, this bill would freeze physicians fees at the current level until January 2009. In January, 2009 fees would increase by 1.1%. The Grassley bill reduces the Physician Assistance and Quality Initiative Fund amount from $4.96 billion to $4.09 billion for 2013 and adds $30.66 billion for expenditures during the years 2014 through 2017, which would only be available for an adjustment to the update of the conversion factor for that year. Like the Baucus bill, the Grassley alternative includes provisions to extend a number of expiring provisions in Medicare and Medicaid. According to the CBO,[4] other provisions in the bill would offset these costs and others in the bill, so that there would be no change in direct spending over either the 5- or 10-year budget window. The main source for these offsets comes from reductions in spending for (1) the Medicare Advantage program, although the Grassley alternative relies on a slightly slower phase-out of the indirect medical education payments[5], and (2) Medicaid and TANF provisions.

This report provides a brief summary of (1) S. 3101 as introduced, including amendments made by the Chairman ("Medicare Improvements for Patients and Providers Act of 2008," version GOEO8452), and (2) the provisions in Senator Grassley's alternative ("Preserving Access to Medicare Act of 2008," version GOEO8440).

On June 24, 2008, the House passed H.R. 6331, the Medicare Improvements for Patients and Providers Act of 2008, under suspension of the rules by a vote of 355 to 59.[6] The House bill is also designed to avert the Medicare reduction in payments for physicians, which would otherwise occur by law beginning on July 1, 2008, and make other changes. This bill would make changes to the Medicare Advantage program. This bill would add a provision to terminate all contracts under the first round of the Durable Medical Equipment, prosthetics, orthotics, and other medical supplies (DMEPOS) competitive acquisition program, set to start July 1, 2008.

In this report, references are made to the following public laws:

- Balanced Budget Act of 1997 (P.L. 105-33, BBA)
- Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173, MMA)
- Deficit Reduction Act (P.L. 109-171, DRA)
- Tax Relief and Health Care Act of 2006 (P.L. 109-432, TRHCA)
- Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 110-173, MMSEA)

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[4] The CBO cost estimate is available at [http://www.cbo.gov/ftpdocs/93xx/doc9370/SFC-R_Medicare_20080611.pdf].

[5] A direct comparison of the saving effects of the difference in this provision versus the Baucus provision is not available. CBO's scoring of this reduction in S. 3101 includes additional changes to the MA program.

[6] For a summary of H.R. 6331, as passed, see CRS Report RS22904, *Summary of Major Provisions in House-Passed H.R. 6331, the Medicare Improvements for Patients and Providers Act of 2008*, by Hinda Chaikind, Jim Hahn, Paulette C. Morgan, and Jennifer O'Sullivan.

Summary of Provisions in S. 3101 - The Medicare Improvements for Patients and Providers Act of 2008

Title I - Medicare

Subtitle A - Beneficiary Improvements

Part I - Prevention, Mental Health, and Marketing

Section 101. Improvements to Coverage of Preventive Services. The provision would add "additional preventive services" to the list of Medicare-covered preventive services. The term "additional preventive services" would mean services not otherwise described in Medicare law that identify medical conditions or risk factors and that the Secretary determined were (1) reasonable and necessary for the prevention or early detection of an illness or disability; (2) recommended with a grade of A or B by the United States Preventive Services Task Force; and (3) appropriate for individuals entitled to Medicare Part A or enrolled in Part B. In making the determinations, the Secretary would be required to use the process for making national coverage determinations. As part of the use of such process, the Secretary could conduct an assessment of the relation between predicted outcomes and the expenditures for such services and could take into the account the results of such assessment in making such determination.

The provision would modify the list of services covered under the initial preventive physical exam (also known as "Welcome to Medicare") to include measurement of body mass index. It would also add end-of-life planning upon agreement with the individual. End of life planning would be defined as verbal or written information regarding an individual's ability to prepare an advance directive in the case that an injury or illness caused the individual to be unable to make health care decisions and whether or not the physician was willing to follow the individual's wishes as expressed in an advance directive.

The provision would waive the deductible for the initial preventive screening exam and extend the eligibility period for this service from the first six months to the first year of Part B enrollment.

Section 102. Elimination of Discriminatory Copayment Rates for Medicare Outpatient Psychiatric Services. Medicare Part B generally pays 80% of the approved amount for covered services in excess of the annual deductible. However, Medicare recognizes only 62.5% 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% (80% X 62.5%) of Medicare's recognized amount for these services. The provision would raise the 62.5% level to 68.75% in 2010 and 2011, 75% in 2012, 81.25% in 2013, and 100% in 2014 and subsequent years. When the provision was fully phased-in in 2014, outpatient psychiatric services would be paid on the same basis as other Part B services.

Section 103. Prohibitions and Limitations on Certain Sales and Marketing Activities under Medicare Advantage Plans and Prescription Drug Plans. This provision would establish new prohibitions on the marketing activities of MA and PDP plans and their agents. Except in instances when the beneficiary initiates contact, plans would be prohibited from soliciting beneficiaries door-to-door or on the phone. Cross-selling of non-health related products, providing meals to prospective enrollees, marketing in areas where health care is delivered (i.e., physician offices or pharmacies), and using sales agents that are not State licensed would also be prohibited. The provision would require that by November 15, 2008, the Secretary establish limitations on other plan marketing activities such as co-branding, marketing appointments with prospective enrollees, and agent compensation and training. Agent and broker terminations would have to be reported to the State along with the reasons for their termination. Finally, after January 1, 2010, MA and PDP plans would be required to include plan type in all plan names.

Section 104. Improvements to the Medigap Program. Many Medicare beneficiaries have individually purchased health insurance policies, commonly referred to as "Medigap" policies that supplement Medicare's coverage. Medigap policies are subject to certain statutory requirements. 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. The provision would require the Secretary to provide for the implementation of the changes in the NAIC model law and regulation approved by the NAIC on March 11, 2007, as modified to reflect the changes in this Act and the Genetic Information Nondiscrimination Act of 2008 (P.L. 110-233). The provision would prohibit a carrier from issuing a new or revised Medigap policy that met the requirements of the revised NAIC model law and regulations for coverage effective before June 1, 2010. Further, policy issuers would be required to offer at least policies with benefit packages labeled "C" or "F" in addition to the current requirement that issuers offer at least policies designated "A."

Part II - Low-Income Programs

Section 111. Extension of Qualifying Individual (QI) Program. Certain low-income individuals who are aged or have disabilities, as defined under the Supplemental Security Income (SSI) program, and who are eligible for Medicare are also eligible to have their Medicare Part B premiums paid for by Medicaid under the Medicare Savings Program (MSP). Eligible groups include Qualified Medicare Beneficiaries (QMBs), Specified Low-Income Medicare Beneficiaries (SLMBs), and Qualifying Individuals (QI-1s). QMBs have incomes no greater than 100% of the federal poverty level (FPL) and assets no greater than $4,000 for an individual and $6,000 for a couple. SLMBs meet QMB criteria, except that their incomes are greater than 100% of FPL but do not exceed 120% FPL. QI-1s meet the QMB criteria, except that their income is between 120% and 135% of poverty and they are not otherwise eligible for Medicaid. The QI-1 program is currently slated to terminate June 2008. The bill would extend authorization for the QI-1 program through December 2009.

In general, Medicaid payments are shared between federal and state governments according to a matching formula. Unlike the QMB and SLMB programs, federal spending under the QI-1 program is subject to annual limits. Expenditures under the QI-1 program are paid 100% by the federal government (from the Part B trust fund) up to a state's allocation level. States are required to cover only the number of people which would bring their annual spending on these population groups to their allocation levels. For the period beginning on January 1, 2008, and ending on June 30, 2008, the total allocation amount was $200 million. The bill would extend the allocation of $200 million from the period of January 1, 2008, through June 30, 2008, to the period of January 1, 2008, through September 30, 2008, and increase the allocation amount for this period to $300 million. The provision would also allocate $100 million for the period that begins October 1, 2008, and ends December 31, 2008; would allocate $350 million for the period that begins January 1, 2009 and ends September 30, 2009; and would allocate $150 million for the period that begins October 1, 2009 and ends on December 31, 2009.

Section 112. Application of Full Low Income Subsidy (LIS) Assets Test under Medicare Savings Program. Certain low-income individuals who are aged or have disabilities, as defined under the Supplemental Security Income (SSI) program, and who are eligible for Medicare are also eligible to have their Medicare Part B premiums paid for by Medicaid under the Medicare Savings Program (MSP) and are eligible to receive the Medicare Part D low-income subsidy. Currently, in order for beneficiaries to be eligible for the MSP they must have assets that are no greater than $4,000 for an individual and $6,000 for a couple. The bill alters these asset tests. Beginning January 1, 2010, individuals could qualify under the MSP program with assets levels of $6,000 for an individual and $9,000 for a couple as of 2006. These amounts would be updated annually by increases in the Consumer Price Index (CPI) and rounded to the nearest multiple of $10. The bill further modifies the definition of assets to exclude the value of an individual or couple's life insurance.

Section 113. Eliminating Barriers to Enrollment. The Commissioner of the Social Security Administration (SSA) is required to make low-income subsidy (LIS) determinations for persons applying at SSA offices. The provision would extend the outreach requirements currently applicable to the Commissioner of SSA. The Commissioner would be required, for each individual submitting an application for LIS, requesting an application for LIS, or otherwise identified by the Commissioner as potentially eligible for LIS, to (1) provide information describing the LIS program and the Medicare Savings program ((MSP) which provides Medicaid assistance for Medicare Part B premiums, and for some persons, Medicare cost-sharing charges); (2) provide an application for enrollment under the LIS program; (3) transmit data from such application to the state for purposes of initiating an application for MSP (beginning January 2010, with the applicants consent); (4) provide information on how the individual could obtain assistance in completing the application and an application under the MSP program, including information on how they could contact the appropriate State health insurance assistance program; and (5) make such application and information available in local social security offices. The Commissioner would be required to provide training to SSA employees who were involved in receiving LIS applications.

The provision would provide for reimbursement of SSA costs. The Government Accountability Office (GAO) would be required to conduct a study of the impact of this section on increasing participation in MSP and on states and the SSA. GAO would be required to submit a report by January 1, 2012, to Congress, the Commissioner, and the Secretary.

Section 114. Elimination of Medicare Part D Late Enrollment Penalties Paid by 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. The Centers for Medicare and Medicaid Services (CMS) has waived this penalty through 2008 for persons deemed eligible for a low-income subsidy after the close of their initial enrollment period. The provision would waive late enrollment penalties for persons who are determined to be eligible for a low-income subsidy beginning January 2009.

Section 115. Eliminating Application of Estate Recovery. Beneficiaries are allowed to retain certain assets and still qualify for Medicaid. The Medicaid estate recovery program is intended to enable states to recoup these private assets upon a beneficiary's death to recover certain Medicaid expenditures made on behalf of these individuals. Since 1993, Medicaid law has required states to recover, from the estate of the beneficiary, amounts paid by the program for certain long-term care and related services, and given states the option to recover for other services, such as amounts Medicaid paid for Medicare cost-sharing on behalf of dual eligibles who are entitled to Medicare Part A and/or Part B and are eligible for full Medicaid benefits.

There are two instances in which states are required to seek recovery of payments for Medicaid assistance: (1) when an individual of any age is an inpatient in a nursing facility or an intermediate care facility for the mentally retarded (ICF/MR) and is not reasonably expected to be discharged from the institution and return home; and (2) when an individual age 55 years and older receives Medicaid assistance for nursing facility services, home and community-based services and related hospital and prescription drug services. Included in these groups are dual eligibles who are entitled to Medicare Part A and/or Part B and are eligible for full Medicaid benefits.

