

1 **TITLE VI—COMMITTEE ON**
2 **FINANCE**

3 **SEC. 6000. AMENDMENTS TO SOCIAL SECURITY ACT; TABLE**
4 **OF CONTENTS OF TITLE.**

5 (a) AMENDMENTS TO SOCIAL SECURITY ACT.—Ex-
6 cept as otherwise specifically provided, whenever in this
7 title an amendment is expressed in terms of an amend-
8 ment to or repeal of a section or other provision, the ref-
9 erence shall be considered to be made to that section or
10 other provision of the Social Security Act.

11 (b) REFERENCES TO THE SECRETARY.—In this title,
12 the term “Secretary” means the Secretary of Health and
13 Human Services.

14 (c) TABLE OF CONTENTS OF TITLE.—The table of
15 contents of this title is as follows:

TITLE VI—FINANCE

Sec. 6000. Amendments to Social Security Act; table of contents of title.

Subtitle A—Medicaid

CHAPTER 1—PAYMENT FOR PRESCRIPTION DRUGS UNDER MEDICAID

- Sec. 6001. Pharmacy reimbursement.
- Sec. 6002. Increase in rebates for covered outpatient drugs.
- Sec. 6003. Improved regulation of authorized generic drugs.
- Sec. 6004. Collection of rebates for certain physician administered drugs.

CHAPTER 2—LONG-TERM CARE UNDER MEDICAID

- Sec. 6011. Reform of Medicaid asset transfer rules.
- Sec. 6012. State long-term care partnerships.

CHAPTER 3—ELIMINATING FRAUD, WASTE, AND ABUSE IN MEDICAID

- Sec. 6021. Enhancing third party recovery.
- Sec. 6022. Limitation on use of contingency fee arrangements.
- Sec. 6023. Encouraging the enactment of State False Claims Acts.

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- Sec. 6024. Employee education about False Claims Recovery.
- Sec. 6025. Prohibition on restocking and double billing of prescription drugs.
- Sec. 6026. Medicaid integrity program.

CHAPTER 4—STATE FINANCING UNDER MEDICAID

- Sec. 6031. Reforms of targeted case management.
- Sec. 6032. Temporary Federal matching payments for Federal assistance.
- Sec. 6033. Managed care organization provider tax reform.
- Sec. 6034. Inclusion of podiatrists as physicians.
- Sec. 6035. DSH allotment for the District of Columbia.
- Sec. 6036. Demonstration project regarding Medicaid reimbursement for stabilization of emergency medical conditions by non-publicly owned or operated institutions for mental diseases.

CHAPTER 5—IMPROVING THE MEDICAID AND STATE CHILDREN’S HEALTH INSURANCE PROGRAMS

SUBCHAPTER A—FAMILY OPPORTUNITY ACT

- Sec. 6041. Short title of subchapter.
- Sec. 6042. Opportunity for families of disabled children to purchase Medicaid coverage for such children.
- Sec. 6043. Demonstration projects regarding home and community-based alternatives to psychiatric residential treatment facilities for children.
- Sec. 6044. Development and support of family-to-family health information centers.
- Sec. 6045. Restoration of Medicaid eligibility for certain SSI beneficiaries.

SUBCHAPTER B—STATE CHILDREN’S HEALTH INSURANCE PROGRAM

- Sec. 6051. Rules for availability, redistribution, and extended availability of allotments for fiscal years 2003, 2004, and 2005.
- Sec. 6052. Authority to use up to 10 percent of fiscal year 2006 and 2007 allotments for outreach.
- Sec. 6053. Prohibition against covering nonpregnant childless adults with SCHIP funds.
- Sec. 6054. Continued authority for qualifying States to use certain funds for medicaid expenditures.
- Sec. 6055. Grants to promote innovative outreach and enrollment under medicaid and SCHIP.

SUBCHAPTER C—MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION

- Sec. 6061. Money Follows the Person Rebalancing Demonstration.

CHAPTER 6—OPTION FOR HURRICANE KATRINA DISASTER STATES TO DELAY APPLICATION

- Sec. 6071. Option for Hurricane Katrina disaster States to delay application.

Subtitle B—Medicare

- Sec. 6101. Improvements to the medicare-dependent hospital (MDH) program.
- Sec. 6102. Reduction in payments to skilled nursing facilities for bad debt.

- Sec. 6103. Two-year extension of the 50 percent compliance threshold used to determine whether a hospital or unit of a hospital is an inpatient rehabilitation facility under the medicare program.
- Sec. 6104. Prohibition on physician self referrals to physician owned, limited service hospitals.
- Sec. 6105. Minimum update for physicians' services for 2006.
- Sec. 6106. One-year extension of hold harmless provisions for small rural hospitals and sole community hospitals under the prospective payment system for hospital outpatient department services.
- Sec. 6107. Update to the composite rate component of the basic case-mix adjusted prospective payment system for dialysis services.
- Sec. 6108. One-year extension of moratorium on therapy caps.
- Sec. 6109. Transfer of title of certain DME to patient after 13-month rental.
- Sec. 6110. Establishment of medicare value-based purchasing programs.
- Sec. 6111. Phase-out of risk adjustment budget neutrality in determining the amount of payments to Medicare Advantage organizations.
- Sec. 6112. Elimination of Medicare Advantage regional plan stabilization fund.
- Sec. 6113. Rural PACE provider grant program.
- Sec. 6114. Waiver of part B late enrollment penalty for certain international volunteers.
- Sec. 6115. Delivery of services at Federally qualified health centers.

- 1 **Subtitle A—Medicaid**
- 2 **CHAPTER 1—PAYMENT FOR**
- 3 **PRESCRIPTION DRUGS UNDER MEDICAID**
- 4 **SEC. 6001. PHARMACY REIMBURSEMENT.**
- 5 (a) DEFINITION OF AVERAGE MANUFACTURER
- 6 PRICE.—
- 7 (1) IN GENERAL.—Section 1927(k)(1) (42
- 8 U.S.C. 1396r-8(k)(1)) is amended—
- 9 (A) in the paragraph heading, by striking
- 10 “PRICE” and inserting “PRICE; WEIGHTED AV-
- 11 ERAGE MANUFACTURER PRICE”;
- 12 (B) by striking “The term” and inserting
- 13 the following:
- 14 “(A) IN GENERAL.—The term”; and
- 15 (C) by adding at the end the following:

1 “(B) CALCULATION REQUIREMENTS.—For
2 purposes of subparagraph (A), the average
3 manufacturer price shall be calculated accord-
4 ing to the following:

5 “(i) SALES EXEMPTED FROM COM-
6 PUTATION.—Without regard to—

7 “(I) sales exempt from inclusion
8 in the determination of best price
9 under subsection (c)(1)(C)(i);

10 “(II) such other sales as the Sec-
11 retary identifies as sales to an entity
12 that are merely nominal in amount
13 under subsection (c)(1)(C)(ii)(III);
14 and

15 “(III) bona fide service fees (as
16 defined in subparagraph (E)) that are
17 paid by a manufacturer to an entity,
18 that represent fair market value for a
19 bona fide service, and that are not
20 passed on in whole or in part to a cli-
21 ent or customer of an entity.

22 “(ii) SALE PRICE NET OF DIS-
23 COUNTS.—By including the following:

24 “(I) Cash discounts and volume
25 discounts.

1 “(II) Free goods that are contin-
2 gent upon any purchase requirement
3 or agreement.

4 “(III) Sales at a nominal price
5 that are contingent upon any pur-
6 chase requirement or agreement.

7 “(IV) Chargebacks, rebates pro-
8 vided to a pharmacy (including a mail
9 order pharmacy but excluding a phar-
10 macy benefit manager), or any other
11 direct or indirect discounts.

12 “(V) Any other price concessions,
13 which may be based on recommenda-
14 tions of the Inspector General of the
15 Department of Health and Human
16 Services, that would result in a reduc-
17 tion of the cost to the purchaser, but
18 only if the Secretary provides notice
19 of the Secretary’s intent to include
20 such price concessions in accordance
21 with section 553 of title 5, United
22 States Code.

23 “(C) WEIGHTED AVERAGE MANUFAC-
24 TURER PRICE.—The term ‘weighted average
25 manufacturer price’ means, with respect to a

1 rebate period and multiple source drug, the vol-
2 ume-weighted average of the average manufac-
3 turer prices reported under subsection
4 (b)(3)(A)(i)(I) for all drug products described
5 in paragraph (7)(A)(i) that are therapeutically
6 equivalent and bioequivalent forms of the drug,
7 determined by—

8 “(i) computing the sum of the prod-
9 ucts (for each National Drug Code as-
10 signed to such drug products) of—

11 “(I) the average manufacturer
12 price; and

13 “(II) the total number of units
14 reported sold under subsection
15 (b)(3)(A)(i)(I); and

16 “(ii) dividing the sum determined
17 under clause (i) by the sum of the total
18 number of units under clause (i)(II) for all
19 National Drug Codes assigned to such
20 drug products.

21 “(D) LIMITATION ON SALES AT A NOMINAL
22 PRICE.—

23 “(i) IN GENERAL.—For purposes of
24 clauses (i)(II) and (ii)(III) of subpara-
25 graph (B), only sales by a manufacturer of

1 covered outpatient drugs that are single
2 source drugs, innovator multiple source
3 drugs, or authorized generic drugs at
4 nominal prices to the following shall be
5 considered to be sales at a nominal price or
6 merely nominal in amount:

7 “(I) A covered entity described in
8 section 340B(a)(4) of the Public
9 Health Service Act.

10 “(II) An intermediate care facil-
11 ity for the mentally retarded.

12 “(III) A State-owned or operated
13 nursing facility.

14 “(IV) Any other facility or entity
15 that the Secretary determines is a
16 safety net provider to which sales of
17 such drugs at a nominal price would
18 be appropriate based on the following
19 factors:

20 “(aa) The type of facility.

21 “(bb) The services provided
22 by the facility.

23 “(cc) The patient population
24 served by the facility.

1 “(dd) The number of other
2 facilities eligible to purchase at
3 nominal prices in the same serv-
4 ice area.

5 “(ii) NONAPPLICATION.—Clause (i)
6 shall not apply with respect to sales by a
7 manufacturer at a nominal price of covered
8 outpatient drugs that are single source
9 drugs, innovator multiple source drugs, or
10 authorized generic drugs pursuant to a
11 master agreement under section 8126 of
12 title 38, United States Code.

13 “(E) BONA FIDE SERVICE FEES.—For
14 purposes of subparagraph (B)(i)(III), the term
15 ‘bona fide service fees’ means expenses that are
16 for an itemized service actually performed by an
17 entity on behalf of a manufacturer that would
18 have generally been paid for by the manufac-
19 turer at the same rate had these services been
20 performed by another entity.”.

21 (2) CONFORMING AMENDMENTS.—Section
22 1927(b)(3)(A)(i) (42 U.S.C. 1396r–8(b)(3)(A)(i)),
23 as amended by section 6003(a), is amended—

24 (A) in subclause (I)—

1 (i) by inserting “and the total number
2 of units sold” after “(as defined in sub-
3 section (k)(1))”; and

4 (ii) by striking “and” at the end;

5 (B) in subclause (II), by adding “and” at
6 the end; and

7 (C) by adding at the end the following:

8 “(III) information and data on
9 any sales that were made during such
10 period at a nominal price, including,
11 with respect to each such sale, the
12 purchaser, the name of the product,
13 the amount or number of units of the
14 product sold at a nominal price, and
15 the nominal price paid;”.

16 (3) EFFECTIVE DATE.—

17 (A) IN GENERAL.—Except as provided in
18 subparagraph (B), the amendments made by
19 this subsection shall take effect on January 1,
20 2006.

21 (B) EXCEPTION.—Subparagraph (D) of
22 section 1927(k)(1) of the Social Security Act
23 (42 U.S.C. 1396r–8(k)(1)) (as added by para-
24 graph (1)) shall not apply with respect to a con-
25 tract in effect on the date of enactment of this

1 Act pursuant to which pharmaceutical products
2 are or may be available at nominal prices until
3 the expiration date of such contract, or October
4 1, 2006, whichever is earlier, and shall apply to
5 sales made, and rebate periods beginning, on or
6 after that date.

7 (b) UPPER PAYMENT LIMIT FOR INGREDIENT COST
8 OF COVERED OUTPATIENT DRUGS.—

9 (1) IN GENERAL.—Section 1927(e) (42 U.S.C.
10 1396r-8(e)) is amended to read as follows:

11 “(e) PHARMACY REIMBURSEMENT LIMITS.—

12 “(1) UPPER PAYMENT LIMIT FOR INGREDIENT
13 COST OF COVERED OUTPATIENT DRUGS.—No Fed-
14 eral financial participation shall be available for pay-
15 ment for the ingredient cost of a covered outpatient
16 drug that exceeds the upper payment limit for that
17 drug established under paragraph (2).

18 “(2) UPPER PAYMENT LIMIT.—

19 “(A) IN GENERAL.—Except as provided in
20 subparagraphs (B) and (C), the upper payment
21 limit established under this paragraph for the
22 ingredient cost of a—

23 “(i) single source drug, is 105 percent
24 of the average manufacturer price for that
25 drug; and

1 “(ii) multiple source drug, is 115 per-
2 cent of the weighted average manufacturer
3 price for that drug.

4 “(B) EXCEPTION FOR INITIAL SALES PERI-
5 ODS.—

6 “(i) IN GENERAL.—In the case of a
7 covered outpatient drug during an initial
8 sales period (not to exceed 2 calendar
9 quarters) in which data on sales for the
10 drug is not sufficiently available from the
11 manufacturer to compute the average man-
12 ufacturer price or the weighted average
13 manufacturer price, the Secretary shall es-
14 tablish the upper payment limit for the in-
15 gredient cost of such drug to apply only
16 during such period based on the following:

17 “(I) In the case of a single
18 source drug, such upper payment
19 limit shall be the wholesale acquisition
20 cost for the drug.

21 “(II) In the case of a first non-
22 innovator multiple source drug, such
23 upper payment limit shall be the aver-
24 age manufacturer price for the single
25 source drug that is rated as thera-

1 peutically equivalent and bioequivalent
2 to such drug, minus 10 percent.

3 “(III) In the case of a subse-
4 quent noninnovator multiple source
5 drug—

6 “(aa) if the Secretary has
7 sufficient data to determine the
8 weighted average manufacturer
9 price for the drug, such upper
10 payment limit shall be the
11 weighted average manufacturer
12 price determined for the thera-
13 peutically equivalent and bio-
14 equivalent form of the drug; and

15 “(bb) if the Secretary does
16 not have sufficient data to deter-
17 mine the weighted average manu-
18 facturer price for the drug, such
19 upper payment limit shall be the
20 average manufacturer price for
21 the single source drug that is
22 rated as therapeutically equiva-
23 lent and bioequivalent to the
24 drug, minus 10 percent.

1 “(ii) DEFINITION OF WHOLESAL AC-
2 QUISITION COST.—For purposes of clause
3 (i), the term ‘wholesale acquisition cost’
4 means, with respect to a drug or biological,
5 the manufacturer’s list price for the drug
6 or biological to wholesalers or direct pur-
7 chasers in the United States, not including
8 prompt pay or other discounts, rebates, or
9 reductions in price, for the most recent
10 month for which the information is avail-
11 able, as reported in wholesale price guides
12 or other publications of drug or biological
13 pricing data.

14 “(C) EXCEPTION FOR CERTAIN INNOVATOR
15 MULTIPLE SOURCE DRUGS.—In the case of an
16 innovator multiple source drug that a pre-
17 scribing health care provider determines is nec-
18 essary for treatment of a condition and that a
19 noninnovator multiple source drug would not be
20 as effective for the individual or would have ad-
21 verse effects for the individual or both, and for
22 which the provider obtains prior authorization
23 in accordance with a program described in sub-
24 section (d)(5), the upper payment limit for the
25 innovator multiple source drug shall be 105

1 percent of the average manufacturer price for
2 such drug.

3 “(D) UPDATES; AVAILABILITY OF DATA.—

4 “(i) FREQUENCY OF DETERMINA-
5 TION.—The Secretary shall update the
6 upper payment limits applicable under this
7 paragraph on a quarterly basis, taking into
8 account the most recent data collected for
9 purposes of determining such limits and
10 the Food and Drug Administration’s most
11 recent publication of ‘Approved Drug
12 Products with Therapeutic Equivalence
13 Evaluations’.

14 “(ii) COLLECTION OF DATA.—

15 “(I) IN GENERAL.—Beginning on
16 January 1, 2006, the Secretary shall
17 collect data with respect to the aver-
18 age manufacturer prices and volume
19 of sales of covered outpatient drugs
20 (or, in the case of covered outpatient
21 drugs that are first marketed after
22 such date, beginning with the first
23 quarter during which the drugs are
24 first marketed).

1 “(II) DATA REPORTED FOR PUR-
2 POSES OF DETERMINING WEIGHTED
3 AVERAGE MANUFACTURER PRICE.—
4 Insofar as there is a lag in the report-
5 ing of the information on rebates and
6 chargebacks so that adequate data are
7 not available on a timely basis to up-
8 date the weighted average manufac-
9 turer price for a multiple source drug,
10 the manufacturer of such drug shall
11 apply a methodology based on a 12-
12 month rolling average for the manu-
13 facturer to estimate costs attributable
14 to rebates and charge backs for such
15 drug. For years after 2006, the Sec-
16 retary shall establish a uniform meth-
17 odology to estimate and apply such
18 costs.

19 “(iii) AVAILABILITY OF DATA TO
20 STATES.—Notwithstanding subsection
21 (b)(3)(D), beginning with the first quarter
22 of fiscal year 2006 for which data is avail-
23 able, and for each fiscal year quarter
24 thereafter, the Secretary shall make avail-
25 able to States the most recently reported

1 average manufacturer prices for single
2 source drugs and weighted average manu-
3 facturer prices for multiple source drugs.

4 “(E) AUTHORITY TO ENTER CON-
5 TRACTS.—The Secretary may enter into con-
6 tracts with appropriate entities to determine av-
7 erage manufacturer prices, volume, and other
8 data necessary to calculate the upper payment
9 limit for a covered outpatient drug established
10 under this subsection and to calculate that pay-
11 ment limit.

12 “(3) STATE USE OF PRICE DATA.—

13 “(A) DISTRIBUTION OF DATA.—The Sec-
14 retary shall devise and implement a means for
15 electronic distribution of the most recently cal-
16 culated weighted average manufacturer price
17 and the average manufacturer price for all cov-
18 ered outpatient drugs to each State agency des-
19 igned under section 1902(a)(5) with responsi-
20 bility for the administration or supervision of
21 the administration of the State plan under this
22 title.

23 “(B) AUTHORITY TO ESTABLISH PAYMENT
24 RATES BASED ON DATA.—A State may use the
25 price data received in accordance with subpara-

1 graph (A) in establishing payment rates for the
2 ingredient costs and dispensing fees for covered
3 outpatient drugs dispensed to individuals eligi-
4 ble for medical assistance under this title.

5 “(4) REASONABLE DISPENSING FEES RE-
6 QUIRED.—

7 “(A) IN GENERAL.—A State which pro-
8 vides medical assistance for covered outpatient
9 drugs shall pay a dispensing fee for each cov-
10 ered outpatient drug for which Federal finan-
11 cial participation is available in accordance with
12 this section in accordance with the following:

13 “(i) The dispensing fee for a noninno-
14 vator multiple source drug shall be greater
15 than the dispensing fee for an innovator
16 multiple source drug that is rated as thera-
17apeutically equivalent and bioequivalent to
18 such drug.

19 “(ii) In establishing such dispensing
20 fees, the State takes into consideration
21 such requirements as the Secretary shall,
22 by regulation, establish, and which shall in-
23 clude consideration of the following:

24 “(I) Any reasonable costs associ-
25 ated with a pharmacist’s time in

1 checking for information about an in-
2 dividual’s coverage or performing
3 quality assurance activities.

4 “(II) Costs associated with—

5 “(aa) the measurement or
6 mixing of a covered outpatient
7 drug;

8 “(bb) filling the container
9 for the drug;

10 “(cc) physically providing
11 the completed prescription to an
12 individual enrolled in the pro-
13 gram under this title;

14 “(dd) delivery;

15 “(ee) special packaging;

16 “(ff) overhead related to
17 maintaining the facility and
18 equipment necessary to operate
19 the pharmacy, including the sala-
20 ries of pharmacists and other
21 pharmacy workers;

22 “(gg) geographic factors
23 that impact operational costs;

24 “(hh) patient counseling;
25 and

1 “(ii) the dispensing of drugs
2 requiring specialty pharmacy care
3 management services (as deter-
4 mined by the Secretary in ac-
5 cordance with subparagraph
6 (B)).

7 “(B) DETERMINATION OF DRUGS REQUIR-
8 ING SPECIALTY PHARMACY CARE MANAGEMENT
9 SERVICES.—

10 “(i) IN GENERAL.—Not later than 15
11 months after the date of enactment of the
12 Deficit Reduction Omnibus Reconciliation
13 Act of 2005, the Secretary shall establish
14 a list of covered outpatient drugs which re-
15 quire specialty pharmacy care management
16 services that includes only those drugs for
17 which the Secretary determines that access
18 by individuals eligible for medical assist-
19 ance under this title would be seriously im-
20 paired without the provision of specialty
21 pharmacy care management services.

22 “(ii) SPECIALTY PHARMACY CARE
23 MANAGEMENT SERVICES DEFINED.—For
24 purposes of this paragraph, the term ‘spe-
25 cialty pharmacy care management services’

1 means services provided in connection with
2 the dispensing or administration of a cov-
3 ered outpatient drug which the Secretary
4 determines requires—

5 “(I) significant caregiver and
6 provider contact and education re-
7 garding the relevant disease state,
8 prevention, treatment, drug indica-
9 tions, benefits, risks, complications,
10 use, pharmacy counseling, and expla-
11 nation of existing provider guidelines;

12 “(II) patient compliance services,
13 including coordination of provider vis-
14 its with drug delivery, compliance with
15 a drug dosing regimen, mailing or
16 telephone call reminders, compiling
17 compliance data, and assisting pro-
18 viders in developing compliance pro-
19 grams; or

20 “(III) tracking services, including
21 developing referral processes with pro-
22 viders, screening referrals, and track-
23 ing patient weight for dosing require-
24 ments.

1 “(iii) QUARTERLY UPDATES.—The
2 Secretary shall update the list of covered
3 outpatient drugs requiring specialty phar-
4 macy management services on a quarterly
5 basis.

6 (2) CONFORMING AMENDMENTS.—

7 (A) Section 1927(b)(3)(D)(i) (42 U.S.C.
8 1396r-8(b)(3)(D)(i)) is amended by inserting
9 “(including with respect to the determination of
10 weighted average manufacturer prices under
11 subsection (e)(2) and the distribution of weight-
12 ed average manufacturer prices and average
13 manufacturer prices for covered outpatient
14 drugs to States under subsection (e)(3))” after
15 “this section”.

16 (B) Section 1903(i)(10) (42 U.S.C.
17 1396b(i)(10)) is amended—

18 (i) in subparagraph (A), by striking
19 “and” at the end;

20 (ii) in subparagraph (B), by striking
21 “or” at the end and inserting “and”; and

22 (iii) by adding at the end the fol-
23 lowing:

24 “(C) with respect to any amount expended for
25 the ingredient cost of a covered outpatient drug that

1 exceeds the upper payment limit for that drug estab-
2 lished under section 1927(e); or”.

3 (3) EFFECTIVE DATE.—The amendments made
4 by this subsection take effect with respect to a State
5 on the later of—

6 (A) January 1, 2007; or

7 (B) the date that is 6 months after the
8 close of the first regular session of the State
9 legislature that begins after the date of enact-
10 ment of this Act.

11 (c) INTERIM UPPER PAYMENT LIMIT.—

12 (1) IN GENERAL.—With respect to a State pro-
13 gram under title XIX of the Social Security Act,
14 during the period that begins on January 1, 2006,
15 and ends on the effective date applicable to such
16 State under subsection (b)(3), the Secretary shall—

17 (A) apply the Federal upper payment limit
18 established under section 447.332(b) of title 42,
19 Code of Federal Regulations to the State by
20 substituting “125 percent” for “150 percent”;
21 and

22 (B) in the case of covered outpatient drugs
23 under title XIX of such Act that are marketed
24 as of July 1, 2005, and are subject to Federal
25 upper payment limits that apply under section

1 447.332 of title 42, Code of Federal Regula-
2 tions, use average wholesale prices, direct
3 prices, and wholesale acquisition costs for such
4 drugs that do not exceed such prices and costs
5 as of such date to determine the Federal upper
6 payment limits that apply under section
7 447.332 of title 42, Code of Federal Regula-
8 tions to such drugs during such period.

9 (2) APPLICATION TO NEW DRUGS.—Paragraph
10 (1)(A) shall apply to a covered outpatient drug
11 under title XIX of the Social Security Act that is
12 first marketed after July 1, 2005, but before Janu-
13 ary 1, 2007, and is subject to the Federal upper
14 payment limit established under section 447.332(b)
15 of title 42, Code of Federal Regulations.

16 **SEC. 6002. INCREASE IN REBATES FOR COVERED OUT-**
17 **PATIENT DRUGS.**

18 (a) INCREASE IN BASIC REBATE FOR SINGLE
19 SOURCE DRUGS AND INNOVATOR MULTIPLE SOURCE
20 DRUGS.—Section 1927(c)(1)(B)(i) (42 U.S.C. 1396r-
21 8(c)(1)(B)(i)) is amended—

22 (1) in subclause (IV), by striking “and” after
23 the semicolon;

24 (2) in subclause (V)—

1 (A) by inserting “and before January 1,
2 2006,” after “1995,”; and

3 (B) by striking the period and inserting “;
4 and”; and

5 (3) by adding at the end the following:

6 “(VI) after December 31, 2005,
7 is 17 percent.”.

8 (b) INCREASE IN REBATE FOR OTHER DRUGS.—Sec-
9 tion 1927(c)(3)(B) (42 U.S.C. 1396r-8(c)(3)(B)) is
10 amended—

11 (1) in clause (i), by striking “and” at the end;

12 (2) in clause (ii)—

13 (A) by inserting “and before January 1,
14 2006,” after “December 31, 1993,”; and

15 (B) by striking the period at the end and
16 inserting “; and”; and

17 (3) by adding at the end the following:

18 “(iii) after December 31, 2005, is 17
19 percent.”.

20 **SEC. 6003. IMPROVED REGULATION OF AUTHORIZED GE-**
21 **NERIC DRUGS.**

22 (a) INCLUSION WITH OTHER REPORTED AVERAGE
23 MANUFACTURER AND BEST PRICES.—Section
24 1927(b)(3)(A) (42 U.S.C. 1396r-8(b)(3)(A)) is
25 amended—

1 (1) by striking clause (i) and inserting the fol-
2 lowing:

3 “(i) not later than 30 days after the
4 last day of each rebate period under the
5 agreement—

6 “(I) on the average manufacturer
7 price (as defined in subsection (k)(1))
8 for each covered outpatient drug for
9 the rebate period under the agreement
10 (including for each such drug that is
11 an authorized generic drug or is any
12 other drug sold under a new drug ap-
13 plication approved under section
14 505(c) of the Federal Food, Drug,
15 and Cosmetic Act); and

16 “(II) for each single source drug,
17 innovator multiple source drug, au-
18 thorized generic drug, and any other
19 drug sold under a new drug applica-
20 tion approved under section 505(c) of
21 the Federal Food, Drug, and Cos-
22 metic Act, on the manufacturer’s best
23 price (as defined in subsection
24 (c)(1)(C)) for such drug for the rebate
25 period under the agreement;”; and

1 (2) in clause (ii), by inserting “(including for
2 such drugs that are authorized generic drugs or are
3 any other drugs sold under a new drug application
4 approved under section 505(c) of the Federal Food,
5 Drug, and Cosmetic Act)” after “drugs”.

6 (b) CONFORMING AMENDMENTS.—Section 1927 of
7 such Act (42 U.S.C. 1396r–8) is amended—

8 (1) in subsection (c)(1)(C)—

9 (A) in clause (i), in the matter preceding
10 subclause (I), by striking “or innovator multiple
11 source drug of a manufacturer” and inserting
12 “, innovator multiple source drug, or authorized
13 generic drug of a manufacturer, or any other
14 drug of a manufacturer that is sold under a
15 new drug application approved under section
16 505(c) of the Federal Food, Drug, and Cos-
17 metic Act”; and

18 (B) in clause (ii)—

19 (i) in subclause (II), by striking
20 “and” at the end;

21 (ii) in subclause (III), by striking the
22 period at the end and inserting “; and”;
23 and

24 (iii) by adding at the end the fol-
25 lowing:

1 “(IV) in the case of a manufac-
2 turer that approves, allows, or other-
3 wise permits an authorized generic
4 drug or any other drug of the manu-
5 facturer to be sold under a new drug
6 application approved under section
7 505(c) of the Federal Food, Drug,
8 and Cosmetic Act, shall be inclusive of
9 the lowest price for such authorized
10 generic or other drug available from
11 the manufacturer during the rebate
12 period to any wholesaler, retailer, pro-
13 vider, health maintenance organiza-
14 tion, nonprofit entity, or governmental
15 entity within the United States, ex-
16 cluding those prices described in sub-
17 clauses (I) through (IV) of clause
18 (i).”;

19 (2) in subsection (k)—

20 (A) in paragraph (1), as amended by sec-
21 tion 6001(a)(1)(B), by adding at the end the
22 following:

23 “(F) INCLUSION OF AUTHORIZED GENERIC
24 DRUGS.—In the case of a manufacturer that
25 approves, allows, or otherwise permits an au-

1 thorized generic drug or any other drug of the
2 manufacturer to be sold under a new drug ap-
3 plication approved under section 505(c) of the
4 Federal Food, Drug, and Cosmetic Act, such
5 term shall be inclusive of the average price paid
6 for such authorized generic or other drug.”; and

7 (B) by adding at the end the following:

8 “(10) AUTHORIZED GENERIC DRUG.—The term
9 ‘authorized generic drug’ means a listed drug (as
10 that term is used in section 505(j) of the Federal
11 Food, Drug, and Cosmetic Act) that—

12 “(A) has been approved under section
13 505(c) of such Act; and

14 “(B) is marketed, sold, or distributed di-
15 rectly or indirectly to the retail class of trade
16 under a different labeling, packaging (other
17 than repackaging as the listed drug in blister
18 packs, unit doses, or similar packaging for use
19 in institutions), product code, labeler code,
20 trade name, or trade mark than the listed
21 drug.”.

22 (c) EFFECTIVE DATE.—The amendments made by
23 this section take effect on January 1, 2006.

1 **SEC. 6004. COLLECTION OF REBATES FOR CERTAIN PHYSI-**
2 **CIAN ADMINISTERED DRUGS.**

3 (a) IN GENERAL.—Section 1927(a) (42 U.S.C.
4 1396r–8(a)) is amended by adding at the end the fol-
5 lowing:

6 “(7) REQUIREMENT FOR SUBMISSION OF UTILI-
7 ZATION DATA FOR CERTAIN PHYSICIAN-ADMINIS-
8 TERED DRUGS.—In order for payment to be avail-
9 able under section 1903(a) for a covered outpatient
10 drug that is physician administered (as determined
11 by the Secretary), and that is administered on or
12 after January 1, 2006, the State shall provide for
13 the submission of such utilization data and coding
14 (including both J-codes and National Drug Code
15 numbers) for each such drug as the Secretary may
16 specify as necessary in order to secure rebates for
17 payments made under this title.”.

18 (b) LIMITATION ON PAYMENT.—Section 1903(i)(10)
19 (42 U.S.C. 1396b(i)(10)), as amended by section
20 6001(b)(2)(B), is amended—

21 (1) in subparagraph (B), by striking “and” at
22 the end;

23 (2) in subparagraph (C), by striking “; or” at
24 the end and inserting “, and”; and

25 (3) by adding at the end the following:

1 State may determine the period of ineligibility applicable
2 to such individual under this paragraph by—

3 “(i) treating the total, cumulative uncompen-
4 sated value of all assets transferred by the individual
5 (or individual’s spouse) during all months on or
6 after the look-back date specified in subparagraph
7 (B) as 1 transfer for purposes of clause (i) or (ii)
8 (as the case may be) of subparagraph (E); and

9 “(ii) beginning such period on the earliest date
10 which would apply under subparagraph (D) to any
11 of such transfers.”.

12 (c) INCLUSION OF TRANSFER OF CERTAIN NOTES
13 AND LOANS ASSETS.—Section 1917(c)(1) (42 U.S.C.
14 1396p(c)(1)), as amended by subsection (b), is amended
15 by adding at the end the following:

16 “(G) For purposes of this paragraph with respect to
17 a transfer of assets, the term ‘assets’ includes funds used
18 to purchase a promissory note, loan, or mortgage unless
19 such note, loan, or mortgage—

20 “(i) has a repayment term that is actuarially
21 sound (as determined in accordance with actuarial
22 publications of the Office of the Chief Actuary of the
23 Social Security Administration);

1 “(ii) provides for payments to be made in equal
2 amounts during the term of the loan, with no defer-
3 ral and no balloon payments made; and

4 “(iii) prohibits the cancellation of the balance
5 upon the death of the lender.

6 In the case of a promissory note, loan, or mortgage that
7 does not satisfy the requirements of clauses (i) through
8 (iii), the value of such note, loan, or mortgage shall be
9 the outstanding balance due as of the date of the individ-
10 ual’s application for medical assistance for services de-
11 scribed in subparagraph (C).”.

12 (d) TREATMENT OF ANNUITIES.—

13 (1) INCLUSION OF TRANSFERS TO PURCHASE
14 BALLOON ANNUITIES.—Section 1917(c)(1) (42
15 U.S.C. 1396p(c)(1)), as amended by subsection (c),
16 is amended by adding at the end the following:

17 “(H) For purposes of this paragraph with respect to
18 a transfer of assets, the term ‘assets’ includes an annuity
19 purchased by or on behalf of an annuitant who has applied
20 for medical assistance with respect to nursing facility serv-
21 ices or other long-term care services under this title
22 unless—

23 “(i) the annuity is—

1 “(I) an annuity described in subsection (b)
2 or (q) of section 408 of the Internal Revenue
3 Code of 1986; or

4 “(II) purchased with proceeds from—

5 “(aa) an account or trust described in
6 subsection (a), (c), (p) of section 408 of
7 such Code;

8 “(bb) a simplified employee pension
9 (within the meaning of section 408(k) of
10 such Code); or

11 “(cc) a Roth IRA described in section
12 408A of such Code; or

13 “(ii) the annuity—

14 “(I) is irrevocable and nonassignable;

15 “(II) is actuarially sound (as determined in
16 accordance with actuarial publications of the
17 Office of the Chief Actuary of the Social Secu-
18 rity Administration); and

19 “(III) provides for payments in equal
20 amounts during the term of the annuity, with
21 no deferral and no balloon payments made.”.

22 (2) REQUIREMENT FOR STATE TO BE NAMED
23 AS A REMAINDER BENEFICIARY.—Section 1917(c)(1)
24 (42 U.S.C. 1396p(c)(1)), as amended by paragraph
25 (1), is amended by adding at the end the following:

1 “(I) For purposes of this paragraph, the purchase of
2 an annuity shall be treated as the disposal of an asset
3 for less than fair market value unless the State is named
4 as the remainder beneficiary in the first position for at
5 least the total amount of medical assistance paid on behalf
6 of the annuitant under this title or is named as such a
7 beneficiary in the second position after the community
8 spouse and such spouse does not dispose of any such re-
9 mainder for less than fair market value.”.