The bill would prohibit states from recovering amounts paid for Medicare cost-sharing on behalf of dual eligibles who are entitled to Medicare Part A and/or Part B and who are eligible for full Medicaid benefits. The provision would take effect as of January 1, 2010.

Section 116. 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 the Part D low-income subsidy program generally follow those used for determining eligibility under the Medicare Savings program (which in turn link back to the definitions used for purposes of the Supplemental Security Income program). For purposes of the LIS, the provision would exclude from the definition of income, support and maintenance furnished in kind. It would also exclude from the definition of resources

any part of the value of any life insurance policy. The provision would be effective January 1, 2010.

Section 117. Judicial Review of Decisions of the Commissioner of Social Security under the Medicare Part D Low-Income Subsidy Program. For those found ineligible for LIS by the Commissioner of Social Security, a right to a judicial review would be added.

Section 118. Translation of Model Form. Medicaid law requires the Secretary to develop and distribute to the states a simplified application form for use by Medicare Savings applicants in states which elect to use the model form. The provision would require the Secretary to provide for the translation of the model application form into at least 10 languages, other than English.

Section 119. Medicare Enrollment Assistance. Beneficiaries may obtain information on Medicare from a variety of sources including from state health insurance assistance programs (SHIPs). SHIPs are state-based programs that use community-based networks to provide Medicare beneficiaries with local personalized assistance on a wide variety of Medicare and health insurance topics. They receive Federal funding for their activities. The provision would require the Secretary to provide for the transfer of a total of $7.5 million to the CMS Program Management Account for FY2009 for the purpose of making grants to the states for SHIPs. Two-thirds of the total would be allocated among the states based on the number in each state of persons with incomes below 150% of poverty who had not enrolled to receive a low income subsidy relative to the total number of such individuals in all states. One third of the total would be allocated among the states based on the number of Part D eligible beneficiaries residing in rural areas in each state relative to the total number of such individuals in all states.

The provision would also require the Secretary, to provide for the total of $7.5 million to the Administration on Aging for FY2009 for the purpose of making grants to the states for area agencies on aging to be used to provide outreach to eligible Medicare beneficiaries. It would also require the Secretary to provide for the transfer of a total of $5.0 million to the Administration on Aging for FY2009 for the purpose of making grants to Aging and Disability Resource Centers (that are established centers on the date of enactment) under the Aging and Disability Center grant program. Each grant would be used to provide outreach to individuals regarding benefits under Part D and the Medicare Savings Program.

Subtitle B - Provisions Relating to Part A

Section 121. Expansion and Extension of the Medicare Rural Hospital Flexibility Program. BBA established the Medicare Rural Hospital Flexibility Program which created the critical access hospital (CAH) designation under Medicare and authorized a grant program (FLEX grants) which is administered by the Health Resources and Services Administration (HRSA). There are certain limitations imposed on the use of grant funds for administrative expenses, both at the state and federal level. The grant program has been authorized at $35 million from FY2005 through FY2008.

The purpose of the grant program would be expanded. The Secretary would be able to award grants to States to increase the delivery of mental health services or other health services deemed necessary to meet the needs of veterans and other residents of rural areas, including rural census tracks, as defined by HRSA. The Secretary would require the State demonstrate appropriate consultation with the state hospital association, rural hospitals, mental health providers, and other stakeholders.

When awarding grants, the Secretary would be required to give special consideration to applications submitted by states where veterans make up a high percentage of the state's total population. This consideration would be given without regard to the number of veterans of Operation Iraqi Freedom and Operation Enduring Freedom living in the areas in which mental health care and other health care services would be delivered. The Director of the Office of Rural Health of the Department of Veterans Affairs would be consulted when awarding grants to states. A state awarded such a grant may use the funds to reimburse providers of services. A state would not be able to expend more than 15% of the grant amount on administrative expenses.

An independent evaluation of the mental and other health grants would be required. No later than one year after the date on which the last grant is awarded, the Secretary would submit a report to Congress which would assess the impact of the grants on increasing the delivery of mental health services to veterans living in rural areas, particularly those who served in Operation Iraqi Freedom and Operation Enduring Freedom and to other rural individuals.

HRSA would be authorized to spend up to 5% of the total amount appropriated for FLEX and SHIP grants for each of the fiscal years from 2005 through 2008 on administering the grants. Beginning FY2009, HRSA would be authorized to spend up to 5% of the total amount appropriated for grants.

The FLEX grant program would be available to provide support for CAHs for quality improvement, quality reporting, performance improvements and would be authorized at $55 million for each fiscal year from 2009 and 2010. The new rural mental health and other services grants would be authorized at $50 million for each of fiscal year, 2009 and 2010, to be available until expended.

An additional grant program would be established where eligible CAHs would be able to receive a grant to transition to a skilled nursing or assisted living facility. An eligible CAH is one that has an average daily acute census of less than 0.5 and an average daily swing bed census of greater than 10.0. Matching funds from the state would be required. The CAH would surrender its CAH status within 180 days of receiving the grant. These grants would not be able to exceed $1 million. There would be $5 million appropriated from the Federal Insurance Trust Fund for making these grants.

Section 122. Rebasing for Sole Community Hospitals. Medicare payments to sole community hospitals for inpatient hospital services are made on the basis of the federal per discharge payment amount or on the basis of its updated hospital-specific per discharge amount from FY1982, FY1987, or FY1996, whichever would result in the largest payment. For cost reporting periods beginning

on or after January 1, 2009, an SCH would be able to elect payment based on its FY2006 hospital-specific payment amount per discharge. This amount would be increased by the annual update starting for discharges on or after January 1, 2009.

Section 123. Demonstration Project on Community Integration Models in Certain Rural Counties. A three-year demonstration project in 4 states would be established beginning October 1, 2009, that would allow states to develop and test a new model for the delivery of health care services for the purpose of better integrating the delivery of acute care, extended care, and other essential health care services. Eligible participants would be Rural Hospital Flexibility Program grantees in a state where at least 65% of the counties have 6 or few residents per square mile. No more than 6 counties in the 4 participating states would be selected. An eligible county has 6 or fewer residents per square mile and must have a facility designated as a CAH on the date of enactment that meets certain criteria. Participating health care providers would be paid at a rate that covers at least the reasonable costs of furnishing acute care, extended care, and other essential health care services. Methods to coordinate the survey and certification process would be tested. Participants and the Secretary would work to revise states' Medicaid payments. The demonstration would be administered jointly by the Office of Rural Health Policy of the Health Resources and Services Administration (HRSA) and CMS.

The Secretary would ensure that the aggregate Medicare expenditures under the project do not exceed the amount that would have been expended without the project and would provide for the transfer of necessary funds from the Medicare trust funds. There would be $800,000 authorized to be appropriated to the Office of Rural Health Policy (ORHP) of HRSA for each of the fiscal years 2010, 2011, and 2112, which would remain available for the project's duration.

No later than two years after the demonstration's implementation date, ORHP in coordination with CMS would submit a congressional status report with initial recommendations. A final report with recommendations for legislation and for administrative action would be due no later than one year after the project's completion.

Section 124. Extension of the Reclassification of Certain Hospitals. Section 508 of MMA provided $900 million for a one-time, three year geographic reclassification of certain hospital who were otherwise unable to qualify for administrative reclassification to areas with higher wage index values. These reclassifications were subsequently extended to September 30, 2008. MMSEA extended certain hospital reclassifications made through the Secretary's authority to make exceptions and adjustments during the FY2005 rulemaking process until September 30, 2008. This provision would extend the Section 508 and the special exception reclassifications until September 30, 2009.

Section 125. Revocation of Unique Deeming Authority of the Joint Commission. In order to receive Medicare payments, Medicare providers and suppliers must meet certain health and safety requirements specified in statute. Alternatively, a provider can be deemed to meet these requirements if it has been accredited by an approved national accreditation body. This provision would revoke

the unique authority granted the Joint Commission of Healthcare Organizations (JCAHO) to accredit hospitals. Hospitals, like other Medicare provider entities, would be accredited by national accrediting organizations approved by the Secretary. This provision would not take effect until 24 months after the legislation were enacted and would not affect those hospitals currently being accredited or under accreditation by JCAHO. The provision does not remove the unique authority granted the American Osteopathic Association (AOA) to accredit provider entities for participation in the program.

Subtitle C - Provisions Relating to Part B

Part I - Physicians' Services

Section 131. Physician Payment, Efficiency, and Quality Improvements. Section 101 of the MMA increased the update to the conversion factor for Medicare physician payment by 0.5% compared with 2007 rates for the first six months of 2008. The current update formula requires a reduction in the fee schedule of 10.6% for physician reimbursement for services provided between July 1 and December 31, 2008, and by additional amounts annually for at least several years thereafter. This provision would avert this reduction and would extend the 0.5% increase in the physician fee schedule that was set to expire on June 30, 2008, through the end of 2008. For 2009, the update to the conversion factor would be 1.1%. The conversion factor for 2010 and subsequent years would be computed as if this modification had never applied.

By law, Medicare Part B premiums are calculated so that beneficiaries contribute 25% of total Part B expenditures. The estimate of Medicare Part B beneficiary premiums for 2009 would be modified by this provision by excluding $1.2 billion of benefits and administrative costs from the calculation.

TRHCA created the physician assistance and quality initiative (PAQI) Fund, which is to be available to the Secretary of HHS for physician payment and quality improvement initiatives. The MMSEA, as well as provisions in the Department of Labor, Health and Human Services, and Education and Related Agencies Appropriations Act of 2008 (division G of the Consolidated Appropriations Act of 2008) modified the amounts that will be available in the PAQI Fund and the years in which the monies can be spent. This provision would modify the statute so that funds for expenditures during 2013, an amount equal to $4.96 billion, would be eliminated.

The physician quality reporting system, which currently runs only through 2009, would be extended through 2010. Eligible professionals who provide covered professional services would be eligible for the incentive payment if (1) there are quality measures that have been established under the physician reporting system that are applicable to any services furnished by such professional for the reporting period; and (2) the eligible professional satisfactorily submits data to the Secretary on the quality measures. These providers, in addition to the amount otherwise paid under Medicare, would also be paid an incentive payment equal to 1.5% for 2007 and 2008 and 2.0% for 2009 and 2010 of the allowed charges under this part for all such covered professional services furnished by the eligible professional from the Part B

Trust Fund. The provision would also define satisfactory reporting of measures for group practices and include qualified audiologists as eligible professionals for purposes of Medicare payment, beginning in 2009.

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. The GAO noted that certain public and private health care purchasers routinely evaluate physicians in their networks using measures of efficiency and other factors and that the purchasers it studied linked their evaluation results to a range of incentives to encourage efficiency. This provision would establish a physician feedback program with the intent to improve efficiency and to control costs. Under the Physician Feedback Program, to be implemented by January 1, 2009, the Secretary would use Medicare claims data to provide confidential reports to physicians that measure the resources involved in furnishing care to Medicare beneficiaries. The resources to be considered in this program may be measured on an episode basis, on a per capita basis, or on both an episode and a per capita basis. The GAO would conduct a study of the Physician Feedback Program as described above, including the implementation of the Program, and would submit a report to Congress by March 1, 2011 containing the results of the study, together with recommendations for such legislation and administrative action as the Comptroller General determines appropriate.

Finally, the provision would require the Secretary of Health and Human Services to develop a plan to transition to a value-based purchasing program for payment under the Medicare program for covered professional services. Not later than May 1, 2010, the Secretary of Health and Human Services would submit a report to Congress containing the plan, together with recommendations for such legislation and administrative action as the Secretary determines appropriate.