10 (3) INCLUSION OF CERTAIN ANNUITIES IN AN
11 ESTATE.—Section 1917(b)(4) (42 U.S.C.
12 1396p(b)(4)) is amended—

13 (A) in subparagraph (A), by striking
14 “and” at the end;

15 (B) in subparagraph (B), by striking the
16 period at the end and inserting “; and”; and

17 (C) by adding at the end the following:

18 “(C) shall include an annuity unless the annu-
19 ity was purchased from a financial institution or
20 other business that sells annuities in the State as
21 part of its regular business.”.

22 (e) INCLUSION OF TRANSFERS TO PURCHASE LIFE
23 ESTATES.—Section 1917(c)(1) (42 U.S.C. 1396p(c)(1)),
24 as amended by subsection (d)(2), is amended by adding
25 at the end the following:

1 “(J) For purposes of this paragraph with respect to
2 a transfer of assets, the term ‘assets’ includes the pur-
3 chase of a life estate interest in another individual’s home
4 unless the purchaser resides in the home for a period of
5 at least 1 year after the date of the purchase.

6 (f) PROTECTION AGAINST UNDUE HARDSHIP.—Sec-
7 tion 1917(c) (42 U.S.C. 1396p(c)) is amended by adding
8 at the end the following:

9 “(6) For purposes of paragraph (2)(D) and sub-
10 section (d)(5), the procedures established by the State in
11 accordance with standards specified by the Secretary shall
12 provide for—

13 “(A) notice, before application of the provisions
14 of paragraph (1) or subsection (d), to an individual
15 who is an applicant for medical assistance under this
16 title who would be subject to such a penalty under
17 such provisions that an undue hardship exception ex-
18 ists;

19 “(B) a timely process before the imposition of
20 a penalty for determining whether an undue hard-
21 ship waiver will be granted for the individual;

22 “(C) a process under which an adverse deter-
23 mination can be appealed; and

24 “(D) application of criteria that specifies that
25 an undue hardship exists when application of the

1 provisions of paragraph (1) or subsection (d) would
2 deprive the individual of medical care such that the
3 individual's health or life would be endangered or
4 when the application of such provisions would de-
5 prive the individual of food, clothing, shelter, or
6 other necessities of life.”.

7 (g) EFFECTIVE DATES.—

8 (1) IN GENERAL.—Except as provided in para-
9 graphs (2) and (3), the amendments made by this
10 section shall apply to payments under title XIX of
11 the Social Security Act (42 U.S.C. 1396 et seq.) for
12 calendar quarters beginning on or after the date of
13 enactment of this Act, without regard to whether or
14 not final regulations to carry out such amendments
15 have been promulgated by such date.

16 (2) EXCEPTIONS.—The amendments made by
17 this section shall not apply—

18 (A) to medical assistance provided for serv-
19 ices furnished before the date of enactment;

20 (B) with respect to assets disposed of on
21 or before the date of enactment of this Act; or

22 (C) with respect to trusts established on or
23 before the date of enactment of this Act.

24 (3) EXTENSION OF EFFECTIVE DATE FOR
25 STATE LAW AMENDMENT.—In the case of a State

1 plan under title XIX of the Social Security Act (42
2 U.S.C. 1396 et seq.) which the Secretary of Health
3 and Human Services determines requires State legis-
4 lation in order for the plan to meet the additional
5 requirements imposed by the amendments made by
6 a provision of this section, the State plan shall not
7 be regarded as failing to comply with the require-
8 ments of such title solely on the basis of its failure
9 to meet these additional requirements before the
10 first day of the first calendar quarter beginning
11 after the close of the first regular session of the
12 State legislature that begins after the date of the en-
13 actment of this Act. For purposes of the previous
14 sentence, in the case of a State that has a 2-year
15 legislative session, each year of the session is consid-
16 ered to be a separate regular session of the State
17 legislature.

18 **SEC. 6012. STATE LONG-TERM CARE PARTNERSHIPS.**

19 (a) EXPANSION OF STATE LONG-TERM CARE PART-
20 NERSHIPS.—

21 (1) IN GENERAL.—Section 1917(b)(1)(C)(ii)
22 (42 U.S.C. 1396p(b)(1)(C)(ii)) is amended to read
23 as follows:

24 “(ii) Clause (i) shall not apply in the case of an
25 individual who received medical assistance under—

1 “(I) a Qualified State Long-Term Care In-
2 surance Partnership (as defined in paragraph
3 (5)); or

4 “(II) under a State plan of a State
5 which—

6 “(aa) had a State plan amendment
7 approved as of May 14, 1993, which pro-
8 vided for the disregard of any assets or re-
9 sources to the extent that payments are
10 made under a long-term care insurance
11 policy or because an individual has received
12 (or is entitled to receive) benefits under a
13 long-term care insurance policy; and

14 “(bb) has a State plan amendment
15 which satisfies the requirements of sub-
16 paragraphs (B) through (G) of paragraph
17 (5) in the case of any long-term care insur-
18 ance policy sold under such plan amend-
19 ment on or after the date that is 2 years
20 after the date of enactment of such para-
21 graph.

22 For purposes of this clause and paragraphs (5) and
23 (6), the term ‘long-term care insurance policy’ in-
24 cludes a certificate issued under a group insurance
25 contract.”.

1 (2) SATISFACTION OF MINIMUM FEDERAL
2 STANDARDS, TAX QUALIFICATIONS, INFLATION PRO-
3 TECTION, AND OTHER REQUIREMENTS FOR LONG-
4 TERM CARE INSURANCE PARTNERSHIPS.—Section
5 1917(b) (42 U.S.C. 1396p(b)) is amended by insert-
6 ing at the end the following:

7 “(5) The term ‘Qualified State Long-Term
8 Care Insurance Partnership’ means a program of-
9 fered in a State with an approved State plan amend-
10 ment that provides for the following:

11 “(A) Subject to the limit specified in sub-
12 paragraph (D), the disregard of any assets or
13 resources in an amount equal to the amount of
14 payments made to, or on behalf of, an indi-
15 vidual who is a beneficiary under any long-term
16 care insurance policy sold under such plan
17 amendment.

18 “(B) A requirement that the State will
19 treat benefits paid under any long-term care in-
20 surance policy sold under a plan amendment of
21 another State that maintains a Qualified Long-
22 Term Care Insurance Partnership or is de-
23 scribed in subsection (b)(1)(C)(ii)(II) the same
24 as the State treats benefits paid under such a
25 policy sold under the State’s plan amendment.

1 “(C) A requirement that any long-term
2 care insurance policy sold under such plan
3 amendment—

4 “(i) be a qualified long-term care in-
5 surance contract within the meaning of
6 section 7702B(b) of the Internal Revenue
7 Code of 1986; and

8 “(ii) meet the requirements described
9 in paragraph (6).

10 “(D) A requirement that any such policy
11 sold under the State plan amendment shall pro-
12 vide for—

13 “(i) compound annual inflation pro-
14 tection of at least 5 percent; and

15 “(ii) asset protection that does not ex-
16 ceed \$250,000.

17 The dollar amount specified in the preceding
18 sentence shall be increased, beginning with
19 2007, from year to year based on the percent-
20 age increase in the medical care expenditure
21 category of the Consumer Price Index for All
22 Urban Consumers (United States city average),
23 published by the Bureau of Labor Statistics,
24 rounded to the nearest \$100.

1 “(E) A requirement that an insurer may
2 rescind a long-term care insurance policy sold
3 under such State plan amendment that has
4 been in effect for at least 2 years or deny an
5 otherwise valid long-term care insurance claim
6 under such a policy only upon a showing of mis-
7 representation that is material to the accept-
8 ance of coverage, pertains to the claim made,
9 and could not have been known by the insurer
10 at the time the policy was sold.

11 “(F) A requirement that any individual
12 who sells such a policy receive training, and
13 demonstrate evidence of an understanding of,
14 the policy and how the policy relates to other
15 public and private coverage of long-term care.

16 “(G) A requirement that the issuer of any
17 such policy report—

18 “(i) to the Secretary, such informa-
19 tion or data as the Secretary may require;
20 and

21 “(ii) to the State, the information or
22 data reported to the Secretary (if any), the
23 information or data required under the
24 minimum reporting requirements developed
25 under section 6012(b)(2)(B) of the Deficit

1 Reduction Omnibus Reconciliation Act of
2 2005, and such additional information or
3 data as the State may require.

4 For purposes of applying this paragraph, if a long-
5 term care insurance policy is exchanged for another
6 such policy, the date coverage became effective
7 under the first policy shall determine when coverage
8 first becomes effective.

9 “(6)(A) For purposes of subparagraph (C)(ii)
10 of paragraph (5), the requirements of this paragraph
11 are met if a long-term care insurance policy sold
12 under a plan amendment described in that para-
13 graph meets—

14 “(i) MODEL REGULATION.—The following
15 requirements of the model regulation:

16 “(I) Section 6A (relating to guaran-
17 teed renewal or noncancellability), other
18 than paragraph (5) thereof, and the re-
19 quirements of section 6B of the model Act
20 relating to such section 6A.

21 “(II) Section 6B (relating to prohibi-
22 tions on limitations and exclusions) other
23 than paragraph (7) thereof.

24 “(III) Section 6C (relating to exten-
25 sion of benefits).

1 “(IV) Section 6D (relating to continu-
2 ation or conversion of coverage).

3 “(V) Section 6E (relating to dis-
4 continuance and replacement of policies).

5 “(VI) Section 7 (relating to uninten-
6 tional lapse).

7 “(VII) Section 8 (relating to disclo-
8 sure), other than sections 8F, 8G, 8H, and
9 8I thereof.

10 “(VIII) Section 9 (relating to required
11 disclosure of rating practices to consumer).

12 “(IX) Section 11 (relating to prohibi-
13 tions against post-claims underwriting).

14 “(X) Section 12 (relating to minimum
15 standards).

16 “(XI) Section 14 (relating to applica-
17 tion forms and replacement coverage).

18 “(XII) Section 15 (relating to report-
19 ing requirements).

20 “(XIII) Section 22 (relating to filing
21 requirements for marketing).

22 “(XIV) Section 23 (relating to stand-
23 ards for marketing), including inaccurate
24 completion of medical histories, other than

1 paragraphs (1), (6), and (9) of section
2 23C.

3 “(XV) Section 25 (relating to prohibi-
4 tion against preexisting conditions and
5 probationary periods in replacement poli-
6 cies or certificates).

7 “(XVI) The provisions of section 26
8 relating to contingent nonforfeiture bene-
9 fits, if the policyholder declines the offer of
10 a nonforfeiture provision described in para-
11 graph (4).

12 “(XVII) Section 29 (relating to stand-
13 ard format outline of coverage).

14 “(XVIII) Section 30 (relating to re-
15 quirement to deliver shopper’s guide).

16 “(ii) MODEL ACT.—The following require-
17 ments of the model Act:

18 “(I) Section 6C (relating to pre-
19 existing conditions).

20 “(II) Section 6D (relating to prior
21 hospitalization).

22 “(III) The provisions of section 8 re-
23 lating to contingent nonforfeiture benefits.

24 “(IV) Section 6F (relating to right to
25 return).

1 “(V) Section 6G (relating to outline of
2 coverage).

3 “(VI) Section 6H (relating to require-
4 ments for certificates under group plans).

5 “(VII) Section 6J (relating to policy
6 summary).

7 “(VIII) Section 6K (relating to
8 monthly reports on accelerated death bene-
9 fits).

10 “(B) DEFINITIONS.—For purposes of this
11 paragraph—

12 “(i) MODEL PROVISIONS.—The terms
13 ‘model regulation’ and ‘model Act’ mean the
14 long-term care insurance model regulation, and
15 the long-term care insurance model Act, respec-
16 tively, promulgated by the National Association
17 of Insurance Commissioners (as adopted as of
18 October 2000).

19 “(ii) COORDINATION.—Any provision of
20 the model regulation or model Act listed under
21 clause (i) or (ii) of subparagraph (A) shall be
22 treated as including any other provision of such
23 regulation or Act necessary to implement the
24 provision.

1 “(iii) DETERMINATION.—For purposes of
2 this paragraph, the determination of whether
3 any requirement of a model regulation or the
4 model Act has been met shall be made by the
5 Secretary.”.

6 (3) EFFECTIVE DATE.—The amendments made
7 by this subsection take effect on October 1, 2007,
8 and apply to long-term care insurance policies sold
9 on or after that date.

10 (b) DEVELOPMENT OF UNIFORM STANDARDS AND
11 RECOMMENDATIONS.—

12 (1) IN GENERAL.—Not later than 1 year after
13 the date of enactment of this Act, the Secretary, in
14 consultation with the National Association of Insur-
15 ance Commissioners, issuers of long-term care insur-
16 ance policies, States with experience with long-term
17 care insurance partnership plans, other States, and
18 representatives of consumers of long-term care in-
19 surance policies shall develop the uniform standards
20 described in paragraph (2) and submit recommenda-
21 tions to Congress with respect to the issues identi-
22 fied in paragraph (3).

23 (2) UNIFORM STANDARDS.—The uniform
24 standards described in this paragraph are the fol-
25 lowing:

1 (A) RECIPROCITY.—Standards for ensur-
2 ing that long-term care insurance policies
3 issued under a State long-term care insurance
4 partnership under section 1917(b)(1)(C)(ii) of
5 the Social Security Act (42 U.S.C.
6 1396p(b)(1)(C)(ii)) (as amended by subsection
7 (a)) are portable to other States with such a
8 partnership.

9 (B) MINIMUM REPORTING REQUIRE-
10 MENTS.—Standards for minimum reporting re-
11 quirements for issuers of long-term care insur-
12 ance policies under such State long-term care
13 insurance partnerships that shall specify the
14 data and information that each such issuer
15 shall report to the State with which it has such
16 a partnership. The requirements developed in
17 accordance with this subparagraph shall specify
18 the type and format of the data and informa-
19 tion to be reported and the frequency with
20 which such reports are to be made.

21 (C) SUITABILITY.—Suitability standards
22 for determining whether a long-term care insur-
23 ance policy is appropriate for the needs of an
24 applicant, based on guidance of the National

1 Association of Insurance Commissioners regard-
2 ing suitability.

3 (3) RECOMMENDATIONS.—The recommenda-
4 tions described in this paragraph are the following:

5 (A) INCONTESTABILITY.—Recommendations
6 regarding whether the requirements relating
7 to incontestability for long-term care insurance
8 policies sold under a State long-term care
9 insurance partnership program under section
10 1917(b)(1)(C)(ii) of the Social Security Act
11 should be modified based on guidance of the
12 National Association of Insurance Commis-
13 sioners regarding incontestability.

14 (B) NONFORFEITURE.—Recommendations
15 regarding whether requirements relating to non-
16 forfeiture for issuers of long-term care insurance
17 policies under a State long-term care in-
18 surance partnership program under section
19 1917(b)(1)(C)(ii) of such Act should be modi-
20 fied to reflect changes in an insured's financial
21 circumstances.

22 (C) INDEPENDENT CERTIFICATION FOR
23 BENEFITS ASSESSMENT.—Recommendations re-
24 garding whether uniform standards for requir-
25 ing benefits assessment evaluations to be con-

1 ducted by independent entities should be estab-
2 lished for issuers of long-term care insurance
3 policies under such a State partnership pro-
4 gram and, if so, what such standards should be.

5 (D) RATING REQUIREMENTS.—Rec-
6 ommendations regarding whether uniform
7 standards for the establishment of, and annual
8 increases in, premiums for long-term care in-
9 surance policies sold under such a State part-
10 nership program should be established and, if
11 so, what such standards should be.

12 (E) DISPUTE RESOLUTION.—Rec-
13 ommendations regarding whether uniform
14 standards are needed to ensure fair adjudica-
15 tion of coverage disputes under long-term care
16 insurance policies sold under such a State part-
17 nership program and the delivery of the benefits
18 promised under such policies.

19 (4) STATE REPORTING REQUIREMENTS.—Noth-
20 ing in paragraph (2)(B) shall be construed as pro-
21 hibiting a State from requiring an issuer of a long-
22 term care insurance policy sold in the State (regard-
23 less of whether the policy is issued under a State
24 long-term care insurance partnership under section
25 1917(b)(1)(C)(ii) of the Social Security Act) to re-

1 quire the issuer to report information or data to the
2 State that is in addition to the information or data
3 required under the minimum reporting requirements
4 developed under that paragraph.

5 (c) ANNUAL REPORTS TO CONGRESS.—The Sec-
6 retary of Health and Human Services shall annually re-
7 port to Congress on the long-term care insurance partner-
8 ships established in accordance with section
9 1917(b)(1)(C)(ii) of the Social Security Act (42 U.S.C.
10 1396p(b)(1)(C)(ii)) (as amended by subsection (a)(1)).
11 Such reports shall include analyses of the extent to which
12 such partnerships expand or limit access of individuals to
13 long-term care and the impact of such partnerships on
14 Federal and State expenditures under the Medicare and
15 Medicaid programs.

16 **CHAPTER 3—ELIMINATING FRAUD,**
17 **WASTE, AND ABUSE IN MEDICAID**

18 **SEC. 6021. ENHANCING THIRD PARTY RECOVERY.**

19 (a) CLARIFICATION OF RIGHT OF RECOVERY
20 AGAINST ANY THIRD PARTY LEGALLY RESPONSIBLE FOR
21 PAYMENT OF A CLAIM FOR A HEALTH CARE ITEM OR
22 SERVICE.—Section 1902(a)(25) (42 U.S.C. 1396a(a)(25))
23 is amended—

24 (1) in subparagraph (A), in the matter pre-
25 ceding clause (i)—

1 (A) by inserting “, including self-insured
2 plans” after “health insurers”; and

3 (B) by striking “and health maintenance
4 organizations” and inserting “health mainte-
5 nance organizations, pharmacy benefit man-
6 agers, or other parties that are, by statute, con-
7 tract, or agreement, legally responsible for pay-
8 ment of a claim for a health care item or serv-
9 ice”; and

10 (2) in subparagraph (G)—

11 (A) by inserting “a self-insured plan,”
12 after “1974,”; and

13 (B) by striking “and a health maintenance
14 organization” and inserting “a health mainte-
15 nance organization, a pharmacy benefit man-
16 ager, or other party that is, by statute, con-
17 tract, or agreement, legally responsible for pay-
18 ment of a claim for a health care item or serv-
19 ice”.

20 (b) REQUIREMENT FOR THIRD PARTIES TO PROVIDE
21 THE STATE WITH COVERAGE ELIGIBILITY AND CLAIMS
22 DATA.—Section 1902(a)(25) (42 U.S.C. 1396a(a)(25)) is
23 amended—

24 (1) in subparagraph (G), by striking “and” at
25 the end;

1 (2) in subparagraph (H), by adding “and” after
2 the semicolon at the end; and

3 (3) by inserting after subparagraph (H), the
4 following:

5 “(I) that the State shall provide assur-
6 ances satisfactory to the Secretary that the
7 State has in effect laws requiring health insur-
8 ers, including self-insured plans, group health
9 plans (as defined in section 607(1) of the Em-
10 ployee Retirement Income Security Act of
11 1974), service benefit plans, health maintenance
12 organizations, pharmacy benefit managers, or
13 other parties that are, by statute, contract, or
14 agreement, legally responsible for payment of a
15 claim for a health care item or service, as a
16 condition of doing business in the State, to—

17 “(i) provide eligibility and claims pay-
18 ment data with respect to an individual
19 who is eligible for, or is provided, medical
20 assistance under the State plan, upon the
21 request of the State;

22 “(ii) accept the subrogation of the
23 State to any right of an individual or other
24 entity to payment from the party for an

1 item or service for which payment has been
2 made under the State plan;

3 “(iii) respond to any inquiry by the
4 State regarding a claim for payment for
5 any health care item or service submitted
6 not later than 3 years after the date of the
7 provision of such health care item or serv-
8 ice; and

9 “(iv) agree not to deny a claim sub-
10 mitted by the State solely on the basis of
11 the date of submission of the claim;”.

12 (c) EFFECTIVE DATE.—Except as provided in section
13 6026(e), the amendments made by this section take effect
14 on January 1, 2006.

15 **SEC. 6022. LIMITATION ON USE OF CONTINGENCY FEE AR-**
16 **RANGEMENTS.**

17 (a) IN GENERAL.—Section 1903(i) (42 U.S.C.
18 1396b(i)), as amended by section 104(b) of the QI, TMA,
19 and Abstinence Programs Extension and Hurricane
20 Katrina Unemployment Relief Act of 2005 (Public Law
21 109–91), is amended—

22 (1) in paragraph (19), by adding “or” at the
23 end;

24 (2) by striking the period at the end of para-
25 graph (21) and inserting “; or”; and

1 (3) by inserting after paragraph (21), the fol-
2 lowing:

3 “(22) with respect to any amount expended in
4 connection with a contract or agreement (other than
5 a risk contract under section 1903(m)) between the
6 State agency under section 1902(a)(5) (or any State
7 or local agency designated by such agency to admin-
8 ister any portion of the State plan under this title)
9 and a consultant or other contractor if the terms of
10 compensation for the consultant or other contractor
11 do not meet the standards established by the Inspec-
12 tor General of the Department of Health and
13 Human Services under section 6022(b) of the Def-
14 icit Reduction Omnibus Reconciliation Act of
15 2005.”.

16 (b) CONTINGENCY FEE ARRANGEMENT STAND-
17 ARDS.—Not later than 6 months after the date of enact-
18 ment of this Act, the Inspector General of the Department
19 of Health and Human Services shall issue standards for
20 the terms of compensation of consultants and other indi-
21 viduals or entities contracting with State agencies (or their
22 designees) administering State Medicaid plans under title
23 XIX of the Social Security Act that ensure prudent pur-
24 chasing and program integrity with respect to Federal
25 funds. The Inspector General shall annually review and,

1 as necessary, revise such standards to promptly address
2 new compensation arrangements that may present a risk
3 to program integrity under such title.

4 (c) EFFECTIVE DATE.—Except as provided in section
5 6026(e), the amendments made by subsection (a) take ef-
6 fect on January 1, 2007.

7 **SEC. 6023. ENCOURAGING THE ENACTMENT OF STATE**
8 **FALSE CLAIMS ACTS.**

9 (a) IN GENERAL.—Title XIX (42 U.S.C. 1396 et
10 seq.) is amended by inserting after section 1908A the fol-
11 lowing:

12 “STATE FALSE CLAIMS ACT REQUIREMENTS FOR
13 INCREASED STATE SHARE OF RECOVERIES

14 “SEC. 1909. (a) IN GENERAL.—Notwithstanding sec-
15 tion 1905(b), if a State has in effect a law relating to
16 false or fraudulent claims that meets the requirements of
17 subsection (b), the Federal medical assistance percentage
18 with respect to any amounts recovered under a State ac-
19 tion brought under such law, shall be decreased by 10 per-
20 centage points.

21 “(b) REQUIREMENTS.—For purposes of subsection
22 (a), the requirements of this subsection are that the In-
23 spector General of the Department of Health and Human
24 Services, in consultation with the Attorney General, deter-
25 mines that the State has in effect a law that meets the
26 following requirements:

1 “(1) The law establishes liability to the State
2 for false or fraudulent claims described in section
3 3729 of title 31, United States Code, with respect
4 to any expenditure described in section 1903(a).

5 “(2) The law contains provisions that are at
6 least as effective in rewarding and facilitating qui
7 tam actions for false or fraudulent claims as those
8 described in sections 3730 through 3732 of title 31,
9 United States Code.

10 “(3) The law contains a requirement for filing
11 an action under seal for 60 days with review by the
12 State Attorney General.

13 “(4) The law contains a civil penalty that is not
14 less than the amount of the civil penalty authorized
15 under section 3729 of title 31, United States Code.

16 “(5) The law contains provisions that are de-
17 signed to prevent a windfall recovery for a qui tam
18 relator in the event that the relator files a Federal
19 and State action for the same false or fraudulent
20 claim.

21 “(c) DEEMED COMPLIANCE.—A State that, as of
22 January 1, 2007, has a law in effect that meets the re-
23 quirements of subsection (b) shall be deemed to be in com-
24 pliance with such requirements for so long as the law con-
25 tinues to meet such requirements.

1 “(d) NO PRECLUSION OF BROADER LAWS.—Nothing
2 in this section shall be construed as prohibiting a State
3 that has in effect a law that establishes liability to the
4 State for false or fraudulent claims described in section
5 3729 of title 31, United States Code, with respect to pro-
6 grams in addition to the State program under this title,
7 or with respect to expenditures in addition to expenditures
8 described in section 1903(a), from being considered to be
9 in compliance with the requirements of subsection (a) so
10 long as the law meets such requirements.”.

11 (b) EFFECTIVE DATE.—Except as provided in sec-
12 tion 6026(e), the amendments made by this section take
13 effect on January 1, 2007.

14 **SEC. 6024. EMPLOYEE EDUCATION ABOUT FALSE CLAIMS**
15 **RECOVERY.**

16 (a) IN GENERAL.—Section 1902(a) (42 U.S.C.
17 1396a(a)) is amended—

18 (1) in paragraph (66), by striking “and” at the
19 end;

20 (2) in paragraph (67) by striking the period at
21 the end and inserting “; and”; and

22 (3) by inserting after paragraph (67) the fol-
23 lowing:

24 “(68) provide that any entity that receives or
25 makes annual payments under the State plan of at

1 least \$1,000,000, as a condition of receiving such
2 payments, shall—

3 “(A) establish written policies, procedures,
4 and protocols for training of all employees of
5 the entity (including management), and of any
6 contractor or agent of the entity, that includes
7 a detailed discussion of the False Claims Act
8 established under sections 3729 through 3733
9 of title 31, United States Code, administrative
10 remedies for false claims and statements estab-
11 lished under chapter 38 of title 31, United
12 States Code, any State laws pertaining to civil
13 or criminal penalties for false claims and state-
14 ments, and whistleblower protections under
15 such laws, with respect to the role of such laws
16 in preventing and detecting fraud, waste, and
17 abuse in Federal health care programs (as de-
18 fined in section 1128B(f));

19 “(B) include as part of such written poli-
20 cies, procedures, and protocols, detailed provi-
21 sions and training regarding the entity’s poli-
22 cies and procedures for detecting and pre-
23 venting fraud, waste, and abuse;

24 “(C) include in any employee handbook for
25 the entity, a specific discussion of the laws de-

1 “(E) with respect to any amount expended for
2 reimbursement to a pharmacy under this title for
3 the ingredient cost of a covered outpatient drug for
4 which the pharmacy has already received payment
5 under this title (other than with respect to a reason-
6 able restocking fee for such drug); or”.

7 (b) **EFFECTIVE DATE.**—The amendments made by
8 subsection (a) take effect on the first day of the first fiscal
9 year quarter that begins after the date of enactment of
10 this Act.

11 **SEC. 6026. MEDICAID INTEGRITY PROGRAM.**

12 (a) **ESTABLISHMENT OF MEDICAID INTEGRITY PRO-**
13 **GRAM; MEDICAID CFO; MEDICAID PROGRAM INTEGRITY**
14 **OVERSIGHT BOARD.**—Title XIX (42 U.S.C. 1396 et seq.)
15 is amended—

16 (1) by redesignating section 1936 as section
17 1938; and

18 (2) by inserting after section 1935 the fol-
19 lowing:

20 “MEDICAID INTEGRITY PROGRAM

21 “SEC. 1936. (a) **IN GENERAL.**—There is hereby es-
22 tablished the Medicaid Integrity Program (in this section
23 referred to as the ‘Program’) under which the Secretary
24 shall promote the integrity of the program under this title
25 by entering into contracts in accordance with this section

1 with eligible entities to carry out the activities described
2 in subsection (b).

3 “(b) ACTIVITIES DESCRIBED.—The activities de-
4 scribed in this subsection are as follows:

5 “(1) Review of the actions of individuals or en-
6 tities furnishing items or services (whether on a fee-
7 for-service, risk, or other basis) for which payment
8 may be made under a State plan approved under
9 this title (or under any waiver of such plan approved
10 under section 1115) to determine whether fraud,
11 waste, or abuse has occurred, is likely to occur, or
12 whether such actions have any potential for resulting
13 in an expenditure of funds under this title in a man-
14 ner which is not intended under the provisions of
15 this title.

16 “(2) Audit of claims for payment for items or
17 services furnished, or administrative services ren-
18 dered, under a State plan under this title,
19 including—

20 “(A) cost reports;

21 “(B) consulting contracts; and

22 “(C) risk contracts under section 1903(m).

23 “(3) Identification and recovery of overpay-
24 ments to individuals or entities receiving Federal
25 funds under this title.

1 “(4) Education of providers of services, man-
2 aged care entities, beneficiaries, and other individ-
3 uals with respect to payment integrity and benefit
4 quality assurance issues.

5 “(c) ELIGIBLE ENTITY AND CONTRACTING REQUIRE-
6 MENTS.—

7 “(1) IN GENERAL.—An entity is eligible to
8 enter into a contract under the Program to carry
9 out any of the activities described in subsection (b)
10 if the entity satisfies the requirements of paragraphs
11 (2) and (3).

12 “(2) ELIGIBILITY REQUIREMENTS.—The re-
13 quirements of this paragraph are the following:

14 “(A) The entity has demonstrated capa-
15 bility to carry out the activities described in
16 subsection (b).

17 “(B) In carrying out such activities, the
18 entity agrees to cooperate with the Inspector
19 General of the Department of Health and
20 Human Services, the Attorney General, and
21 other law enforcement agencies, as appropriate,
22 in the investigation and deterrence of fraud and
23 abuse in relation to this title and in other cases
24 arising out of such activities.

1 “(C) The entity complies with such conflict
2 of interest standards as are generally applicable
3 to Federal acquisition and procurement.

4 “(D) The entity meets such other require-
5 ments as the Secretary may impose.

6 “(3) CONTRACTING REQUIREMENTS.—The enti-
7 ty has contracted with the Secretary in accordance
8 with such procedures as the Secretary shall by regu-
9 lation establish, except that such procedures shall in-
10 clude the following:

11 “(A) Procedures for identifying, evalu-
12 ating, and resolving organizational conflicts of
13 interest that are generally applicable to Federal
14 acquisition and procurement.

15 “(B) Competitive procedures to be used—
16 “(i) when entering into new contracts
17 under this section;

18 “(ii) when entering into contracts that
19 may result in the elimination of respon-
20 sibilities under section 202(b) of the
21 Health Insurance Portability and Account-
22 ability Act of 1996; and

23 “(iii) at any other time considered ap-
24 propriate by the Secretary.

1 “(C) Procedures under which a contract
2 under this section may be renewed without re-
3 gard to any provision of law requiring competi-
4 tion if the contractor has met or exceeded the
5 performance requirements established in the
6 current contract.

7 The Secretary may enter into such contracts without
8 regard to final rules having been promulgated.

9 “(4) LIMITATION ON CONTRACTOR LIABIL-
10 ITY.—The Secretary shall by regulation provide for
11 the limitation of a contractor’s liability for actions
12 taken to carry out a contract under the Program,
13 and such regulation shall, to the extent the Sec-
14 retary finds appropriate, employ the same or com-
15 parable standards and other substantive and proce-
16 dural provisions as are contained in section 1157.

17 “(d) COMPREHENSIVE PLAN FOR PROGRAM INTEG-
18 RITY.—

19 “(1) 5-YEAR PLAN.—With respect to the 5 fis-
20 cal year period beginning with fiscal year 2006, and
21 each such 5-fiscal year period that begins thereafter,
22 the Secretary shall establish a comprehensive plan
23 for ensuring the integrity of the program established
24 under this title by combatting fraud, waste, and
25 abuse.

1 “(2) CONSULTATION.—Each 5-fiscal year plan
2 established under paragraph (1) shall be developed
3 by the Secretary in consultation with the Attorney
4 General, the Director of the Federal Bureau of In-
5 vestigation, the Comptroller General of the United
6 States, the Inspector General of the Department of
7 Health and Human Services, and State officials with
8 responsibility for controlling provider fraud and
9 abuse under State plans under this title.

10 “(e) APPROPRIATION.—

11 “(1) IN GENERAL.—Out of any money in the
12 Treasury of the United States not otherwise appro-
13 priated, there are appropriated to carry out the
14 Medicaid Integrity Program under this section, with-
15 out further appropriation—

16 “(A) for each of fiscal years 2006 through
17 2008, \$50,000,000; and

18 “(B) for each fiscal year after fiscal year
19 2008, \$75,000,000.

20 “(2) AVAILABILITY.—Amounts appropriated
21 pursuant to paragraph (1) shall remain available
22 until expended.

23 “(3) ANNUAL REPORT.—Not later than 180
24 days after the end of each fiscal year (beginning

1 with fiscal year 2006), the Secretary shall submit a
2 report to Congress which identifies—

3 “(A) the use of funds appropriated pursu-
4 ant to paragraph (1); and

5 “(B) the effectiveness of the use of such
6 funds.”.

7 “MEDICAID CHIEF FINANCIAL OFFICER; MEDICAID
8 PROGRAM INTEGRITY OVERSIGHT BOARD

9 “SEC. 1937. (a) ESTABLISHMENT OF MEDICAID
10 CFO.—

11 “(1) IN GENERAL.—There is established in the
12 Centers for Medicare & Medicaid Services within the
13 Office of Financial Management the position of
14 Medicaid Chief Financial Officer. The Medicaid
15 Chief Financial Officer shall be appointed by, and
16 report directly to, the Administrator of such Cen-
17 ters. The Medicaid Chief Financial Officer may be
18 removed only for cause.

19 “(2) DUTIES AND AUTHORITY.—The duties
20 and authority of the Medicaid Chief Financial Offi-
21 cer with respect to the management and expenditure
22 of Federal funds under this title shall be comparable
23 to the duties and authority of other Chief Financial
24 Officers with respect to the management and ex-
25 penditure of Federal funds under Federal health
26 care programs (as defined in section 1128B(f)).

1 “(b) PROGRAM INTEGRITY OVERSIGHT BOARD.—
2 The Secretary shall establish a Medicaid Program Integ-
3 rity Oversight Board. The duties and authority of the
4 Medicaid Program Integrity Oversight Board shall be
5 comparable to the duties and authority of other oversight
6 boards established for purposes of Federal health care pro-
7 grams (as so defined) and shall include responsibility for
8 identifying vulnerabilities in the State programs estab-
9 lished under this title and developing strategies for mini-
10 mizing integrity risks to such programs.”.

11 (b) STATE REQUIREMENT TO COOPERATE WITH IN-
12 TEGRITY PROGRAM EFFORTS.—Section 1902(a) (42
13 U.S.C. 1396a(a)), as amended by section 6024(a), is
14 amended—

15 (1) in paragraph (67), by striking “and” at the
16 end;

17 (2) in paragraph (68), by striking the period at
18 the end and inserting “; and”; and

19 (3) by inserting after paragraph (68), the fol-
20 lowing:

21 “(69) provide that the State must comply with
22 any requirements determined by the Secretary to be
23 necessary for carrying out the Medicaid Integrity
24 Program established under section 1936, or the du-
25 ties of the Medicaid Chief Financial Officer and the

1 Medicaid Program Integrity Oversight Board estab-
2 lished under section 1937.”.

3 (c) INCREASED FUNDING FOR MEDICAID FRAUD AND
4 ABUSE CONTROL ACTIVITIES.—

5 (1) IN GENERAL.—Out of any money in the
6 Treasury of the United States not otherwise appro-
7 priated, there are appropriated to the Office of the
8 Inspector General of the Department of Health and
9 Human Services, without further appropriation,
10 \$25,000,000 for each of fiscal years 2006 through
11 2010, for activities of such Office with respect to the
12 Medicaid program under title XIX of the Social Se-
13 curity Act (42 U.S.C. 1396 et seq.).

14 (2) AVAILABILITY; AMOUNTS IN ADDITION TO
15 OTHER AMOUNTS APPROPRIATED FOR SUCH ACTIVI-
16 TIES.—Amounts appropriated pursuant to para-
17 graph (1) shall—

18 (A) remain available until expended; and

19 (B) be in addition to any other amounts
20 appropriated or made available to the Office of
21 the Inspector General of the Department of
22 Health and Human Services for activities of
23 such Office with respect to the Medicaid pro-
24 gram.

1 (3) ANNUAL REPORT.—Not later than 180 days
2 after the end of each fiscal year (beginning with fis-
3 cal year 2006), the Inspector General of the Depart-
4 ment of Health and Human Services shall submit a
5 report to Congress which identifies—

6 (A) the use of funds appropriated pursuant
7 to paragraph (1); and

8 (B) the effectiveness of the use of such
9 funds.

10 (d) INCREASE IN CMS STAFFING DEVOTED TO EN-
11 SURING MEDICAID PROGRAM INTEGRITY.—The Secretary
12 shall significantly increase the number of full-time equiva-
13 lent employees whose duties consist solely of ensuring the
14 integrity of the Medicaid program established under title
15 XIX of the Social Security Act by providing effective sup-
16 port and assistance to States to combat provider fraud
17 and abuse.

18 (e) DELAYED EFFECTIVE DATE FOR CHAPTER.—in
19 the case of a State plan under title XIX of the Social Se-
20 curity Act which the Secretary determines requires State
21 legislation in order for the plan to meet the additional re-
22 quirements imposed by the amendments made by a provi-
23 sion of this chapter, the State plan shall not be regarded
24 as failing to comply with the requirements of such Act
25 solely on the basis of its failure to meet these additional

1 requirements before the first day of the first calendar
2 quarter beginning after the close of the first regular ses-
3 sion of the State legislature that begins after the date of
4 enactment of this Act. For purposes of the previous sen-
5 tence, in the case of a State that has a 2-year legislative
6 session, each year of the session shall be considered to be
7 a separate regular session of the State legislature.

8 **CHAPTER 4—STATE FINANCING UNDER**
9 **MEDICAID**

10 **SEC. 6031. REFORMS OF TARGETED CASE MANAGEMENT.**

11 (a) IN GENERAL.—Section 1915(g) (42 U.S.C.
12 1396n(g)(2)) is amended by striking paragraph (2) and
13 inserting the following:

14 “(2) For purposes of this subsection:

15 “(A)(i) The term ‘case management services’
16 means services which will assist individuals eligible
17 under the plan in gaining access to needed medical,
18 social, educational, and other services.

19 “(ii) Such term includes the following:

20 “(I) Assessment of an eligible individual to
21 determine service needs, including activities
22 that focus on needs identification, to determine
23 the need for any medical, educational, social, or
24 other services. Such assessment activities in-
25 clude the following:

1 “(aa) Taking client history.

2 “(bb) Identifying the needs of the in-
3 dividual, and completing related docu-
4 mentation.

5 “(cc) Gathering information from
6 other sources such as family members,
7 medical providers, social workers, and edu-
8 cators, if necessary, to form a complete as-
9 sessment of the eligible individual.

10 “(II) Development of a specific care plan
11 based on the information collected through an
12 assessment, that specifies the goals and actions
13 to address the medical, social, educational, and
14 other services needed by the eligible individual,
15 including activities such as ensuring the active
16 participation of the eligible individual and work-
17 ing with the individual (or the individual’s au-
18 thorized health care decision maker) and others
19 to develop such goals and identify a course of
20 action to respond to the assessed needs of the
21 eligible individual.

22 “(III) Referral and related activities to
23 help an individual obtain needed services, in-
24 cluding activities that help link eligible individ-
25 uals with medical, social, educational providers

1 or other programs and services that are capable
2 of providing needed services, such as making re-
3 ferrals to providers for needed services and
4 scheduling appointments for the individual.

5 “(IV) Monitoring and followup activities,
6 including activities and contacts that are nec-
7 essary to ensure the care plan is effectively im-
8 plemented and adequately addressing the needs
9 of the eligible individual, and which may be
10 with the individual, family members, providers,
11 or other entities and conducted as frequently as
12 necessary to help determine such matters as—

13 “(aa) whether services are being fur-
14 nished in accordance with an individual’s
15 care plan;

16 “(bb) whether the services in the care
17 plan are adequate; and

18 “(cc) whether there are changes in the
19 needs or status of the eligible individual,
20 and if so, making necessary adjustments in
21 the care plan and service arrangements
22 with providers.

23 “(iii) Such term does not include the direct de-
24 livery of an underlying medical, educational, social,
25 or other service to which an eligible individual has

1 been referred, including, with respect to the direct
2 delivery of foster care services, services such as (but
3 not limited to) the following:

4 “(I) Research gathering and completion of
5 documentation required by the foster care pro-
6 gram.

7 “(II) Assessing adoption placements.

8 “(III) Recruiting or interviewing potential
9 foster care parents.

10 “(IV) Serving legal papers.

11 “(V) Home investigations.

12 “(VI) Providing transportation.

13 “(VII) Administering foster care subsidies.

14 “(VIII) Making placement arrangements.

15 “(B) The term ‘targeted case management serv-
16 ices’ are case management services that are fur-
17 nished without regard to the requirements of section
18 1902(a)(1) and section 1902(a)(10)(B) to specific
19 classes of individuals or to individuals who reside in
20 specified areas.

21 “(3) With respect to contacts with individuals who
22 are not eligible for medical assistance under the State plan
23 or, in the case of targeted case management services, indi-
24 viduals who are eligible for such assistance but are not

1 part of the target population specified in the State plan,
2 such contacts—

3 “(A) are considered an allowable case manage-
4 ment activity, when the purpose of the contact is di-
5 rectly related to the management of the eligible indi-
6 vidual’s care; and

7 “(B) are not considered an allowable case man-
8 agement activity if such contacts relate directly to
9 the identification and management of the noneligible
10 or nontargeted individual’s needs and care.

11 “(4)(A) In accordance with section 1902(a)(25), Fed-
12 eral financial participation only is available under this title
13 for case management services or targeted case manage-
14 ment services if there are no other third parties liable to
15 pay for such services, including as reimbursement under
16 a medical, social, educational, or other program.

17 “(B) A State shall allocate the costs of any part of
18 such services which are reimbursable under another feder-
19 ally funded program in accordance with OMB Circular A-
20 87 (or any related or successor guidance or regulations
21 regarding allocation of costs among federally funded pro-
22 grams) under an approved cost allocation program.”.

23 (b) EFFECTIVE DATE.—The amendment made by
24 subsection (a) shall take effect on January 1, 2006.

1 **SEC. 6032. TEMPORARY FEDERAL MATCHING PAYMENTS**
2 **FOR FEDERAL ASSISTANCE.**

3 (a) 100 PERCENT FEDERAL MATCHING PAYMENTS
4 FOR MEDICAL ASSISTANCE PROVIDED TO SPECIFIED IN-
5 DIVIDUALS.—

6 (1) IN GENERAL.—Notwithstanding section
7 1905(b) of the Social Security Act (42 U.S.C.
8 1396d(b)), for items and services furnished during
9 the period that begins on August 28, 2005, and ends
10 on May 15, 2006, the Federal medical assistance
11 percentage for providing medical assistance for such
12 items and services under a State Medicaid plan to
13 a specified individual (as defined in subsection (b)),
14 and for costs directly attributable to all administra-
15 tive activities that relate to the provision of such
16 medical assistance, shall be 100 percent.

17 (2) APPLICATION TO CHILD HEALTH ASSIST-
18 ANCE.—Notwithstanding section 2105(b) of the So-
19 cial Security Act (42 U.S.C. 1397ee(b)), for items
20 and services furnished during the period described in
21 paragraph (1), the Federal matching rate for pro-
22 viding child health assistance for such items and
23 services under a State child health plan to a speci-
24 fied individual (as so defined), and for costs directly
25 attributable to all administrative activities that re-

1 late to the provision of such child health assistance,
2 shall be 100 percent.

3 (b) SPECIFIED INDIVIDUAL.—

4 (1) IN GENERAL.—For purposes of subsection
5 (a), the term “specified individual” means an indi-
6 vidual who, on any day during the week preceding
7 August 28, 2005, had a primary residence in a Lou-
8 isiana parish described in paragraph (2), a Mis-
9 sissippi county described in paragraph (3), or an
10 Alabama county described in paragraph (4).

11 (2) LOUISIANA PARISHES DESCRIBED.—For
12 purposes of paragraph (1), the Louisiana parishes
13 described in this paragraph are the following:

- 14 (A) Acadia.
- 15 (B) Ascension.
- 16 (C) Assumption.
- 17 (D) Calcasieu.
- 18 (E) Cameron.
- 19 (F) East Baton Rouge.
- 20 (G) East Feliciana.
- 21 (H) Iberia.
- 22 (I) Iberville.
- 23 (J) Jefferson.
- 24 (K) Jefferson Davis.
- 25 (L) Lafayette.

- 1 (M) Lafourche.
- 2 (N) Livingston.
- 3 (O) Orleans.
- 4 (P) Pointe Coupee.
- 5 (Q) Plaquemines.
- 6 (R) St. Bernard.
- 7 (S) St. Charles.
- 8 (T) St. Helena.
- 9 (U) St. James.
- 10 (V) St. John.
- 11 (W) St. Mary.
- 12 (X) St. Martin.
- 13 (Y) St. Tammany.
- 14 (Z) Tangipahoa.
- 15 (AA) Terrebonne.
- 16 (BB) Vermilion.
- 17 (CC) Washington.
- 18 (DD) West Baton Rouge.
- 19 (EE) West Feliciana.

20 (3) MISSISSIPPI COUNTIES DESCRIBED.—For
21 purposes of paragraph (1), the Mississippi counties
22 described in this paragraph are the following:

- 23 (A) Adams.
- 24 (B) Amite.
- 25 (C) Attala.

- 1 (D) Clairborne.
- 2 (E) Choctaw.
- 3 (F) Clarke.
- 4 (G) Copiah.
- 5 (H) Covington.
- 6 (I) Forrest.
- 7 (J) Franklin.
- 8 (K) George.
- 9 (L) Greene.
- 10 (M) Hancock.
- 11 (N) Harrison.
- 12 (O) Hinds.
- 13 (P) Jackson.
- 14 (Q) Jasper.
- 15 (R) Jefferson.
- 16 (S) Jefferson Davis.
- 17 (T) Jones.
- 18 (U) Kemper.
- 19 (V) Lamar.
- 20 (W) Lauderdale.
- 21 (X) Lawrence.
- 22 (Y) Leake.
- 23 (Z) Lincoln.
- 24 (AA) Lowndes.
- 25 (BB) Madison.

- 1 (CC) Marion.
- 2 (DD) Neshoba.
- 3 (EE) Newton.
- 4 (FF) Noxubee.
- 5 (GG) Oktibbeha.
- 6 (HH) Pearl River.
- 7 (II) Perry.
- 8 (JJ) Pike.
- 9 (KK) Rankin.
- 10 (LL) Scott.
- 11 (MM) Simpson.
- 12 (NN) Smith.
- 13 (OO) Stone.
- 14 (PP) Walthall.
- 15 (QQ) Warren.
- 16 (RR) Wayne.
- 17 (SS) Wilkinson.
- 18 (TT) Winston.
- 19 (UU) Yazoo.

20 (4) ALABAMA COUNTIES DESCRIBED.—For pur-
21 poses of paragraph (1) the Alabama counties de-
22 scribed in this paragraph are the following:

- 23 (A) Baldwin.
- 24 (B) Choctaw.
- 25 (C) Clarke.

- 1 (D) Greene.
2 (E) Hale.
3 (F) Marengo.
4 (G) Mobile.
5 (H) Pickens.
6 (I) Sumter.
7 (J) Tuscaloosa.
8 (K) Washington.

9 (c) FMAP ADJUSTMENT.—Notwithstanding the first
10 sentence of section 1905(b) of the Social Security Act (42
11 U.S.C. 1396d(b)), if, for purposes of titles XIX and XXI
12 of the Social Security Act (42 U.S.C. 1396 et seq., 1397aa
13 et seq.), the Federal medical assistance percentage deter-
14 mined for Alaska for fiscal year 2006 or fiscal year 2007
15 is less than the Federal medical assistance percentage de-
16 termined for Alaska for fiscal year 2005, the Federal med-
17 ical assistance percentage determined for Alaska for fiscal
18 year 2005 shall be substituted for the Federal medical as-
19 sistance percentage otherwise determined for Alaska for
20 fiscal year 2006 or fiscal year 2007, as the case may be.

21 **SEC. 6033. MANAGED CARE ORGANIZATION PROVIDER TAX**

22 **REFORM.**

23 (a) IN GENERAL.—Section 1903(w)(7)(A)(viii) (42
24 U.S.C. 1396b(w)(7)(A)(viii)) is amended to read as fol-
25 lows:

1 “(viii) Services of managed care organiza-
2 tions (including health maintenance organiza-
3 tions, preferred provider organizations, and
4 such other similar organizations as the Sec-
5 retary may specify by regulation).”.

6 (b) EFFECTIVE DATE.—

7 (1) IN GENERAL.—Except as provided in para-
8 graph (2), the amendment made by subsection (a)
9 shall take effect on January 1, 2006.

10 (2) NONAPPLICATION.—The amendment made
11 by subsection (a) shall not apply in the case of a
12 State that, as of December 31, 2005, has in effect
13 a tax imposed on the class of health care items and
14 services described in section 1903(w)(7)(A)(viii) of
15 the Social Security Act (42 U.S.C.
16 1396b(w)(7)(A)(viii)) (as in effect before the date of
17 enactment of this Act).

18 **SEC. 6034. INCLUSION OF PODIATRISTS AS PHYSICIANS.**

19 (a) IN GENERAL.—Section 1905(a)(5)(A) (42 U.S.C.
20 1396d(a)(5)(A)) is amended by striking “section
21 1861(r)(1)” and inserting “paragraphs (1) and (3) of sec-
22 tion 1861(r)”.

23 (b) EFFECTIVE DATE.—The amendment made by
24 subsection (a) shall apply to services furnished on or after
25 January 1, 2006.

1 **SEC. 6035. DSH ALLOTMENT FOR THE DISTRICT OF COLUM-**
2 **BIA.**

3 (a) IN GENERAL.—The table in section 1923(f)(2)
4 (42 U.S.C. 1396r-4(f)(2)) is amended under each of the
5 columns for FY 00, FY 01, and FY 02, in the entry for
6 the District of Columbia, by striking “32” and inserting
7 “49”.

8 (b) EFFECTIVE DATE.—The amendments made by
9 subsection (a) shall take effect as if enacted on October
10 1, 2005 and shall apply to expenditures made on or after
11 that date.

12 **SEC. 6036. DEMONSTRATION PROJECT REGARDING MED-**
13 **ICAID REIMBURSEMENT FOR STABILIZATION**
14 **OF EMERGENCY MEDICAL CONDITIONS BY**
15 **NON-PUBLICLY OWNED OR OPERATED INSTI-**
16 **TUTIONS FOR MENTAL DISEASES.**

17 (a) AUTHORITY TO CONDUCT DEMONSTRATION
18 PROJECT.—The Secretary shall establish a demonstration
19 project under which an eligible State (as defined in sub-
20 section (b)) shall provide reimbursement under the State
21 medicaid plan to an institution for mental diseases that
22 is not publicly owned or operated and that is subject to
23 the requirements of section 1867 of the Social Security
24 Act (42 U.S.C, 1395dd) for the provision of medical as-
25 sistance available under such plan to an individual who—

1 (1) has attained age 21, but has not attained
2 age 65;

3 (2) is eligible for medical assistance under such
4 plan; and

5 (3) requires such medical assistance to stabilize
6 an emergency medical condition.

7 (b) ELIGIBLE STATE DEFINED.—

8 (1) APPLICATION.—Upon approval of an appli-
9 cation submitted by a State described in paragraph
10 (2), the State shall be an eligible State for purposes
11 of conducting a demonstration project under this
12 section.

13 (2) STATE DESCRIBED.—A State described in
14 this paragraph is each of the following:

15 (A) Arizona.

16 (B) Arkansas.

17 (C) Louisiana.

18 (D) Maine.

19 (E) North Dakota.

20 (F) Wyoming.

21 (G) Four other States selected by the Sec-
22 retary to provide geographic diversity on the
23 basis of the application to conduct a demonstra-
24 tion project under this section submitted by
25 such States.

1 (c) LENGTH OF DEMONSTRATION PROJECT.—The
2 demonstration project established under this section shall
3 be conducted for a period of 3 consecutive years.

4 (d) LIMITATIONS ON FEDERAL FUNDING.—

5 (1) APPROPRIATION.—

6 (A) IN GENERAL.—Out of any funds in the
7 Treasury not otherwise appropriated, there is
8 appropriated to carry out this section,
9 \$30,000,000 for fiscal year 2006.

10 (B) BUDGET AUTHORITY.—Subparagraph

11 (A) constitutes budget authority in advance of
12 appropriations Act and represents the obliga-
13 tion of the Federal Government to provide for
14 the payment of the amounts appropriated under
15 that subparagraph.

16 (2) 3-YEAR AVAILABILITY.—Funds appro-
17 priated under paragraph (1) shall remain available
18 for obligation through December 31, 2008.

19 (3) LIMITATION ON PAYMENTS.—In no case
20 may—

21 (A) the aggregate amount of payments
22 made by the Secretary to eligible States under
23 this section exceed \$30,000,000; or

24 (B) payments be provided by the Secretary
25 under this section after December 31, 2008.

1 (4) FUNDS ALLOCATED TO STATES.—The Sec-
2 retary shall allocate funds to eligible States based on
3 their applications and the availability of funds.

4 (5) PAYMENTS TO STATES.—The Secretary
5 shall pay to each eligible State, from its allocation
6 under paragraph (4), an amount each quarter equal
7 to the Federal medical assistance percentage of ex-
8 penditures in the quarter for medical assistance de-
9 scribed in subsection (a).

10 (e) REPORTS.—

11 (1) ANNUAL PROGRESS REPORTS.—The Sec-
12 retary shall submit annual reports to Congress on
13 the progress of the demonstration project conducted
14 under this section.

15 (2) FINAL REPORT AND RECOMMENDATION.—
16 Not later than March 31, 2009, the Secretary shall
17 submit to Congress a final report on the demonstra-
18 tion project conducted under this section that shall
19 include the following:

20 (A) A determination as to whether the
21 demonstration project resulted in increased ac-
22 cess to inpatient mental health services under
23 the medicaid program.

24 (B) An analysis regarding whether the
25 demonstration project produced a significant re-

1 duction in the use of higher cost emergency
2 room visits for individuals eligible for medical
3 assistance under the medicaid program.

4 (C) An assessment of the impact of the
5 demonstration project on the costs related to
6 the provision of inpatient psychiatric care and
7 services under the medicaid program.

8 (D) A recommendation regarding whether
9 the demonstration project should be continued
10 after December 31, 2008, and expanded on a
11 national basis.

12 (f) WAIVER AUTHORITY.—

13 (1) IN GENERAL.—The Secretary shall waive
14 the limitation of subdivision (B) following paragraph
15 (28) of section 1905(a) of the Social Security Act
16 (42 U.S.C. 1396d(a)) (relating to limitations on pay-
17 ments for care or services for individuals under 65
18 years of age who are patients in an institution for
19 mental diseases) for purposes of carrying out the
20 demonstration project under this section.

21 (2) LIMITED OTHER WAIVER AUTHORITY.—The
22 Secretary may waive other requirements of titles XI
23 and XIX of the Social Security Act (including the
24 requirements of sections 1902(a)(1) (relating to
25 statewideness) and 1902(a)(10)(B) (relating to com-

1 parability)) only to extent necessary to carry out the
2 demonstration project under this section.

3 (g) DEFINITIONS.—In this section:

4 (1) EMERGENCY MEDICAL CONDITION.—The
5 term “emergency medical condition” has the mean-
6 ing given that term in section 1867(e)(1) of the So-
7 cial Security Act (42 U.S.C. 1395dd(e)(1)).

8 (2) FEDERAL MEDICAL ASSISTANCE PERCENT-
9 AGE.—The term “Federal medical assistance per-
10 centage” has the meaning given that term with re-
11 spect to a State in section 1905(b) of the Social Se-
12 curity Act (42 U.S.C. 1396d(b)).

13 (3) INSTITUTION FOR MENTAL DISEASES.—The
14 term “institution for mental diseases” has the mean-
15 ing given that term in section 1905(i) of the Social
16 Security Act (42 U.S.C. 1396d(i)).

17 (4) MEDICAL ASSISTANCE.—The term “medical
18 assistance” has the meaning given that term in sec-
19 tion 1905(a) of the Social Security Act (42 U.S.C.
20 1396d(a)).

21 (5) STABILIZE.—The term “stabilize” has the
22 meaning given that term in section 1867(e)(3)(A) of
23 the Social Security Act (42 U.S.C.
24 1395dd(e)(3)(A)).

1 (6) STATE.—The term “State” has the mean-
2 ing given that term for purposes of title XIX of the
3 Social Security Act (42 U.S.C. 1396 et seq.).

4 **CHAPTER 5—IMPROVING THE MEDICAID**
5 **AND STATE CHILDREN’S HEALTH IN-**
6 **SURANCE PROGRAMS**

7 **Subchapter A—Family Opportunity Act**

8 **SEC. 6041. SHORT TITLE OF SUBCHAPTER.**

9 This subchapter may be cited as the “Family Oppor-
10 tunity Act of 2005” or the “Dylan Lee James Act”.

11 **SEC. 6042. OPPORTUNITY FOR FAMILIES OF DISABLED**
12 **CHILDREN TO PURCHASE MEDICAID COV-**
13 **ERAGE FOR SUCH CHILDREN.**

14 (a) STATE OPTION TO ALLOW FAMILIES OF DIS-
15 ABLED CHILDREN TO PURCHASE MEDICAID COVERAGE
16 FOR SUCH CHILDREN.—

17 (1) IN GENERAL.—Section 1902 (42 U.S.C.
18 1396a) is amended—

19 (A) in subsection (a)(10)(A)(ii)—

20 (i) by striking “or” at the end of sub-
21 clause (XVII);

22 (ii) by adding “or” at the end of sub-
23 clause (XVIII); and

24 (iii) by adding at the end the fol-
25 lowing new subclause:

1 “(XIX) who are disabled children
2 described in subsection (cc)(1);” and
3 (B) by adding at the end the following new
4 subsection:

5 “(cc)(1) Individuals described in this paragraph are
6 individuals—

7 “(A) who are children who have not attained 19
8 years of age and are born—

9 “(i) on or after January 1, 2002 (or, at
10 the option of a State, on or after an earlier
11 date), in the case of the second, third, and
12 fourth quarters of fiscal year 2008;

13 “(ii) on or after October 1, 1996 (or, at
14 the option of a State, on or after an earlier
15 date), in the case of each quarter of fiscal year
16 2009; and

17 “(iii) after October 1, 1990, in the case of
18 each quarter of fiscal year 2010 and each quar-
19 ter of any fiscal year thereafter;

20 “(B) who would be considered disabled under
21 section 1614(a)(3)(C) but for having earnings or
22 deemed income or resources (as determined under
23 title XVI for children) that exceed the requirements
24 for receipt of supplemental security income benefits;
25 and

1 “(C) whose family income does not exceed such
2 income level as the State establishes and does not
3 exceed—

4 “(i) 300 percent of the poverty line (as de-
5 fined in section 2110(c)(5)) applicable to a fam-
6 ily of the size involved; or

7 “(ii) such higher percent of such poverty
8 line as a State may establish, except that—

9 “(I) any medical assistance provided
10 to an individual whose family income ex-
11 ceeds 300 percent of such poverty line may
12 only be provided with State funds; and

13 “(II) no Federal financial participa-
14 tion shall be provided under section
15 1903(a) for any medical assistance pro-
16 vided to such an individual.”.

17 (2) INTERACTION WITH EMPLOYER-SPONSORED
18 FAMILY COVERAGE.—Section 1902(cc) (42 U.S.C.
19 1396a(cc)), as added by paragraph (1)(B), is
20 amended by adding at the end the following new
21 paragraph:

22 “(2)(A) If an employer of a parent of an individual
23 described in paragraph (1) offers family coverage under
24 a group health plan (as defined in section 2791(a) of the
25 Public Health Service Act), the State shall—

1 “(i) require such parent to apply for, enroll in,
2 and pay premiums for such coverage as a condition
3 of such parent’s child being or remaining eligible for
4 medical assistance under subsection
5 (a)(10)(A)(ii)(XIX) if the parent is determined eligi-
6 ble for such coverage and the employer contributes
7 at least 50 percent of the total cost of annual pre-
8 miums for such coverage; and

9 “(ii) if such coverage is obtained—

10 “(I) subject to paragraph (2) of section
11 1916(h), reduce the premium imposed by the
12 State under that section in an amount that rea-
13 sonably reflects the premium contribution made
14 by the parent for private coverage on behalf of
15 a child with a disability; and

16 “(II) treat such coverage as a third party
17 liability under subsection (a)(25).

18 “(B) In the case of a parent to which subparagraph
19 (A) applies, a State, subject to paragraph (1)(C)(ii), may
20 provide for payment of any portion of the annual premium
21 for such family coverage that the parent is required to
22 pay. Any payments made by the State under this subpara-
23 graph shall be considered, for purposes of section 1903(a),
24 to be payments for medical assistance.”.

1 (b) STATE OPTION TO IMPOSE INCOME-RELATED
2 PREMIUMS.—Section 1916 (42 U.S.C. 1396o) is
3 amended—

4 (1) in subsection (a), by striking “subsection
5 (g)” and inserting “subsections (g) and (h)”; and

6 (2) by adding at the end the following new sub-
7 section:

8 “(h)(1) With respect to disabled children provided
9 medical assistance under section 1902(a)(10)(A)(ii)(XIX),
10 subject to paragraph (2), a State may (in a uniform man-
11 ner for such children) require the families of such children
12 to pay monthly premiums set on a sliding scale based on
13 family income.

14 “(2) A premium requirement imposed under para-
15 graph (1) may only apply to the extent that—

16 “(A) in the case of a disabled child described in
17 that paragraph whose family income—

18 “(i) does not exceed 200 percent of the
19 poverty line, the aggregate amount of such pre-
20 mium and any premium that the parent is re-
21 quired to pay for family coverage under section
22 1902(cc)(2)(A)(i) and other cost-sharing
23 charges do not exceed 5 percent of the family’s
24 income; and

1 (2) Section 1905(u)(2)(B) (42 U.S.C.
2 1396d(u)(2)(B)) is amended by adding at the end the fol-
3 lowing sentence: “Such term excludes any child eligible for
4 medical assistance only by reason of section
5 1902(a)(10)(A)(ii)(XIX).”.

6 (d) EFFECTIVE DATE.—The amendments made by
7 this section shall apply to medical assistance for items and
8 services furnished on or after January 1, 2008.

9 **SEC. 6043. DEMONSTRATION PROJECTS REGARDING HOME**
10 **AND COMMUNITY-BASED ALTERNATIVES TO**
11 **PSYCHIATRIC RESIDENTIAL TREATMENT FA-**
12 **CILITIES FOR CHILDREN.**

13 (a) IN GENERAL.—The Secretary is authorized to
14 conduct, during each of fiscal years 2007 through 2011,
15 demonstration projects (each in the section referred to as
16 a “demonstration project”) in accordance with this section
17 under which up to 10 States (as defined for purposes of
18 title XIX of the Social Security Act) are awarded grants,
19 on a competitive basis, to test the effectiveness in improv-
20 ing or maintaining a child’s functional level and cost-effec-
21 tiveness of providing coverage of home and community-
22 based alternatives to psychiatric residential treatment for
23 children enrolled in the Medicaid program under title XIX
24 of such Act.

25 (b) APPLICATION OF TERMS AND CONDITIONS.—

1 (1) IN GENERAL.—Subject to the provisions of
2 this section, for the purposes of the demonstration
3 projects, and only with respect to children enrolled
4 under such demonstration projects, a psychiatric res-
5 idential treatment facility (as defined in section
6 483.352 of title 42 of the Code of Federal Regula-
7 tions) shall be deemed to be a facility specified in
8 section 1915(c) of the Social Security Act (42
9 U.S.C. 1396n(c)), and to be included in each ref-
10 erence in such section 1915(c) to hospitals, nursing
11 facilities, and intermediate care facilities for the
12 mentally retarded.

13 (2) STATE OPTION TO ASSURE CONTINUITY OF
14 MEDICAID COVERAGE.—Upon the termination of a
15 demonstration project under this section, the State
16 that conducted the project may elect, only with re-
17 spect to a child who is enrolled in such project on
18 the termination date, to continue to provide medical
19 assistance for coverage of home and community-
20 based alternatives to psychiatric residential treat-
21 ment for the child in accordance with section
22 1915(e) of the Social Security Act (42 U.S.C.
23 1396n(c)), as modified through the application of
24 paragraph (1). Expenditures incurred for providing
25 such medical assistance shall be treated as a home

1 and community-based waiver program under section
2 1915(e) of the Social Security Act (42 U.S.C.
3 1396n(e)) for purposes of payment under section
4 1903 of such Act (42 U.S.C. 1396b).

5 (c) TERMS OF DEMONSTRATION PROJECTS.—

6 (1) IN GENERAL.—Except as otherwise pro-
7 vided in this section, a demonstration project shall
8 be subject to the same terms and conditions as apply
9 to a waiver under section 1915(e) of the Social Se-
10 curity Act (42 U.S.C. 1396n(e)), including the waiv-
11 er of certain requirements under the first sentence
12 of paragraph (3) of such section but not applying
13 the second sentence of such paragraph.

14 (2) BUDGET NEUTRALITY.—In conducting the
15 demonstration projects under this section, the Sec-
16 retary shall ensure that the aggregate payments
17 made by the Secretary under title XIX of the Social
18 Security Act (42 U.S.C. 1396 et seq.) do not exceed
19 the amount which the Secretary estimates would
20 have been paid under that title if the demonstration
21 projects under this section had not been imple-
22 mented.

23 (3) EVALUATION.—The application for a dem-
24 onstration project shall include an assurance to pro-
25 vide for such interim and final evaluations of the

1 demonstration project by independent third parties,
2 and for such interim and final reports to the Sec-
3 retary, as the Secretary may require.

4 (d) PAYMENTS TO STATES; LIMITATIONS TO SCOPE
5 AND FUNDING.—

6 (1) IN GENERAL.—Subject to paragraph (2), a
7 demonstration project approved by the Secretary
8 under this section shall be treated as a home and
9 community-based waiver program under section
10 1915(e) of the Social Security Act (42 U.S.C.
11 1396n(c)) for purposes of payment under section
12 1903 of such Act (42 U.S.C. 1396b).

13 (2) LIMITATION.—In no case may the amount
14 of payments made by the Secretary under this sec-
15 tion for State demonstration projects for a fiscal
16 year exceed the amount available under subsection
17 (f)(2)(A) for such fiscal year.

18 (e) SECRETARY'S EVALUATION AND REPORT.—The
19 Secretary shall conduct an interim and final evaluation of
20 State demonstration projects under this section and shall
21 report to the President and Congress the conclusions of
22 such evaluations within 12 months of completing such
23 evaluations.

24 (f) FUNDING.—

1 (1) IN GENERAL.—For the purpose of carrying
2 out this section, there are appropriated, from
3 amounts in the Treasury not otherwise appropriated,
4 for fiscal years 2007 through 2011, a total of
5 \$218,000,000, of which—

6 (A) the amount specified in paragraph (2)
7 shall be available for each of fiscal years 2007
8 through 2011; and

9 (B) a total of \$1,000,000 shall be available
10 to the Secretary for the evaluations and report
11 under subsection (e).

12 (2) FISCAL YEAR LIMIT.—

13 (A) IN GENERAL.—For purposes of para-
14 graph (1), the amount specified in this para-
15 graph for a fiscal year is the amount specified
16 in subparagraph (B) for the fiscal year plus the
17 difference, if any, between the total amount
18 available under this paragraph for prior fiscal
19 years and the total amount previously expended
20 under paragraph (1)(A) for such prior fiscal
21 years.

22 (B) FISCAL YEAR AMOUNTS.—The amount
23 specified in this subparagraph for—

24 (i) fiscal year 2007 is \$21,000,000;

25 (ii) fiscal year 2008 is \$37,000,000;

1 (iii) fiscal year 2009 is \$49,000,000;

2 (iv) fiscal year 2010 is \$53,000,000;

3 and

4 (v) fiscal year 2011 is \$57,000,000.

5 **SEC. 6044. DEVELOPMENT AND SUPPORT OF FAMILY-TO-**
6 **FAMILY HEALTH INFORMATION CENTERS.**

7 Section 501 (42 U.S.C. 701) is amended by adding
8 at the end the following new subsection:

9 “(c)(1)(A) For the purpose of enabling the Secretary
10 (through grants, contracts, or otherwise) to provide for
11 special projects of regional and national significance for
12 the development and support of family-to-family health in-
13 formation centers described in paragraph (2)—

14 “(i) there is appropriated to the Secretary, out
15 of any money in the Treasury not otherwise
16 appropriated—

17 “(I) \$3,000,000 for fiscal year 2007;

18 “(II) \$4,000,000 for fiscal year 2008; and

19 “(III) \$5,000,000 for fiscal year 2009; and

20 “(ii) there is authorized to be appropriated to
21 the Secretary, \$5,000,000 for each of fiscal years
22 2010 and 2011.

23 “(B) Funds appropriated or authorized to be appro-
24 priated under subparagraph (A) shall—

1 “(i) be in addition to amounts appropriated
2 under subsection (a) and retained under section
3 502(a)(1) for the purpose of carrying out activities
4 described in subsection (a)(2); and

5 “(ii) remain available until expended.

6 “(2) The family-to-family health information centers
7 described in this paragraph are centers that—

8 “(A) assist families of children with disabilities
9 or special health care needs to make informed
10 choices about health care in order to promote good
11 treatment decisions, cost-effectiveness, and improved
12 health outcomes for such children;

13 “(B) provide information regarding the health
14 care needs of, and resources available for, such chil-
15 dren;

16 “(C) identify successful health delivery models
17 for such children;

18 “(D) develop with representatives of health care
19 providers, managed care organizations, health care
20 purchasers, and appropriate State agencies, a model
21 for collaboration between families of such children
22 and health professionals;

23 “(E) provide training and guidance regarding
24 caring for such children;

1 “(F) conduct outreach activities to the families
2 of such children, health professionals, schools, and
3 other appropriate entities and individuals; and

4 “(G) are staffed—

5 “(i) by such families who have expertise in
6 Federal and State public and private health
7 care systems; and

8 “(ii) by health professionals.

9 “(3) The Secretary shall develop family-to-family
10 health information centers described in paragraph (2) in
11 accordance with the following:

12 “(A) With respect to fiscal year 2007, such cen-
13 ters shall be developed in not less than 25 States.

14 “(B) With respect to fiscal year 2008, such
15 centers shall be developed in not less than 40 States.