Section 132. Incentives for Electronic Prescribing. The provision would establish incentives for electronic prescribing in the Medicare program. For 2009 through 2013, Medicare professionals providing covered services to Medicare beneficiaries and who are successful electronic prescribers would receive an incentive payment of 2.0% for 2009 and 2010, 1.0% for 2011 and 2012, and 0.5% for 2013. Providers who did not have a sufficient volume of qualifying services would be excluded from the program, as well as those for whom the Secretary determines that compliance would be a significant hardship, such as for an eligible professional who practices in a rural area without sufficient Internet access. Not later than September 1, 2012, the GAO would submit to Congress a report on the implementation of the incentives for electronic prescribing established by this section.

Section 133. Expanding Access to Primary Care Services. The provision would expand the incentive payment program for primary care services furnished in physician scarcity areas. For primary care services furnished by a primary care physician in a primary care scarcity county on or after January 1, 2011, a 5% incentive payment amount would be paid in addition to the amount that would

otherwise be paid under Medicare. The provision would give the Secretary the authority to expand the duration and scope of the Medical Home Demonstration Project if the expansion would meet either of the following conditions: (1) the expansion of the project is expected to improve the quality of patient care without increasing spending under Medicare, or (2) the expansion of the project is expected to reduce spending under the Medicare program without reducing the quality of patient care. To fund any potential expansion of the demonstration project, $100 million would be made available from the Federal Supplementary Medical Insurance Trust Fund.

The provision would change the application of the budget-neutrality adjustor from the relative value units to the conversion factor, beginning with 2009.

Section 134. Extension of Floor on Medicare Work Geographic Adjustment under the Medicare Physician Fee Schedule. Medicare makes payment for physician services under the fee schedule. Three factors enter into the calculation of the fee schedule payment amount: the relative value for the service, a geographic adjustment and a national dollar conversion factor. The geographic adjustments are indexes that reflect cost differences among areas compared to the national average in a "market basket" of goods. A value of 1.00 represents an average across all areas. The law has placed a temporary floor of 1.00 on the geographic work adjustment for January 2004-June 2008. The provision would extend, through December, 2009, the period that the floor is set at 1.00. In addition, beginning January 1, 2009, it would raise the work geographic adjustment to 1.5 in Alaska if the index would otherwise be less than 1.5.

Section 135. Imaging Provisions. The provision would specify that beginning January 1, 2012, payment may only be made under the physician fee schedule for the technical component of advanced diagnostic imaging services furnished by a supplier if such supplier is accredited by an accreditation organization. Advanced diagnostic imaging services would be defined as including diagnostic magnetic resonance imaging, computed tomography, and certain other services as specified by the Secretary in consultation with physician specialty organizations and other stakeholders. The accreditation organization would have to be designated by the Secretary who would be required to consider specified factors both in designating an accreditation organization and in reviewing and modifying the list of designated organizations.

The Secretary would be required to establish procedures to ensure that the criteria used by an accreditation organization to evaluate a supplier that furnishes the technical component of advanced diagnostic imaging services is specific to each imaging modality.

The provision would require the Secretary to establish a two-year demonstration project using specified models to collect data regarding physician compliance with appropriateness criteria for advanced diagnostic imaging services. The Secretary could focus the demonstration project, such as on services that account for a large amount of Medicare expenditures, services that have recently experienced a high rate of growth, or services for which appropriateness criteria exist. The Secretary, in consultation with medical specialty societies and other stakeholders, would select criteria with respect to the clinical appropriateness of advanced diagnostic imaging

for use in the demonstration. The Secretary would develop mechanisms to provide feedback reports to physicians participating in the project. In addition, the Secretary would be required to evaluate the demonstration project and submit a report to Congress containing the results of the evaluation together with recommendations for legislative and administrative action.

The GAO would be required to conduct a study by imaging modality of the new accreditation requirement and any other relevant questions involving access to and the value of advanced diagnostic imaging services for beneficiaries.

Section 136. Extension of Treatment of Certain Physician Pathology Services under Medicare. Legislation enacted in 1997 specified that independent labs that had agreements with hospitals on July 22, 1999 to bill directly for the technical component of pathology services could continue to do so in 2001 and 2002. The provision has been periodically extended. It is currently extended through June 30, 2008. The provision would be extended through December 31, 2009.

Section 137. Accommodation of Physicians Ordered to Active Duty in the Armed Services. 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. In general, the services cannot be provided by the second physician for more than 60 days. The law permits, for services provided prior to June 30, 2008, reciprocal billing over a longer period in cases where the first physician was called or ordered to active duty as a member of a reserve component of the Armed Forces. The provision would make the accommodation permanent.

Section 138. Adjustment for Medicare Mental Health Services. Medicare pays for mental health services under the physician fee schedule. The provision would increase the fee schedule amount otherwise applicable for certain specified mental health services by 5% for the period July 2008 - December 2009.

Section 139. Improvements for Medicare Anesthesia Teaching Programs. Anesthesia services may be personally performed by the anesthesiologist or the anesthesiologist may medically direct up to four concurrent anesthesia cases. When the anesthesiologist medically directs a case, the payment for the physician's medical direction service is 50% of the amount otherwise recognized if the anesthesiologist personally performed the service. The provision would establish a special payment rule with respect to physicians' services furnished on or after January 1, 2010. In the case of teaching anesthesiologists involved in a single anesthesia case or two concurrent anesthesia cases, the payment amount would be 100% of the fee schedule amount otherwise applicable if the anesthesia services were personally performed by the teaching anesthesiologist alone. This payment provision would only apply if (1) the teaching anesthesiologist was present during all critical or key portions of the anesthesia service or procedure involved; and (2) the teaching anesthesiologist (or another anesthesiologist with whom the teaching anesthesiologist had entered into an arrangement) was immediately available to furnish anesthesia services during the entire procedure. Further, the provision would require the Secretary to make appropriate payment adjustments for items and services furnished by teaching certified registered nurse anesthetists.

Part II - Other Payment and Coverage Improvements

Section 141. Extension of Exceptions Process for Medicare Therapy Caps. The law places annual per beneficiary payment limits for all outpatient therapy services provided by non-hospital providers. There are two beneficiary limits. The first is a $1,810 (in 2008) per beneficiary annual cap for all outpatient physical therapy services and speech language pathology services. The second is a $1,810 (in 2008) per beneficiary annual cap for all outpatient occupational therapy services. The law has required the Secretary to implement an exceptions process for 2006, 2007, and the first half of 2008 for cases in which the provision of additional therapy services was determined to be medically necessary. The provision would extend the exceptions process through 2009.

Section 142. Extension of Payment Rule for Brachytherapy and Therapeutic Radiopharmaceuticals. MMA required Medicare's outpatient prospective payment system to make separate payments for specified brachytherapy sources. Subsequent legislation established that this separate payment will be made using hospitals' charges adjusted to their costs until January 1, 2008. MMSEA extended this payment method for brachytherapy services until July 1, 2008 and established these payments for therapeutic radiopharmaceuticals for services provided on or after January 1, 2008, and before July 1, 2008. This provision would extend cost reimbursement for brachytherapy and therapeutic radiopharmaceuticals until January 1, 2010.

Section 143. Speech-Language Pathology Services. The provision would establish a separate definition for outpatient speech-language pathology services and would permit speech-language pathologists practicing independently to bill Part B subject to the same conditions applicable to physical and occupational therapists in independent practice.

Section 144. Payment and Coverage Improvements for Patients with Chronic Obstructive Pulmonary Disease and Other Conditions.

The provision would include, within the definition of covered medical and other health services, items and services furnished under a cardiac rehabilitation program or under a pulmonary rehabilitation program, subject to specified conditions. The provision would be effective January 1, 2010.

This provision would repeal the requirement that medical equipment suppliers transfer the title for oxygen equipment to the beneficiary after a 36 months rental period, effective January 1, 2009; suppliers would retain ownership of the equipment but would continue to furnish the equipment to the beneficiary during the period of medical need.

Outside of areas where payments for oxygen are determined through a competitive bidding process, starting January 1, 2009, the provision would revise payment rates for oxygen and various types of oxygen equipment. Starting in 2010, the new payment amounts for oxygen equipment (other than portable oxygen and oxygen equipment) would be updated by the increase in the consumer price index.

The Secretary would be required to contract with the Institute of Medicine to (1) conduct a study on the furnishing of, and payments for, oxygen and oxygen equipment under Medicare, and (2) provide a report to the Secretary not later than 18 months after enactment.

Section 145. Revision of Payment for Power-Driven Wheelchairs. The lump-sum payment option for the purchase or replacement of a power wheelchair would be eliminated for all power wheelchairs except complex, rehabilitative wheelchairs. For power wheelchairs purchased through a 13-month rental agreement rather than the lump-sum payment option, the rental payments would be increased during the first three months of the rental period (from 10% to 15% of the purchase price) and reduced for the remaining 10 months (from 7.5% to 6% of the purchase price). This provision would not apply to contracts entered into under the Durable Medical Equipment Competitive Acquisition Program prior to October 1, 2009.

Section 146. Clinical Laboratory Tests. The provision would repeal the current law requirement for competitive bidding for clinical laboratory services. In addition, it would specify that the clinical laboratory fee schedule update otherwise slated to occur each year would be reduced each year from 2009 through 2013 by 0.5 percentage points.

Section 147. Improved Access to Ambulance Services. The provision would increase payments for ground ambulance transports originating in rural areas or rural census tracts by 3% and the payments for such transports originating in other areas by 2% for the period July 1, 2008 - December 31, 2009. The provision would also specify that any area designated as rural for the purposes of making payments for air ambulance services on December 31, 2006, would be treated as rural for the purpose of making air ambulance payments during the period July 1, 2008-December 31, 2009.

Section 148. Extension and Expansion of the Medicare Hold Harmless Provision under the Prospective Payment System for Hospital Outpatient (HOPD) Services for Certain Hospitals. Small rural hospitals (with no more than 100 beds) that are not sole community hospitals (SCHs) can receive additional Medicare payments if their outpatient prospective payment system (OPPS) payments are less than those under the prior reimbursement system. For calendar year (CY) 2006, these hospitals will receive 95% of the difference, 90% of the difference in CY2007 and 85% of the difference in CY2008. The provision would establish that small rural hospitals would receive 85% of the payment difference in CY2009. SCHs with not more than 100 beds would receive 85% of the payment difference for covered OPD services furnished on or after January 1, 2009, and before January 1, 2010.

Section 149. Clarification of Payment for Clinical Laboratory Tests Furnished by Critical Access Hospitals. Medicare outpatient covered clinical laboratory services are generally paid based on a fee schedule. Clinical diagnostic laboratory services provided to patients who receive services directly from critical access hospitals (CAHs) on an outpatient basis are paid 101% of reasonable costs. Clinical laboratory services provided by CAHs to those who are not patients are paid

on the basis of the Medicare fee schedule. In no instance, are Medicare beneficiaries liable for any coinsurance or deductible amounts. Generally, clinical laboratory services provided to skilled nursing facility (SNF) patients (who are Medicare beneficiaries that are covered under Medicare Part A) are paid under consolidated billing as part of the SNF-PPS. Under this provision, starting for services furnished on July 1, 2009, clinical diagnostic laboratory services furnished by a CAH would be reimbursed as outpatient hospital services at 101% of costs without regard to whether the individual to whom such services are furnished is physically present in the CAH, or in a skilled nursing home or a clinic (including a rural health clinic) that is operated by a CAH at the time the specimen is collected.

Section 150. Adding Certain Entities as Originating Sites for Payment of Telehealth Services. Originating sites are defined as the site where a Medicare provider delivers the telehealth service to the patient. The following are qualified as originating sites: (1) office of a physician or physician practitioner; (2) a critical access hospital; (3) a rural health clinic; (4) a federally qualified health center, and (5) a hospital. The proposal would add: (1) a hospital-based or critical access hospital based renal dialysis center (including satellites), (2) a skilled nursing facility, and (3) a community health center to the list of originating sites for payment of telehealth services, effective on January 1, 2009.