16 “(C) With respect to fiscal year 2009 and each
17 fiscal year thereafter, such centers shall be developed
18 in all States.

19 “(4) The provisions of this title that are applicable
20 to the funds made available to the Secretary under section
21 502(a)(1) apply in the same manner to funds made avail-
22 able to the Secretary under paragraph (1)(A).

23 “(5) For purposes of this subsection, the term ‘State’
24 means each of the 50 States and the District of Colum-
25 bia.”.

1 **SEC. 6045. RESTORATION OF MEDICAID ELIGIBILITY FOR**
2 **CERTAIN SSI BENEFICIARIES.**

3 (a) **IN GENERAL.**—Section 1902(a)(10)(A)(i)(II) (42
4 U.S.C. 1396a(a)(10)(A)(i)(II)) is amended—

5 (1) by inserting “(aa)” after “(II)”;

6 (2) by striking “) and” and inserting “and”;

7 (3) by striking “section or who are” and insert-
8 ing “section), (bb) who are”; and

9 (4) by inserting before the comma at the end
10 the following: “, or (cc) who are under 21 years of
11 age and with respect to whom supplemental security
12 income benefits would be paid under title XVI if
13 subparagraphs (A) and (B) of section 1611(c)(7)
14 were applied without regard to the phrase ‘the first
15 day of the month following’ ”.

16 (b) **EFFECTIVE DATE.**—The amendments made by
17 subsection (a) shall apply to medical assistance for items
18 and services furnished on or after the date that is 1 year
19 after the date of enactment of this Act.

1 **Subchapter B—State Children’s Health**
2 **Insurance Program**

3 **SEC. 6051. RULES FOR AVAILABILITY, REDISTRIBUTION,**
4 **AND EXTENDED AVAILABILITY OF ALLOT-**
5 **MENTS FOR FISCAL YEARS 2003, 2004, AND**
6 **2005.**

7 (a) IN GENERAL.—Section 2104 (42 U.S.C. 1397dd)
8 is amended—

9 (1) by amending subsection (e) to read as fol-
10 lows:

11 “(e) AVAILABILITY OF AMOUNTS ALLOTTED.—

12 “(1) IN GENERAL.—Except as provided in para-
13 graph (2), amounts allotted to a State pursuant to
14 this section—

15 “(A) for each of fiscal years 1998 through
16 2003, and for fiscal year 2006 and each fiscal
17 year thereafter, shall remain available for ex-
18 penditure by the State through the end of the
19 second succeeding fiscal year; and

20 “(B) for each of fiscal years 2004 and
21 2005, shall remain available for expenditure by
22 the State during the initial availability period
23 (as defined in paragraph (3)(A)).

1 “(2) AVAILABILITY OF REALLOTMENTS, REDIS-
2 TRIBUTED AMOUNTS, AND EXTENDED AVAIL-
3 ABILITY.—

4 “(A) IN GENERAL.—Amounts reallocated to
5 a State under subsection (f) shall be available
6 for expenditure by the State through the end of
7 the fiscal year in which they are reallocated.

8 “(B) AVAILABILITY OF REDISTRIBUTED
9 FUNDS AND EXTENDED AVAILABILITY.—
10 Amounts redistributed to a State under sub-
11 section (i)(3) or (j)(3) and unused allotments of
12 a State extended under subsection (i)(4) or
13 (j)(4) are available for expenditure by the State
14 during the redistribution/extension period (as
15 defined in paragraph (3)(B)).

16 “(3) PERIODS DEFINED.—For purposes of this
17 section:

18 “(A) INITIAL AVAILABILITY PERIOD.—The
19 term ‘initial availability period’ means, with re-
20 spect to allotments for a fiscal year, the 2-fiscal
21 year period beginning with that fiscal year.

22 “(B) REDISTRIBUTION/EXTENSION PE-
23 RIOD.—The term ‘redistribution/extension pe-
24 riod’ means, with respect to allotments for a

1 fiscal year, the second year following that fiscal
2 year.”; and

3 (2) by adding at the end the following new sub-
4 sections:

5 “(h) RULE FOR REDISTRIBUTION OF FISCAL YEAR
6 2003 ALLOTMENTS.—

7 “(1) COMPUTATION OF UNEXPENDED ALLOT-
8 MENTS FOR FISCAL YEAR 2003.—The Secretary shall
9 determine—

10 “(A) the amount of each State’s allotment
11 under this section for fiscal year 2003 that was
12 not expended by the end of fiscal year 2005;
13 and

14 “(B) the total of the unexpended allot-
15 ments determined under subparagraph (A).

16 “(2) DETERMINATION OF INITIAL PROJECTED
17 SHORTFALLS FOR FISCAL YEAR 2006.—For each
18 State that receives an allotment for fiscal year 2006
19 under subsection (b), the Secretary shall determine
20 the following:

21 “(A) FISCAL YEAR 2005 CARRYOVER.—The
22 amount of the State’s allotment for 2005 that
23 was not expended in fiscal year 2005.

24 “(B) PROJECTED EXPENDITURES FOR FIS-
25 CAL YEAR 2006.—The estimated expenditures

1 for the State as would be reported as quarterly
2 expenditures under section 2105(a) for quarters
3 in fiscal year 2006.

4 “(C) INITIAL PROJECTED SHORTFALL FOR
5 FISCAL YEAR 2006.—The amount, if any, by
6 which the projected expenditures determined
7 under subparagraph (B) for the State for quar-
8 ters in fiscal year 2006 exceeds the sum of the
9 following:

10 “(i) FISCAL YEAR 2005 CARRYOVER.—

11 The amount determined under subpara-
12 graph (A) for the State.

13 “(ii) FISCAL YEAR 2006 ALLOT-
14 MENT.—The amount of the State’s allot-
15 ment for fiscal year 2006.

16 “(D) STATE’S PROPORTION OF AGGREGATE
17 SHORTFALL.—For each State for which there is
18 an excess determined under subparagraph (C),
19 the ratio of—

20 “(i) the amount of such excess; to

21 “(ii) the total of such excesses deter-
22 mined for all States with such an excess.

23 “(3) REDISTRIBUTION OF UNEXPENDED AL-
24 LOTMENTS FOR FISCAL YEAR 2003.—From the total
25 of the unexpended allotments for fiscal year 2003

1 determined under paragraph (1)(B) the Secretary
2 shall redistribute under subsection (f) the following:

3 “(A) STATES OTHER THAN TERRI-
4 TORIES.—There shall be redistributed to each
5 State for which there is an excess determined
6 under paragraph (2)(C) an amount equal to the
7 product of the following:

8 “(i) STATE REDISTRIBUTION POOL.—
9 The amount determined under paragraph
10 (1)(B), reduced by the total amount redis-
11 tributed under subparagraph (B).

12 “(ii) STATE’S SHORTFALL PROPOR-
13 TION.—The ratio described in paragraph
14 (2)(D) for that State.

15 “(B) TERRITORIES.—There shall be redis-
16 tributed to each commonwealth or territory de-
17 scribed in subsection (c)(3) an amount equal to
18 the product of the following:

19 “(i) TERRITORIAL REDISTRIBUTION
20 POOL.—1.05 percent of the amount deter-
21 mined under paragraph (1)(B).

22 “(ii) TERRITORIAL PROPORTION.—
23 The ratio of—

1 “(I) the allotment for fiscal year
2 2003 for such commonwealth or terri-
3 tory under subsection (c), to

4 “(II) the total of all such allot-
5 ments for such fiscal year for such
6 commonwealths or territories under
7 such subsection.

8 “(4) DETERMINATION OF AMOUNTS.—For pur-
9 poses of calculating the amounts described in—

10 “(A) paragraphs (1) and (2)(A), the Sec-
11 retary shall use the amounts reported by the
12 States not later than November 30, 2005, on
13 Form CMS-64 or Form CMS-21, as the case
14 may be, as approved by the Secretary; and

15 “(B) paragraph (2)(B), the Secretary shall
16 use the amounts reported by the States not
17 later than September 30, 2005, on Form CMS-
18 37 or Form CMS-21B, as the case may be, as
19 approved by the Secretary.

20 “(i) REDISTRIBUTION AND EXTENSION OF AVAIL-
21 ABILITY OF UNUSED ALLOTMENTS FOR FISCAL YEAR
22 2004.—Notwithstanding subsection (f):

23 “(1) COMPUTATION OF UNEXPENDED ALLOT-
24 MENTS FOR FISCAL YEAR 2004.—

1 “(A) IN GENERAL.—The Secretary shall
2 determine with respect to each State that re-
3 ceives an allotment for fiscal year 2004 under
4 subsection (b)—

5 “(i) the amount of the State’s allot-
6 ment for such fiscal year that was not ex-
7 pended by the end of fiscal year 2005; and

8 “(ii) the total of the unexpended allot-
9 ments determined under clause (i).

10 “(B) REDUCTION OF UNEXPENDED AL-
11 LOTMENT BY NET FISCAL YEAR 2006 SHORT-
12 FALL.—

13 “(i) IN GENERAL.—In the case of a
14 State described in clause (ii), the Secretary
15 shall reduce, but not below 0, the amount
16 determined for the State under subpara-
17 graph (A)(i) (relating to the State’s unex-
18 pended allotment for fiscal year 2004) by
19 the amount of the allotment of the State
20 for which availability is extended under
21 paragraph (4)(A).

22 “(ii) STATE DESCRIBED.—A State de-
23 scribed in this clause is a State that meets
24 the following requirements:

1 “(I) FULLY SPENT FISCAL YEAR
2 2003 ALLOTMENT.—The State’s allot-
3 ment under this section for fiscal year
4 2003 was fully expended by the end of
5 fiscal year 2005.

6 “(II) DID NOT FULLY EXPEND
7 FISCAL YEAR 2004 ALLOTMENT BY
8 END OF FISCAL YEAR 2005.—The
9 State’s allotment under this section
10 for fiscal year 2004 was not fully ex-
11 pended by the end of fiscal year 2005.

12 “(III) PROJECTED FISCAL YEAR
13 2006 SHORTFALL.—The State has an
14 excess determined under subsection
15 (h)(2)(C) (relating to initial projected
16 fiscal year 2006 shortfall).

17 “(C) TOTALS AND RATIOS.—The Secretary
18 shall determine the following:

19 “(i) REDISTRIBUTION POOL.—A redis-
20 tribution pool equal to the total of the
21 amounts determined under subparagraph
22 (A)(i), as reduced (if applicable) under
23 subparagraph (B)(i).

24 “(ii) STATE PROPORTION TOWARD RE-
25 DISTRIBUTION POOL.—For each State in

1 which the amount determined under sub-
2 paragraph (A)(i) (as reduced, if applicable,
3 under subparagraph (B)(i)) exceeds 0, the
4 ratio of—

5 “(I) such amount (as so reduced)
6 for the State; to

7 “(II) the total determined under
8 clause (i).

9 “(D) AMOUNT OF UNEXPENDED FISCAL
10 YEAR 2004 ALLOTMENT APPLIED TO REDIS-
11 TRIBUTIONS.—For each State described in sub-
12 paragraph (C)(ii), the Secretary shall determine
13 a redistribution/reduction amount equal to the
14 product of the following:

15 “(i) TOTAL AMOUNT REDISTRIB-
16 UTED.—The total amount redistributed
17 under paragraph (3).

18 “(ii) STATE’S PROPORTION OF UNEX-
19 PENDED ALLOTMENTS.—The ratio for the
20 State determined under subparagraph
21 (C)(ii).

22 “(2) DETERMINATION OF NET PROJECTED
23 SHORTFALLS FOR FISCAL YEAR 2006.—For each
24 State that has an excess determined under sub-
25 section (h)(2)(C) (relating to initial projected fiscal

1 year 2006 shortfall), the Secretary shall determine
2 an amount equal to the amount determined under
3 such subsection, reduced by the sum of—

4 “(A) the amount redistributed to the State
5 under subsection (h)(3)(A), and

6 “(B) the amount of funds of the State for
7 which availability is extended under paragraph
8 (4)(A).

9 “(3) REDISTRIBUTION FROM REDISTRIBUTION
10 POOL.—From the redistribution pool determined
11 under paragraph (1)(C)(i)—

12 “(A) STATES OTHER THAN TERRI-
13 TORIES.—There shall be redistributed to each
14 State which has a net projected shortfall under
15 paragraph (2) an amount determined under
16 such paragraph for the State.

17 “(B) TERRITORIES.—There shall be redis-
18 tributed to each commonwealth or territory de-
19 scribed in subsection (c)(3) an amount equal to
20 the product of the following:

21 “(i) TERRITORIAL REDISTRIBUTION
22 POOL.—1.05 percent of the amount of
23 such unexpended allotments determined
24 under paragraph (1)(A)(ii).

1 “(ii) TERRITORIAL PROPORTION.—

2 The ratio of—

3 “(I) the allotment under sub-
4 section (c) for such commonwealth or
5 territory for fiscal year 2004, to

6 “(II) the total of all such allot-
7 ments for such commonwealths and
8 territories.

9 “(4) EXTENDED AVAILABILITY OF REMAINING
10 UNEXPENDED ALLOTMENTS.—

11 “(A) TO MEET NET SHORTFALL FOR FIS-
12 CAL YEAR 2006.—In the case of a State de-
13 scribed in paragraph (1)(B)(ii), the Secretary
14 shall extend the availability of funds from the
15 State’s allotment for fiscal year 2004 to the ex-
16 tent that—

17 “(i) the amount determined under
18 subsection (h)(2)(C) (relating to initial
19 shortfall for fiscal year 2006), exceeds

20 “(ii) the amount redistributed to the
21 State under subsection (h)(3)(A).

22 “(B) OTHER EXTENSIONS.—The Secretary
23 shall extend the availability of funds from allot-
24 ments for fiscal year 2004 for each State which
25 has an unexpended allotment for fiscal year

1 2004 determined under paragraph (1)(A) (as
2 reduced, if applicable, under paragraph (1)(B))
3 by an amount equal to the amount (if any) by
4 which—

5 “(i) the amount of such unexpended
6 allotment (as so reduced) for the State, ex-
7 ceeds

8 “(ii) the redistribution/reduction
9 amount determined under paragraph
10 (1)(D) for the State (relating to the por-
11 tion of the unexpended allotment applied
12 to redistributions).

13 “(5) DETERMINATION OF AMOUNTS.—For pur-
14 poses of calculating the amounts described in—

15 “(A) paragraph (1)(A)(i), the Secretary
16 shall use the amounts reported by the States
17 not later than November 30, 2005, on Form
18 CMS-64 or Form CMS-21, as the case may be,
19 as approved by the Secretary; and

20 “(B) paragraph (1)(B)(i), the Secretary
21 shall use the amounts reported by the States
22 not later than September 30, 2005, on Form
23 CMS-37 or Form CMS-21B, as the case may
24 be, as approved by the Secretary.

1 “(j) REDISTRIBUTION AND EXTENSION OF AVAIL-
2 ABILITY OF UNUSED ALLOTMENTS FOR FISCAL YEAR
3 2005.—Notwithstanding subsection (f):

4 “(1) COMPUTATION OF UNEXPENDED ALLOT-
5 MENTS FOR FISCAL YEAR 2005.—

6 “(A) IN GENERAL.—The Secretary shall
7 determine with respect to each State that re-
8 ceives an allotment for fiscal year 2005 under
9 subsection (b)—

10 “(i) the amount of the State’s allot-
11 ment for fiscal year 2005 that was not ex-
12 pended by the end of fiscal year 2006; and

13 “(ii) the total of the unexpended allot-
14 ments determined under clause (i).

15 “(B) REDUCTION OF UNEXPENDED AL-
16 LOTMENT BY NET FISCAL YEAR 2007 SHORT-
17 FALL.—

18 “(i) IN GENERAL.—In the case of a
19 State described in clause (ii), the Secretary
20 shall reduce, but not below 0, the amount
21 determined for the State under subpara-
22 graph (A)(i) (relating to the State’s unex-
23 pended allotment for fiscal year 2005) by
24 the amount of the allotment of the State

1 for which availability is extended under
2 paragraph (4)(A).

3 “(ii) STATE DESCRIBED.—A State de-
4 scribed in this clause is a State that meets
5 the following requirements:

6 “(I) DID NOT FULLY EXPEND
7 FISCAL YEAR 2005 ALLOTMENT BY
8 END OF FISCAL YEAR 2006.—The
9 State’s allotment under this section
10 for fiscal year 2005 was not fully ex-
11 pended by the end of fiscal year 2006.

12 “(II) PROJECTED SHORTFALL
13 FOR FISCAL YEAR 2007.—The State
14 has an excess determined under para-
15 graph (2)(C) for fiscal year 2007 (re-
16 lating to initial projected fiscal year
17 2007 shortfall).

18 “(C) TOTALS AND RATIOS.—The Secretary
19 shall determine the following:

20 “(i) REDISTRIBUTION POOL.—A redis-
21 tribution pool equal to the total of the
22 amounts determined under subparagraph
23 (A)(i), as reduced (if applicable) under
24 subparagraph (B)(i).

1 “(ii) STATE PROPORTION TOWARD RE-
2 DISTRIBUTION POOL.—For each State in
3 which the amount determined under sub-
4 paragraph (A)(i) (as reduced, if applicable,
5 under subparagraph (B)(i)) exceeds 0, the
6 ratio of—

7 “(I) such amount (as so reduced)
8 for the State; to

9 “(II) the total determined under
10 clause (i).

11 “(D) AMOUNT OF UNEXPENDED FISCAL
12 YEAR 2005 ALLOTMENT APPLIED TO REDIS-
13 TRIBUTIONS.—For each State described in sub-
14 paragraph (C)(ii), the Secretary shall determine
15 a redistribution/reduction amount equal to the
16 product of the following:

17 “(i) TOTAL AMOUNT REDISTRIB-
18 UTED.—The total amount redistributed
19 under paragraph (3).

20 “(ii) STATE’S PROPORTION OF UNEX-
21 PENDED ALLOTMENTS.—The ratio for the
22 State determined under subparagraph
23 (C)(ii).

24 “(2) DETERMINATION OF INITIAL PROJECTED
25 SHORTFALLS FOR FISCAL YEAR 2007.—For each

1 State that receives an allotment for fiscal year 2007
2 under subsection (b), the Secretary shall determine
3 the following:

4 “(A) FISCAL YEAR 2006 CARRYOVER.—The
5 amount of the State’s allotment for fiscal year
6 2006 that was not expended in fiscal year 2006.

7 “(B) PROJECTED EXPENDITURES FOR FIS-
8 CAL YEAR 2007.—The estimated expenditures
9 for the State as would be reported as quarterly
10 expenditures under section 2105(a) for quarters
11 in fiscal year 2007.

12 “(C) INITIAL PROJECTED SHORTFALL FOR
13 FISCAL YEAR 2007.—The amount, if any, by
14 which the projected expenditures determined
15 under subparagraph (B) for the State for quar-
16 ters in fiscal year 2007 exceeds the sum of the
17 following:

18 “(i) FISCAL YEAR 2006 CARRYOVER.—
19 The amount determined under subpara-
20 graph (A) for the State.

21 “(ii) FISCAL YEAR 2007 ALLOT-
22 MENT.—The amount of the State’s allot-
23 ment for fiscal year 2007.

24 “(D) DETERMINATION OF NET PROJECTED
25 SHORTFALLS FOR FISCAL YEAR 2007.—For each

1 State that has an excess determined under sub-
2 paragraph (C), the Secretary shall determine an
3 amount equal to the amount determined under
4 such subparagraph, reduced by the amount of
5 funds (if any) of the State for which availability
6 is extended under paragraph (4)(A).

7 “(E) STATE’S PROPORTION OF NET AG-
8 GREGATE SHORTFALL.—For each State for
9 which there is a net excess determined under
10 subparagraph (D), the ratio of—

11 “(i) the amount of such net excess; to

12 “(ii) the total of such net excesses.

13 “(3) REDISTRIBUTION FROM REDISTRIBUTION
14 POOL.—From the redistribution pool determined
15 under paragraph (1)(C)(i)—

16 “(A) STATES OTHER THAN TERRI-
17 TORIES.—There shall be redistributed to each
18 State for which there is a net projected short-
19 fall under paragraph (2)(D) an amount equal
20 the lesser of the following:

21 “(i) NET FISCAL YEAR 2007 SHORT-
22 FALL.—The amount of the net excess de-
23 scribed in paragraph (2)(D) for the State.

1 “(ii) PORTION OF UNEXPENDED
2 FUNDS AVAILABLE.—The product of the
3 following:

4 “(I) STATE REDISTRIBUTION
5 POOL.—The amount determined
6 under paragraph (1)(C)(i), reduced by
7 the total amount redistributed under
8 subparagraph (B).

9 “(II) STATE’S SHORTFALL PRO-
10 PORTION.—The ratio described in
11 paragraph (2)(E) for that State.

12 “(B) TERRITORIES.—There shall be redis-
13 tributed to each commonwealth or territory de-
14 scribed in subsection (c)(3) an amount equal to
15 the product of the following:

16 “(i) TERRITORIAL REDISTRIBUTION
17 POOL.—1.05 percent of the total amount
18 of unexpended allotments determined
19 under paragraph (1)(A)(ii).

20 “(ii) TERRITORIAL PROPORTION.—
21 The ratio of—

22 “(I) the allotment under sub-
23 section (c) for such commonwealth or
24 territory for fiscal year 2005, to

1 “(II) the total of all such allot-
2 ments for such commonwealths and
3 territories.

4 “(4) EXTENDED AVAILABILITY OF REMAINING
5 UNEXPENDED ALLOTMENTS.—

6 “(A) TO MEET INITIAL PROJECTED
7 SHORTFALL FOR FISCAL YEAR 2007.—In the
8 case of a State that is described in paragraph
9 (1)(B)(ii), the Secretary shall extend the avail-
10 ability of funds from the State’s allotment for
11 fiscal year 2005 to the extent of the amount de-
12 scribed in paragraph (2)(C).

13 “(B) OTHER EXTENSIONS.—If the redis-
14 tribution pool amount determined under para-
15 graph (1)(C)(i) exceeds the total amount redis-
16 tributed under paragraph (3), the Secretary
17 shall extend the availability of funds from allot-
18 ments for fiscal year 2005 for each State which
19 has an unexpended allotment for that fiscal
20 year determined under paragraph (1)(A) (as re-
21 duced, if applicable, under paragraph (1)(B))
22 by an amount equal to the amount (if any) by
23 which—

1 “(i) the amount of the unexpended al-
2 lotment (as so reduced) for the State, ex-
3 ceeds

4 “(ii) the redistribution/reduction
5 amount determined under paragraph
6 (1)(D) for the State (relating to the por-
7 tion of the unexpended allotment applied
8 to redistributions).

9 “(5) DETERMINATION OF AMOUNTS.—For pur-
10 poses of calculating the amounts described in—

11 “(A) paragraph (1)(A), the Secretary shall
12 use the amounts reported by the States not
13 later than November 30, 2006, on Form CMS-
14 64 or Form CMS-21, as the case may be, as
15 approved by the Secretary; or

16 “(B) paragraph (2), the Secretary shall
17 use the amounts reported by the States not
18 later than September 30, 2006, on Form CMS-
19 37 or Form CMS-21B, as the case may be, as
20 approved by the Secretary.”.

21 (b) USE OF REDISTRIBUTED FUNDS FOR CHILD
22 HEALTH ASSISTANCE FOR TARGETED LOW-INCOME
23 CHILDREN.—Section 2105(a) (42 U.S.C. 1397ee(a)) is
24 amended—

1 (1) in paragraph (1), in the matter preceding
2 subparagraph (A), by inserting “or paragraph (3)”
3 after “subparagraph (B)”; and

4 (2) by adding at the end the following:

5 “(3) USE OF REDISTRIBUTED FUNDS FOR
6 CHILD HEALTH ASSISTANCE FOR TARGETED LOW-IN-
7 COME CHILDREN.—For purposes of paragraph (1),
8 the expenditures described in this paragraph are ex-
9 penditures that are not expenditures for child health
10 assistance for targeted low-income children, but only
11 if such expenditures are from any amounts redistrib-
12 uted under subparagraphs (A) or (B) of subsection
13 (h)(3), (i)(3), or (j)(3) of section 2104.”.

14 **SEC. 6052. AUTHORITY TO USE UP TO 10 PERCENT OF FIS-**
15 **CAL YEAR 2006 AND 2007 ALLOTMENTS FOR**
16 **OUTREACH.**

17 Section 2105(c)(2) (42 U.S.C. 1397ee(c)(2)) is
18 amended by adding at the end the following:

19 “(C) USE OF UP TO 10 PERCENT OF 2006
20 AND 2007 ALLOTMENTS FOR OUTREACH ACTIVI-
21 TIES.—Notwithstanding subparagraph (A), a
22 State may use up to 10 percent of the allotment
23 for the State for fiscal year 2006 and for fiscal
24 year 2007 for expenditures incurred during the

1 respective fiscal year for outreach activities as
2 provided in section 2102(c)(1) under the plan.”.

3 **SEC. 6053. PROHIBITION AGAINST COVERING NONPREG-**
4 **NANT CHILDLESS ADULTS WITH SCHIP**
5 **FUNDS.**

6 (a) PROHIBITION ON USE OF SCHIP FUNDS.—Sec-
7 tion 2107 (42 U.S.C. 1397gg) is amended by adding at
8 the end the following:

9 “(f) LIMITATION OF WAIVER AUTHORITY.—Notwith-
10 standing subsection (e)(2)(A) and section 1115(a), on and
11 after the date of enactment of this subsection, the Sec-
12 retary may not approve a waiver, experimental, pilot, or
13 demonstration project that would allow funds made avail-
14 able under this title to be used to provide child health as-
15 sistance or other health benefits coverage to a nonpreg-
16 nant childless adult. For purposes of the preceding sen-
17 tence, a caretaker relative (as such term is defined for pur-
18 poses of carrying out section 1931) shall not be considered
19 a childless adult.”.

20 (b) CONFORMING AMENDMENTS.—Section
21 2105(c)(1) (42 U.S.C. 1397ee(c)(1)) is amended—

22 (1) by inserting “and may not include coverage
23 of a nonpregnant childless adult” after “section
24 2101”); and

1 (2) by adding at the end the following: “For
2 purposes of the preceding sentence, a caretaker rel-
3 ative (as such term is defined for purposes of car-
4 rying out section 1931) shall not be considered a
5 childless adult.”.

6 (c) **RULE OF CONSTRUCTION.**—Nothing in this sec-
7 tion or the amendments made by this section shall be con-
8 strued to—

9 (1) authorize the waiver of any provision of title
10 XIX or XXI of the Social Security Act (42 U.S.C.
11 1396 et seq., 1397aa et seq.) that is not otherwise
12 authorized to be waived under such titles or under
13 title XI of such Act (42 U.S.C. 1301 et seq.) as of
14 the date of enactment of this Act;

15 (2) imply congressional approval of any waiver,
16 experimental, pilot, or demonstration project affect-
17 ing funds made available under the State children’s
18 health insurance program under title XXI of the So-
19 cial Security Act (42 U.S.C. 1397aa et. seq.) or any
20 amendment to such a waiver or project that has
21 been approved as of such date of enactment; or

22 (3) apply to any waiver, experimental, pilot, or
23 demonstration project that would allow funds made
24 available under title XXI of the Social Security Act
25 (42 U.S.C. 1397aa et seq.) to be used to provide

1 child health assistance or other health benefits cov-
2 erage to a nonpregnant childless adult that is ap-
3 proved before the date of enactment of this Act or
4 to any extension, renewal, or amendment of such a
5 waiver or project that is approved on or after such
6 date of enactment.

7 **SEC. 6054. CONTINUED AUTHORITY FOR QUALIFYING**
8 **STATES TO USE CERTAIN FUNDS FOR MED-**
9 **ICAID EXPENDITURES.**

10 (a) IN GENERAL.—Section 2105(g)(1)(A) (42 U.S.C.
11 1397ee(g)(1)(A)) is amended by striking “or 2001” and
12 inserting “2001, 2004, or 2005”.

13 (b) EFFECTIVE DATE.—The amendment made by
14 subsection (a) shall apply to expenditures made under title
15 XIX of the Social Security Act (42 U.S.C. 1396 et seq.)
16 on or after October 1, 2005.

17 **SEC. 6055. GRANTS TO PROMOTE INNOVATIVE OUTREACH**
18 **AND ENROLLMENT UNDER MEDICAID AND**
19 **SCHIP.**

20 Title XXI (42 U.S.C. 1397aa et seq.) is amended by
21 adding at the end the following:

22 **“SEC. 2111. EXPANDED OUTREACH ACTIVITIES.**

23 **“(a) GRANTS TO CONDUCT INNOVATIVE OUTREACH**
24 **AND ENROLLMENT EFFORTS.—**

1 “(1) IN GENERAL.—The Secretary shall award
2 grants to eligible entities to—

3 “(A) conduct innovative outreach and en-
4 rollment efforts that are designed to increase
5 the enrollment and participation of eligible chil-
6 dren under this title and title XIX; and

7 “(B) promote understanding of the impor-
8 tance of health insurance coverage for prenatal
9 care and children.

10 “(2) PERFORMANCE BONUSES.—The Secretary
11 may reserve a portion of the funds appropriated
12 under subsection (g) for a fiscal year for the purpose
13 of awarding performance bonuses during the suc-
14 ceeding fiscal year to eligible entities that meet en-
15rollment goals or other criteria established by the
16 Secretary.

17 “(b) PRIORITY FOR AWARD OF GRANTS.—

18 “(1) IN GENERAL.—In making grants under
19 subsection (a)(1), the Secretary shall give priority
20 to—

21 “(A) eligible entities that propose to target
22 geographic areas with high rates of—

23 “(i) eligible but unenrolled children,
24 including such children who reside in rural
25 areas; or

1 “(ii) racial and ethnic minorities and
2 health disparity populations, including
3 those proposals that address cultural and
4 linguistic barriers to enrollment; and

5 “(B) eligible entities that plan to engage in
6 outreach efforts with respect to individuals de-
7 scribed in subparagraph (A) and that are—

8 “(i) Federal health safety net organi-
9 zations; or

10 “(ii) faith-based organizations or con-
11 sortia.

12 “(2) 10 PERCENT SET ASIDE FOR OUTREACH
13 TO INDIAN CHILDREN.—An amount equal to 10 per-
14 cent of the funds appropriated under subsection (g)
15 for a fiscal year shall be used by the Secretary to
16 award grants to Indian Health Service providers and
17 urban Indian organizations receiving funds under
18 title V of the Indian Health Care Improvement Act
19 (25 U.S.C. 1651 et seq.) for outreach to, and enroll-
20 ment of, children who are Indians.

21 “(c) APPLICATION.—An eligible entity that desires to
22 receive a grant under subsection (a)(1) shall submit an
23 application to the Secretary in such form and manner, and
24 containing such information, as the Secretary may decide.
25 Such application shall include—

1 “(1) quality and outcomes performance meas-
2 ures to evaluate the effectiveness of activities funded
3 by a grant awarded under this section to ensure that
4 the activities are meeting their goals; and

5 “(2) an assurance that the entity shall—

6 “(A) conduct an assessment of the effec-
7 tiveness of such activities against such perform-
8 ance measures; and

9 “(B) cooperate with the collection and re-
10 porting of enrollment data and other informa-
11 tion determined as a result of conducting such
12 assessments to the Secretary, in such form and
13 manner as the Secretary shall require.

14 “(d) DISSEMINATION OF ENROLLMENT DATA AND
15 INFORMATION DETERMINED FROM EFFECTIVENESS AS-
16 SESSMENTS; ANNUAL REPORT.—The Secretary shall—

17 “(1) disseminate to eligible entities and make
18 publicly available the enrollment data and informa-
19 tion collected and reported in accordance with sub-
20 section (c)(2)(B); and

21 “(2) submit an annual report to Congress on
22 the outreach activities funded by grants awarded
23 under this section.

24 “(e) SUPPLEMENT, NOT SUPPLANT.—Federal funds
25 awarded under this section shall be used to supplement,

1 not supplant, non-Federal funds that are otherwise avail-
2 able for activities funded under this section.

3 “(f) DEFINITIONS.—In this section:

4 “(1) ELIGIBLE ENTITY.—The term ‘eligible en-
5 tity’ means any of the following:

6 “(A) A State or local government.

7 “(B) A Federal health safety net organiza-
8 tion.

9 “(C) A national, local, or community-based
10 public or nonprofit private organization.

11 “(D) A faith-based organization or con-
12 sortia, to the extent that a grant awarded to
13 such an entity is consistent with the require-
14 ments of section 1955 of the Public Health
15 Service Act (42 U.S.C. 300x–65) relating to a
16 grant award to non-governmental entities.

17 “(E) An elementary or secondary school.

18 “(2) FEDERAL HEALTH SAFETY NET ORGANI-
19 ZATION.—The term ‘Federal health safety net orga-
20 nization’ means—

21 “(A) an Indian tribe, tribal organization,
22 or an urban Indian organization receiving funds
23 under title V of the Indian Health Care Im-
24 provement Act (25 U.S.C. 1651 et seq.), or an
25 Indian Health Service provider;

1 “(B) a Federally-qualified health center
2 (as defined in section 1905(l)(2)(B));

3 “(C) a hospital defined as a dispro-
4 portionate share hospital for purposes of section
5 1923;

6 “(D) a covered entity described in section
7 340B(a)(4) of the Public Health Service Act
8 (42 U.S.C. 256b(a)(4)); and

9 “(E) any other entity or a consortium that
10 serves children under a federally-funded pro-
11 gram, including the special supplemental nutri-
12 tion program for women, infants, and children
13 (WIC) established under section 17 of the Child
14 Nutrition Act of 1966 (42 U.S.C. 1786), the
15 head start and early head start programs under
16 the Head Start Act (42 U.S.C. 9801 et seq.),
17 the school lunch program established under the
18 Richard B. Russell National School Lunch Act,
19 and an elementary or secondary school.

20 “(3) INDIANS; INDIAN TRIBE; TRIBAL ORGANI-
21 ZATION; URBAN INDIAN ORGANIZATION.—The terms
22 ‘Indian’, ‘Indian tribe’, ‘tribal organization’, and
23 ‘urban Indian organization’ have the meanings given
24 such terms in section 4 of the Indian Health Care
25 Improvement Act (25 U.S.C. 1603).

1 “(g) APPROPRIATION.—There is appropriated, out of
2 any money in the Treasury not otherwise appropriated,
3 \$25,000,000 for fiscal year 2007 for the purpose of
4 awarding grants under this section. Amounts appropriated
5 and paid under the authority of this section shall—

6 “(1) be in addition to amounts appropriated
7 under section 2104 and paid to States in accordance
8 with section 2105; and

9 “(2) not be subject to the limitation on expendi-
10 tures described in section 2105(c)(2)(A).”.

11 **Subchapter C—Money Follows the Person**
12 **Rebalancing Demonstration**

13 **SEC. 6061. MONEY FOLLOWS THE PERSON REBALANCING**
14 **DEMONSTRATION.**

15 (a) PROGRAM PURPOSE AND AUTHORITY.—The Sec-
16 retary is authorized to award, on a competitive basis,
17 grants to States in accordance with this section for dem-
18 onstration projects (each in this section referred to as an
19 “MFP demonstration project”) designed to achieve the
20 following objectives with respect to institutional and home
21 and community-based long-term care services under State
22 Medicaid programs:

23 (1) REBALANCING.—Increase the use of home
24 and community-based, rather than institutional,
25 long-term care services.

1 (2) MONEY FOLLOWS THE PERSON.—Eliminate
2 barriers or mechanisms, whether in the State law,
3 the State Medicaid plan, the State budget, or other-
4 wise, that prevent or restrict the flexible use of Med-
5 icaid funds to enable Medicaid-eligible individuals to
6 receive support for appropriate and necessary long-
7 term services in the settings of their choice.

8 (3) CONTINUITY OF SERVICE.—Increase the
9 ability of the State Medicaid program to assure con-
10 tinued provision of home and community-based long-
11 term care services to eligible individuals who choose
12 to transition from an institutional to a community
13 setting.

14 (4) QUALITY ASSURANCE AND QUALITY IM-
15 PROVEMENT.—Ensure that procedures are in place
16 (at least comparable to those required under the
17 qualified HCB program) to provide quality assur-
18 ance for eligible individuals receiving Medicaid home
19 and community-based long-term care services and to
20 provide for continuous quality improvement in such
21 services.

22 (b) DEFINITIONS.—For purposes of this section:

23 (1) HOME AND COMMUNITY-BASED LONG-TERM
24 CARE SERVICES.—The term “home and community-
25 based long-term care services” means, with respect

1 to a State Medicaid program, home and community-
2 based services (including home health and personal
3 care services) that are provided under the State's
4 qualified HCB program or that could be provided
5 under such a program but are otherwise provided
6 under the Medicaid program.

7 (2) ELIGIBLE INDIVIDUAL.—The term “eligible
8 individual” means, with respect to an MFP dem-
9 onstration project of a State, an individual in the
10 State—

11 (A) who, immediately before beginning
12 participation in the MFP demonstration
13 project—

14 (i) resides (and has resided, for a pe-
15 riod of not less than 6 months or for such
16 longer minimum period, not to exceed 2
17 years, as may be specified by the State) in
18 an inpatient facility;

19 (ii) is receiving Medicaid benefits for
20 inpatient services furnished by such inpa-
21 tient facility; and

22 (iii) with respect to whom a deter-
23 mination has been made that, but for the
24 provision of home and community-based
25 long-term care services, the individual

1 would continue to require the level of care
2 provided in an inpatient facility; and

3 (B) who resides in a qualified residence be-
4 ginning on the initial date of participation in
5 the demonstration project.

6 (3) INPATIENT FACILITY.—The term “inpatient
7 facility” means a hospital, nursing facility, or inter-
8 mediate care facility for the mentally retarded. Such
9 term includes an institution for mental diseases, but
10 only, with respect to a State, to the extent medical
11 assistance is available under the State Medicaid plan
12 for services provided by such institution.

13 (4) MEDICAID.—The term “Medicaid” means,
14 with respect to a State, the State program under
15 title XIX of the Social Security Act (including any
16 waiver or demonstration under such title or under
17 section 1115 of such Act relating to such title).

18 (5) QUALIFIED HCB PROGRAM.—The term
19 “qualified HCB program” means a program pro-
20 viding home and community-based long-term care
21 services operating under Medicaid, whether or not
22 operating under waiver authority.

23 (6) QUALIFIED RESIDENCE.—The term “quali-
24 fied residence” means, with respect to an eligible
25 individual—

1 (A) a home owned or leased by the indi-
2 vidual or the individual's family member;

3 (B) an apartment with an individual lease,
4 with lockable access and egress, and which in-
5 cludes living, sleeping, bathing, and cooking
6 areas over which the individual or the individ-
7 ual's family has domain and control; and

8 (C) a residence, in a community-based res-
9 idential setting, in which no more than 4 unre-
10 lated individuals reside.

11 (7) QUALIFIED EXPENDITURES.—The term
12 “qualified expenditures” means expenditures by the
13 State under its MFP demonstration project for
14 home and community-based long-term care services
15 for an eligible individual participating in the MFP
16 demonstration project, but only with respect to serv-
17 ices furnished during the 12-month period beginning
18 on the date the individual is discharged from an in-
19 patient facility referred to in paragraph (2)(A)(i).

20 (8) SELF-DIRECTED SERVICES.—The term
21 “self-directed” means, with respect to home and
22 community-based long-term care services for an eli-
23 gible individual, such services for the individual
24 which are planned and purchased under the direc-
25 tion and control of such individual or the individ-

1 ual's authorized representative (as defined by the
2 Secretary), including the amount, duration, scope,
3 provider, and location of such services, under the
4 State Medicaid program consistent with the fol-
5 lowing requirements:

6 (A) ASSESSMENT.—There is an assess-
7 ment of the needs, capabilities, and preferences
8 of the individual with respect to such services.

9 (B) SERVICE PLAN.—Based on such as-
10 sessment, there is developed jointly with such
11 individual or the individual's authorized rep-
12 resentative a plan for such services for such in-
13 dividual that is approved by the State and
14 that—

15 (i) specifies those services, if any,
16 which the individual or the individual's au-
17 thorized representative would be respon-
18 sible for directing;

19 (ii) identifies the methods by which
20 the individual or the individual's author-
21 ized representative or an agency designated
22 by an individual or representative will se-
23 lect, manage, and dismiss providers of such
24 services;

1 (iii) specifies the role of family mem-
2 bers and others whose participation is
3 sought by the individual or the individual's
4 authorized representative with respect to
5 such services;

6 (iv) is developed through a person-
7 centered process that—

8 (I) is directed by the individual
9 or the individual's authorized rep-
10 resentative;

11 (II) builds upon the individual's
12 capacity to engage in activities that
13 promote community life and that re-
14 spects the individual's preferences,
15 choices, and abilities; and

16 (III) involves families, friends,
17 and professionals as desired or re-
18 quired by the individual or the indi-
19 vidual's authorized representative;

20 (v) includes appropriate risk manage-
21 ment techniques that recognize the roles
22 and sharing of responsibilities in obtaining
23 services in a self-directed manner and as-
24 sure the appropriateness of such plan
25 based upon the resources and capabilities

1 of the individual or the individual's author-
2 ized representative; and

3 (vi) may include an individualized
4 budget which identifies the dollar value of
5 the services and supports under the control
6 and direction of the individual or the indi-
7 vidual's authorized representative.

8 (C) BUDGET PROCESS.—With respect to
9 individualized budgets described in subpara-
10 graph (B)(vi), the State application under sub-
11 section (c)—

12 (i) describes the method for calcu-
13 lating the dollar values in such budgets
14 based on reliable costs and service utiliza-
15 tion;

16 (ii) defines a process for making ad-
17 justments in such dollar values to reflect
18 changes in individual assessments and
19 service plans; and

20 (iii) provides a procedure to evaluate
21 expenditures under such budgets.

22 (9) STATE.—The term “State” has the mean-
23 ing given such term for purposes of title XIX of the
24 Social Security Act.

1 (c) STATE APPLICATION.—A State seeking approval
2 of an MFP demonstration project shall submit to the Sec-
3 retary, at such time and in such format as the Secretary
4 requires, an application meeting the following require-
5 ments and containing such additional information, provi-
6 sions, and assurances, as the Secretary may require:

7 (1) ASSURANCE OF A PUBLIC DEVELOPMENT
8 PROCESS.—The application contains an assurance
9 that the State has engaged, and will continue to en-
10 gage, in a public process for the design, develop-
11 ment, and evaluation of the MFP demonstration
12 project that allows for input from eligible individ-
13 uals, the families of such individuals, authorized rep-
14 resentatives of such individuals, providers, and other
15 interested parties.

16 (2) OPERATION IN CONNECTION WITH QUALI-
17 FIED HCB PROGRAM TO ASSURE CONTINUITY OF
18 SERVICES.—The State will conduct the MFP dem-
19 onstration project for eligible individuals in conjunc-
20 tion with the operation of a qualified HCB program
21 that is in operation (or approved) in the State for
22 such individuals in a manner that assures continuity
23 of Medicaid coverage for such individuals so long as
24 such individuals continue to be eligible for medical
25 assistance.

1 (3) DEMONSTRATION PROJECT PERIOD.—The
2 application shall specify the period of the MFP dem-
3 onstration project, which shall include at least 2 con-
4 secutive fiscal years in the 5-fiscal-year period begin-
5 ning with fiscal year 2009.

6 (4) SERVICE AREA.—The application shall
7 specify the service area or areas of the MFP dem-
8 onstration project, which may be a statewide area or
9 one or more geographic areas of the State.

10 (5) TARGETED GROUPS AND NUMBERS OF INDI-
11 VIDUALS SERVED.—The application shall specify—

12 (A) the target groups of eligible individuals
13 to be assisted to transition from an inpatient
14 facility to a qualified residence during each fis-
15 cal year of the MFP demonstration project;

16 (B) the projected numbers of eligible indi-
17 viduals in each targeted group of eligible indi-
18 viduals to be so assisted during each such year;
19 and

20 (C) the estimated total annual qualified ex-
21 penditures for each fiscal year of the MFP
22 demonstration project.

23 (6) INDIVIDUAL CHOICE, CONTINUITY OF
24 CARE.—The application shall contain assurances
25 that—

1 (A) each eligible individual or the individ-
2 ual's authorized representative will be provided
3 the opportunity to make an informed choice re-
4 garding whether to participate in the MFP
5 demonstration project;

6 (B) each eligible individual or the individ-
7 ual's authorized representative will choose the
8 qualified residence in which the individual will
9 reside and the setting in which the individual
10 will receive home and community-based long-
11 term care services;

12 (C) the State will continue to make avail-
13 able, so long as the State operates its qualified
14 HCB program consistent with applicable re-
15 quirements, home and community-based long-
16 term care services to each individual who com-
17 pletes participation in the MFP demonstration
18 project for as long as the individual remains eli-
19 gible for medical assistance for such services
20 under such qualified HCB program (including
21 meeting a requirement relating to requiring a
22 level of care provided in an inpatient facility
23 and continuing to require such services).

24 (7) REBALANCING.—The application shall—

1 (A) provide such information as the Sec-
2 retary may require concerning the dollar
3 amounts of State Medicaid expenditures for the
4 fiscal year, immediately preceding the first fis-
5 cal year of the State's MFP demonstration
6 project, for long-term care services and the per-
7 centage of such expenditures that were for in-
8 stitutional long-term care services or were for
9 home and community-based long-term care
10 services;

11 (B)(i) specify the methods to be used by
12 the State to increase, for each fiscal year dur-
13 ing the MFP demonstration project, the dollar
14 amount of such total expenditures for home and
15 community-based long-term care services and
16 the percentage of such total expenditures for
17 long-term care services that are for home and
18 community-based long-term care services; and

19 (ii) describe the extent to which the MFP
20 demonstration project will contribute to accom-
21 plishment of objectives described in subsection
22 (a).

23 (8) MONEY FOLLOWS THE PERSON.—The appli-
24 cation shall describe the methods to be used by the
25 State to eliminate any legal, budgetary, or other bar-

1 riers to flexibility in the availability of Medicaid
2 funds to pay for long-term care services for eligible
3 individuals participating in the project in the appro-
4 priate settings of their choice, including costs to
5 transition from an institutional setting to a qualified
6 residence.

7 (9) MAINTENANCE OF EFFORT AND COST-EF-
8 FECTIVENESS.—The application shall contain or be
9 accompanied by such information and assurances as
10 may be required to satisfy the Secretary that—

11 (A) total expenditures under the State
12 Medicaid program for home and community-
13 based long-term care services will not be less
14 for any fiscal year during the MFP demonstra-
15 tion project than for the greater of such ex-
16 penditures for—

17 (i) fiscal year 2005; or

18 (ii) any succeeding fiscal year before
19 the first year of the MFP demonstration
20 project; and

21 (B) in the case of a qualified HCB pro-
22 gram operating under a waiver under sub-
23 section (c) or (d) of section 1915 of the Social
24 Security Act (42 U.S.C. 1396n), but for the
25 amount awarded under a grant under this sec-

1 tion, the State program would continue to meet
2 the cost-effectiveness requirements of subsection
3 (c)(2)(D) of such section or comparable require-
4 ments under subsection (d)(5) of such section,
5 respectively.

6 (10) WAIVER REQUESTS.—The application shall
7 contain or be accompanied by requests for any modi-
8 fication or adjustment of waivers of Medicaid re-
9 quirements described in subsection (d)(3), including
10 adjustments to the maximum numbers of individuals
11 included and package of benefits, including one-time
12 transitional services, provided.

13 (11) QUALITY ASSURANCE AND QUALITY IM-
14 PROVEMENT.—The application shall include—

15 (A) a plan satisfactory to the Secretary for
16 quality assurance and quality improvement for
17 home and community-based long-term care
18 services under the State Medicaid program, in-
19 cluding a plan to assure the health and welfare
20 of individuals participating in the MFP dem-
21 onstration project; and

22 (B) an assurance that the State will co-
23 operate in carrying out activities under sub-
24 section (f) to develop and implement continuous
25 quality assurance and quality improvement sys-

1 tems for home and community-based long-term
2 care services.

3 (12) OPTIONAL PROGRAM FOR SELF-DIRECTED
4 SERVICES.—If the State elects to provide for any
5 home and community-based long-term care services
6 as self-directed services (as defined in subsection
7 (b)(8)) under the MFP demonstration project, the
8 application shall provide the following:

9 (A) MEETING REQUIREMENTS.—A descrip-
10 tion of how the project will meet the applicable
11 requirements of such subsection for the provi-
12 sion of self-directed services.

13 (B) VOLUNTARY ELECTION.—A description
14 of how eligible individuals will be provided with
15 the opportunity to make an informed election to
16 receive self-directed services under the project
17 and after the end of the project.

18 (C) STATE SUPPORT IN SERVICE PLAN DE-
19 VELOPMENT.—Satisfactory assurances that the
20 State will provide support to eligible individuals
21 who self-direct in developing and implementing
22 their service plans.

23 (D) OVERSIGHT OF RECEIPT OF SERV-
24 ICES.—Satisfactory assurances that the State
25 will provide oversight of eligible individual's re-

1 ceipt of such self-directed services, including
2 steps to assure the quality of services provided
3 and that the provision of such services are con-
4 sistent with the service plan under such sub-
5 section.

6 Nothing in this section shall be construed as requir-
7 ing a State to make an election under the project to
8 provide for home and community-based long-term
9 care services as self-directed services, or as requiring
10 an individual to elect to receive self-directed services
11 under the project.

12 (13) REPORTS AND EVALUATION.—The applica-
13 tion shall provide that—

14 (A) the State will furnish to the Secretary
15 such reports concerning the MFP demonstra-
16 tion project, on such timetable, in such uniform
17 format, and containing such information as the
18 Secretary may require, as will allow for reliable
19 comparisons of MFP demonstration projects
20 across States; and

21 (B) the State will participate in and co-
22 operate with the evaluation of the MFP dem-
23 onstration project.

24 (d) SECRETARY'S AWARD OF COMPETITIVE
25 GRANTS.—

1 (1) IN GENERAL.—The Secretary shall award
2 grants under this section on a competitive basis to
3 States selected from among those with applications
4 meeting the requirements of subsection (c), in ac-
5 cordance with the provisions of this subsection.

6 (2) SELECTION AND MODIFICATION OF STATE
7 APPLICATIONS.—In selecting State applications for
8 the awarding of such a grant, the Secretary—

9 (A) shall take into consideration the man-
10 ner in which, and extent to which, the State
11 proposes to achieve the objectives specified in
12 subsection (a);

13 (B) shall seek to achieve an appropriate
14 national balance in the numbers of eligible indi-
15 viduals, within different target groups of eligi-
16 ble individuals, who are assisted to transition to
17 qualified residences under MFP demonstration
18 projects, and in the geographic distribution of
19 States operating MFP demonstration projects;

20 (C) shall give preference to State applica-
21 tions proposing—

22 (i) to provide transition assistance to
23 eligible individuals within multiple target
24 groups; and

1 (ii) to provide eligible individuals with
2 the opportunity to receive home and com-
3 munity-based long-term care services as
4 self-directed services, as defined in sub-
5 section (b)(8); and

6 (D) shall take such objectives into consid-
7 eration in setting the annual amounts of State
8 grant awards under this section.

9 (3) WAIVER AUTHORITY.—The Secretary is au-
10 thorized to waive the following provisions of title
11 XIX of the Social Security Act, to the extent nec-
12 essary to enable a State initiative to meet the re-
13 quirements and accomplish the purposes of this sec-
14 tion:

15 (A) STATEWIDENESS.—Section
16 1902(a)(1), in order to permit implementation
17 of a State initiative in a selected area or areas
18 of the State.

19 (B) COMPARABILITY.—Section
20 1902(a)(10)(B), in order to permit a State ini-
21 tiative to assist a selected category or categories
22 of individuals described in subsection (b)(2)(A).

23 (C) INCOME AND RESOURCES ELIGI-
24 BILITY.—Section 1902(a)(10)(C)(i)(III), in
25 order to permit a State to apply institutional

1 eligibility rules to individuals transitioning to
2 community-based care.

3 (D) PROVIDER AGREEMENTS.—Section
4 1902(a)(27), in order to permit a State to im-
5 plement self-directed services in a cost-effective
6 manner.

7 (4) CONDITIONAL APPROVAL OF OUTYEAR
8 GRANT.—In awarding grants under this section, the
9 Secretary shall condition the grant for the second
10 and any subsequent fiscal years of the grant period
11 on the following:

12 (A) NUMERICAL BENCHMARKS.—The
13 State must demonstrate to the satisfaction of
14 the Secretary that it is meeting numerical
15 benchmarks specified in the grant agreement
16 for—

17 (i) increasing State Medicaid support
18 for home and community-based long-term
19 care services under subsection (c)(5); and

20 (ii) numbers of eligible individuals as-
21 sisted to transition to qualified residences.

22 (B) QUALITY OF CARE.—The State must
23 demonstrate to the satisfaction of the Secretary
24 that it is meeting the requirements under sub-

1 section (c)(11) to assure the health and welfare
2 of MFP demonstration project participants.

3 (e) PAYMENTS TO STATES; CARRYOVER OF UNUSED
4 GRANT AMOUNTS.—

5 (1) PAYMENTS.—For each calendar quarter in
6 a fiscal year during the period a State is awarded
7 a grant under subsection (d), the Secretary shall pay
8 to the State from its grant award for such fiscal
9 year an amount equal to the lesser of—

10 (A) 90 percent of the amount of qualified
11 expenditures made during such quarter; or

12 (B) the total amount remaining in such
13 grant award for such fiscal year (taking into
14 account the application of paragraph (2)).

15 (2) CARRYOVER OF UNUSED AMOUNTS.—Any
16 portion of a State grant award for a fiscal year
17 under this section remaining at the end of such fis-
18 cal year shall remain available to the State for the
19 next 4 fiscal years, subject to paragraph (3).

20 (3) REAWARDING OF CERTAIN UNUSED
21 AMOUNTS.—In the case of a State that the Sec-
22 retary determines pursuant to subsection (d)(4) has
23 failed to meet the conditions for continuation of a
24 MFP demonstration project under this section in a
25 succeeding year or years, the Secretary shall rescind

1 the grant awards for such succeeding year or years,
2 together with any unspent portion of an award for
3 prior years, and shall add such amounts to the ap-
4 propriation for the immediately succeeding fiscal
5 year for grants under this section.

6 (4) PREVENTING DUPLICATION OF PAYMENT.—

7 The payment under a MFP demonstration project
8 with respect to qualified expenditures shall be in lieu
9 of any payment with respect to such expenditures
10 that could otherwise be paid under Medicaid, includ-
11 ing under section 1903(a) of the Social Security Act.
12 Nothing in the previous sentence shall be construed
13 as preventing the payment under Medicaid for such
14 expenditures in a grant year after amounts available
15 to pay for such expenditures under the MFP dem-
16 onstration project have been exhausted.

17 (f) QUALITY ASSURANCE AND IMPROVEMENT; TECH-
18 NICAL ASSISTANCE; OVERSIGHT.—

19 (1) IN GENERAL.—The Secretary, either di-
20 rectly or by grant or contract, shall provide for tech-
21 nical assistance to, and oversight of, States for pur-
22 poses of upgrading quality assurance and quality im-
23 provement systems under Medicaid home and com-
24 munity-based waivers, including—

1 (A) dissemination of information on prom-
2 ising practices;

3 (B) guidance on system design elements
4 addressing the unique needs of participating
5 beneficiaries;

6 (C) ongoing consultation on quality, in-
7 cluding assistance in developing necessary tools,
8 resources, and monitoring systems; and

9 (D) guidance on remedying programmatic
10 and systemic problems.

11 (2) FUNDING.—From the amounts appro-
12 priated under subsection (h)(1) for the portion of
13 fiscal year 2009 that begins on January 1, 2009,
14 and ends on September 30, 2009, and for fiscal year
15 2010, not more than \$2,400,000 shall be available
16 to the Secretary to carry out this subsection during
17 the period that begins on January 1, 2009, and ends
18 on September 30, 2013.

19 (g) RESEARCH AND EVALUATION.—

20 (1) IN GENERAL.—The Secretary, directly or
21 through grant or contract, shall provide for research
22 on, and a national evaluation of, the program under
23 this section, including assistance to the Secretary in
24 preparing the final report required under paragraph
25 (2). The evaluation shall include an analysis of pro-

1 jected and actual savings related to the transition of
2 individuals to qualified residences in each State con-
3 ducting an MFP demonstration project.

4 (2) FINAL REPORT.—The Secretary shall make
5 a final report to the President and Congress, not
6 later than September 30, 2013, reflecting the eval-
7 uation described in paragraph (1) and providing
8 findings and conclusions on the conduct and effec-
9 tiveness of MFP demonstration projects.

10 (3) FUNDING.—From the amounts appro-
11 priated under subsection (h)(1) for each of fiscal
12 years 2010 through 2013, not more than \$1,100,000
13 per year shall be available to the Secretary to carry
14 out this subsection.

15 (h) APPROPRIATIONS.—

16 (1) IN GENERAL.—There are appropriated,
17 from any funds in the Treasury not otherwise appro-
18 priated, for grants to carry out this section—

19 (A) \$250,000,000 for the portion of fiscal
20 year 2009 beginning on January 1, 2009, and
21 ending on September 30, 2009;

22 (B) \$300,000,000 for fiscal year 2010;

23 (C) \$350,000,000 for fiscal year 2011;

24 (D) \$400,000,000 for fiscal year 2012;

25 and

1 (E) \$450,000,000 for fiscal year 2013.

2 (2) AVAILABILITY.—Amounts made available
3 under paragraph (1) for a fiscal year shall remain
4 available for the awarding of grants to States by not
5 later than September 30, 2013.

6 **CHAPTER 6—OPTION FOR HURRICANE**
7 **KATRINA DISASTER STATES TO DELAY**
8 **APPLICATION**

9 **SEC. 6071. OPTION FOR HURRICANE KATRINA DISASTER**
10 **STATES TO DELAY APPLICATION.**

11 Notwithstanding any provision of this subtitle, or any
12 amendment made by this subtitle, the State of Louisiana,
13 Mississippi, or Alabama may elect to not have the provi-
14 sions of this subtitle, or of any amendment made by this
15 subtitle, apply with respect to the State during any period
16 for which a major disaster declared in accordance with
17 section 401 of the Robert T. Stafford Disaster Relief and
18 Emergency Assistance Act (42 U.S.C. 5170) with respect
19 to a parish, in the case of Louisiana, or a county, in the
20 case of Mississippi or Alabama, as a result of Hurricane
21 Katrina is in effect.

22 **Subtitle B—Medicare**

23 **SEC. 6101. IMPROVEMENTS TO THE MEDICARE-DEPENDENT**
24 **HOSPITAL (MDH) PROGRAM.**

25 (a) 5-YEAR EXTENSION.—

1 (1) EXTENSION OF PAYMENT METHOD-
2 OLOGY.—Section 1886(d)(5)(G) (42 U.S.C.
3 1395ww(d)(5)(G)) is amended—

4 (A) in clause (i), by striking “October 1,
5 2006” and inserting “October 1, 2011”; and

6 (B) in clause (ii)(II)—

7 (i) by striking “October 1, 2006” and
8 inserting “October 1, 2011”; and

9 (ii) by inserting “or for discharges in
10 the fiscal year” after “for the cost report-
11 ing period”.

12 (2) CONFORMING AMENDMENTS.—

13 (A) EXTENSION OF TARGET AMOUNT.—
14 Section 1886(b)(3)(D) (42 U.S.C.
15 1395ww(b)(3)(D)) is amended—

16 (i) in the matter preceding clause
17 (i)—

18 (I) by striking “beginning” and
19 inserting “occurring”; and

20 (II) by striking “October 1,
21 2006” and inserting “October 1,
22 2011”; and

23 (ii) in clause (iv), by striking
24 “through fiscal year 2005” and inserting
25 “through fiscal year 2011”.

1 (B) PERMITTING HOSPITALS TO DECLINE
2 RECLASSIFICATION.—Section 13501(e)(2) of
3 the Omnibus Budget Reconciliation Act of 1993
4 (42 U.S.C. 1395ww note) is amended by strik-
5 ing “through fiscal year 2005” and inserting
6 “through fiscal year 2011”.

7 (b) OPTION TO USE OF 2002 AS BASE YEAR.—Sec-
8 tion 1886(b)(3) (42 U.S.C. 1395ww(b)(3)) is amended—
9 (1) in subparagraph (D), by inserting “subject
10 to subparagraph (K),” after “(d)(5)(G),”; and

11 (2) by adding at the end the following new sub-
12 paragraph:

13 “(K)(i) With respect to discharges occurring on or
14 after October 1, 2006, in the case of a medicare-depend-
15 ent, small rural hospital, for purposes of applying sub-
16 paragraph (D)—

17 “(I) there shall be substituted for the base cost
18 reporting period described in subparagraph (D)(i)
19 the 12-month cost reporting period beginning during
20 fiscal year 2002; and

21 “(II) any reference in such subparagraph to the
22 ‘first cost reporting period’ described in such sub-
23 paragraph is deemed a reference to the first cost re-
24 porting period beginning on or after October 1,
25 2006.

1 “(ii) This subparagraph shall only apply to a hospital
2 if the substitution described in clause (i)(I) results in an
3 increase in the target amount under subparagraph (D) for
4 the hospital.”.

5 (c) ENHANCED PAYMENT FOR AMOUNT BY WHICH
6 THE TARGET EXCEEDS THE PPS RATE.—Section
7 1886(d)(5)(G)(ii)(II) (42 U.S.C.
8 1395ww(d)(5)(G)(iv)(II)) is amended by inserting “(or 75
9 percent in the case of discharges occurring on or after Oc-
10 tober 1, 2006)” after “50 percent”.

11 (d) ENHANCED DISPROPORTIONATE SHARE HOS-
12 PITAL (DSH) TREATMENT FOR MEDICARE DEPENDENT
13 HOSPITALS.—Section 1886(d)(5)(F)(xiv)(II) (42 U.S.C.
14 1395ww(d)(5)(F)(xiv)(II)) is amended by inserting “or, in
15 the case of discharges occurring on or after October 1,
16 2006, as a medicare-dependent, small rural hospital under
17 subparagraph (G)(iv)” before the period at the end.

18 **SEC. 6102. REDUCTION IN PAYMENTS TO SKILLED NURSING**
19 **FACILITIES FOR BAD DEBT.**

20 (a) IN GENERAL.—Section 1861(v)(1) (42 U.S.C.
21 1395x(v)(1)) is amended by adding at the end the fol-
22 lowing new subparagraph:

23 “(V) In determining such reasonable costs for skilled
24 nursing facilities with respect to services furnished on or
25 after October 1, 2005, the amount of bad debts otherwise

1 treated as allowed costs which are attributable to the
2 deductibles and coinsurance amounts under this title shall
3 be reduced by 30 percent of such amount otherwise allow-
4 able.”.

5 (b) TECHNICAL AMENDMENT.—Section
6 1861(v)(1)(T) (42 U.S.C. 1395x(v)(1)(T)) is amended by
7 striking “section 1833(t)(5)(B)” and inserting “section
8 1833(t)(8)(B)”.

9 **SEC. 6103. TWO-YEAR EXTENSION OF THE 50 PERCENT COM-**
10 **PLIANCE THRESHOLD USED TO DETERMINE**
11 **WHETHER A HOSPITAL OR UNIT OF A HOS-**
12 **PITAL IS AN INPATIENT REHABILITATION FA-**
13 **CILITY UNDER THE MEDICARE PROGRAM.**

14 (a) EXTENSION.—

15 (1) IN GENERAL.—Effective as if enacted on
16 June 30, 2005, notwithstanding section
17 412.23(b)(2) of title 42, Code of Federal Regula-
18 tions, during the period beginning on July 1, 2005,
19 and ending on June 30, 2007, the Secretary of
20 Health and Human Services shall not—

21 (A) require a compliance rate, pursuant to
22 the criterion (commonly known as the “75 per-
23 cent rule”) that is used to determine whether a
24 hospital or unit of a hospital is an inpatient re-
25 habilitation facility (as defined in the rule pub-

1 lished in the Federal Register on May 7, 2004,
2 entitled “Medicare Program; Final Rule;
3 Changes to the Criteria for Being Classified as
4 an Inpatient Rehabilitation Facility” (69 Fed.
5 Reg. 25752)), that is greater than the 50 per-
6 cent compliance threshold that became effective
7 on July 1, 2004; or

8 (B) change the designation of an inpatient
9 rehabilitation facility that is in compliance with
10 such 50 percent threshold.

11 (2) RETROACTIVE STATUS AS AN INPATIENT
12 REHABILITATION FACILITY; PAYMENTS; EXPEDITED
13 REVIEW.—The Secretary of Health and Human
14 Services shall establish procedures for—

15 (A) making any necessary retroactive ad-
16 justment to restore the status of a facility as an
17 inpatient rehabilitation facility as a result of
18 subsection (a); and

19 (B) making any necessary payments to in-
20 patient rehabilitation facilities based on such
21 adjustment for discharges occurring on or after
22 July 1, 2005, and before the date of enactment
23 of this Act.

24 (b) SPECIAL RULE.—In the case of a hospital or unit
25 of a hospital that failed to meet the 50 percent compliance

1 threshold described in subsection (a)(1)(A) with respect
2 to the first cost reporting period of the hospital or unit
3 that began on or after July 1, 2004, the following rules
4 shall apply:

5 (1) Such hospital or unit shall be deemed to
6 meet such 50 percent threshold for purposes of sub-
7 section (a).

8 (2) The Secretary shall examine all the claims
9 of the hospital or unit under title XVIII of the So-
10 cial Security Act submitted during the 6-month pe-
11 riod beginning after the end of such first cost re-
12 porting period.

13 (3) If the Secretary determines after such re-
14 view that the hospital or unit is still not in compli-
15 ance with such 50 percent compliance threshold—

16 (A) the deemed status of the hospital or
17 unit under paragraph (1) shall be revoked ret-
18 roactive to the beginning of such 6-month pe-
19 riod; and

20 (B) the Secretary shall provide for the col-
21 lection of any necessary overpayments by rea-
22 son of the revocation under subparagraph (A).

23 (c) STUDY AND REPORT BY THE HHS INSPECTOR
24 GENERAL.—

25 (1) STUDY.—

1 (A) IN GENERAL.—The Inspector General
2 of the Department of Health and Human Serv-
3 ices shall conduct a study of hospitals and units
4 of hospitals that—

5 (i) are designated as inpatient reha-
6 bilitation facilities under title XVIII of the
7 Social Security Act; and

8 (ii) would not be so designated if this
9 section had not been enacted because the
10 hospital or unit has a compliance rate that
11 is greater than the 50 percent compliance
12 threshold described in subsection (a)(1)(A)
13 but is less than the 60 percent compliance
14 threshold that would have become effective
15 on July 1, 2005, but for this section.

16 (B) REQUIREMENT.—In conducting the
17 study under subparagraph (A), the Inspector
18 General shall analyze the types of patients the
19 hospitals and units are treating and issues re-
20 lating to the medical conditions of such patients
21 that do not meet the medical requirements for
22 determining compliance with such threshold.

23 (2) REPORT.—Not later than January 1, 2007,
24 the Inspector General shall submit to Congress and
25 the Secretary a report on the study conducted under

1 paragraph (1), together with such recommendations
2 as the Inspector General determines appropriate.

3 (d) REHABILITATION ADVISORY COUNCIL.—

4 (1) ESTABLISHMENT.—The Secretary shall es-
5 tablish an advisory council to be known as the “Re-
6 habilitation Advisory Council”.

7 (2) MEMBERSHIP.—The membership of the Re-
8 habilitation Advisory Council shall include—

9 (A) physicians;

10 (B) medicare beneficiaries;

11 (C) representatives of inpatient rehabilita-
12 tion facilities; and

13 (D) representatives of other entities and
14 practitioners that provide rehabilitative care in
15 settings other than in such facilities, such as
16 skilled nursing facilities.

17 (3) DUTIES.—

18 (A) ADVICE AND RECOMMENDATIONS.—

19 The Rehabilitation Advisory Council shall pro-
20 vide advice and recommendations to Congress
21 and the Secretary concerning the coverage of
22 rehabilitation services under the medicare pro-
23 gram, including the appropriate medical criteria
24 for determining the appropriateness of inpatient
25 rehabilitation facility admissions.

1 (B) PERIODIC REPORTS.—The Rehabilita-
2 tion Advisory Council shall provide Congress
3 and the Secretary with periodic reports that
4 summarize—

5 (i) the Council’s activities; and

6 (ii) any recommendations for legisla-
7 tion or administrative action the Council
8 considers to be appropriate.

9 (4) TERMINATION.—The Rehabilitation
10 Advisory Council shall terminate on September
11 30, 2010.

12 **SEC. 6104. PROHIBITION ON PHYSICIAN SELF REFERRALS**
13 **TO PHYSICIAN OWNED, LIMITED SERVICE**
14 **HOSPITALS.**

15 (a) PROHIBITION.—Section 1877(d) (42 U.S.C.
16 1395nn(d)) is amended in each of paragraphs (2)(B) and
17 (3)(B) by striking “effective for the 18-month period be-
18 ginning on the date of enactment of the Medicare Pre-
19 scription Drug, Improvement, and Modernization Act of
20 2003” and inserting “on and after December 8, 2003”.

21 (b) REVISIONS TO THE REQUIREMENTS TO QUALIFY
22 FOR THE EXCEPTION TO THE DEFINITION OF SPECIALTY
23 HOSPITAL.—Section 1877(h)(7)(B) (42 U.S.C.
24 1395nn(h)(7)(B)) is amended—

1 (1) by redesignating clauses (iii), (iv), and (v)
2 as clauses (vi), (vii), and (viii), respectively;

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

5 “(iii) for which the percent of invest-
6 ment in the hospital by physician investors
7 at any time on or after June 8, 2005, is
8 no greater than the percent of such invest-
9 ment by physician investors as of such
10 date;

11 “(iv) for which the percent of invest-
12 ment in the hospital by any physician in-
13 vestor at any time on or after June 8,
14 2005, is no greater than the percent of
15 such investment by such physician as of
16 such date;

17 “(v) for which the number of oper-
18 ating rooms at the hospital at any time on
19 or after June 8, 2005, is no greater than
20 the number of such rooms as of such
21 date;” and

22 (3) by striking clause (vii), as so redesignated,
23 and inserting the following:

24 “(vii) for which—

1 “(I) during the period beginning
2 on December 8, 2003, and ending on
3 June 7, 2005, any increase in the
4 number of beds occurs only in the fa-
5 cilities on the main campus of the
6 hospital and does not exceed 50 per-
7 cent of the number of beds in the hos-
8 pital as of November 18, 2003, or 5
9 beds, whichever is greater; and

10 “(II) the number of beds at the
11 hospital at any time on or after June
12 8, 2005, is no greater than the num-
13 ber of such beds as of such date;
14 and”.