Section 151. MedPAC Study and Report on Improving Chronic Care Demonstration Programs. The Medicare Payment Advisory Commission (MedPAC) would be required to conduct a study and provide a report to Congress no later than June 15, 2009, on the feasibility and advisability of establishing a Medicare Chronic Care Practice Research Network to serve as a standing network of providers testing new models of care coordination and other care approaches for chronically ill beneficiaries, including the initiation, operation, evaluation, and if appropriate, expansion of such models to the broader Medicare patient population, They would also be required to make recommendations for appropriate legislative and administrative action.

Section 152. Increase of FQHC Payment Limits. The provision would increase the payment limits otherwise applicable for federally qualified health centers (FQHCs) in 2010 by $5 for each patient visit. In subsequent years the previous year's amount would be increased by the increase in the Medicare economic index (MEI). The provision would also require the GAO to study whether the structure for FQHC payments adequately reimburses FQHCs for care furnished to Medicare beneficiaries.

Section 153. Kidney Disease Education and Awareness Provisions. A new section would be added to the Public Health Service Act, allowing the Secretary to establish pilot projects for chronic kidney disease to (1) increase awareness; (2) increase screening; and (3) enhance surveillance systems to better assess prevalence and incidence. The Secretary would select at least 3 states in which to conduct pilot projects, for no longer than five years, beginning on January 1, 2009. GAO would conduct an evaluation and report to Congress not later than 12 months after completion of the pilot projects. There are authorized to be appropriated such sums as may be necessary to carry out this provision.

Medicare coverage would be expanded to include coverage for kidney disease education services, defined as education services (1) for an individual with stage IV chronic kidney disease who requires dialysis or a kidney transplant; (2) furnished upon the referral of the physician managing the individual's kidney condition or by a qualified person; (3) designed to provide comprehensive information regarding managing co-morbidities, including delaying the need for dialysis, prevention of uremic complications, and options for renal replacement therapy; and (4) designed to meet an individual's needs and provide an opportunity to participate in the choice of therapy. The Secretary would set standards for the educational services. Individuals would be eligible for no more than 6 sessions of kidney disease education services, effective for services furnished on or after January 1, 2010.

Section 154. Renal Dialysis Provisions. The composite rate for dialysis services furnished on or after January 1, 2009, and before January 1, 2010, would be increased by 1% above the December 31, 2008 amount. Beginning January 1, 2010, the composite rate would be increased by 1% above the December 31, 2009 amount.

Beginning January 1, 2009, the payment rate for dialysis services would be "site neutral" and in applying the geographic index to providers of services, the labor share would be based on the labor share otherwise applied for renal dialysis facilities. Adjustments would no longer be made to the composite rate for hospital-based dialysis facilities to reflect higher overhead costs.

Beginning January 1, 2011, the Secretary would implement a bundled payment system making a single payment for Medicare renal dialysis services, ensuring that the estimated total payment for 2011 for Medicare renal dialysis services would equal 98% of payments that would have been made if the bundled payment system had not been implemented. The term "renal dialysis services" would include (1) items and services which were included in the composite rate as of December 31, 2010; (2) erythropoiesis stimulating agents (ESAs) or any other oral form of such agents furnished to individuals for the treatment of End State Renal Disease (ESRD); (3) other drugs and biologicals for which payment was made separately (before bundling), and any oral equivalent form of such drug or biological; and (4) diagnostic laboratory tests and other items and services furnished to individuals for the treatment of ESRD. The term "renal dialysis services" would not include vaccines.

Payments would include adjustments for (1) case mix; (2) high cost outliers due to unusual variations in the type or amount of medically necessary care, including variations in the amount of ESAs necessary for anemia management; (3) the extent that costs in rural, low-volume facilities exceed the costs incurred by other facilities, with a minimum payment adjustment of 10% for services furnished between January 1, 2011, and January 1, 2014; and (4) others as determined by the Secretary.

The bundled payments system would be phased in equally over four years, (fully implemented by January 1, 2014). A provider of dialysis services or facility would be allowed to make a one-time election to be excluded from the phase-in and be paid entirely based on the bundled payment system. Estimated total payments during the phase-in would equal the estimated total payments that would otherwise occur.

Beginning in 2012, the Secretary would annually increase the bundled payment amounts by an ESRD market basket increase factor appropriate for a bundled payment system for renal dialysis minus 1 percentage point. For the portion of the payment based on the old composite rate system, the composite rate would be updated by the ESRD market basket increase factor minus 1 percentage point.

The demonstration established in the MMA for a bundled case-mix adjusted payment system for ESRD services would be repealed.

Beginning in January 1, 2012, providers of renal dialysis services and renal dialysis facilities would be subject to quality incentive requirements and they would be subject to a reduction of up to 2% if they did not meet the requirements. The requirements would include measures on (1) anemia management and dialysis adequacy; (2) to the extent feasible, patient satisfaction; and (3) other areas.

The Secretary would develop a methodology to assess the total performance of each provider or facility, referred to as the "total performance score." Any reductions in payments would apply a larger reduction to those achieving the lowest scores. The Secretary would make performance information available to the public, provide certificates to be displayed in patient areas, and would allow the provider or facility the opportunity to review the information, prior to it being made public.

No later than March 1, 2013, GAO must submit a report to Congress on the implementation of the payment system and the quality initiatives.

Subtitle D - Provisions Relating to Part C

Section 161. Phase-Out of Indirect Medical Education (IME). Beginning in 2010, the Medicare Advantage benchmarks for every county would be adjusted to phase-out the cost of indirect medical education (IME). The amount phased-out each year would be based on a ratio of (a) a specified percentage (0.60% in the first year), relative to (b) the proportion of per capita costs in original Medicare in the county that IME costs represent. The effect of the ratio is to phase-out a higher proportion of IME costs in areas where IME makes up a smaller percentage of per capita spending in original Medicare. After 2010, the numerator phase-out percentage would be increased by 0.60 percentage points each year. This provision would not apply to the benchmarks for plans in the PACE program (Programs of All-Inclusive Care for the Elderly).

Section 162. Revisions to Requirements for Medicare Advantage Private Fee-for-Service (PFFS) Plans. MA coordinated care plans are required to form networks by contracting with providers to meet access requirements; PFFS plans may meet access requirements by establishing payment rates for providers that are not less than rates paid under original Medicare. This provision would require PFFS plans sponsored by employers or unions to establish contracted networks of providers to meet access requirements starting in 2011.

Non-employer sponsored MA PFFS plans would be required to establish contracted networks of providers in network areas defined as areas having at least two plans with networks (such as health maintenance organizations [HMOs],

provider sponsored organizations [PSOs], or local preferred provider organizations [PPOs]). In areas without at least two network-based plans, the non-employer PFFS plan would retain the ability to establish access requirements through establishing payment rates that are not less than those under original Medicare.

Section 163. Revisions to Quality Improvement Programs. Beginning January 1, 2010, this provision would require PFFS and Medical Savings Account (MSA) plans to have a quality improvement program like other MA plans. As part of their quality improvement program, PFFS and MSA plans would be required to collect data from both in-network and out-of-network providers. The provision would remove the requirement that the Secretary establish separate data collection requirements for MA regional plans.

Section 164. Revisions Relating to Specialized Medicare Advantage Plans for Special Needs Individuals. This provision would extend the time current SNPs may restrict enrollment to special needs individuals and extend the moratorium on the Secretary's authority to designate new SNP plans until January 1, 2011. Starting January 1, 2010, all new enrollees to a SNP plan would be required to meet the definition of a special needs individual. The provision implements additional requirements for all three types of SNP plans: Institutional, Medicaid, and Chronic Care. Institutional SNPs would be required to use a state assessment tool to determine eligibility. Medicaid SNPs would be required to contract with the State or other entity to deliver benefits; Medicaid SNPs that did not comply with that requirement would be permitted to participate in 2010, but would not be allowed to expand their service area. Further, Medicaid SNPs would be required to provide prospective enrollees with descriptions of benefits and cost sharing under the Medicaid program and which would be covered by the SNP. Chronic Care SNPs would be required to comply with a revised definition of a Chronic Care SNP. The provision would also mandate that SNPs comply with certain care management requirements such as having an appropriate network of providers, performing enrollee health assessments, and arranging for interdisciplinary teams to manage care for enrollees. SNPs would have to collect and report data related to these requirements. To ensure compliance, the provision requires the Secretary conduct a review of SNP plans in conjunction with its periodic financial audit of MA plans. Plans would be expected to comply with these new requirements beginning January 1, 2010.

Section 165. Limitation on Out-Of-Pocket Costs for Dual Eligibles and Qualified Medicare Beneficiaries Enrolled in a Specialized Medicare Advantage Plan for Special Needs Individuals. Effective January 1, 2010, Medicaid Special Needs Plans (SNPs) serving beneficiaries eligible for full benefits under Medicaid, or limited benefits under the Qualified Medicare Beneficiary program, would be prohibited from charging cost-sharing in excess of what would be permitted under Medicaid.

Section 166. Adjustment to the Medicare Advantage Stabilization Fund. The MMA created the MA Regional Plan Stabilization Fund with an initial level of $10 billion. Subsequent legislation reduced this amount to $1.79 billion. Also, currently a portion of the savings accrued in the regional plan bidding process is added to the Fund. This provision would reduce the initial funding to one dollar.

Money from the regional plan bidding process would continue to flow into the Fund. Expenditures would be delayed one year, until 2014.

Section 167. Access to Medicare Reasonable Cost Contract Plans. Reasonable Cost Contract Plans are MA plans that are reimbursed by Medicare for the actual cost of enrollees. These plans are allowed to operate indefinitely unless there are two other MA plans of the same type that operate for the entire year in the cost contract's service area. The provision would extend for one year — from January 1, 2009, to January 1, 2010 — the length of time reasonable cost plans could continue operating regardless of any other MA plans serving the area. The provision specifies that to prohibit the cost plan from participating after January 1, 2010, the two plans in the service area must be offered by different organizations. Finally, the provision would modify the minimum enrollment requirements for local or regional plans operating within the cost plan's service area.

GAO would be required to submit a report to Congress on the reasons why cost-based plans may be unable to become MA plans, together with recommendations for legislation and administrative action as appropriate by December 31, 2009.

Section 168. MEDPAC Study and Report on Quality Measures. The Medicare Payment Advisory Commission (MEDPAC) would be required to conduct a study on how comparable measures of performance and patient experience can be collected and reported by 2011 for MA and original Medicare. Not later than March 31, 2010, MEDPAC would be required to submit a report to Congress containing the results of the study, together with recommendations for legislation and administrative action as appropriate.

Section 169. MEDPAC Study and Report on Medicare Advantage Payments. The Medicare Payment Advisory Commission (MEDPAC) would be required to conduct a study on the correlation between MA costs of providing Medicare coverage (as reflected in plan bids) and county level, per-capita spending in the original fee-for-service (FFS) program. The study would be required to include differences in plan type and geographic area. Based on the results of this study, and other data, MEDPAC would be required to examine (1) alternatives to county-level payments and (2) the accuracy and completeness of county-level estimates of spending in original Medicare. Not later than March 31, 2010, MEDPAC would be required to submit a report to Congress containing the results of the study, together with recommendations for improving estimates, legislation and administrative action as appropriate.