15 (c) EFFECTIVE DATE.—The amendments made by
16 this section shall take effect on June 8, 2005.

17 **SEC. 6105. MINIMUM UPDATE FOR PHYSICIANS’ SERVICES**
18 **FOR 2006.**

19 (a) MINIMUM UPDATE FOR 2006.—Section 1848(d)
20 (42 U.S.C. 1395w-4(d)), as amended by section 6110(c),
21 is amended by adding at the end the following new para-
22 graph:

23 “(7) UPDATE FOR 2006.—The update to the
24 single conversion factor established in paragraph
25 (1)(C) for 2006 shall be not less than 1 percent.”.

1 (b) CONFORMING AMENDMENT.—Section
2 1848(d)(4)(B) (42 U.S.C. 1395w-4(d)(4)(B)) is amended,
3 in the matter preceding clause (i), by striking “paragraph
4 (5)” and inserting “paragraphs (5) and (7)”.

5 (c) NOT TREATED AS CHANGE IN LAW AND REGULA-
6 TION IN SUSTAINABLE GROWTH RATE DETERMINA-
7 TION.—The amendments made by this section shall not
8 be treated as a change in law for purposes of applying
9 section 1848(f)(2)(D) of the Social Security Act (42
10 U.S.C. 1395w-4(f)(2)(D)).

11 **SEC. 6106. ONE-YEAR EXTENSION OF HOLD HARMLESS PRO-**
12 **VISIONS FOR SMALL RURAL HOSPITALS AND**
13 **SOLE COMMUNITY HOSPITALS UNDER THE**
14 **PROSPECTIVE PAYMENT SYSTEM FOR HOS-**
15 **PITAL OUTPATIENT DEPARTMENT SERVICES.**

16 Section 1833(t)(7)(D)(i) (42 U.S.C.
17 1395l(t)(7)(D)(i)) is amended by striking “January 1,
18 2006” and inserting “January 1, 2007”.

19 **SEC. 6107. UPDATE TO THE COMPOSITE RATE COMPONENT**
20 **OF THE BASIC CASE-MIX ADJUSTED PRO-**
21 **SPECTIVE PAYMENT SYSTEM FOR DIALYSIS**
22 **SERVICES.**

23 Section 1881(b)(12) (42 U.S.C. 1395rr(b)(12)) is
24 amended—

1 (1) in subparagraph (F), in the flush matter at
2 the end, by striking “Nothing” and inserting “Ex-
3 cept as provided in subparagraph (G), nothing”;

4 (2) by redesignating subparagraph (G) as sub-
5 paragraph (H); and

6 (3) by inserting after subparagraph (F) the fol-
7 lowing new subparagraph:

8 “(G) The Secretary shall increase the amount of the
9 composite rate component of the basic case-mix adjusted
10 system under subparagraph (B) for dialysis services fur-
11 nished on or after January 1, 2006, by 1.6 percent above
12 the amount of such composite rate component for such
13 services furnished on December 31, 2005.”.

14 **SEC. 6108. ONE-YEAR EXTENSION OF MORATORIUM ON**
15 **THERAPY CAPS.**

16 Section 1833(g)(4) (42 U.S.C. 1395l(g)(4)) is
17 amended by striking “and 2005” and inserting “2005,
18 and 2006”.

19 **SEC. 6109. TRANSFER OF TITLE OF CERTAIN DME TO PA-**
20 **TIENT AFTER 13-MONTH RENTAL.**

21 (a) IN GENERAL.—Section 1834(a)(7)(A) (42 U.S.C.
22 1395m(a)(7)(A)) is amended to read as follows:

23 “(A) PAYMENT.—In the case of an item of
24 durable medical equipment not described in

1 paragraphs (2) through (6), the following rules
2 shall apply:

3 “(i) RENTAL.—

4 “(I) IN GENERAL.—Payment for
5 the item shall be made on a monthly
6 basis for the rental of the item during
7 the period of medical need (but pay-
8 ments under this clause may not ex-
9 tend over a period of continuous use
10 (as determined by the Secretary) of
11 longer than 13 months).

12 “(II) PAYMENT AMOUNT.—Sub-
13 ject to subparagraph (B), the amount
14 recognized for the item—

15 “(aa) for each of the first 3
16 months of such period is 10 per-
17 cent of the purchase price recog-
18 nized under paragraph (8) with
19 respect to the item; and

20 “(bb) for each of the re-
21 maining months of such period is
22 7.5 percent of such purchase
23 price.

24 “(ii) OWNERSHIP AFTER RENTAL.—

1 “(I) TRANSFER OF TITLE.—On
2 the first day that begins after the
3 13th continuous month during which
4 payment is made for the rental of an
5 item under clause (i), the supplier of
6 the item shall transfer title to the
7 item to the individual.

8 “(II) MAINTENANCE AND SERV-
9 ICING.—After the supplier transfers
10 title to the item under subclause (I),
11 maintenance and servicing payments
12 shall, if the Secretary determines such
13 payments are reasonable and nec-
14 essary, be made (for parts and labor
15 not covered by the supplier’s or manu-
16 facturer’s warranty, as determined by
17 the Secretary to be appropriate for
18 the particular type of durable medical
19 equipment), and such payments shall
20 be in an amount determined to be ap-
21 propriate by the Secretary.”.

22 (b) EFFECTIVE DATE.—The amendment made by
23 subsection (a) shall apply to items furnished for which the
24 first rental month occurs on or after January 1, 2006.

1 **SEC. 6110. ESTABLISHMENT OF MEDICARE VALUE-BASED**
2 **PURCHASING PROGRAMS.**

3 (a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et
4 seq.) is amended—

5 (1) by redesignating part E as part F; and

6 (2) by inserting after part D the following new
7 part:

8 “PART E—VALUE-BASED PURCHASING
9 “QUALITY MEASUREMENT SYSTEMS FOR VALUE-BASED
10 PURCHASING PROGRAMS

11 “SEC. 1860E-1. (a) ESTABLISHMENT.—

12 “(1) IN GENERAL.—The Secretary shall develop
13 quality measurement systems in accordance with
14 subsections (b), (c), (d), and (e), for purposes of
15 providing value-based payments to—

16 “(A) hospitals pursuant to section 1860E-
17 2;

18 “(B) physicians and practitioners pursuant
19 to section 1860E-3;

20 “(C) plans pursuant to section 1860E-4;

21 “(D) end stage renal disease providers and
22 facilities pursuant to section 1860E-5; and

23 “(E) home health agencies pursuant to
24 section 1860E-6.

1 “(2) QUALITY.—The systems developed under
2 paragraph (1) shall measure the quality of the care
3 furnished by the provider involved.

4 “(3) HIGH QUALITY HEALTH CARE DEFINED.—
5 In this part, the term ‘high quality health care’
6 means health care that is safe, effective, patient-cen-
7 tered, timely, equitable, efficient, necessary, and ap-
8 propriate.

9 “(b) REQUIREMENTS FOR SYSTEMS.—Under each
10 quality measurement system described in subsection
11 (a)(1), the Secretary shall do the following:

12 “(1) MEASURES.—

13 “(A) IN GENERAL.—Subject to subpara-
14 graph (B), the Secretary shall select measures
15 of quality to be used by the Secretary under
16 each system.

17 “(B) REQUIREMENTS.—In selecting the
18 measures to be used under each system pursu-
19 ant to subparagraph (A), the Secretary shall, to
20 the extent feasible and practicable, ensure
21 that—

22 “(i) such measures are evidence-
23 based, reliable and valid, actionable, and
24 reasonable to collect and report;

1 “(ii) measures of process, structure,
2 outcomes, and beneficiary experience of
3 care are included;

4 “(iii) except for the system that is
5 used to provide value-based payments to
6 physicians and practitioners under section
7 1860E-3, measures of efficiency (where ef-
8 ficiency is improved quality care through
9 the effective use of resources) are included;

10 “(iv) measures of overuse and
11 underuse of health care items and services
12 are included;

13 “(v)(I) at least 1 measure of health
14 information technology infrastructure that
15 enables the provision of high quality health
16 care and facilitates the exchange of health
17 information, such as the use of 1 or more
18 elements of a qualified health information
19 system (as defined in subparagraph (E)),
20 is included during the first year each sys-
21 tem is implemented; and

22 “(II) additional measures of health in-
23 formation technology infrastructure are in-
24 cluded in subsequent years;

1 “(vi) in the case of the system that is
2 used to provide value-based payments to
3 hospitals under section 1860E–2, by not
4 later than January 1, 2008, at least 5
5 measures that take into account the unique
6 characteristics of small hospitals located in
7 rural areas and frontier areas are included;
8 and

9 “(vii) measures that assess the quality
10 of care furnished to frail individuals over
11 the age of 75 and to individuals with mul-
12 tiple complex chronic conditions are in-
13 cluded.

14 “(C) REQUIREMENT FOR COLLECTION OF
15 DATA ON A MEASURE FOR 1 YEAR PRIOR TO
16 USE UNDER THE SYSTEMS.—Data on any
17 measure selected by the Secretary under sub-
18 paragraph (A) must be collected by the Sec-
19 retary for at least a 12-month period before
20 such measure may be used to determine wheth-
21 er a provider receives a value-based payment
22 under a program described in subsection (a)(1).

23 “(D) AUTHORITY TO VARY MEASURES.—
24 The Secretary may vary the measures selected
25 under subparagraph (A) by the entity or indi-

1 vidual involved based on factors such as the
2 type of, the size of, and the scope and volume
3 of services provided by, the entity or individual.
4 If the Secretary varies the measures for pro-
5 viders under the preceding sentence, the Sec-
6 retary shall ensure that such measures are
7 aligned to promote coordinated quality of care
8 across provider settings.

9 “(E) QUALIFIED HEALTH INFORMATION
10 SYSTEM DEFINED.—For purposes of subpara-
11 graph (B)(iv)(I), the term ‘qualified health in-
12 formation system’ means a computerized sys-
13 tem (including hardware, software, and train-
14 ing) that—

15 “(i) protects the privacy and security
16 of health information and properly
17 encrypts such health information;

18 “(ii) maintains and provides access to
19 patients’ health records in an electronic
20 format;

21 “(iii) incorporates decision support
22 software to reduce medical errors and en-
23 hance health care quality;

1 “(iv) is consistent with data standards
2 and certification processes recommended
3 by the Secretary;

4 “(v) allows for the reporting of quality
5 measures; and

6 “(vi) includes other features deter-
7 mined appropriate by the Secretary.

8 “(2) WEIGHTS OF MEASURES.—The Secretary
9 shall assign weights to the measures used by the
10 Secretary under each system. If the Secretary deter-
11 mines appropriate, in assigning the weights under
12 the preceding sentence, some measures may be
13 weighted more heavily than other measures.

14 “(3) RISK ADJUSTMENT.—The Secretary shall
15 establish procedures, as appropriate, to control for
16 differences in beneficiary health status and bene-
17 ficiary characteristics. To the extent feasible, such
18 procedures may be based on existing models for con-
19 trolling for such differences.

20 “(4) MAINTENANCE.—

21 “(A) IN GENERAL.—The Secretary shall,
22 as determined appropriate, but not more often
23 than once each 12-month period, review and re-
24 vise each system, including through—

1 “(i) the refinement of measures under
2 the systems and the retirement of existing
3 outdated measures under the system;

4 “(ii) the refinement of the weights as-
5 signed to measures under the system; and

6 “(iii) the refinement of the risk ad-
7 justment procedures established pursuant
8 to paragraph (3) under the system.

9 “(B) REVISION SHALL ALLOW FOR COM-
10 PARISON OF DATA.—Each revision under sub-
11 paragraph (A) of a quality measurement system
12 shall allow for the comparison of data from one
13 year to the next for purposes of providing
14 value-based payments under the programs de-
15 scribed in subsection (a)(1).

16 “(5) USE OF MOST RECENT QUALITY DATA.—

17 “(A) IN GENERAL.—Except as provided in
18 subparagraph (B), the Secretary shall use the
19 most recent quality data with respect to the
20 provider involved that is available to the Sec-
21 retary.

22 “(B) INSUFFICIENT DATA DUE TO LOW
23 VOLUME.—If the Secretary determines that
24 there is insufficient data with respect to a
25 measure or measures because of a low number

1 of services provided, the Secretary may aggregate
2 data across more than 1 fiscal or calendar
3 year, as the case may be.

4 “(c) REQUIREMENTS FOR DEVELOPING AND RE-
5 VIEWING AND REVISING THE SYSTEMS.—In developing
6 and reviewing and revising each quality measurement sys-
7 tem under this section, the Secretary shall—

8 “(1) consult with, and take into account the
9 recommendations of, the entity that the Secretary
10 has an arrangement with under subsection (e);

11 “(2) consult with provider-based groups, clinical
12 specialty societies, and certification boards;

13 “(3) take into account existing quality measure-
14 ment systems that have been developed through a
15 rigorous process of validation and with the involve-
16 ment of entities and persons described in subsection
17 (e)(2)(B); and

18 “(4) take into account—

19 “(A) each of the reports by the Medicare
20 Payment Advisory Commission that are re-
21 quired under section 1860E–3(a)(1);

22 “(B) the results of appropriate studies, re-
23 ports, and demonstration programs; and

24 “(C) the report by the Institute of Medi-
25 cine of the National Academy of Sciences under

1 section 238(b) of the Medicare Prescription
2 Drug, Improvement, and Modernization Act of
3 2003 (Public Law 108–173).

4 “(d) REQUIREMENTS FOR IMPLEMENTING THE SYS-
5 TEMS.—In implementing each quality measurement sys-
6 tem under this section, the Secretary shall consult with
7 entities—

8 “(1) that have joined together to develop strate-
9 gies for quality measurement and reporting, includ-
10 ing the feasibility of collecting and reporting mean-
11 ingful data on quality measures; and

12 “(2) that involve representatives of health care
13 providers, health plans, consumers, employers, pur-
14 chasers, quality experts, government agencies, and
15 other individuals and groups that are interested in
16 quality of care.

17 “(e) ARRANGEMENT WITH AN ENTITY TO PROVIDE
18 ADVICE AND RECOMMENDATIONS.—

19 “(1) ARRANGEMENT.—On and after July 1,
20 2006, the Secretary shall have in place an arrange-
21 ment with an entity that meets the requirements de-
22 scribed in paragraph (2) under which such entity
23 provides the Secretary with advice on, and rec-
24 ommendations with respect to, the development and
25 review and revision of the quality measurement sys-

1 items under this section, including the assigning of
2 weights to the measures under subsection (b)(2).

3 “(2) REQUIREMENTS DESCRIBED.—The re-
4 quirements described in this paragraph are the fol-
5 lowing:

6 “(A) The entity is a private nonprofit enti-
7 ty governed by an executive director and a
8 board.

9 “(B) The members of the entity include
10 representatives of—

11 “(i)(I) health plans and providers re-
12 ceiving reimbursement under this title for
13 the provision of items and services, includ-
14 ing health plans and providers with experi-
15 ence in the care of the frail elderly and in-
16 dividuals with multiple complex chronic
17 conditions; or

18 “(II) groups representing such health
19 plans and providers;

20 “(ii) groups representing individuals
21 receiving benefits under this title;

22 “(iii) purchasers and employers or
23 groups representing purchasers or employ-
24 ers;

1 “(iv) organizations that focus on qual-
2 ity improvement as well as the measure-
3 ment and reporting of quality measures;

4 “(vi) organizations that certify and li-
5 cense such providers;

6 “(vi) State government health pro-
7 grams;

8 “(vii) persons skilled in the conduct
9 and interpretation of biomedical, health
10 services, and health economics research
11 and with expertise in outcomes and effec-
12 tiveness research and technology assess-
13 ment; and

14 “(viii) persons or entities involved in
15 the development and establishment of
16 standards and certification for health in-
17 formation technology systems and clinical
18 data.

19 “(C) The membership of the entity is rep-
20 resentative of individuals with experience
21 with—

22 “(i) urban health care issues;

23 “(ii) safety net health care issues; and

24 “(iii) rural and frontier health care
25 issues.

1 “(D) The entity does not charge a fee for
2 membership for participation in the work of the
3 entity related to the arrangement with the Sec-
4 retary under paragraph (1). If the entity does
5 require a fee for membership for participation
6 in other functions of the entity, there shall be
7 no linkage between such fee and participation
8 in the work of the entity related to such ar-
9 rangement with the Secretary.

10 “(E) The entity—

11 “(i) permits members described in
12 subparagraph (B) to vote on matters of
13 the entity related to the arrangement with
14 the Secretary under paragraph (1); and

15 “(ii) ensures that such members have
16 an equal vote on such matters.

17 “(F) With respect to matters related to the
18 arrangement with the Secretary under para-
19 graph (1), the entity conducts its business in an
20 open and transparent manner and provides the
21 opportunity for public comment.

22 “(G) The entity operates as a voluntary
23 consensus standards setting organization as de-
24 fined for purposes of section 12(d) of the Na-
25 tional Technology Transfer and Advancement

1 Act of 1995 (Public Law 104–113) and Office
2 of Management and Budget Revised Circular
3 A–119 (published in the Federal Register on
4 February 10, 1998).

5 “(3) AUTHORIZATION OF APPROPRIATIONS.—
6 For the purpose of carrying out the provisions of
7 this subsection, there are authorized to be
8 appropriated—

9 “(A) for each of the fiscal years 2006 and
10 2007, \$3,000,000; and

11 “(B) for fiscal year 2008 and each subse-
12 quent fiscal year, an amount equal to the sum
13 of—

14 “(i) \$3,000,000; and

15 “(ii) such amount multiplied by the
16 percentage (if any) by which the average of
17 the Consumer Price Index for all urban
18 consumers (United States city average) for
19 the 12-month period ending with June of
20 the calendar year in which such fiscal year
21 begins exceeds such average for the 12-
22 month period ending with June 2006.

23 “PPS HOSPITAL VALUE-BASED PURCHASING PROGRAM

24 “SEC. 1860E–2. (a) PROGRAM.—

25 “(1) IN GENERAL.—The Secretary shall estab-
26 lish a program under which value-based payments

1 are provided each fiscal year to hospitals that dem-
2 onstrate the provision of high quality health care to
3 individuals who are entitled to benefits under part A
4 and are inpatients of the hospital.

5 “(2) PROGRAM TO BEGIN IN FISCAL YEAR
6 2007.—The Secretary shall establish the program
7 under this section so that value-based payments de-
8 scribed in subsection (b) are made with respect to
9 fiscal year 2007 and each subsequent fiscal year.

10 “(3) APPLICABILITY OF PROGRAM TO HOS-
11 PITALS.—For purposes of this section, the term
12 ‘hospital’ means a subsection (d) hospital (as defined
13 in section 1886(d)(1)(B)).

14 “(b) VALUE-BASED PAYMENTS.—

15 “(1) IN GENERAL.—Subject to paragraph (4),
16 the Secretary shall make a value-based payment to
17 a hospital with respect to a fiscal year if the Sec-
18 retary determines that the quality of the care pro-
19 vided in that year to individuals who are entitled to
20 benefits under part A and are inpatients of the
21 hospital—

22 “(A) has substantially improved (as deter-
23 mined by the Secretary) over the prior year; or

24 “(B) exceeds a threshold established by the
25 Secretary.

1 “(2) USE OF SYSTEM.—In determining which
2 hospitals qualify for a value-based payment under
3 paragraph (1), the Secretary shall use the quality
4 measurement system developed for this section pur-
5 suant to section 1860E–1(a).

6 “(3) DETERMINATION OF AMOUNT OF AWARD
7 AND ALLOCATION OF AWARDS.—

8 “(A) IN GENERAL.—The Secretary shall
9 determine—

10 “(i) the amount of a value-based pay-
11 ment under paragraph (1) provided to a
12 hospital; and

13 “(ii) subject to subparagraph (B), the
14 allocation of the total amount available
15 under subsection (d) for value-based pay-
16 ments for any fiscal year between pay-
17 ments with respect to hospitals that meet
18 the requirement under subparagraph (A)
19 of paragraph (1) and hospitals that meet
20 the requirement under subparagraph (B)
21 of such paragraph.

22 “(B) REQUIREMENTS REGARDING THE
23 AMOUNT OF FUNDING AVAILABLE FOR VALUE-
24 BASED PAYMENTS FOR HOSPITALS EXCEEDING

1 A THRESHOLD.—The Secretary shall ensure
2 that—

3 “(i) a majority of the total amount
4 available under subsection (d) for value-
5 based payments for any fiscal year is pro-
6 vided to hospitals that are receiving such
7 payments because they meet the require-
8 ment under paragraph (1)(B); and

9 “(ii) with respect to fiscal year 2008
10 and each subsequent fiscal year, the per-
11 centage of the total amount available
12 under subsection (d) for value-based pay-
13 ments for any fiscal year that is used to
14 make payments to hospitals that meet such
15 requirement is greater than such percent-
16 age in the previous fiscal year.

17 “(4) REQUIREMENTS.—

18 “(A) REQUIRED SUBMISSION OF DATA.—
19 In order for a hospital to be eligible for a value-
20 based payment for a fiscal year, the hospital
21 must have complied with the requirements
22 under section 1886(b)(3)(B)(viii)(II) with re-
23 spect to that fiscal year.

24 “(B) ATTESTATION REGARDING DATA.—In
25 order for a hospital to be eligible for a value-

1 based payment for a fiscal year, the hospital
2 must have provided the Secretary (under proce-
3 dures established by the Secretary) with an at-
4 testation that the data submitted under section
5 1886(b)(3)(B)(viii)(II) for the fiscal year is
6 complete and accurate.

7 “(5) TOTAL AMOUNT OF VALUE-BASED PAY-
8 MENTS EQUAL TO TOTAL AMOUNT OF AVAILABLE
9 FUNDING.—The Secretary shall establish payment
10 amounts under paragraph (3)(A) so that, as esti-
11 mated by the Secretary, the total amount of value-
12 based payments made in a fiscal year under para-
13 graph (1) is equal to the total amount available
14 under subsection (d) for such payments for the year.

15 “(6) PAYMENT METHODS AND TIMING OF PAY-
16 MENTS.—

17 “(A) IN GENERAL.—Subject to subpara-
18 graph (B), the payment of value-based pay-
19 ments under paragraph (1) shall be based on
20 such a method as the Secretary determines ap-
21 propriate.

22 “(B) TIMING.—The Secretary shall ensure
23 that value-based payments under paragraph (1)
24 with respect to a fiscal year are made by not
25 later than the close of the following fiscal year.

1 “(c) DESCRIPTION OF HOW HOSPITALS WOULD
2 HAVE FARED UNDER PROGRAM.—Not later than Janu-
3 ary 1, 2007, the Secretary shall provide each hospital with
4 a description of the Secretary’s estimate of how payments
5 to the hospital under this title would have been affected
6 with respect to items and services furnished during a pe-
7 riod, as determined by the Secretary, if the program under
8 this section (and the amendments made by paragraphs (1)
9 and (2) of section 6110(b) of the Deficit Reduction Omni-
10 bus Reconciliation Act of 2005) had been in effect with
11 respect to that period.

12 “(d) FUNDING.—

13 “(1) AMOUNT.—The amount available for
14 value-based payments under this section with respect
15 to a fiscal year shall be equal to the amount of the
16 reduction in expenditures under the Federal Hos-
17 pital Insurance Trust Fund under section 1817 in
18 the year as a result of the amendments made by sec-
19 tion 6110(b)(2) of the Deficit Reduction Omnibus
20 Reconciliation Act of 2005, as estimated by the Sec-
21 retary.

22 “(2) PAYMENTS FROM TRUST FUND.—Pay-
23 ments to hospitals under this section shall be made
24 from the Federal Hospital Insurance Trust Fund.

1 submit to Congress and the Secretary a report by
2 not later than June 1, 2007, on the advisability and
3 feasibility of including renal dialysis facilities de-
4 scribed in subsection (a)(3)(A) of section 1860E-5
5 in the value-based purchasing program under such
6 section 1860E-5 or establishing a value-based pur-
7 chasing program under this title for such facilities;
8 (D) taking into account the results to date of the
9 demonstration of bundled case-mix adjusted pay-
10 ment system for ESRD services under section
11 623(e) of the Medicare Prescription Drug, Improve-
12 ment, and Modernization Act of 2003, conduct a
13 study, and submit to Congress and the Secretary a
14 report by not later than June 1, 2008, on the imple-
15 mentation of the ESRD provider and facility value-
16 based purchasing program under section 1860E-5,
17 including issues for the Secretary to consider in op-
18 erating the ESRD provider and facility value-based
19 purchasing program and recommendations on such
20 issues; and (E) conduct a study, and submit to Con-
21 gress and the Secretary a report by not later than
22 June 1, 2007, on the advisability and feasibility of
23 establishing a value-based purchasing program
24 under this title for skilled nursing facilities (as de-
25 fined in section 1819(a)).

1 “(2) PROGRAM TO BEGIN IN 2009.—The Sec-
2 retary shall establish the program under this section
3 so that value-based payments described in subsection
4 (b) are made with respect to 2009 and each subse-
5 quent year.

6 “(3) DEFINITION OF PHYSICIAN AND PRACTI-
7 TIONER.—In this section:

8 “(A) PHYSICIAN.—The term ‘physician’
9 has the meaning given that term in section
10 1861(r).

11 “(B) PRACTITIONER.—The term ‘practi-
12 tioner’ means—

13 “(i) a practitioner described in section
14 1842(b)(18)(C);

15 “(ii) a physical therapist (as described
16 in section 1861(p));

17 “(iii) an occupational therapist (as so
18 described); and

19 “(iv) a qualified speech-language pa-
20 thologist (as defined in section
21 1861(ll)(3)(A)).

22 “(4) IDENTIFICATION OF PHYSICIANS AND
23 PRACTITIONERS.—For purposes of applying this sec-
24 tion and paragraphs (4)(G) and (6) of section
25 1848(d), the Secretary shall establish procedures for

1 the identification of physicians and practitioners,
2 such as through physician or practitioner billing
3 units or other units, provider identification numbers,
4 taxpayer identification numbers, the National Pro-
5 vider Identifier, and unique physician identifier
6 numbers.

7 “(b) VALUE-BASED PAYMENTS.—

8 “(1) IN GENERAL.—Subject to paragraph (4),
9 the Secretary shall make a value-based payment to
10 a physician or a practitioner with respect to a year
11 if the Secretary determines that both the quality of
12 the care and the efficiency of the care provided in
13 that year by the physician or practitioner to individ-
14 uals enrolled under part B—

15 “(A) has substantially improved (as deter-
16 mined by the Secretary) over the prior year; or

17 “(B) exceeds a threshold established by the
18 Secretary.

19 “(2) USE OF SYSTEMS AND DATA.—

20 “(A) IN GENERAL.—In determining which
21 physicians and practitioners qualify for a value-
22 based payment under paragraph (1), the Sec-
23 retary shall use—

24 “(i) the quality measurement system
25 developed for this section pursuant to sec-

1 tion 1860E–1(a) with respect to the qual-
2 ity of the care provided by the physician or
3 practitioner; and

4 “ (ii) the comparative utilization sys-
5 tem developed under subsection (c) with
6 respect to the efficiency and appropriate-
7 ness of such care.

8 “(3) DETERMINATION OF AMOUNT OF AWARD
9 AND ALLOCATION OF AWARDS.—

10 “(A) IN GENERAL.—The Secretary shall
11 determine—

12 “ (i) the amount of a value-based pay-
13 ment under paragraph (1) provided to a
14 physician or a practitioner; and

15 “ (ii) subject to subparagraph (B), the
16 allocation of the total amount available
17 under subsection (e) for value-based pay-
18 ments for any year between payments with
19 respect to physicians and practitioners that
20 meet the requirement under subparagraph
21 (A) of paragraph (1) and physicians and
22 practitioners that meet the requirement
23 under subparagraph (B) of such para-
24 graph.

1 “(B) REQUIREMENTS REGARDING THE
2 AMOUNT OF FUNDING AVAILABLE FOR VALUE-
3 BASED PAYMENTS FOR PHYSICIANS AND PRAC-
4 TITIONERS EXCEEDING A THRESHOLD.—The
5 Secretary shall ensure that—

6 “(i) a majority of the total amount
7 available under subsection (e) for value-
8 based payments for any year is provided to
9 physicians and practitioners that are re-
10 ceiving such payments because they meet
11 the requirement under paragraph (1)(B);
12 and

13 “(ii) with respect to 2010 and each
14 subsequent year, the percentage of the
15 total amount available under subsection (e)
16 for value-based payments for any year that
17 is used to make payments to physicians
18 and practitioners that meet such require-
19 ment is greater than such percentage in
20 the previous year.

21 “(4) REQUIREMENTS.—

22 “(A) REQUIRED SUBMISSION OF DATA.—
23 In order for a physician or a practitioner to be
24 eligible for a value-based payment for a year,
25 the physician or practitioner must have com-

1 plied with the requirements under section
2 1848(d)(6)(B)(ii) with respect to that year.

3 “(B) ATTESTATION REGARDING DATA.—In
4 order for a physician or a practitioner to be eli-
5 gible for a value-based payment for a year, the
6 physician or practitioner must have provided
7 the Secretary (under procedures established by
8 the Secretary) with an attestation that the data
9 submitted under section 1848(d)(6)(B)(ii) with
10 respect to that year is complete and accurate.

11 “(5) TOTAL AMOUNT OF VALUE-BASED PAY-
12 MENTS EQUAL TO TOTAL AMOUNT OF AVAILABLE
13 FUNDING.—The Secretary shall establish payment
14 amounts under paragraph (3)(A) so that, as esti-
15 mated by the Secretary, the total amount of value-
16 based payments made in a year under paragraph (1)
17 is equal to the total amount available under sub-
18 section (e) for such payments for the year.

19 “(6) PAYMENT METHODS AND TIMING OF PAY-
20 MENTS.—

21 “(A) IN GENERAL.—Subject to subpara-
22 graph (B), the payment of value-based pay-
23 ments under paragraph (1) shall be based on
24 such a method as the Secretary determines ap-
25 propriate.

1 “(B) TIMING.—The Secretary shall ensure
2 that value-based payments under paragraph (1)
3 with respect to a year are made by not later
4 than December 31 of the subsequent year.

5 “(c) COMPARATIVE UTILIZATION SYSTEM.—

6 “(1) DEVELOPMENT.—The Secretary, in con-
7 sultation with relevant stakeholders, shall develop a
8 comparative utilization system for purposes of pro-
9 viding value-based payments under subsection (b).

10 “(2) MEASURES OF EFFICIENCY AND APPRO-
11 PRIATENESS OF CARE.—The comparative utilization
12 system developed under paragraph (1) shall measure
13 the efficiency and appropriateness of the care pro-
14 vided by a physician or practitioner.

15 “(3) REQUIREMENTS FOR SYSTEM.—Under the
16 comparative utilization system described in para-
17 graph (1), the Secretary shall do the following:

18 “(A) MEASURES.—The Secretary shall se-
19 lect measures of efficiency appropriateness to
20 be used by the Secretary under the system. The
21 Secretary may vary the measures selected under
22 the preceding sentence by the type or specialty
23 of the physician or practitioner. If the Secretary
24 varies the measures for providers under the pre-
25 ceding sentence, the Secretary shall ensure that

1 such measures are aligned to promote coordi-
2 nated quality of care across provider settings.

3 “(B) USE OF CLAIMS DATA FOR UTILIZA-
4 TION PATTERNS.—

5 “(i) REVIEW OF CLAIMS DATA.—The
6 Secretary shall review claims data with re-
7 spect to services furnished or ordered by
8 physicians and practitioners.

9 “(ii) USE OF MOST RECENT CLAIMS
10 DATA.—The Secretary shall use the most
11 recent claims data with respect to the phy-
12 sician or practitioner that is available to
13 the Secretary.

14 “(C) RISK ADJUSTMENT.—The Secretary
15 shall establish procedures, as appropriate, to
16 control for differences in beneficiary health sta-
17 tus and beneficiary characteristics.

18 “(4) ANNUAL REPORTS.—Beginning in 2007,
19 the Secretary shall provide physicians and practi-
20 tioners with annual reports on the utilization of
21 items and services under this title based upon the
22 review of claims data under paragraph (3)(B). With
23 respect to reports provided in 2007 and 2008, such
24 reports are confidential and the Secretary shall not
25 make such reports available to the public.

1 “(d) DESCRIPTION OF HOW PHYSICIANS AND PRAC-
2 TITIONERS WOULD HAVE FARED UNDER PROGRAM.—
3 NOT LATER THAN MARCH 1, 2009, THE SECRETARY SHALL
4 PROVIDE EACH PHYSICIAN AND PRACTITIONER WITH A
5 DESCRIPTION OF THE SECRETARY’S ESTIMATE OF HOW
6 PAYMENTS TO THE PHYSICIAN OR PRACTITIONER UNDER
7 THIS TITLE WOULD HAVE BEEN AFFECTED WITH RE-
8 SPECT TO ITEMS AND SERVICES FURNISHED DURING A PE-
9 RIOD, AS DETERMINED BY THE SECRETARY, IF THE PRO-
10 GRAM UNDER THIS SECTION (AND THE AMENDMENTS
11 MADE BY PARAGRAPHS (1) AND (2) OF SECTION 6110(C) OF
12 THE DEFICIT REDUCTION OMNIBUS RECONCILIATION
13 ACT OF 2005) HAD BEEN IN EFFECT WITH RESPECT TO
14 THAT PERIOD.

15 “(e) FUNDING.—

16 “(1) AMOUNT.—The amount available for
17 value-based payments under this section with respect
18 to a year shall be equal to the amount of the reduc-
19 tion in expenditures under the Federal Supple-
20 mentary Medical Insurance Trust Fund under sec-
21 tion 1841 in the year as a result of the amendments
22 made by section 6110(c)(2) of the Deficit Reduction
23 Omnibus Reconciliation Act of 2005, as estimated
24 by the Secretary.

1 “(2) PAYMENTS FROM TRUST FUND.—Pay-
2 ments to physicians and practitioners under this sec-
3 tion shall be made from the Federal Supplementary
4 Medical Insurance Trust Fund.

5 “PLAN VALUE-BASED PURCHASING PROGRAM
6 “SEC. 1860E-4. (a) PROGRAM.—

7 “(1) IN GENERAL.—The Secretary shall estab-
8 lish a program under which value-based payments
9 are provided each year to Medicare Advantage orga-
10 nizations offering Medicare Advantage plans under
11 part C that demonstrate the provision of high qual-
12 ity health care to enrollees under the plan.

13 “(2) PROGRAM TO BEGIN IN 2009.—The Sec-
14 retary shall establish the program under this section
15 so that value-based payments under subsection (b)
16 are made with respect to 2009 and each subsequent
17 year.

18 “(3) DEFINITIONS OF MEDICARE ADVANTAGE
19 ORGANIZATION AND PLAN.—

20 “(A) IN GENERAL.—In this section:

21 “(i) MEDICARE ADVANTAGE ORGANI-
22 ZATION.—The term ‘Medicare Advantage
23 organization’ has the meaning given such
24 term in section 1859(a)(1).

25 “(ii) MEDICARE ADVANTAGE PLAN.—
26 The term ‘Medicare Advantage plan’ has

1 the meaning given such term in section
2 1859(b)(1).

3 “(B) APPLICABILITY OF PROGRAM TO
4 MEDICARE ADVANTAGE REGIONAL AND LOCAL
5 PLANS.—For purposes of this section, the term
6 ‘Medicare Advantage plan’ shall include both
7 Medicare Advantage regional plans (as defined
8 in section 1859(b)(4)) and Medicare Advantage
9 local plans (as defined in section 1859(b)(5)).

10 “(C) APPLICABILITY OF PROGRAM TO REA-
11 SONABLE COST CONTRACTS.—Except for para-
12 graphs (5) and (6) of subsection (b), for pur-
13 poses of this section, the terms—

14 “(i) ‘Medicare Advantage organiza-
15 tion’ and ‘organization’ include an organi-
16 zation that is providing benefits under a
17 reasonable cost reimbursement contract
18 under section 1876(h); and

19 “(ii) ‘Medicare Advantage plan’ and
20 ‘plan’ include such a contract.

21 “(b) VALUE-BASED PAYMENTS.—

22 “(1) IN GENERAL.—Subject to paragraph (4),
23 the Secretary shall make value-based payments to
24 Medicare Advantage organizations with respect to
25 each Medicare Advantage plan offered by the organi-

1 zation during a year if the Secretary determines that
2 the quality of the care provided under the plan—

3 “(A) has substantially improved (as deter-
4 mined by the Secretary) over the prior year; or

5 “(B) exceeds a threshold established by the
6 Secretary.

7 “(2) USE OF SYSTEM.—In determining which
8 organizations offering Medicare Advantage plans
9 qualify for a value-based payment under paragraph
10 (1), the Secretary shall—

11 “(A) use the quality measurement system
12 developed for this section pursuant to section
13 1860E–1(a); and

14 “(B) ensure that awards are based on data
15 from a full 12-month period (or 24-month pe-
16 riod in the case of an award described in para-
17 graph (1)(A)), such periods determined without
18 regard to calendar year periods.

19 “(3) DETERMINATION OF AMOUNT OF AWARD
20 AND ALLOCATION OF AWARDS.—

21 “(A) IN GENERAL.—The Secretary shall
22 determine—

23 “(i) the amount of a value-based pay-
24 ment under paragraph (1) provided to an
25 organization with respect to a plan; and

1 “(ii) subject to subparagraph (B), the
2 allocation of the total amount available
3 under subsection (d) for value-based pay-
4 ments for any year between payments with
5 respect to plans that meet the requirement
6 under subparagraph (A) of paragraph (1)
7 and plans that meet the requirement under
8 subparagraph (B) of such paragraph.

9 “(B) REQUIREMENT REGARDING THE
10 AMOUNT OF FUNDING AVAILABLE FOR VALUE-
11 BASED PAYMENTS FOR PLANS EXCEEDING A
12 THRESHOLD.—The Secretary shall ensure
13 that—

14 “(i) a majority of the total amount
15 available under subsection (d) for value-
16 based payments for any year is provided to
17 organizations, with respect to plans offered
18 by such organizations, that are receiving
19 such payments because they meet the re-
20 quirement under paragraph (1)(B); and

21 “(ii) with respect to 2010 and each
22 subsequent year, the percentage of the
23 total amount available under subsection (d)
24 for value-based payments for any year that
25 is used to make payments to organizations,

1 with respect to plans offered by such orga-
2 nizations, that meet such requirement is
3 greater than such percentage in the pre-
4 vious year.

5 “(4) USE OF PAYMENTS.—Value-based pay-
6 ments received under this section may only be used
7 for the following purposes:

8 “(A) To invest in quality improvement pro-
9 grams operated by the organization with respect
10 to the plan.

11 “(B) To enhance beneficiary benefits under
12 the plan.

13 “(5) REQUIRED SUBMISSION OF DATA.—In
14 order for an organization to be eligible for a value-
15 based payment for a year with respect to a Medicare
16 Advantage plan or a reasonable cost contract, the
17 organization must have provided for the collection,
18 analysis, and reporting of data pursuant to sections
19 1852(e)(3) (or submitted the data under section
20 1876(h)(6) in the case of a reasonable cost contract)
21 with respect to the plan or contract for the 2 years
22 preceding that year.

23 “(6) NO EFFECT ON MEDICARE ADVANTAGE
24 PLAN BIDS.—In order for a Medicare Advantage or-
25 ganization to be eligible for a value-based payment

1 for a year with respect to a Medicare Advantage
2 plan, the organization must have provided the Sec-
3 retary with an attestation that the program under
4 this section, including the payment adjustments
5 made by reason of the amendments made by section
6 6110(d)(2)(A) of the Deficit Reduction Omnibus
7 Reconciliation Act of 2005, had no effect on the in-
8 tegrity and actuarial soundness of the bid submitted
9 under section 1854 for the plan for the year.

10 “(7) TOTAL AMOUNT OF VALUE-BASED PAY-
11 MENTS EQUAL TO TOTAL AMOUNT OF REDUCTION IN
12 PAYMENTS.—The Secretary shall establish payment
13 amounts under paragraph (3)(A) so that, as esti-
14 mated by the Secretary, the total amount of value-
15 based payments made in a year under paragraph (1)
16 is equal to the total amount available under sub-
17 section (d) for such payments for the year.

18 “(8) PAYMENT METHODS AND TIMING OF PAY-
19 MENTS.—

20 “(A) IN GENERAL.—Subject to subpara-
21 graph (B), the payment of value-based pay-
22 ments under paragraph (1) shall be based on
23 such a method as the Secretary determines ap-
24 propriate.

1 “(B) TIMING.—The Secretary shall ensure
2 that value-based payments under paragraph (1)
3 with respect to a year are made by not later
4 than March 1 of the subsequent year.

5 “(c) DESCRIPTION OF HOW PLANS WOULD HAVE
6 FARED UNDER PROGRAM.—NOT LATER THAN MARCH 1,
7 2009, THE SECRETARY SHALL PROVIDE EACH MEDICARE
8 ADVANTAGE ORGANIZATION OFFERING A MEDICARE AD-
9 VANTAGE PLAN WITH A DESCRIPTION OF THE SEC-
10 RETARY’S ESTIMATE OF HOW PAYMENTS UNDER THIS
11 TITLE TO SUCH ORGANIZATION WITH RESPECT TO THE
12 PLAN FOR A PERIOD, AS DETERMINED BY THE SEC-
13 RETARY, WOULD HAVE BEEN AFFECTED IF THE PROGRAM
14 UNDER THIS SECTION (AND THE AMENDMENTS MADE BY
15 SECTION 6110(D) OF THE DEFICIT REDUCTION OMNIBUS
16 RECONCILIATION ACT OF 2005) HAD BEEN IN EFFECT
17 WITH RESPECT TO THAT PERIOD.

18 “(d) FUNDING.—

19 “(1) AMOUNT.—The amount available for
20 value-based payments under this section with respect
21 to a year shall be equal to the amount of the reduc-
22 tion in expenditures under the Federal Hospital In-
23 surance Trust Fund under section 1817 and the
24 Federal Supplementary Medical Insurance Trust
25 Fund under section 1841 in the year as a result of

1 the amendments made by section 6110(d)(2) of the
2 Deficit Reduction Omnibus Reconciliation Act of
3 2005, as estimated by the Secretary.

4 “(2) PAYMENTS FROM TRUST FUNDS.—Pay-
5 ments to organizations under this section shall be
6 made from the Federal Hospital Insurance Trust
7 Fund and the Federal Supplementary Medical In-
8 surance Trust Fund in the same proportion as pay-
9 ments to Medicare Advantage organizations are
10 made from such Trust Funds under the first sen-
11 tence of section 1853(f).

12 “ESRD PROVIDER AND FACILITY VALUE-BASED
13 PURCHASING PROGRAM

14 “SEC. 1860E–5. (a) PROGRAM.—

15 “(1) IN GENERAL.—The Secretary shall estab-
16 lish a program under which value-based payments
17 are provided each year to providers of services and
18 renal dialysis facilities that—

19 “(A) provide items and services to individ-
20 uals with end stage renal disease who are en-
21 rolled under part B; and

22 “(B) demonstrate the provision of high
23 quality health care to such individuals.

24 “(2) PROGRAM TO BEGIN IN 2007.—The Sec-
25 retary shall establish the program under this section
26 so that value-based payments described in subsection

1 (b) are made with respect to 2007 and each subse-
2 quent year.

3 “(3) EXCLUSIONS FROM PROGRAM.—

4 “(A) PEDIATRIC FACILITIES.—Any renal
5 dialysis facility at least 50 percent of whose pa-
6 tients are individuals under 18 years of age
7 shall not be included in the program under this
8 section.

9 “(B) PROVIDERS AND FACILITIES CUR-
10 RENTLY PARTICIPATING IN BUNDLED CASE-MIX
11 DEMONSTRATION NOT INCLUDED IN PRO-
12 GRAM.—Any provider of services or renal dialy-
13 sis facility that is currently participating in the
14 bundled case-mix adjusted payment system for
15 ESRD services demonstration project under
16 section 623(e) of the Medicare Prescription
17 Drug, Improvement, and Modernization Act of
18 2003 (Public Law 108–173) shall not be in-
19 cluded in the program under this section, but
20 only for so long as the provider or facility is so
21 participating.

22 “(b) VALUE-BASED PAYMENTS.—

23 “(1) IN GENERAL.—Subject to paragraph (4),
24 the Secretary shall make a value-based payment to
25 a provider of services or a renal dialysis facility with

1 respect to a year if the Secretary determines that
2 the quality of the care provided in that year by the
3 provider or facility to individuals with end stage
4 renal disease who are enrolled under part B—

5 “(A) has substantially improved (as deter-
6 mined by the Secretary) over the prior year; or

7 “(B) exceeds a threshold established by the
8 Secretary.

9 “(2) USE OF SYSTEM.—In determining which
10 providers of services and renal dialysis facilities
11 qualify for a value-based payment under paragraph
12 (1), the Secretary shall use the quality measurement
13 system developed for this section pursuant to section
14 1860E–1(a).

15 “(3) DETERMINATION OF AMOUNT OF AWARD
16 AND ALLOCATION OF AWARDS.—

17 “(A) IN GENERAL.—The Secretary shall
18 determine—

19 “(i) the amount of a value-based pay-
20 ment under paragraph (1) provided to a
21 provider of services or a renal dialysis fa-
22 cility; and

23 “(ii) subject to subparagraphs (B)
24 and (C), the allocation of the total amount
25 available under subsection (c) for value-

1 based payments for any year between pay-
2 ments with respect to providers and facili-
3 ties that meet the requirement under sub-
4 paragraph (A) of paragraph (1) and pro-
5 viders and facilities that meet the require-
6 ment under subparagraph (B) of such
7 paragraph.

8 “(B) REQUIREMENT REGARDING AMOUNT
9 OF FUNDING AVAILABLE FOR VALUE-BASED
10 PAYMENTS FOR PROVIDERS AND FACILITIES
11 EXCEEDING A THRESHOLD.—The Secretary
12 shall ensure that—

13 “(i) a majority of the total amount
14 available under subsection (c) for value-
15 based payments for any year is provided to
16 providers of services and renal dialysis fa-
17 cilities that are receiving such payments
18 because they meet the requirement under
19 paragraph (1)(B); and

20 “(ii) with respect to 2009 and each
21 subsequent year, the percentage of the
22 total amount available under subsection (c)
23 for value-based payments for any year that
24 is used to make payments to providers and
25 facilities that meet such requirement is

1 greater than such percentage in the pre-
2 vious year.

3 “(C) ONLY VALUE-BASED PAYMENTS FOR
4 PROVIDERS AND FACILITIES EXCEEDING A
5 THRESHOLD IN 2007.—With respect to 2007,
6 the entire amount available under subsection (c)
7 for value-based payments for that year shall be
8 used to make payments to providers of services
9 and renal dialysis facilities that meet the re-
10 quirement under paragraph (1)(B).

11 “(4) REQUIREMENTS.—

12 “(A) REQUIRED SUBMISSION OF DATA.—

13 “(i) IN GENERAL.—In order for a pro-
14 vider of services or a renal dialysis facility
15 to be eligible for a value-based payment for
16 a year, the provider or facility must have
17 provided for the submission of data in ac-
18 cordance with clause (ii) with respect to
19 that year.

20 “(ii) SUBMISSION OF DATA.—For
21 2007 and each subsequent year, each pro-
22 vider of services and renal dialysis facility
23 that receives payments under paragraph
24 (12) shall submit to the Secretary such
25 data that the Secretary determines is ap-

1 appropriate for the measurement of health
2 outcomes and other indices of quality, in-
3 cluding data necessary for the operation of
4 the program under this section. Such data
5 shall be submitted in a form and manner,
6 and at a time, specified by the Secretary
7 for purposes of this clause.

8 “(iii) AVAILABILITY TO THE PUB-
9 LIC.—The Secretary shall establish proce-
10 dures for making data submitted under
11 clause (ii) available to the public in a clear
12 and understandable form. Such procedures
13 shall ensure that a provider or facility has
14 the opportunity to review the data that is
15 to be made public with respect to the pro-
16 vider or facility prior to such data being
17 made public.

18 “(B) ATTESTATION REGARDING DATA.—In
19 order for a provider of services or a renal dialy-
20 sis facility to be eligible for a value-based pay-
21 ment for a year, the provider or facility must
22 have provided the Secretary (under procedures
23 established by the Secretary) with an attesta-
24 tion that the data submitted under subpara-

1 graph (A)(ii) for the year is complete and accu-
2 rate.

3 “(5) TOTAL AMOUNT OF VALUE-BASED PAY-
4 MENTS EQUAL TO TOTAL AMOUNT OF AVAILABLE
5 FUNDING.—The Secretary shall establish payment
6 amounts under paragraph (3)(A) so that, as esti-
7 mated by the Secretary, the total amount of value-
8 based payments made in a year under paragraph (1)
9 is equal to the total amount available under sub-
10 section (c) for such payments for the year.

11 “(6) PAYMENT METHODS AND TIMING OF PAY-
12 MENTS.—

13 “(A) IN GENERAL.—Subject to subpara-
14 graph (B), the payment of value-based pay-
15 ments under paragraph (1) shall be based on
16 such a method as the Secretary determines ap-
17 propriate.

18 “(B) TIMING.—The Secretary shall ensure
19 that value-based payments under paragraph (1)
20 with respect to a year are made by not later
21 than December 31 of the subsequent year.

22 “(c) FUNDING.—

23 “(1) AMOUNT.—The amount available for
24 value-based payments under this section with respect
25 to a year shall be equal to the amount of the reduc-

1 “(3) HOME HEALTH AGENCY DEFINED.—In
2 this section, the term “home health agency” has the
3 meaning given that term in section 1861(o).

4 “(b) VALUE-BASED PAYMENTS.—

5 “(1) IN GENERAL.—Subject to paragraph (4),
6 the Secretary shall make a value-based payment to
7 a home health agency with respect to a year if the
8 Secretary determines that the quality of the care
9 provided in that year by the agency to individuals
10 entitled to benefits under part A or enrolled under
11 part B—

12 “(A) has substantially improved (as deter-
13 mined by the Secretary) over the prior year; or

14 “(B) exceeds a threshold established by the
15 Secretary.

16 “(2) USE OF SYSTEM.—In determining which
17 home health agencies qualify for a value-based pay-
18 ment under paragraph (1), the Secretary shall use
19 the quality measurement system developed for this
20 section pursuant to section 1860E-1(a).

21 “(3) DETERMINATION OF AMOUNT OF AWARD
22 AND ALLOCATION OF AWARDS.—

23 “(A) IN GENERAL.—The Secretary shall
24 determine—

1 “(i) the amount of a value-based pay-
2 ment under paragraph (1) provided to a
3 home health agency; and

4 “(ii) subject to subparagraph (B), the
5 allocation of the total amount available
6 under subsection (d) for value-based pay-
7 ments for any year between payments with
8 respect to agencies that meet the require-
9 ment under subparagraph (A) of para-
10 graph (1) and agencies that meet the re-
11 quirement under subparagraph (B) of such
12 paragraph.

13 “(B) REQUIREMENTS REGARDING THE
14 AMOUNT OF FUNDING AVAILABLE FOR VALUE-
15 BASED PAYMENTS FOR AGENCIES EXCEEDING A
16 THRESHOLD.—The Secretary shall ensure
17 that—

18 “(i) a majority of the total amount
19 available under subsection (d) for value-
20 based payments for any year is provided to
21 home health agencies that are receiving
22 such payments because they meet the re-
23 quirement under paragraph (1)(B); and

24 “(ii) with respect to 2009 and each
25 subsequent year, the percentage of the

1 total amount available under subsection (d)
2 for value-based payments for any year that
3 is used to make payments to agencies that
4 meet such requirement is greater than
5 such percentage in the previous year.

6 “(4) REQUIREMENTS.—

7 “(A) REQUIRED SUBMISSION OF DATA.—

8 In order for a home health agency to be eligible
9 for a value-based payment for a year, the agen-
10 cy must have complied with the requirements
11 under section 1895(b)(3)(B)(v)(II) with respect
12 to that year.

13 “(B) ATTESTATION REGARDING DATA.—In

14 order for a home health agency to be eligible for
15 a value-based payment for a year, the agency
16 must have provided the Secretary (under proce-
17 dures established by the Secretary) with an at-
18 testation that the data submitted under section
19 1895(b)(3)(B)(v)(II) with respect to that year
20 is complete and accurate.

21 “(5) TOTAL AMOUNT OF VALUE-BASED PAY-

22 MENTS EQUAL TO TOTAL AMOUNT OF AVAILABLE

23 FUNDING.—The Secretary shall establish payment

24 amounts under paragraph (3)(A) so that, as esti-

25 mated by the Secretary, the total amount of value-

1 based payments made in a year under paragraph (1)
2 is equal to the total amount available under sub-
3 section (d) for such payments for the year.

4 “(6) PAYMENT METHODS AND TIMING OF PAY-
5 MENTS.—

6 “(A) IN GENERAL.—Subject to subpara-
7 graph (B), the payment of value-based pay-
8 ments under paragraph (1) shall be based on
9 such a method as the Secretary determines ap-
10 propriate.

11 “(B) TIMING.—The Secretary shall ensure
12 that value-based payments under paragraph (1)
13 with respect to a year are made by not later
14 than December 31 of the subsequent year.

15 “(c) DESCRIPTION OF HOW AGENCIES WOULD HAVE
16 FARED UNDER PROGRAM.—NOT LATER THAN JANUARY
17 1, 2008, THE SECRETARY SHALL PROVIDE EACH HOME
18 HEALTH AGENCY WITH A DESCRIPTION OF THE SEC-
19 RETARY’S ESTIMATE OF HOW PAYMENTS TO THE AGENCY
20 UNDER THIS TITLE WOULD HAVE BEEN AFFECTED WITH
21 RESPECT TO ITEMS AND SERVICES FURNISHED DURING A
22 PERIOD, AS DETERMINED BY THE SECRETARY, IF THE
23 PROGRAM UNDER THIS SECTION (AND THE AMENDMENTS
24 MADE BY SECTION 6110(F) OF THE DEFICIT REDUCTION

1 OMNIBUS RECONCILIATION ACT OF 2005) HAD BEEN IN
2 EFFECT WITH RESPECT TO THAT PERIOD.

3 “(d) FUNDING.—

4 “(1) AMOUNT.—The amount available for
5 value-based payments under this section with respect
6 to a year shall be equal to the amount of the reduc-
7 tion in expenditures under the Federal Hospital In-
8 surance Trust Fund under section 1817 and Federal
9 Supplementary Medical Insurance Trust Fund under
10 section 1841 in the year as a result of the applica-
11 tion of section 1895(b)(3)(D), as estimated by the
12 Secretary.

13 “(2) PAYMENTS FROM TRUST FUND.—Pay-
14 ments to home health agencies under this section
15 shall be made from the Federal Hospital Insurance
16 Trust Fund and Federal Supplementary Medical In-
17 surance Trust Fund, in the same proportion as pay-
18 ments for home health services are made from such
19 trust funds.”.

20 (b) HOSPITALS.—

21 (1) VOLUNTARY SUBMISSION OF HOSPITAL
22 QUALITY DATA.—

23 (A) UPDATE FOR HOSPITALS THAT SUB-
24 MIT QUALITY DATA.—Section 1886(b)(3)(B)
25 (42 U.S.C. 1395ww(b)(3)(B)) is amended—

- 1 (i) in clause (vii)—
- 2 (I) in subclause (I), by striking
- 3 “for each of fiscal years 2005 through
- 4 2007” and inserting “for fiscal years
- 5 2005 and 2006”; and
- 6 (II) in subclause (II), by striking
- 7 “Each” and inserting “For fiscal
- 8 years 2005 and 2006, each”; and
- 9 (ii) by adding at the end the following
- 10 new clause:
- 11 “(viii)(I) For purposes of clause
- 12 (i)(XX), for fiscal year 2007 and each sub-
- 13 sequent fiscal year, in the case of a sub-
- 14 section (d) hospital that does not submit
- 15 data in accordance with subclause (II) with
- 16 respect to such a fiscal year, the applicable
- 17 percentage increase under such clause for
- 18 such fiscal year shall be reduced by 2 per-
- 19 centage points. Such reduction shall apply
- 20 only with respect to the fiscal year in-
- 21 volved, and the Secretary shall not take
- 22 into account such reduction in computing
- 23 the applicable percentage increase under
- 24 clause (i)(XX) for a subsequent fiscal year.

1 “(II) For fiscal year 2007 and each
2 subsequent fiscal year, each subsection (d)
3 hospital shall submit to the Secretary such
4 data that the Secretary determines is ap-
5 propriate for the measurement of health
6 care quality, including data necessary for
7 the operation of the PPS hospital value-
8 based purchasing program under section
9 1860E-2. Such data shall be submitted in
10 a form and manner, and at a time, speci-
11 fied by the Secretary for purposes of this
12 clause.

13 “(III) The Secretary shall establish
14 procedures for making data submitted
15 under subclause (II) available to the public
16 in a clear and understandable form. Such
17 procedures shall ensure that a subsection
18 (d) hospital has the opportunity to review
19 the data that is to be made public with re-
20 spect to the hospital prior to such data
21 being made public.”.

22 (B) CONFORMING AMENDMENTS.—Section
23 1886(b)(3)(B)(i) (42 U.S.C.
24 1395ww(b)(3)(B)(i)) is amended—

1 (i) in subclause (XIX), by striking
2 “2007” and inserting “2006”; and

3 (ii) in subclause (XX)—

4 (I) by striking “2008” and in-
5 serting “2007”; and

6 (II) by inserting “subject to
7 clause (viii),” after “fiscal year,”.

8 (2) REDUCTION IN PAYMENTS IN ORDER TO
9 FUND PROGRAM.—

10 (A) REDUCTION IN PAYMENTS.—Section
11 1886(d)(5)(A) (42 U.S.C. 1395ww(d)(5)(A)) is
12 amended—

13 (i) in clause (iv), by striking “5 per-
14 cent nor more than 6 percent” and insert-
15 ing “the applicable lower percent nor more
16 than the applicable upper percent”; and

17 (ii) by adding at the end the following
18 new clause:

19 “(vii) For purposes of clause (iv)—

20 “(I) for fiscal years prior to 2007, the ‘lower
21 percent’ is 5.0 percent and the ‘upper percent’ is 6.0
22 percent;

23 “(II) for fiscal year 2007, the ‘lower percent’ is
24 4.0 percent and the ‘upper percent’ is 5.0 percent;

1 “(III) for fiscal year 2008, the ‘lower percent’
2 is 3.75 percent and the ‘upper percent’ is 4.75 per-
3 cent;

4 “(IV) for fiscal year 2009, the ‘lower percent’
5 is 3.5 percent and the ‘upper percent’ is 4.5 percent;

6 “(V) for fiscal year 2010, the ‘lower percent’ is
7 3.25 percent and the ‘upper percent’ is 4.25 percent;
8 and

9 “(VI) for fiscal year 2011 and each subsequent
10 fiscal year, the ‘lower percent’ is 3.0 percent and the
11 ‘upper percent’ is 4.0 percent.”.

12 (B) CONTINUATION OF CURRENT LEVEL
13 OF REDUCTIONS TO THE AVERAGE STANDARD-
14 IZED AMOUNT.—Section 1886(d)(3)(B) (42
15 U.S.C. 1395ww(d)(3)(B)) is amended to read
16 as follows:

17 “(B) REDUCING FOR VALUE OF OUTLIER PAY-
18 MENTS AND FOR FUNDING OF HOSPITAL VALUE-
19 BASED PURCHASING PROGRAM.—

20 “(i) IN GENERAL.—The Secretary shall re-
21 duce each of the average standardized amounts
22 determined under subparagraph (A) by a factor
23 equal to a fraction—

24 “(I) the numerator of which is the
25 sum of—

1 “(aa) the additional payments
2 described in paragraph (5)(A) (relat-
3 ing to outlier payments); and

4 “(bb) the applicable percent of
5 the total payments projected or esti-
6 mated to be made based on DRG pro-
7 spective payment rates for discharges
8 in that year; and

9 “(II) the denominator of which is the
10 total payments projected or estimated to
11 be made based on DRG prospective pay-
12 ment rates for discharges in that year.

13 “(ii) APPLICABLE PERCENT.—For pur-
14 poses of clause (i)(I)(bb), the term ‘applicable
15 percent’ means—

16 “(I) for fiscal years prior to fiscal
17 year 2007, 0 percent;

18 “(II) for fiscal year 2007, 1.0 percent;

19 “(III) for fiscal year 2008, 1.25 per-
20 cent;

21 “(IV) for fiscal year 2009, 1.5 per-
22 cent;

23 “(V) for fiscal year 2010, 1.75 per-
24 cent; and

1 “(VI) for fiscal year 2011 and each
2 subsequent year, 2.0 percent.”.

3 (3) VALUE-BASED PURCHASING DEMONSTRA-
4 TION PROGRAM FOR CRITICAL ACCESS HOSPITALS.—

5 (A) ESTABLISHMENT.—Not later than 6
6 months after the date of enactment of this Act,
7 the Secretary shall establish a 2-year dem-
8 onstration program under which the Secretary
9 establishes a value-based purchasing program
10 under the medicare program under title XVIII
11 of the Social Security Act for critical access
12 hospitals (as defined in section 1861(mm)(1) of
13 such Act (42 U.S.C. 1395x(mm)(1)) in order to
14 test innovative methods of measuring and re-
15 warding quality health care furnished by such
16 hospitals.

17 (B) SITES.—The Secretary shall conduct
18 the demonstration program at 6 critical access
19 hospitals. The Secretary shall ensure that such
20 hospitals are representative of the spectrum of
21 such hospitals that participate in the medicare
22 program.

23 (C) WAIVER AUTHORITY.—The Secretary
24 may waive such requirements of titles XI and

1 XVIII of the Social Security Act as may be nec-
2 essary to carry out the demonstration program.

3 (D) FUNDING.—The Secretary shall pro-
4 vide for the transfer from the Federal Hospital
5 Insurance Trust Fund under section 1817 of
6 the Social Security Act (42 U.S.C. 1395i) of
7 such funds as are necessary for the costs of car-
8 rying out the demonstration program.

9 (E) REPORT.—Not later than 6 months
10 after the demonstration program is completed,
11 the Secretary shall submit to Congress a report
12 on the demonstration program together with
13 recommendations on the establishment of a per-
14 manent value-based purchasing program under
15 the medicare program for critical access hos-
16 pitals and recommendations for such other leg-
17 islation or administrative action as the Sec-
18 retary determines appropriate.

19 (c) PHYSICIANS AND PRACTITIONERS.—

20 (1) VOLUNTARY SUBMISSION OF PHYSICIAN
21 AND PRACTITIONER QUALITY DATA.—

22 (A) UPDATE FOR PHYSICIANS AND PRACTI-
23 TIONERS THAT SUBMIT QUALITY DATA.—Sec-
24 tion 1848(d)(4) (42 U.S.C. 1395w-4(d)(4)) is

1 amended by adding at the end the following
2 new subparagraph:

3 “(G) ADJUSTMENT IF QUALITY DATA NOT
4 SUBMITTED.—

5 “(i) ADJUSTMENT.—For 2007 and
6 each subsequent year, in the case of serv-
7 ices furnished by a physician or a practi-
8 tioner (as defined in section 1860E–
9 3(a)(3)) that does not submit data in ac-
10 cordance with clause (ii) with respect to
11 such a year, the update otherwise deter-
12 mined under subparagraph (A) shall be re-
13 duced by 2 percentage points. Such reduc-
14 tion shall apply only with respect to the
15 year involved, and the Secretary shall not
16 take into account such reduction in com-
17 puting the conversion factor for a subse-
18 quent year.

19 “(ii) SUBMISSION OF QUALITY
20 DATA.—For 2007 and each subsequent
21 year, each physician and practitioner (as
22 defined in section 1860E–3(a)(3)) shall
23 submit to the Secretary such data that the
24 Secretary determines is appropriate for the
25 measurement of health outcomes and other

1 indices of quality, including data necessary
2 for the operation of the physician and
3 practitioner value-based purchasing pro-
4 gram under section 1860E-3. Such data
5 shall be submitted in a form and manner,
6 and at a time, specified by the Secretary
7 for purposes of this subparagraph.

8 “(iii) AVAILABLE TO THE PUBLIC.—

9 “(I) IN GENERAL.—Subject to
10 subclauses (II) and (III), the Sec-
11 retary shall establish procedures for
12 making data submitted under clause
13 (ii), with respect to items and services
14 furnished on or after January 1,
15 2008, available to the public in 3
16 phases as follows:

17 “(aa) PHASE I.—During
18 phase I, the Secretary shall make
19 available to the public the iden-
20 tity of physicians and practi-
21 tioners that are submitting such
22 data.

23 “(bb) PHASE II.—During
24 phase II, the Secretary shall
25 make available to the public the

1 identity of physicians and practi-
2 tioners that are receiving a value-
3 based payment under section
4 1860E-3.

5 “(cc) PHASE III.—During
6 phase III, the Secretary shall
7 make data submitted under
8 clause (ii) available to the public
9 in a clear and understandable
10 form.

11 “(II) REVIEW.—The procedures
12 established under subclause (I) shall
13 ensure that a physician or practitioner
14 has the opportunity to review the data
15 that is to be made public with respect
16 to the physician or practitioner under
17 subclause (I)(cc) prior to such data
18 being made public.

19 “(III) EXCEPTIONS.—The Sec-
20 retary shall establish exceptions to the
21 requirement for making data available
22 to the public under subclause (I). In
23 providing for such exceptions, the Sec-
24 retary shall take into account the size

1 and specialty representation of the
2 practice involved.”.

3 (B) CONFORMING AMENDMENT.—Section
4 1848(d)(4)(A) (42 U.S.C. 1395w-4(d)(4)(A)) is
5 amended, in the matter preceding clause (i), by
6 striking “subparagraph (F)” and inserting
7 “subparagraphs (F) and (G)”.

8 (2) REDUCTION IN CONVERSION FACTOR FOR
9 PHYSICIANS AND PRACTITIONERS THAT SUBMIT
10 QUALITY DATA IN ORDER TO FUND PROGRAM.—

11 (A) IN GENERAL.—Section 1848(d) (42
12 U.S.C. 1395w-4(d)) is amended by adding at
13 the end the following new paragraph:

14 “(6) REDUCTION IN CONVERSION FACTOR FOR
15 PHYSICIANS AND PRACTITIONERS IN ORDER TO
16 FUND VALUE-BASED PURCHASING PROGRAM.—

17 “(A) IN GENERAL.—For 2009 and each
18 subsequent year, the single conversion factor
19 otherwise applicable under this subsection to
20 services furnished in the year by a physician or
21 a practitioner (as defined in section 1860E-
22 3(a)(3)) that complies with the requirements
23 under paragraph (4)(G)(ii) for the year (deter-
24 mined after application of the update under

1 paragraph (4)) shall be reduced by the applica-
2 ble percent.

3 “(B) APPLICABLE PERCENT.—For pur-
4 poses of subparagraph (A), the term ‘applicable
5 percent’ means—

6 “(i) for 2009, 1.0 percent;

7 “(ii) for 2010, 1.25 percent;

8 “(iii) for 2011, 1.5 percent;

9 “(iv) for 2012, 1.75 percent; and

10 “(v) for 2013 and each subsequent
11 year, 2.0 percent.”.

12 (B) CONFORMING AMENDMENT.—Section
13 1848(d)(1)(A) (42 U.S.C. 1395w-4(d)(1)(A)) is
14 amended by striking “The conversion factor”
15 and inserting “Subject to paragraph (6), the
16 conversion factor”.

17 (d) PLANS.—

18 (1) SUBMISSION OF QUALITY DATA.—

19 (A) MEDICARE ADVANTAGE ORGANIZA-
20 TIONS.—Section 1852(e) (42 U.S.C. 1395w-
21 22(e)), as amended by section 722 of the Medi-
22 care Prescription Drug, Improvement, and
23 Modernization Act of 2003 (Public Law 108-
24 173; 117 Stat. 2347), is amended—

- 1 (i) in paragraph (1), by striking “an
2 MA private fee-for-service plan or”; and
- 3 (ii) in paragraph (3)—
- 4 (I) in subparagraph (A)—
- 5 (aa) in clause (i), by adding
6 at the end the following new sen-
7 tence: “Such data shall include
8 data necessary for the operation
9 of the plan value-based pur-
10 chasing program under section
11 1860E-4.”;
- 12 (bb) by redesignating clause
13 (iv) as clause (vi); and
- 14 (cc) by inserting after clause
15 (iii) the following new clauses:
- 16 “(iv) APPLICATION TO MA PRIVATE
17 FEE-FOR-SERVICE PLANS.—The Secretary
18 shall establish as appropriate by regulation
19 requirements for the collection, analysis,
20 and reporting of data that permits the
21 measurement of health outcomes and other
22 indices of quality for MA organizations
23 with respect to MA private fee-for-service
24 plans.”.

1 “(v) AVAILABILITY TO THE PUBLIC.—
2 The Secretary shall establish procedures
3 for making data reported under this sub-
4 paragraph available to the public in a clear
5 and understandable form. Such procedures
6 shall ensure that an MA organization has
7 the opportunity to review the data that is
8 to be made public with respect to the plan
9 offered by the organization prior to such
10 data being made public.”; and

11 (II) in subparagraph (B)—
12 (aa) in clause (i), by striking
13 “The” and inserting “Subject to
14 clause (ii), the”; and
15 (bb) by striking clause (ii)
16 and inserting the following new
17 clause:

18 “(ii) CHANGES IN TYPES OF DATA.—
19 Subject to clause (iii), the Secretary may
20 only change the types of data that are re-
21 quired to be submitted under subpara-
22 graph (A) after submitting to Congress a
23 report on the reasons for such changes
24 that was prepared—

1 “(I) in the case of data necessary
2 for the operation of the plan value-
3 based purchasing program under sec-
4 tion 1860E-4, after the requirements
5 under subsections (c) and (d) of sec-
6 tion 1860E-1 have been complied
7 with; and

8 “(II) in the case of any other
9 data, in consultation with MA organi-
10 zations and private accrediting bod-
11 ies.”.

12 (B) ELIGIBLE ENTITIES WITH REASON-
13 ABLE COST CONTRACTS.—Section 1876(h) (42
14 U.S.C. 1395mm(h)) is amended by adding at
15 the end the following new paragraph:

16 “(6)(A) With respect to plan years beginning on or
17 after January 1, 2006, an eligible entity with a reasonable
18 cost reimbursement contract under this subsection shall
19 submit to the Secretary such data that the Secretary de-
20 termines is appropriate for the measurement of health out-
21 comes and other indices of quality, including data nec-
22 essary for the operation of the plan value-based pur-
23 chasing program under section 1860E-4. Such data shall
24 be submitted in a form and manner, and at a time, speci-
25 fied by the Secretary for purposes of this subparagraph.