Subtitle E - Provisions Relating to Part D

Part I - Improving Pharmacy Access

Section 171. Prompt Payment by Prescription Drug Plans and MA-PD Plans under Part D. For plan years beginning on or after January 1, 2010, the negotiated contracts between pharmacies and Medicare part D prescription drug plans (PDP sponsors or MA-PD plans) would be required to provide that

payment would be issued, mailed, or otherwise transmitted with respect to all "clean claims" submitted by pharmacies within the "applicable number of calendar days" after the date on which the claim is received. This requirement would not apply to pharmacies that dispense drugs by mail order only or are located in, or contract with, a long-term care facility. "Clean claims" are defined as those claims that have no defect or impropriety, including any lack of any required substantiating documentation, or particular circumstance requiring special treatment that prevents timely payment from being made. Claims submitted electronically would be considered to have been received on the date on which the claim is transferred. Claims not submitted electronically would be considered to have been received on the 5th day after the postmark date of the claim or the date specified in the time stamp of the transmission. The term "applicable number of calendar days" would be defined as 14 days for claims submitted electronically and 30 days for claims submitted otherwise.

If payment is not issued, mailed, or otherwise transmitted within the applicable number of calendar days after a clean claim is received, the PDP sponsor or MA-PD plan would be required to pay interest to the pharmacy that submitted the claim. This interest charge would not be counted against the administrative costs of a PDP sponsor or MA-PD plan or treated as allowable risk corridor costs. The Secretary may provide that a PDP sponsor or MA-PD plan would not be charged interest in cases with exigent circumstances, including natural disasters and other unique and unexpected events, that prevent the timely processing of claims.

A claim would be deemed to be clean if the PDP sponsor or MA-PD plan does not provide notice of any deficiency in the claim within 10 days of the date of receipt, for claims submitted electronically, and, otherwise, within 15 days of the date of receipt. If the PDP sponsor or MA-PD plan determines that the submitted claim is not a clean claim, the PDP sponsor or MA-PD plan would be required to notify the claimant, specifying all defects or improprieties in the claim and listing all additional information or documents necessary for the proper processing and payment of the claim. If the sponsor or plan does not notify the claimant of any defect or impropriety in the claim within 10 days of the date on which additional information is received, the claim would be deemed a clean claim. If a PDP sponsor or MA-PD plan does not pay or contest a claim within the applicable number of days after the date of receipt, the claim would be deemed a clean claim and would be required to be paid. PDP sponsors or MA-PD plans would be required to pay all clean claims (and remittance) submitted electronically by electronic transfer of funds if the pharmacy so requests or has requested previously.

Section 172. Submission of Claims by Pharmacies Located in or Contracting with Long-Term Care Pharmacies. For plan years beginning on or after January 1, 2010, contracts between PDP sponsors and pharmacies located in or contracting with long-term care facilities would be required to provide that the pharmacy would have between 30 and 90 days to submit claims for reimbursement.

Section 173. Regular Update of Prescription Drug Pricing Standard. For plan years beginning on or after January 1, 2009, contracts between pharmacies and PDP sponsors or MA-PD plans that use the cost of a drug as the standard for reimbursement of pharmacies would be required to provide that the

sponsor update the standard at least every seven days, to accurately reflect the market price of acquiring the drug.

Part II - Other Provisions

Section 175. Inclusion of Barbiturates and Benzodiazepines as Covered Part D Drugs. Prescription drug plans and MA-PD plans are not currently required to include barbiturates or benzodiazepines in their formularies. For prescriptions dispensed on or after January 1, 2012, plans would be required to include benzodiazepines in their formularies. Barbiturates would also be required to be included in formularies for the indications of epilepsy, cancer, or chronic mental health disorder.

Section 176. Formulary Requirements With Respect to Certain Categories or Classes of Drugs. Under Medicare Part D, formularies of prescription drug plans and MA-PD plans must include 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. CMS stated that it instituted the policy because it felt it necessary to ensure that Medicare beneficiaries reliant on these drugs would not be substantially discouraged from enrolling with Part D plans and to mitigate the risks and complications associated with interruption of therapy for vulnerable populations.

Beginning with plan year 2010, the Secretary would be required to identify categories and classes of drugs for which (1) restricted access to the category or class would have major or life threatening clinical consequences for individuals who have a disease or disorder treated by the drugs in such category or class; and (2) there is significant clinical need for such individuals to have access to multiple drugs within a category or class due to unique chemical actions and pharmacological effects of the drugs within the category or class, such as drugs used in the treatment of cancer.

PDP sponsors would be required to include all covered Part D drugs in the categories and classes identified by the Secretary. However, the Secretary could establish a formal exceptions process that ensured that any exception was based upon scientific evidence and medical standards of practice, and included a public notice and comment period.

Subtitle F - Other Provisions

Section 181. Use of Part D Data. In order to maintain the confidentiality of sensitive data, and to protect trade secrets, MMA placed restrictions on the Medicare Part D data and limited access only for specific purposes. On May 27, 2008, the CMS issued a final rule that would allow the Secretary to use the claims information that is now being collected for Part D payment purposes for other research, analysis, reporting, and public health functions. Some organizations who submitted comments on the rule questioned the CMS's authority to use the Part D data for other than payment purposes. The provision would grant CMS authority to

use and share data from the Medicare Part D program by amending Section 1860D-12(b)(3)(D) of the Social Security Act (42 U.S.C. 1395w-112(b)(3)(D)). As a result of this modification, information provided to the Secretary in the administration of the Part D program could be used for the purposes of improving public health through research on the utilization, safety, effectiveness, quality, and efficiency of health care services (as the Secretary determines appropriate), and for conducting Congressional oversight, monitoring, and analysis of the Medicare program.

Section 182. Revision of Definition of Medically Accepted Indication for Drugs. The term medically accepted indication includes any use which has been approved by the Food and Drug Administration (FDA). The term also includes another use if the drug itself has been approved by the FDA and the use has been supported by one or more citations (or approved for inclusion) in one or more compendia specified in the law or other authoritative compendia identified by the Secretary, unless the Secretary determines that the use is not medically appropriate or the use is identified as not indicated in one or more compendia. The Secretary may revise the list of compendia as appropriate. CMS has proposed a formal process for accepting and acting on requests for changes to the list of compendia.

On and after January 1, 2010, no compendia would be permitted to be included on the Secretary's list of compendia unless the compendia has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests. For plan years beginning on or after January 1, 2009, the Secretary would be required to include the compendia used in the Medicaid program in the list of compendia, provided that the compendia for the Medicaid program has a publicly transparent process for evaluating therapies and for identifying potential conflicts of interests on and after January 1, 2010. If the compendia for the Medicaid program do not meet these criteria, the Secretary would be required to revise the compendia for the Medicaid program accordingly. In the case of a covered part D drug to be used in an anticancer chemotherapeutic regimen, PDPs and MA-PDs would have the authority to determine, based upon guidance provided by the Secretary, whether such use is medically accepted based on supportive clinical evidence in peer reviewed medical literature appearing in publications which have been identified by the Secretary.

Section 183. Contract with a Consensus-Based Entity Regarding Performance Measurement. This provision would enable the Secretary to contract with an organization that would develop and endorse health care quality measures. For this purpose, up to $10 million from the Medicare Part A and Part B Trust Funds would be made available for the period of fiscal years 2009 through 2012. The provision also includes the Sense of the Senate that the contract with the consensus-based entity should not be construed as diminishing the significant contributions of the Boards of Medicine, the quality alliances, and other clinical and technical experts to efforts to measure and improve the quality of health care services. The GAO would conduct studies on the performance of the consensus-based entity and report on (1) its duties under the contract and (2) the costs incurred by the entity in performing such duties. These reports would be due not later than 18 months and 36 months after the effective date of the first contract, together with recommendations for such legislation and administrative action as the Comptroller General would determine appropriate.

Section 184. Cost-Sharing For Clinical Trials. The Secretary could develop alternative methods of payment for items and services provided under clinical trials and comparative effectiveness studies sponsored or supported by an agency of the Department of Health and Human Services, as determined by the Secretary. These payments would be necessary to preserve the scientific validity of such trials or studies, such as in the case where masking the identity of interventions from patients and investigators is necessary to comply with the particular trial or study design.

Section 185. Addressing Health Care Disparities. The Secretary would initiate data collection and analysis efforts to address health care disparities across race, ethnicity, and gender. The Secretary would prepare several reports that would (1) identify approaches (including defining methodologies) for identifying and collecting and evaluating data on health care disparities on the basis of race, ethnicity, and gender for the original Medicare fee-for-service program, and (2) include recommendations on the most effective strategies and approaches to reporting Health Effectiveness Data and Information Set (HEDIS) quality measures and other nationally recognized quality performance measures, as appropriate, on the basis of race, ethnicity, and gender. Not later than four years after enactment, and four years thereafter, the Secretary would submit to Congress a report that includes recommendations for improving the identification of health care disparities for Medicare beneficiaries based on analyses of the data collected as described above. Not later than 24 months after the date of the enactment of this section, the Secretary would implement the approaches identified in this report for the ongoing, accurate, and timely collection and evaluation of data on health care disparities on the basis of race, ethnicity, and gender.

Section 186. Demonstration to Improve Care to Previously Uninsured. Within one year after enactment, the Secretary would establish a demonstration project to determine the greatest needs and most effective methods of outreach to Medicare beneficiaries who were previously uninsured. The demonstration would be in no fewer than 10 sites, and would include state health insurance assistance programs, community health centers, community-based organizations, community health workers, and other service providers under Medicare parts A, B, and C. The Secretary would conduct the demonstration project for a period of two years and would submit a report to Congress not later than one year after completion that would include (1) an analysis of the effectiveness of outreach activities targeting beneficiaries who were previously uninsured, and (2) the effect of the outreach on beneficiary access to care, utilization of services, efficiency and cost-effectiveness of health care delivery, patient satisfaction, and select health outcomes.

Section 187. Office of the Inspector General Report on Compliance with and Enforcement of National Standards on Culturally and Linguistically Appropriate Services (CLAS) in Medicare. The National Standards on Culturally and Linguistically Appropriate Services (CLAS) were published in the Federal Register on December 22, 2000 (Vol. 65, No. 247, pp. 80865-80879) as national standards for adoption or adaptation by stakeholder organizations and agencies. The CLAS standards are primarily directed at health care organizations and were initially derived from an analysis of current practice and

policy on cultural competence. The CLAS standards are intended to provide a common understanding and consistent definitions of culturally and linguistically appropriate services in health care, and to offer a practical framework for the implementation of services and organizational structures that can help health care organizations and providers be responsive to the cultural and linguistic issues presented by diverse populations. Not later than two years after enactment, the HHS Inspector General would prepare and publish a report on: (1) the extent to which Medicare providers and plans are complying with the Office for Civil Rights' Guidance to Federal Financial Assistance Recipients Regarding Title VI Prohibition Against National Origin Discrimination Affecting Limited English Proficient Persons and the Office of Minority Health's Culturally and Linguistically Appropriate Services Standards in health care, and (2) a description of the costs associated with or savings related to the provision of language services. The report would include recommendations on improving compliance with CLAS Standards and recommendations on improving enforcement of CLAS Standards. Not later than one year after the date of publication of the report, the Department of Health and Human Services would implement changes responsive to any deficiencies identified in the report.

Section 188. Medicare Improvement Funding. The Secretary would establish a Medicare Improvement Fund that would be available to the Secretary to make improvements under the original fee-for-service program under parts A and B for Medicare beneficiaries. For FY2013, $1.439 billion and for FY2014, $21.17 billion would be made available from the Part A and B Trust Funds.

For purposes of carrying out the provisions of, and amendments made by, this Act, in addition to any other amounts provided in such provisions and amendments, additional funds would be made available to CMS. For fiscal years 2009 through 2013, the Secretary of Health and Human Services would transfer $140 million from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to the CMS Program Management Account. The amounts drawn from the funds would be in the same proportion as for Medicare managed care payments (Medicare Advantage), that is, in a proportion that reflects the relative weight that benefits under part A and under part B represent of the actuarial value of the total benefits.

Title II - Medicaid

Section 201. Extension of Transitional Medical Assistance (TMA) and Abstinence Education Program. States are required to continue Medicaid benefits for certain low-income families who would otherwise lose coverage because of changes in their income (e.g., an increase in hours of employment). This continuation is called transitional medical assistance (TMA). Permanent law requires four months of TMA, and Section 1925 of the Social Security Act (which has a sunset date) requires up to 12 months for families who would otherwise lose coverage for work-related reasons. Since 2001, Section 1925 TMA requirements have been funded through a series of short-term extensions, most recently through June 30, 2008.

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). Funds for this program (referred to as the Title V Abstinence Education block grant) must be requested by states when they solicit Title V Maternal and Child Health block grant funds and must be used exclusively for teaching abstinence. Although it has not yet been reauthorized, the latest temporary extension continued funding through June 30, 2008.

The provision would extend Section 1925 TMA requirements and the abstinence education program through December 31, 2009, with funding at the level provided through the first quarter of FY2008.

Section 202. Medicaid DSH Extension. 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 Tennessee and Hawaii, however, are equal to zero because the states operate their state Medicaid programs under the provisions of a Section 1115 research and demonstration waiver. Such research and demonstration waivers allow for states to waive various provisions of Medicaid law specified in Title XIX of SSA (such as the requirement to make disproportionate share payments) to conduct demonstrations as long as the demonstrations are likely to assist in promoting the objectives of the Medicaid program.

Congress has enacted special DSH provisions for Tennessee and Hawaii in the past. Both states received a special allotment for FY2007 and part of FY2008. Tennessee's allotment amount was set at $30 million for FY2007, and the same amount was prorated for the applicable portion of FY2008. Hawaii's allotment was set at $10 million for 2007 and similarly prorated for FY2008. Both states have, in addition, been allowed to submit state plan amendments describing their methodologies for distributing such payments for the Secretary's approval. The provision would extend the special DSH allotment arrangements for Tennessee and Hawaii through a portion of FY2010. Allotment amounts would be equal to $30 million for Tennessee for each full year — 2008 and 2009 — and one-quarter of that amount would be available for the first quarter of FY2010. Hawaii's $10 million allotment would be extended for each full fiscal year — 2008 and 2009 — and $2.5 million would be available for the first quarter of FY2010.

Section 203. Pharmacy Reimbursement under Medicaid. Under current law, state Medicaid programs set the prices paid to pharmacies for Medicaid outpatient drugs. Federal reimbursements for those drugs, however, are limited to a federal upper limit (FUL). The DRA established that FULs applying to drugs available from multiple sources (generic drugs, for the most part) be re-calculated by CMS to be equal to 250% of the average manufacturer's price (AMP, the average price paid by wholesalers to manufacturers) as reported to CMS by the manufacturers. Upon full implementation of the DRA provisions, AMPs are to become publicly available.

Important components of the new FUL formula have been issued in a final rule in July of 2007. The rule defines a number of terms related to drug pricing under

Medicaid, including definitions impacted by DRA provisions such as AMP, multiple source drugs, and nominal prices. The rule has been contested, and CMS is prohibited from implementing its provisions until the court hears the case and makes a final determination of its legality. In the interim, FUL formulas remain calculated by CMS as equal to 150% of the published price for the least costly therapeutic equivalent. The provision would retain, through September 30, 2009, the FUL formulas for federal reimbursement of multiple source drugs as described in federal regulations in effect as of December 21, 2006 (42 CFR 447). Under those instructions, FULS are calculated to be equal to 150% of the published price for the least costly therapeutic equivalent. In addition, the Secretary would not be permitted to make AMP prices publicly available prior to such date.

Section 204. Review of Administrative Claim Determinations. The federal government and the states share in the cost of Medicaid expenditures that states incur for services provided to Medicaid beneficiaries and for the administration of their Medicaid programs. States submit quarterly expense reports in order to receive federal reimbursement for a share of these costs. If HHS believes that a state's claim for federal financial participation (FFP) for state expenditures is improper or erroneous, it may disallow the claim. Disputes that pertain to disallowances of FFP in Medicaid expenditures are heard by the Department of Health and Human Services, Departmental Appeals Board (the Board) in accordance with specified procedures.

The provision would establish new timelines and procedures for the administrative review of disallowances of federal financial participation under Medicaid. In the case where the Secretary disallows FFP for a state claim under Medicaid, the state would be permitted to receive a reconsideration of the disallowance (or a reconsideration of an unfavorable reconsideration of a disallowance) if the state files an appeal with the Board within 60 days after receiving notice. The provision would also permit States to obtain judicial review by filing an action in any United States District Court located within the appealing state, or if several States jointly appeal, in any United States District Court that is located within any State that is a party to the appeal. Judicial review would be permitted only in the case that (1) no motion for reconsideration was filed during the 60-day period after the state received notice of the disallowance of FFP under Medicaid, or (2) if the State filed a motion for an appeal, during the 60 day period that begins on the date of the Board's decision on such motion.

Title III - Miscellaneous

Section 301. Extension of TANF Supplemental Grants. TANF provides supplemental grants for 17 states with exceptionally high population growth in the early 1990s, historic (pre-1996) welfare grants per poor person lower than 35% of the national average, or a combination of above average population growth and below average historic welfare grants per poor person. Grants were authorized at $800 million over FY1998 through FY2001, and annual grants grew from $79 million in FY1998 to $319 million in FY2001. Congress froze supplemental grants at the $319 million annual level when it extended supplemental grants for FY2002 and subsequent years. The DRA provided the last extension of supplemental grants,

continuing their funding through FY2008. (Other TANF grants are funded through FY2010.)

The proposal would extend supplemental grants at the $319 million level through FY2009. In FY2009, each of the 17 qualifying states would receive the same supplemental grant amount as it did in FY2008.

Section 302. 70 Percent Federal Matching for Foster Care and Adoption Assistance for the District of Columbia. Under Title IV-E of the Social Security Act, states are entitled to receive federal reimbursement for a portion of the cost of each foster care maintenance payment or adoption assistance payment provided on behalf of an eligible child. The federal reimbursement rate for these payments is equal to each state's Federal Medical Assistance Percentage (FMAP) rate as defined under Title XIX. In general, Title XIX provides that a state's FMAP (including the District of Columbia's FMAP) is calculated annually and may range from 50%-83% based on the state's per capita income. (States with higher per capita income receive a lower reimbursement rate and vice versa.) However, for purposes of the Medicaid program and the State Children's Health Insurance Program (SCHIP), only, Title XIX sets the District of Columbia's FMAP at 70%.

This provision would entitle the District of Columbia to receive federal reimbursement for its eligible foster care maintenance and adoption assistance payments at 70% (by amending Title IV-E to fix the District of Columbia's FMAP at that rate for those payments). It would make this change effective beginning with the first day, of the first quarter of FY2009.

Section 303. Extension of Special Diabetes Grant Programs. 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 FY2009. 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 Indians and Alaskan Natives. Appropriations are set at $150 million per year during the period FY2004 through FY2009. The law also requires the Secretary of HHS to conduct an evaluation of these two diabetes programs, and submit two reports to the appropriate committees of Congress. An interim report was due not later than January 1, 2000, and a final report was due not later than January 1, 2007.

For each of these two grant programs, the provision would provide appropriations of $150 million per year for FY2010 and FY2011. It would also redesignate the final report in current law that was due in January 2007 to be a second interim report, and would add a new final report that would be due not later than January 1, 2011.

Section 304. IOM Reports on Best Practices for Conducting Systematic Reviews of Clinical Effectiveness Research and for Developing Clinical Protocols. Within 60 days after the date of enactment of this Act, the Secretary would be required to enter into a contract with the IOM to conduct (a) a study on the best methods used in developing clinical practice

guidelines, and (b) a study to identify the methodological standards for conducting systematic reviews of clinical effectiveness research on health and health care. The purpose of these studies would be to ensure that organizations developing such guidelines have information on approaches that are objective, scientifically valid, and consistent. Not later than 18 months after the effective date of the contract, the IOM would be required to submit a report to the Secretary and the appropriate committees of Congress, that contains the results of the studies and recommendations for legislation and administrative action. The contract with the IOM would require that stakeholders with expertise in making clinical recommendations participate on the panel responsible for study (a), and stakeholders with expertise in conducting clinical effectiveness research participate on the panel responsible for study (b).

To carry out these studies, this provision would appropriate, out of any funds in the Treasury not otherwise appropriated, $3 million for FY2009 and FY2010.

Summary of Provisions in the Preserving Access to Medicare Act of 2008 (S. 3118)

Title I - Medicare

Subtitle A - Rural Beneficiary Access Extension and Improvements

Section 100. Short Title. The subtitle would be cited as the "Craig Thomas Rural Hospital and Provider Equity Act of 2008."

Section 101. Temporary Improvements to the Medicare Inpatient Hospital Payment Adjustment for Low-volume Hospitals. Under Medicare's Inpatient Prospective Payment System (IPPS), certain low-volume hospitals receive a payment adjustment to account for their higher costs per discharge. Under regulations, qualifying hospitals (those located more than 25 road miles from another comparable hospital) with less than 200 annual total discharges receive a 25% payment increase for every Medicare discharge. A temporary adjustment that would increase payment in FY2009 for certain low-volume hospitals would be created. In FY2009, a low volume hospital could be located more than 15 road miles from another comparable hospital and have 1,500 discharges of individuals entitled to or enrolled for Medicare Part A benefits. For FY2009, the Secretary would determine the applicable percentage increase using a linear sliding scale starting at 25% for low-volume hospitals below a certain threshold.

Section 102. Use of Non-Wage Adjusted PPS Rate under the Medicare Dependent Hospital (MDH) Program. Medicare dependent hospitals (MDHs) are certain small rural hospitals that are not sole community hospitals (SCH) with 100 or fewer beds and a high proportion of patients who are Medicare beneficiaries. MDHs may qualify for higher Medicare payments if their updated FY1982, FY1987, or FY2002 hospital specific cost per discharge exceeds the national discharge payment amount. Starting for discharges on October 1, 2008

and before October 1, 2009, an MDH's Medicare payment would not be adjusted for different area wage levels if that results in higher payments.

Starting October 1, 2008, Wesley Woods Geriatric Hospital would be paid as a MDH.

Section 103. Ambulance Service Improvements. The provision is the same as Section 147 in S. 3101.

Section 104. Extension of Authorization for FLEX Grants. The FLEX grant program would be expanded and provide funds to support CAHs' quality improvement, quality reporting, performance improvements and benchmarking. Also, the FLEX grant program would be authorized at $55 million in each of FY2009 and FY2010. These two provisions are the same as those in S. 3101.

Section 105. Rebasing for Sole Community Hospitals. The provision for SCHs is the same as in Section 122 of S. 3101 with the following addition: Starting October 1, 2008, Halifax Regional Medical Center in Roanoke Rapids, North Carolina would be deemed to meet the case mix requirement necessary to qualify as a rural referral center.

Section 106. Extension and Expansion of the Medicare Hold Harmless Provision under the Prospective Payment System for Hospital Outpatient Department (HOPD) Services for Certain Hospitals. The provision is the same as Section 148 in S. 3101.

Section 107. Clarification of Payment for Clinical Laboratory Tests Furnished by Critical Access Hospitals. This provision is similar to Section 149 of S. 3101, except the individual furnished services would have to be present in the same county as the hospital in order for those clinical diagnostic laboratory services to be considered as an outpatient service and paid at 101% of costs. Also, the State of Alabama would be able to certify one hospital as a necessary provider of health care after January 1, 2006 that is in the county seat of Butler, Alabama and is a 32-mile drive from another hospital or CAH.

Section 108. Extension of Floor on Medicare Work Geographic Adjustment under the Medicare Physician Fee Schedule. This provision is the same as Section 134 in S. 3101.

Section 109. Extension of Treatment of Certain Physician Pathology Services under Medicare. The provision is the same as Section 136 in S. 3101.

Section 110. Adding Hospital-Based Renal Dialysis Centers (including Satellites) as Originating Sites for Payment of Telehealth Services. These providers are included in the list of originating sites for telehealth services included in S. 3101, Section 150.

Section 111. Adding Skilled Nursing Facilities as Originating Sites for Payment of Telehealth Services. These providers are included in the list of originating sites for telehealth services included in S. 3101, Section 150.

Section 112. Applying Rural Home Health Add-on Policy for 2009. The Medicare home health prospective payment system, which was implemented on October 1, 2000, provides a standardized payment for a 60-day episode of care furnished to a Medicare beneficiary. Medicare's payment is adjusted to reflect the type and intensity of care furnished and area wages as measured by the hospital wage index. The MMA provided for a one-year 5% additional payment for home health services furnished in rural areas. The temporary payment began for episodes and visits ending on or after April 1, 2004, and before April 1, 2005. It was made without regard to certain budget neutrality provisions and was not included in the base for determination of payment updates. The DRA extended the 5% additional payment for rural home health episodes and visits beginning on or after January 1, 2006 and before January 1, 2007. The provision would re-instate the 5% additional payment for rural home health episodes and visits ending on or after January 1, 2009, and before January 1, 2010.

Subtitle B - Other Provisions Relating to Part A

Section 121. Extension of the Reclassification of Certain Hospitals under the Medicare Program. The two provisions affecting Section 508 and special exception reclassifications are the same as in Section 124 of S. 3101.

The following provisions are not in S. 3101: A permanent wage index floor would be created for certain hospitals in a state where one hospital's wages comprise no less than 65% of that state's rural wage index (taking into account a redesignation of a rural hospital to an urban area that was established in the Social Security Amendments of 1983 and not taking into account Medicare Geographic Classification Review Board redesignations or certain other reclassifications). This provision would be implemented in a budget neutral fashion and would be effective for discharges starting October 1, 2008.

Also, for Medicare inpatient hospital payments for discharges during FY2009, FY2010, and FY2011, Ball Memorial Hospital is deemed to be located in the Indianapolis-Carmel, IN core based statistical area. With certain exceptions, this reclassification would be treated as a decision of the Medicare Geographic Classification Review Board.

Section 122. Institute of Medicine Study and Report on Post-Acute Care. No later than six months after enactment, the Secretary would enter into a contract with the Institute of Medicine (IOM) of the National Academy of Sciences to conduct a study on short-term and long-term steps to reform Medicare's current post-acute care payment and delivery system. No later than two years after the effective date of the contract, IOM would submit a report to the Secretary on the results of the study, including appropriate recommendations for legislation and administrative actions. The Secretary would provide for the transfer of $2.7 million from the Federal Hospital Insurance Trust fund for this IOM study.

Section 123. Revocation of Unique Deeming Authority of the Joint Commission. This provision is the same as Section 125 in S. 3101.

Section 124. MedPAC Study and Report on Payments for Hospice Care. The provision would require the Medicare Payment Advisory Commission (MedPAC) to conduct a study on payments for hospice care under Medicare and submit a report to Congress no later than June 15, 2009. The report would include an analysis of potential changes in payment methodologies for hospice care under the Medicare program and recommendations for legislation and administrative action, as MedPAC deems appropriate. The report would also include revisions to the per beneficiary aggregate cap amount that may reflect (1) hospice patient characteristics, (2) variation in hospice care utilization by patient characteristics, (3) average lengths of stay in hospice care, (4) disease category, (5) geographic differences, (6) specific types of hospice care services provided, and (7) site of service.

Section 125. Introducing the Principals of Value-Based Health Care into the Medicare Program. In response to recommendations from a number of health policy analysts and organizations, including MedPAC, Congress has legislated and CMS has modified some Medicare payment systems to incorporate principles of value-based purchasing, including pay-for-reporting bonuses for hospitals and physicians. The provision would grant the Secretary the authority to design and implement a system under which a portion of the payments that would otherwise be made under the Medicare program would be based on the quality and efficiency of their performance. The Secretary would first implement such a system in settings where measures are well-accepted and already collected, including hospitals, physicians' offices, home health agencies, skilled nursing facilities, and renal dialysis facilities. The initial focus of these value-based programs would be on quality, but the Secretary would add measures of efficiency as they are identified. The system would also include incentives for reducing unwarranted geographic variations in quality and efficiency.

Subtitle C - Other Provisions Relating to Part B

Section 131. Physician Payment, Efficiency, and Quality Improvements. Each of the bills includes the identical treatment for Medicare physician payments in the short term by extending the 0.5% increase in physician payment in 2007 through the end of 2008 and increasing payments for 2009 by 1.1%. However, there are a number of differences in the remainder of the section.

(1) The Republican alternative bill does not contain the provision in S. 3101 that would exclude a certain amount of benefits and administrative costs from the calculation of the beneficiary Part B premium.

(2) The two bills make different adjustments to the Physician Assistance and Quality Initiative Fund. While S. 3101 would eliminate the entirety of the $4.96 billion available in the fund in 2013 under current law, this provision would reduce the amount from $4.96 billion to $4.09 billion for 2013 and add $30.66 billion for expenditures during the years 2014 through 2017, which would only be available for an adjustment to the update of the conversion factor for that year.

(3) The provision that extends the physician quality reporting system omits a phrase in S. 3101 so that the exception would apply to "a specified area [S. 3101: or medical topic] for which no measure has been endorsed."

This provision also appropriates $140 million to CMS for fiscal years 2009 through 2013 for the purpose of carrying out the provisions and amendments of this act from any money in the Treasure not otherwise appropriated.

Section 132. Incentives for Electronic Prescribing. This provision is similar to Section 132 in S. 3101, except that in describing examples of providers for whom electronic prescribing might lead to a hardship exemption, the provision also includes the bolded example as follows: "such as for an eligible professional who practices in a rural area without sufficient Internet access **or an eligible professional who frequently sends prescriptions to pharmacies that are not capable of receiving prescriptions electronically**."

Section 133. Increasing the Number of Sites for the Electronic Health Records Demonstration. CMS is implementing a five-year demonstration project that will encourage small- to medium-sized primary care physician practices to use electronic health records (EHR) to improve the quality of patient care. The goal is to produce better health outcomes and greater patient satisfaction through electronic management of health care information. According to CMS, financial incentives will be provided to as many as 1,200 small- to medium-sized physician practices in 12 communities over a five-year period for using certified EHRs to improve quality, as measured by their performance on specific clinical quality measures. Additional bonus payments will be available, based on a standardized survey measuring the number of EHR functionalities incorporated by the physician practice. Total payments under the demonstration for all five years may be up to $58,000 per physician or up to $290,000 per practice. This provision would appropriate $45 million out of funds in the Treasury for fiscal years 2009 through 2014 for administrative costs to increase the number of sites, up to 40, in which the Electronic Health Records Demonstration is being conducted.

Section 134. Primary Care Improvements. This provision is similar to Section 133 in S. 3101 except that the title to Section 133 in S. 3101 is, "Expanding Access to Primary Care Services."

Section 135. Medicare Anesthesia Teaching Program Improvements. This provision is the same as Section 139 in S. 3101.

Section 136. Medicare Coordinated Care Practice Research Network Demonstration. No later than October 1, 2009, the Secretary would be required to establish a five-year demonstration program to test best practice coordinated care projects for Medicare beneficiaries with multiple chronic conditions. Initially, at least 8 organizations would be selected. The demonstration could be expanded, under specified circumstances. The Secretary would submit a report to Congress, no later than four years after the establishment of the demonstration, including an evaluation of the effectiveness of each site, including specified information.

The Secretary would provide for the transfer of $15 million to the CMS Program Management Account, from the Hospital Insurance and Supplementary Medicare Insurance Trust Funds. Except for the original $15 million, the Secretary would be required to ensure that aggregate payments did not exceed the amount which would have been paid if the demonstration were not implemented.

Section 137. Imaging Provisions. This provision is the same as Section 135 in S. 3101, except that (1) it would amend the in-office ancillary services exception to the physician self-referral prohibitions to specify that the Secretary include a disclosure requirement for magnetic resonance imaging, computed tomography, positron emission tomography, and any other radiology services specified as designated health services that the Secretary determines appropriate; and (2) it would not include a GAO study on interest rate and equipment utilization assumptions used in determining practice expenses as required under S. 3101.

Section 138. Accommodation of Physicians Ordered to Active Duty in the Armed Services. This provision is the same as Section 137 in S. 3101.

Section 139. Extension of Exceptions Process for Medicare Therapy Caps. This provision is the same as Section 141 in S. 3101.

Section 140. Speech-Language Pathology Services. This section is the same as Section 143 in S. 3101.

Section 141. Coverage of Items and Services under a Cardiac Rehabilitation Program and a Pulmonary Rehabilitation Program. This section is the same as Section 144(a) of S. 3101 (relating to services under cardiac and pulmonary rehabilitation programs), except that it specifies that services may be delivered in a physician-directed clinic rather than in "other settings determined appropriate by the Secretary" as in S. 3101.

Section 142. Repeal of Transfer of Ownership of Oxygen Equipment. This provision is the same as Section 144(b) of S. 3101. However, this provision does not include other oxygen-related provisions included in Section 144 of S. 3101. It does not include revisions to payment rates for oxygen and oxygen equipment, or an Institute of Medicine study.

Section 143. Extension of Payment Rule for Brachytherapy and Therapeutic Radiopharmaceuticals. This provision is the same as Section 142 of S. 3101.

Section 144. Clinical Laboratory Tests. This provision is the same as Section 146 in S. 3101.

Section 145. Sense of the Senate on Delayed Implementation of Competitive Bidding for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEOS). The Secretary is required to establish a competitive acquisition program for specified durable medical equipment, prosthetics, orthotics and supplies (DMEPOS); the competitive acquisition program would replace the Medicare fee schedule payments. The program is to be phased-in,

starting in 10 of the largest metropolitan statistical areas (MSAs) some time in 2008; expanding to 80 of the largest MSAs in 2009 and remaining areas after 2009. This provision would express the sense of the Senate that the implementation of the DMEPOS competitive bidding program should be delayed 18 months in order to review and address ongoing concerns about the bidding process and to ensure continued access. The provision specifies that the delay should be offset by a reduction in current payment rates for DMEPOS equipment under Medicare.

Subtitle D - End Stage Renal Disease Program Reforms

Section 151. Kidney Disease Education and Awareness Provisions. The provision is similar to Section 153 in S. 3101, except S. 3101 would authorize such sums as necessary for the chronic kidney disease initiative pilot projects.

Section 152. Renal Dialysis Provisions. The provision is similar to Section 154 in S. 3101, except for differences in the calculation of performance scores and standards for quality measures. S. 3101 requires that the GAO study on bundling and quality be completed on March 1, 2013, while this bill would require completion on April 1, 2012.

Subtitle E - Provisions Relating to Part C

Section 161. Phase-Out of Indirect Medical Education (IME). This provision is the same as Section 161 in S. 3101.

Section 162. Revisions to Quality Improvement Programs. This provision is similar to Section 163 in S. 3101, except PFFS and MSA plans would be required to collect administrative and beneficiary survey data from out-of-network providers.

Section 163. Revisions Relating to Specialized Medicare Advantage Plans for Special Needs Individuals. This provision is similar to Section 164 in S. 3101, except that at least 90% (rather than 100%) of beneficiaries enrolled in an Institutional SNP would be required to be institutionalized, 90% (rather than 100%) of beneficiaries enrolled in a Medicaid SNP would be required to be entitled to Medicaid, and 90% (rather than 100%) of beneficiaries enrolled in a Chronic Care SNP would be required to have a severe or disabling condition. These provisions would be effective one year earlier than in S. 3101 (January 1, 2009, instead of January 1, 2010). Medicaid SNPs would be required to document arrangements with the State Medicaid agency to address coordination of operations, but unlike S. 3101, the provision would not restrict service area expansions if the provision was not fulfilled. Medicaid SNPs would be required to have in place arrangements to ensure that enrollees were not deemed liable for excess cost-sharing. The provision would also prohibit the Secretary from enrolling individuals in Chronic Care SNPs until January 1, 2011 unless the SNP was available in 2008.

Section 164. Adjustment to the Medicare Advantage Stabilization Fund. This provision is the same as Section 166 in S. 3101.

Section 165. Access to Medicare Reasonable Cost Contract Plans. This provision is similar to Section 167 in S. 3101, except that it would clarify the statute by replacing references to "service area" with the word "county."

Section 166. MedPAC Study and Report on Medicare Advantage Payments. The provision is similar to Section 169 of S. 3101, except that MedPAC would be required to examine alternate approaches to achieving payment neutrality in the Medicare program such as (1) blends of national and local per-capita FFS spending; (2) price adjusted per capita spending based on geography and utilization; and (3) blends of national per capita spending in FFS with MA plan bids.

Section 167. Marketing of Medicare Advantage Plans and Prescription Drug Plans. This provision is similar to Section 103 in S. 3101, except that MA and PDP plans would also be required to establish and maintain a system for confirming that beneficiaries have enrolled in the plan and understand the plan's rules. The provision also does not require plans to include plan type in their plan name.

Subtitle F - Other Provisions

Section 171. Contract with a Consensus-Based Entity Regarding Performance Measurement. This provision is the same as Section 183 in S. 3101.

Section 172. Use of Part D Data. This provision is the same as Section 181 in S. 3101.

Section 173. Inclusion of Medicare Providers and Suppliers in Federal Payment Levy and Administrative Offset Program. The Federal Payment Levy Program (FPLP) authorizes the Internal Revenue Service (IRS) to collect overdue taxes through a continuous levy on federal payments made to delinquent taxpayers. This provision would require that CMS process all payments through the FPLP by September 30, 2011.

Title II - Medicaid

Section 201. Extension of Transitional Medical Assistance (TMA) and Abstinence Education Program through Fiscal Year 2009. This provision is similar to Section 201 in S. 3101, except that it would extend Section 1925 TMA requirements and the abstinence education program through September 30, 2009, with funding at the level provided through the fourth quarter of FY2007.

Section 202. Extension of Qualifying Individual (QI) Program through Fiscal Year 2009. The provision is similar to Section 111 in S. 3101, except that it would increase the allocation amount for the period through September 30, 2008 to $375 million; would allocate $150 million for the period that begins October 1, 2008 and ends December 31, 2008; would allocate $350 million for the period that begins January 1, 2009 and ends September 30, 2009; and would not

allocate any funds for the period that begins October 1, 2009, and ends on December 31, 2009.

Section 203. Medicaid DSH Extension through December 31, 2009. This provision is the same as Section 202 in S. 3101.

Section 204. Asset Verification through Access to Information Held by Financial Institutions. The Social Security Administration (SSA) is piloting 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%) of applicants and recipients who were overpaid based on this financial account verification system. Under the Right to Financial Privacy Act of 1978 (P.L. 95-630), government authorities and financial institutions must meet certain requirements in order to receive or provide the financial records of customers.

The provision would require each state to implement an asset verification program for purposes of determining or redetermining eligibility for Medicaid. The Secretary would require California, New York, and New Jersey to implement an asset verification program for Medicaid by the end of FY2009. Other states would be required to implement their programs on a staggered basis through the end of FY2013. Under these programs, states would require aged, blind or disabled applicants for, or recipients of, Medicaid to provide authorization for the state to obtain financial records that it determines to be needed in connection with an eligibility determination. An authorization would be considered or deemed to meet certain requirements of the Right to Financial Privacy Act. The state would be required to inform any person who provides authorization of its duration and scope. If an applicant for, or recipient of, Medicaid (or any other person whose resources are material to the determination of the eligibility of the applicant or recipient) refuses to provide or revokes any authorization, the state may determine that the applicant or recipient is ineligible for Medicaid. A state may select and enter into a contract with a public or private entity meeting such criteria and qualifications as the state determines appropriate to implement an asset verification program. The Secretary would provide technical assistance to states, and states would be required to furnish reports at such times, in such format, and containing such information as the Secretary determines appropriate. Reasonable state expenses for carrying out this program would be treated, for purposes of reimbursement, as administrative expenses under Medicaid. For states that are required to implement an asset verification program but fail to do so, a withholding of federal matching payments would occur with respect to the amount expended by such state for Medicaid for individuals subject to asset verification, unless (1) the state demonstrates to the Secretary's satisfaction that the state made a good faith effort to comply; (2) the state submits to the Secretary (and the Secretary approves) a corrective action plan to remedy such noncompliance not later than 60 days after the date of a finding that the state is noncompliant; and (3) the state fulfills the terms of such corrective action plan not later than 12 months after the date of such submission (and approval).

Section 205. Application of Medicare Payment Adjustment for Certain Hospital-Acquired Conditions to Payments for Inpatient Hospital Services under Medicaid. For inpatient hospital services under Medicare, the DRA required the Secretary to identify conditions that (1) are high cost or high volume or both, (2) result in the assignment of a case to a diagnosis related group (DRG) that has a higher payment when present as a secondary diagnosis, and (3) could reasonably have been prevented through the application of evidence-based guidelines. For inpatient discharges occurring on or after October 1, 2008, hospitals will not receive additional payment for cases in which one of the selected conditions (identified by CMS) was not present on admission. That is, the case would be paid as if the secondary diagnosis was not present. Under this provision, state Medicaid plans would be required to ensure that higher payments are not made for services related to the presence of a condition that could be identified by a secondary diagnostic code, as described in Medicare statute. This provision would also take effect on October 1, 2008.

Section 206. Reduction in Payments for Medicaid Administrative Costs to Prevent Duplication of Such Payments under TANF. Under the former Aid to Families with Dependent Children (AFDC) cash welfare program, AFDC and Medicaid program eligibility were linked, and many AFDC families also qualified for food stamps. As a result, states often collected necessary eligibility information for all three programs during a single interview or performed other shared administrative tasks and charged the full amount of the cost to AFDC as a matter of convenience. When Congress replaced AFDC with Temporary Assistance for Needy Families (TANF) in 1996, the TANF block grants were calculated in part on the basis of pre-1996 federal welfare spending, including any amounts received by states as reimbursement for common administrative costs. As a result, TANF block grants are higher in many states than they would be if common administrative costs attributable to Medicaid and food stamps were excluded from the calculations. To compensate, Congress has permanently reduced federal reimbursement for food stamp administrative costs in most states by a flat dollar amount that reflects the administrative costs attributable to food stamps that are included in each state's TANF block grant (the annual reductions total about $200 million). Federal reimbursement for Medicaid administrative costs has not been reduced in a similar manner.

Beginning with the first quarter of FY2009, the provision would reduce federal reimbursement for Medicaid administrative costs each quarter by an amount equal to ¼ of the annualized amount determined for the Medicaid program under section 16(k)(2)(B) of the Food Stamp Act of 1977 (i.e., administrative costs attributable to Medicaid).

Section 207. 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 Regional Medical Center of Memphis is a hospital in a

tri-state region that provides a significant amount of uncompensated care to individuals in all three states. To assist the medical center in obtaining financial support from the two states in which it is not located, Congress has twice passed a provision allowing it to make intergovernmental transfers to those non-residing states, in order to obtain additional federal matching funds. The first provision, Section 1001(e) of the MMA, contained a sunset date of December 31, 2005. Section 6051(c) of the DRA extended the MMA provision for one year; which expired on December 31, 2006.

The provision would re-establish that funds transferred from certain out of state providers to fund a different state's share of Medicaid costs are allowable if the Secretary determines that the use of such funds is proper and in the interest of the Medicaid program. Funds used as the non-Federal share of Medicaid that are transferred from, or certified by, a publicly owned regional medical center located in another state would be permissible as the state share of Medicaid costs as long as the center meets certain specified criteria.

Section 208. Grants to Improve Outreach and Enrollment under Medicaid. States share in the costs of Medicaid, based on a formula 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 appropriate, out of any money in the Treasury not otherwise appropriated, $25 million for FY2009 for a grant program under Medicaid to finance outreach and enrollment efforts that increase participation of Medicaid-eligible individuals. Ten percent of the funding would be set-side for grants for Indian Health Service providers and urban Indian organizations. Remaining funds would be distributed based on specified parameters to certain entities (e.g., states, local governments, and faith-based organizations) to conduct outreach campaigns that target geographic areas with high rates of eligible but not enrolled children who reside in rural areas, or racial and ethnic minorities and health disparity populations. Grant funds would also be targeted at proposals that address cultural and linguistic barriers to enrollment. The Secretary would be required to make enrollment data and other information required as a part of the grant application publicly available, and not later than December 31, 2008, would be required to submit a report to Congress on the outreach and enrollment activities conducted under these grants. Federal funds awarded to eligible entities would be used to supplement, not supplant, non-federal funds that are otherwise available for outreach and enrollment activities and would remain available until expended.

Title III - Miscellaneous

Section 301. Extension of TANF Supplemental Grants through Fiscal Year 2009. This provision is the same as Section 301 in S. 3101.

Section 302. Special Diabetes Programs for Type I Diabetes and Indians. This provision is the same as Section 303 in S. 3101.

Section 303. Additional Funding for State Health Insurance Assistance Programs, Area Agencies on Aging, and Aging and Disability Resource Centers. The Secretary makes grants to states to fund the

activities of State Health Insurance Assistance Programs (SHIPs), State Area Agencies on Aging (AoAs), and State Aging and Disability Resource Centers (ADRCs). SHIPs, AoAs, and ADRCs are community-based entities that provide information, counseling, and assistance to Medicare-eligible individuals on obtaining appropriate health insurance. For FY2009, the provision would provide $19 million for SHIPs and $6 million for AoAs and ADRCs. The Secretary would be required to use a portion of the funds to provide outreach to individuals eligible for a Part D low-income subsidy or eligible for enrollment in the Medicare Savings Program.

Section 304. Extension of Federal Reimbursement of Emergency Health Services Furnished to Undocumented Aliens. BBA provided $25 million in funding for state emergency health services furnished to undocumented aliens for each of FY1998 through FY2001. For each of these fiscal years, funds were distributed among the 12 states with the highest number of undocumented aliens. In a given fiscal year, each state's portion of the total funds available was based on its share of total undocumented aliens in all of the eligible states based on the estimates provided by the Department of Homeland Security.

The MMA provided $250 million in additional federal funding for this purpose for each of fiscal years 2005-2008. Of this amount, $167 million was allocated among eligible providers in all states according to a specified formula; the remaining money was distributed among eligible providers in the six states with the highest number of undocumented alien apprehensions for such fiscal year according to a specified formula. From the $250 million in state allotments described above, the Secretary paid directly to eligible providers for unreimbursed costs incurred by providing emergency health care services during that fiscal year to certain specified groups of undocumented aliens. The Secretary determined the payment amount for each eligible provider and if necessary reduced the amount of payment to eligible providers to ensure that each eligible provider was paid. Funds remained available until they were expended. The provision would provide $200 million in additional federal funding for state emergency health services furnished to undocumented aliens for each of FY2009 and FY2010. The Secretary may not use more than $8 million of the FY2009 federal funding for the administration of this section.