1 “(B) The Secretary shall establish procedures for
2 making data reported under subparagraph (A) available
3 to the public in a clear and understandable form. Such
4 procedures shall ensure that an eligible entity has the op-
5 portunity to review the data that is to be made public with
6 respect to the contract prior to such data being made pub-
7 lic.”.

8 (C) EFFECTIVE DATE.—The amendments
9 made by this subsection shall apply to plan
10 years beginning on or after January 1, 2006.

11 (D) SENSE OF THE SENATE.—It is the
12 sense of the Senate that, in establishing the
13 timeframes for Medicare Advantage organiza-
14 tions and entities with a reasonable cost reim-
15 bursement contract under section 1876(h) of
16 the Social Security Act (42 U.S.C. 1395mm(h))
17 to report quality data under sections 1852(e)(3)
18 and 1876(h)(6), respectively, of such Act, as
19 added by this section, the Secretary should take
20 into account other timeframes for reporting
21 quality data that such organizations and enti-
22 ties are subject to under other Federal and
23 State programs and in the commercial market.

24 (2) REDUCTION IN PAYMENTS TO ORGANIZA-
25 TIONS IN ORDER TO FUND PROGRAM.—

1 (A) MEDICARE ADVANTAGE PAYMENTS.—

2 (i) IN GENERAL.—Section 1853(a)(1)
3 (42 U.S.C. 1395w-23(a)(1)), as amended
4 by section 222(e) of the Medicare Prescrip-
5 tion Drug, Improvement, and Moderniza-
6 tion Act of 2003 (Public Law 108-173;
7 117 Stat. 2200), is amended—

8 (I) in clauses (i) and (ii) of sub-
9 paragraph (B), by inserting “and, for
10 2009 and each subsequent year, ex-
11 cept in the case of an MSA plan or an
12 MA plan for which there was no con-
13 tract under section 1857 during either
14 of the preceding 2 years, reduced by
15 the applicable percent (as defined in
16 subparagraph (I))” after “(G)”; and

17 (II) by adding at the end the fol-
18 lowing new subparagraph:

19 “(I) APPLICABLE PERCENT.—For pur-
20 poses of clauses (i) and (ii) of subparagraph
21 (B), the term ‘applicable percent’ means—

22 “(i) for 2009, 1.0 percent;

23 “(ii) for 2010, 1.25 percent;

24 “(iii) for 2011, 1.5 percent;

25 “(iv) for 2012, 1.75 percent; and

1 “(v) for 2013 and each subsequent
2 year, 2.0 percent.”.

3 (iii) REDUCTIONS IN PAYMENTS DO
4 NOT AFFECT THE REBATE FOR BIDS
5 BELOW THE BENCHMARK.—The amend-
6 ments made by subparagraph (A) shall not
7 be construed to have any effect on—

8 (I) the determination of whether
9 a Medicare Advantage plan has aver-
10 age per capita monthly savings de-
11 scribed in paragraph (3)(C) or (4)(C)
12 of section 1854(b) of the Social Secu-
13 rity Act (42 U.S.C. 1395w-24(b)); or

14 (II) the amount of such savings.

15 (A) REASONABLE COST CONTRACT PAY-
16 MENTS.—Section 1876(h) (42 U.S.C.
17 1395mm(h)), as amended by subsection (a)(2),
18 is amended by adding at the end the following
19 new paragraph:

20 “(7) Notwithstanding the preceding provisions of this
21 subsection, the Secretary shall reduce each payment to an
22 eligible organization under this subsection with respect to
23 benefits provided on or after January 1, 2009, by an
24 amount equal to the applicable percent (as defined in sec-
25 tion 1853(a)(1)(I)) of the payment amount.”.

1 (3) REQUIREMENT FOR REPORTING ON USE OF
2 VALUE-BASED PAYMENTS.—

3 (A) MA PLANS.—Section 1854(a) (42
4 U.S.C. 1395w-24(a)), as amended by section
5 222(a) of the Medicare Prescription Drug, Im-
6 provement, and Modernization Act of 2003
7 (Public Law 108-173; 117 Stat. 2193), is
8 amended—

9 (i) in paragraph (1)(A)(i), by striking
10 “or (6)(A)” and inserting “(6)(A), or (7)”;
11 and

12 (ii) by adding at the end the fol-
13 lowing:

14 “(7) SUBMISSION OF INFORMATION OF HOW
15 VALUE-BASED PAYMENTS WILL BE USED.—For an
16 MA plan for a plan year beginning on or after Janu-
17 ary 1, 2011, the information described in this para-
18 graph is a description of how the organization offer-
19 ing the plan will use any value-based payments that
20 the organization received under section 1860E-4
21 with respect to the plan for the year preceding the
22 year in which such information is submitted.”.

23 (B) REASONABLE COST CONTRACTS.—Sec-
24 tion 1876(h) (42 U.S.C. 1395mm(h)), as

1 amended by subsection (c)(2), is amended by
2 adding at the end the following new paragraph:

3 “(8) Not later than July 1 of each year (beginning
4 in 2010), any eligible entity with a reasonable cost reim-
5 bursement contract under this subsection that received a
6 value-based payment under section 1860E-4 with respect
7 to the contract for the preceding year shall submit to the
8 Secretary a report containing a description of how the or-
9 ganization will use such payments under the contract.”.

10 (e) ESRD PROVIDERS AND FACILITIES.—

11 (1) VOLUNTARY SUBMISSION OF QUALITY
12 DATA.—Section 1881(b) (42 U.S.C. 1395rr(b)) is
13 amended by adding at the end the following new
14 paragraph:

15 “(14) By not later than July 31, 2006, the Sec-
16 retary shall establish procedures under which pro-
17 viders of services and renal dialysis facilities that re-
18 ceive payments under paragraph (12) or (13) may
19 submit to the Secretary data that permits the meas-
20 urement of health outcomes and other indices of
21 quality.”.

22 (2) REDUCTION IN CASE-MIX ADJUSTED PRO-
23 SPECTIVE PAYMENT AMOUNT IN ORDER TO FUND
24 PROGRAM.—Section 1881(b)(12) (42 U.S.C.
25 1395rr(b)(12)) is amended—

1 (A) by redesignating subparagraph (G) as
2 subparagraph (H); and

3 (B) by inserting after subparagraph (F)
4 the following new subparagraph:

5 “(G)(i) In the case of any payment made under
6 this paragraph for an item or service furnished on
7 or after January 1, 2007, such payment shall be re-
8 duced by the applicable percent. The preceding sen-
9 tence shall not apply to a payment for an item or
10 service furnished by a provider of services or a renal
11 dialysis facility that is excluded from the program
12 under section 1860E–5 by reason of subsection
13 (a)(3) of such section at the time the item or service
14 is furnished.

15 “(ii) For purposes of clause (i), the term ‘appli-
16 cable percent’ means—

17 “(I) for 2007, 1.0 percent;

18 “(II) for 2008, 1.25 percent;

19 “(III) for 2009, 1.5 percent;

20 “(IV) for 2010, 1.75 percent; and

21 “(V) for 2011 and each subsequent year,
22 2.0 percent.”.

23 (3) VALUE-BASED PURCHASING UNDER THE
24 DEMONSTRATION OF BUNDLED CASE-MIX ADJUSTED
25 PAYMENT SYSTEM FOR ESRD SERVICES.—Section

1 623(e) of the Medicare Prescription Drug, Improve-
2 ment, and Modernization Act of 2003 (42 U.S.C.
3 1395rr note) is amended by adding at the end the
4 following new paragraph:

5 “(7) VALUE-BASED PURCHASING PROGRAM.—
6 As part of the demonstration project under this sub-
7 section, the Secretary shall, beginning January 1,
8 2007, implement a value-based purchasing program
9 for providers and facilities participating in the dem-
10 onstration project. The Secretary shall implement
11 such value-based purchasing program in a similar
12 manner as the ESRD provider and facility value-
13 based purchasing program is implemented under
14 section 1860E–5 of the Social Security Act, includ-
15 ing the funding of such program.”.

16 (f) HOME HEALTH AGENCIES.—

17 (1) UPDATE FOR HOME HEALTH AGENCIES
18 THAT SUBMIT QUALITY DATA.—Section
19 1895(b)(3)(B) (42 U.S.C.fff(b)(3)(B)) is amended—

20 (A) in clause (ii)(IV), by inserting “subject
21 to clause (v),” after “subsequent year,”; and

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

24 “(v) ADJUSTMENT IF QUALITY DATA
25 NOT SUBMITTED.—

1 “(I) ADJUSTMENT.—For pur-
2 poses of clause (ii)(IV), for 2007 and
3 each subsequent year, in the case of a
4 home health agency that does not sub-
5 mit data in accordance with subclause
6 (II) with respect to such a year, the
7 home health market basket percentage
8 increase applicable under such clause
9 for such year shall be reduced by 2
10 percentage points. Such reduction
11 shall apply only with respect to the
12 year involved, and the Secretary shall
13 not take into account such reduction
14 in computing the prospective payment
15 amount under this section for a subse-
16 quent year.

17 “(II) SUBMISSION OF QUALITY
18 DATA.—For 2007 and each subse-
19 quent year, each home health agency
20 shall submit to the Secretary such
21 data that the Secretary determines is
22 appropriate for the measurement of
23 health care quality, including data
24 necessary for the operation of the
25 home health agency value-based pur-

1 chasing program under section
2 1860E-6. Such data shall be sub-
3 mitted in a form and manner, and at
4 a time, specified by the Secretary for
5 purposes of this clause.

6 “(III) PUBLIC AVAILABILITY OF
7 DATA SUBMITTED.—The Secretary
8 shall establish procedures for making
9 data submitted under subclause (II)
10 available to the public in a clear and
11 understandable form. Such procedures
12 shall ensure that a home health agen-
13 cy has the opportunity to review the
14 data that is to be made public with
15 respect to the agency prior to such
16 data being made public.”

17 (2) REDUCTION IN STANDARD PROSPECTIVE
18 PAYMENT AMOUNT FOR AGENCIES THAT SUBMIT
19 QUALITY DATA IN ORDER TO FUND PROGRAM.—Sec-
20 tion 1895(b)(3) (42 U.S.C. 1395fff(b)(3)) is amend-
21 ed by adding at the end the following new subpara-
22 graph:

23 “(D) REDUCTION IN ORDER TO FUND
24 VALUE-BASED PURCHASING PROGRAM.—

1 “(i) IN GENERAL.—For 2008 and
2 each subsequent year, in the case of a
3 home health agency that complies with the
4 submission requirements under section
5 1895(b)(3)(B)(v)(II) for the year, the
6 standard prospective payment amount (or
7 amounts) otherwise applicable under this
8 paragraph for the year shall be reduced by
9 the applicable percent.

10 “(ii) APPLICABLE PERCENT.—For
11 purposes of clause (i), the term ‘applicable
12 percent’ means—

13 “(I) for 2008, 1.0 percent;

14 “(II) for 2009, 1.25 percent;

15 “(III) for 2010, 1.5 percent;

16 “(IV) for 2011, 1.75 percent;

17 and

18 “(V) for 2012 and each subse-
19 quent year, 2.0 percent.”.

20 (g) SKILLED NURSING FACILITIES.—

21 (1) REQUIREMENT FOR SKILLED NURSING FA-
22 CILITIES TO REPORT FUNCTIONAL CAPACITY OF
23 MEDICARE RESIDENTS UPON ADMISSION AND DIS-
24 CHARGE.—Section 1819(b) (42 U.S.C. 1395i–3(b))

1 is amended by adding at the end the following new
2 paragraph:

3 “(9) REPORTING FUNCTIONAL CAPACITY AT AD-
4 MISSION AND DISCHARGE.—

5 “(A) IN GENERAL.—On and after October
6 1, 2006, a skilled nursing facility must submit
7 a report to the Secretary on the functional ca-
8 pacity of each resident who is entitled to bene-
9 fits under this part at the time of—

10 “(i) the admission of such resident;

11 and

12 “(ii) the discharge of such resident.

13 “(B) TIMEFRAME.—A report required
14 under subparagraph (A) shall be submitted
15 within 10 days of the admission or discharge,
16 as the case may be.”.

17 (2) VOLUNTARY SUBMISSION OF SKILLED
18 NURSING FACILITY QUALITY DATA.—Section
19 1888(e)(4)(E) (42 U.S.C. 1395yy(e)(4)(E)) is
20 amended—

21 (A) in clause (ii)(IV), by inserting “subject
22 to clause (iii),” after “subsequent fiscal year,”;
23 and

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

1 “(iii) ADJUSTMENT IF QUALITY DATA
2 NOT SUBMITTED.—

3 “(I) ADJUSTMENT.—For pur-
4 poses of clause (ii)(IV), for fiscal year
5 2009 and each subsequent fiscal year,
6 in the case of a skilled nursing facility
7 that does not submit data in accord-
8 ance with subclause (II) with respect
9 to such a fiscal year, the skilled nurs-
10 ing facility market basket percentage
11 change applicable under such clause
12 for such fiscal year shall be reduced
13 by 2 percentage points. Such reduc-
14 tion shall apply only with respect to
15 the fiscal year involved, and the Sec-
16 retary shall not take into account
17 such reduction in computing the Fed-
18 eral per diem rate under this section
19 for a subsequent fiscal year.

20 “(II) SUBMISSION OF QUALITY
21 DATA.—For fiscal year 2008 and each
22 subsequent fiscal year, each skilled
23 nursing facility shall submit to the
24 Secretary such data that the Sec-
25 retary determines, after conducting a

1 study in consultation with the entities
2 described in subsections (c)(1), (c)(2),
3 and (d) of section 1860E-1, is appro-
4 priate for the measurement of health
5 outcomes and other indices of quality.
6 Such data shall be submitted in a
7 form and manner, and at a time,
8 specified by the Secretary for pur-
9 poses of this clause.

10 “(III) PUBLIC AVAILABILITY OF
11 DATA SUBMITTED.—The Secretary
12 shall establish procedures for making
13 data submitted under subclause (II)
14 available to the public in a clear and
15 understandable form. Such procedures
16 shall ensure that a facility has the op-
17 portunity to review the data that is to
18 be made public with respect to the fa-
19 cility prior to such data being made
20 public.”.

21 (h) CONFORMING REFERENCES TO PREVIOUS PART
22 E.—Any reference in law (in effect before the date of the
23 enactment of this Act) to part E of title XVIII of the So-
24 cial Security Act is deemed a reference to part F of such
25 title (as in effect after such date).

1 **SEC. 6111. PHASE-OUT OF RISK ADJUSTMENT BUDGET NEU-**
2 **TRALITY IN DETERMINING THE AMOUNT OF**
3 **PAYMENTS TO MEDICARE ADVANTAGE ORGA-**
4 **NIZATIONS.**

5 (a) IN GENERAL.—Section 1853 (42 U.S.C. 1395w–
6 23) is amended—

7 (1) in subsection (j)(1)—

8 (A) in subparagraph (A)—

9 (i) by inserting “(or, beginning with
10 2007, $\frac{1}{12}$ of the applicable amount deter-
11 mined under subsection (k)(1))” after
12 “1853(c)(1)”; and

13 (ii) by inserting “(for years before
14 2007)” after “adjusted as appropriate”;

15 (B) in subparagraph (B), by inserting
16 “(for years before 2007)” after “adjusted as
17 appropriate”; and

18 (2) by adding at the end the following new sub-
19 section:

20 “(k) DETERMINATION OF APPLICABLE AMOUNT FOR
21 PURPOSES OF CALCULATING THE BENCHMARK
22 AMOUNTS.—

23 “(1) APPLICABLE AMOUNT DEFINED.—For
24 purposes of subsection (j), subject to paragraph (2),
25 the term ‘applicable amount’ means for an area—

26 “(A) for 2007—

1 “(i) if such year is not specified under
2 subsection (c)(1)(D)(ii), an amount equal
3 to the amount specified in subsection
4 (c)(1)(C) for the area for 2006—

5 “(I) first adjusted by the re-
6 scaling factor for 2006 for the area
7 (as made available by the Secretary in
8 the announcement of the rates on
9 April 4, 2005, under subsection
10 (b)(1), but excluding any national ad-
11 justment factors for coding intensity
12 and risk adjustment budget neutrality
13 that were included in such factor);
14 and

15 “(II) then increased by the na-
16 tional per capita MA growth percent-
17 age, described in subsection (c)(6) for
18 that succeeding year, but not taking
19 into account any adjustment under
20 subparagraph (C) of such subsection
21 for a year before 2004;

22 “(ii) if such year is specified under
23 subsection (c)(1)(D)(ii), an amount equal
24 to the greater of—

1 “(I) the amount determined
2 under clause (i) for the area for the
3 year; or

4 “(II) the amount specified in
5 subsection (c)(1)(D) for the area for
6 the year; and

7 “(B) for a subsequent year—

8 “(i) if such year is not specified under
9 subsection (c)(1)(D)(ii), an amount equal
10 to the amount determined under this para-
11 graph for the area for the previous year,
12 increased by the national per capita MA
13 growth percentage, described in subsection
14 (c)(6) for that succeeding year, but not
15 taking into account any adjustment under
16 subparagraph (C) of such subsection for a
17 year before 2004; and

18 “(ii) if such year is specified under
19 subsection (c)(1)(D)(ii), an amount equal
20 to the greater of—

21 “(I) the amount determined
22 under clause (i) for the area for the
23 year; or

1 “(II) the amount specified in
2 subsection (c)(1)(D) for the area for
3 the year.

4 “(2) ADJUSTMENT.—

5 “(A) IN GENERAL.—Except as provided in
6 subparagraph (D), in the case of 2007 through
7 2010, the applicable amount determined under
8 paragraph (1) shall be increased by a factor
9 equal to 1 plus the product of—

10 “(i) the percent determined under
11 subparagraph (B) for the year; and

12 “(ii) the applicable percent for the
13 year under subparagraph (C).

14 “(B) PERCENT DETERMINED.—

15 “(i) IN GENERAL.—For purposes of
16 subparagraph (A)(i), subject to clause (ii),
17 the percent determined under this subpara-
18 graph for a year is a percent equal to a
19 fraction—

20 “(I) the numerator of which is an
21 amount equal to—

22 “(aa) the Secretary’s esti-
23 mate of the total payments that
24 would have been made under this
25 part in the year if all the month-

1 ly payment amounts for all MA
2 plans were equal to $\frac{1}{12}$ of the
3 annual MA capitation rate under
4 subsection (c)(1) for the area and
5 year; minus

6 “(bb) the Secretary’s esti-
7 mate of the total payments that
8 would have been made under this
9 part in the year if all the month-
10 ly payment amounts for all MA
11 plans were equal to $\frac{1}{12}$ of the
12 MA area-specific non-drug
13 monthly benchmark amount
14 under subsection (j) for the area
15 and year; and

16 “(II) the denominator of which is
17 equal to the total amount estimated
18 for the year under subclause (I)(bb).

19 “(ii) REQUIREMENTS.—In estimating
20 the amounts under clause (i), the
21 Secretary—

22 “(I) shall—

23 “(aa) use a complete set of
24 the most recent and representa-
25 tive Medicare Advantage risk

1 scores under subsection (a)(3)
2 that are available from the risk
3 adjustment model announced for
4 the year;

5 “(bb) adjust the risk scores
6 to reflect changes in treatment
7 and coding practices in the fee-
8 for-service sector;

9 “(cc) adjust the risk scores
10 for differences in coding patterns
11 between Medicare Advantage
12 plans and providers under part A
13 and B to the extent that the Sec-
14 retary has identified such dif-
15 ferences;

16 “(dd) as necessary, adjust
17 the risk scores for late data sub-
18 mitted by Medicare Advantage
19 organizations;

20 “(ee) as necessary, adjust
21 the risk scores for lagged cohorts;
22 and

23 “(ff) as necessary, adjust
24 the risk scores for changes in en-

1 rollment in Medicare Advantage
2 plans during the year; and

3 “(II) may take into account the
4 estimated health risk of enrollees in
5 preferred provider organization plans
6 (including MA regional plans) for the
7 year.

8 In order to make the adjustment required
9 under item (cc) and to ensure payment ac-
10 curacy, the Secretary shall conduct an
11 analysis of the differences described in
12 such item. The Secretary shall complete
13 such analysis by a date necessary to ensure
14 that the results of such analysis are incor-
15 porated into the payment rates for a year
16 not later than 2008. In conducting such
17 analysis, the Secretary shall use data sub-
18 mitted with respect to 2004 and subse-
19 quent years, as available.

20 “(C) APPLICABLE PERCENT.—For pur-
21 poses of subparagraph (A)(ii), the term ‘appli-
22 cable percent’ means—

23 “(i) for 2007, 55 percent;

24 “(ii) for 2008, 40 percent;

25 “(iii) for 2009, 25 percent; and

1 “(iv) for 2010, 5 percent.

2 “(D) TERMINATION OF ADJUSTMENT.—

3 The Secretary shall not make any adjustment
4 under subparagraph (A) in a year if the
5 amount estimated under subparagraph
6 (B)(i)(I)(bb) for the year is equal to or greater
7 than the amount estimated under subparagraph
8 (B)(i)(I)(aa) for the year.

9 “(3) NO ADDITIONAL ADJUSTMENTS.—

10 “(A) IN GENERAL.—Except for the adjust-
11 ment provided for in paragraph (2), the Sec-
12 retary may not make any adjustment to the ap-
13 plicable amount determined in paragraph (1)
14 for any year.

15 “(B) RULE OF CONSTRUCTION.—Nothing
16 in this subsection shall be construed to limit the
17 authority of the Secretary to risk adjust the
18 amount under subsection (c)(1)(D) pursuant to
19 clause (i) of such subsection.”.

20 (b) REFINEMENTS TO HEALTH STATUS ADJUST-
21 MENT.—Section 1853(a)(1)(C) (42 U.S.C. 1395w-23) is
22 amended by inserting after the first sentence the following
23 new sentence: “In applying such adjustment for health
24 status to such payment amounts, the Secretary shall en-
25 sure that such adjustment reflects changes in treatment

1 and coding practices in the fee-for-service sector and re-
2 flects differences in coding patterns between Medicare Ad-
3 vantage plans and providers under part A and B to the
4 extent that the Secretary has identified such differences.”.

5 **SEC. 6112. ELIMINATION OF MEDICARE ADVANTAGE RE-**
6 **GIONAL PLAN STABILIZATION FUND.**

7 (a) **ELIMINATION.**—

8 (1) **IN GENERAL.**—Subsection (e) of section
9 1858 (42 U.S.C. 1395w-27a) is repealed.

10 (2) **CONFORMING AMENDMENT.**—Section
11 1858(f)(1) (42 U.S.C. 1395w-27a(f)(1)) is amended
12 by striking “subject to subsection (e),”.

13 (3) **EFFECTIVE DATE.**—The amendments made
14 by this subsection shall take effect as if included in
15 the enactment of section 221(c) of the Medicare Pre-
16 scription Drug, Improvement, and Modernization
17 Act of 2003 (Public Law 108-173; 117 Stat. 2181).

18 (b) **TIMEFRAME FOR PART A AND B PAYMENTS.**—
19 Notwithstanding sections 1816(c) and 1842(c)(2) of the
20 Social Security Act or any other provision of law—

21 (1) any payment from the Federal Hospital In-
22 surance Trust Fund under section 1817 of the So-
23 cial Security Act (42 U.S.C. 1395i) or from the Fed-
24 eral Supplementary Medical Insurance Trust Fund
25 under section 1841 of such Act (42 U.S.C. 1395t)

1 for claims submitted under part A or B of title
2 XVIII of such Act for items and services furnished
3 under such part A or B, respectively, that would
4 otherwise be payable during the period beginning on
5 September 22, 2006, and ending on September 30,
6 2006, shall be paid on the first business day of Oc-
7 tober 2006; and

8 (2) no interest or late penalty shall be paid to
9 an entity or individual for any delay in a payment
10 by reason of the application of paragraph (1).

11 **SEC. 6113. RURAL PACE PROVIDER GRANT PROGRAM.**

12 (a) DEFINITIONS.—In this section:

13 (1) CMS.—The term “CMS” means the Cen-
14 ters for Medicare & Medicaid Services.

15 (2) ELIGIBLE PARTICIPANT.—The term “eligi-
16 ble participant” means a PACE program eligible in-
17 dividual (as defined in sections 1894(a)(5) and
18 1934(a)(5) of the Social Security Act (42 U.S.C.
19 1395eee(a)(5); 1396u–4(a)(5))).

20 (3) PACE PROGRAM.—The term “PACE pro-
21 gram” has the meaning given that term in sections
22 1894(a)(2) and 1934(a)(2) of the Social Security
23 Act (42 U.S.C. 1395eee(a)(2); 1396u–4(a)(2)).

24 (4) PACE PROVIDER.—The term “PACE pro-
25 vider” has the meaning given that term in section

1 1894(a)(3) or 1934(a)(3) of the Social Security Act
2 (42 U.S.C. 1395eee(a)(3); 1396u-4(a)(3)).

3 (5) RURAL AREA.—The term “rural area” has
4 the meaning given that term in section
5 1886(d)(2)(D) of the Social Security Act (42 U.S.C.
6 1395ww(d)(2)(D)).

7 (6) RURAL PACE PILOT SITE.—The term “rural
8 PACE pilot site” means a PACE provider that has
9 been approved to provide services in a geographic
10 service area that is, in whole or in part, a rural area,
11 and that has received a site development grant
12 under this section.

13 (7) SECRETARY.—The term “Secretary” means
14 the Secretary of Health and Human Services.

15 (b) SITE DEVELOPMENT GRANTS AND TECHNICAL
16 ASSISTANCE PROGRAM.—

17 (1) SITE DEVELOPMENT GRANTS.—

18 (A) IN GENERAL.—The Secretary shall es-
19 tablish a process and criteria to award site de-
20 velopment grants to qualified PACE providers
21 that have been approved to serve a geographic
22 service area that is, in whole or in part, a rural
23 area.

24 (B) AMOUNT PER AWARD.—A site develop-
25 ment grant awarded under subparagraph (A) to

1 any individual rural PACE pilot site shall not
2 exceed \$750,000.

3 (C) NUMBER OF AWARDS.—Not more than
4 15 rural PACE pilot sites shall be awarded a
5 site development grant under subparagraph
6 (A).

7 (D) USE OF FUNDS.—Funds made avail-
8 able under a site development grant awarded
9 under subparagraph (A) may be used for the
10 following expenses only to the extent such ex-
11 penses are incurred in relation to establishing
12 or delivering PACE program services in a rural
13 area:

14 (i) Feasibility analysis and planning.

15 (ii) Interdisciplinary team develop-
16 ment.

17 (iii) Development of a provider net-
18 work, including contract development.

19 (iv) Development or adaptation of
20 claims processing systems.

21 (v) Preparation of special education
22 and outreach efforts required for the
23 PACE program.

1 (vi) Development of expense reporting
2 required for calculation of outlier payments
3 or reconciliation processes.

4 (vii) Development of any special qual-
5 ity of care or patient satisfaction data col-
6 lection efforts.

7 (viii) Establishment of a working cap-
8 ital fund to sustain fixed administrative,
9 facility, or other fixed costs until the pro-
10 vider reaches sufficient enrollment size.

11 (ix) Startup and development costs in-
12 curred prior to the approval of the rural
13 PACE pilot site's PACE provider applica-
14 tion by CMS.

15 (x) Any other efforts determined by
16 the rural PACE pilot site to be critical to
17 its successful startup, as approved by the
18 Secretary.

19 (E) APPROPRIATION.—

20 (i) IN GENERAL.—Out of funds in the
21 Treasury not otherwise appropriated, there
22 are appropriated to the Secretary to carry
23 out this subsection for the period of fiscal
24 years 2006 through 2007, \$7,500,000.

1 (ii) AVAILABILITY.—Funds appro-
2 priated under clause (i) shall remain avail-
3 able for expenditure through fiscal year
4 2010.

5 (2) TECHNICAL ASSISTANCE PROGRAM.—The
6 Secretary shall establish a technical assistance pro-
7 gram to provide—

8 (A) outreach and education to State agen-
9 cies and provider organizations interested in es-
10 tablishing PACE programs in rural areas; and

11 (B) technical assistance necessary to sup-
12 port rural PACE pilot sites.

13 (c) COST OUTLIER PROTECTION FOR RURAL PACE
14 PILOT SITES.—

15 (1) ESTABLISHMENT OF FUND FOR REIM-
16 BURSEMENT OF OUTLIER COSTS.—

17 (A) IN GENERAL.—Notwithstanding any
18 other provision of law, the Secretary shall es-
19 tablish an outlier fund to reimburse rural
20 PACE pilot sites for outlier costs (as defined in
21 subparagraph (B)) incurred for eligible partici-
22 pants who reside in a rural area in accordance
23 with the expense payment specified in subpara-
24 graph (C).

25 (B) OUTLIER COSTS DEFINED.—

1 (i) IN GENERAL.—In subparagraph
2 (A), the term “outlier costs” means the in-
3 patient and related physician and ancillary
4 costs in excess of \$50,000 incurred within
5 a given 12-month period for an eligible
6 participant who resides in a rural area.

7 (ii) INCLUSION IN ONLY 1 PERIOD.—
8 Outlier costs may not be included in more
9 than one 12-month period for purposes of
10 calculating an outlier expense payment
11 under subparagraph (C).

12 (C) OUTLIER EXPENSE PAYMENT.—

13 (i) PAYMENT FOR OUTLIER COSTS.—
14 Subject to clause (ii), in the case of a rural
15 PACE pilot site that has incurred outlier
16 costs for an eligible participant, the rural
17 PACE pilot site shall receive an outlier ex-
18 pense payment equal to 80 percent of such
19 costs.

20 (ii) LIMITATIONS.—

21 (I) COSTS INCURRED PER ELIGI-
22 BLE PARTICIPANT.—The total amount
23 of outlier expense payments made
24 under clause (i) to a rural PACE pilot
25 site for outlier costs incurred with re-

1 spect to an eligible participant shall
2 not exceed \$100,000 for the 12-month
3 period used to calculate the payment.

4 (II) COSTS INCURRED PER PRO-
5 VIDER.—No rural PACE pilot site
6 may receive more than \$500,000 in
7 total outlier expense payments in a
8 12-month period.

9 (III) LIMITATION OF OUTLIER
10 COST REIMBURSEMENT PERIOD.—A
11 rural PACE pilot site shall only re-
12 ceive outlier expense payments under
13 this subparagraph with respect to
14 outlier costs incurred during the first
15 3 years of the site's operation.

16 (D) REQUIREMENT TO ACCESS RISK RE-
17 SERVES PRIOR TO PAYMENT.—A rural PACE
18 pilot site shall access and exhaust any risk re-
19 serves held or arranged for the provider (other
20 than revenue or reserves maintained to satisfy
21 the requirements of section 460.80(c) of title
22 42, Code of Federal Regulations) and any
23 working capital established through a site devel-
24 opment grant awarded under subsection (b)(1),

1 prior to receiving any payment from the outlier
2 fund.

3 (E) APPROPRIATION.—

4 (i) IN GENERAL.—Out of funds in the
5 Treasury not otherwise appropriated, there
6 are appropriated to the Secretary to carry
7 out this subsection for the period of fiscal
8 years 2006 through 2007, \$10,000,000.

9 (ii) AVAILABILITY.—Funds appro-
10 priated under clause (i) shall remain avail-
11 able for expenditure through fiscal year
12 2010.

13 (d) EVALUATION OF PACE PROVIDERS SERVING
14 RURAL SERVICE AREAS.—Not later than 60 months after
15 the date of enactment of this Act, the Secretary shall sub-
16 mit a report to Congress containing an evaluation of the
17 experience of rural PACE pilot sites.

18 (e) AMOUNTS IN ADDITION TO PAYMENTS UNDER
19 SOCIAL SECURITY ACT.—Any amounts paid under the au-
20 thority of this section to a PACE provider shall be in addi-
21 tion to payments made to the provider under section 1894
22 or 1934 of the Social Security Act (42 U.S.C. 1395eee;
23 1396u-4).

1 **SEC. 6114. WAIVER OF PART B LATE ENROLLMENT PEN-**
2 **ALTY FOR CERTAIN INTERNATIONAL VOLUN-**
3 **TEERS.**

4 (a) IN GENERAL.—

5 (1) WAIVER OF PENALTY.—Section 1839(b)(42
6 U.S.C. 1395r(b)) is amended in the second sentence
7 by inserting the following before the period at the
8 end: “or months for which the individual can dem-
9 onstrate that the individual was an individual de-
10 scribed in section 1837(k)(3)”.

11 (2) SPECIAL ENROLLMENT PERIOD.—

12 (A) IN GENERAL.—Section 1837 (42
13 U.S.C. 1395p) is amended by adding at the end
14 the following new subsection:

15 “(k)(1) In the case of an individual who—

16 “(A) at the time the individual first satisfies
17 paragraph (1) or (2) of section 1836, is described in
18 paragraph (3), and has elected not to enroll (or to
19 be deemed enrolled) under this section during the in-
20 dividual’s initial enrollment period; or

21 “(B) has terminated enrollment under this sec-
22 tion during a month in which the individual is de-
23 scribed in paragraph (3),

24 there shall be a special enrollment period described in
25 paragraph (2).

1 “(2) The special enrollment period referred to in
2 paragraph (1) is the 6-month period beginning on the first
3 day of the month which includes the date that the indi-
4 vidual is no longer described in paragraph (3).

5 “(3) For purposes of paragraph (1), an individual de-
6 scribed in this paragraph is an individual that is serving
7 as a volunteer outside of the United States through a
8 program—

9 “(A) that covers at least a 12-month period;
10 and

11 “(B) that is sponsored by an organization de-
12 scribed in section 501(c)(3) of the Internal Revenue
13 Code of 1986 and exempt from taxation under sec-
14 tion 501(a) of such Code.”.

15 (B) COVERAGE PERIOD.—Section 1838
16 (42 U.S.C. 1395q) is amended by adding at the
17 end the following new subsection:

18 “(f) Notwithstanding subsection (a), in the case of
19 an individual who enrolls during a special enrollment pe-
20 riod pursuant to section 1837(k), the coverage period shall
21 begin on the first day of the month following the month
22 in which the individual so enrolls.”.

23 (b) EFFECTIVE DATE.—The amendment made by
24 subsection (a)(1) shall apply to months beginning with

1 January 2007 and the amendments made by subsection
2 (a)(2) shall take effect on January 1, 2007.

3 **SEC. 6115. DELIVERY OF SERVICES AT FEDERALLY QUALI-**
4 **FIED HEALTH CENTERS.**

5 (a) COVERAGE.—

6 (1) IN GENERAL.—Section 1861(aa)(3) (42
7 U.S.C. 1395x(aa)(3)) is amended—

8 (A) in subparagraph (A), by striking “,
9 and” and inserting “and services described in
10 subsections (qq) and (vv); and”;

11 (B) in subparagraph (B), by striking “sec-
12 tions 329, 330, and 340” and inserting “section
13 330”; and

14 (C) in the flush matter at the end, by in-
15 serting “by the center or by a health care pro-
16 fessional under contract with the center” after
17 “outpatient of a Federally qualified health cen-
18 ter”.

19 (2) CONSOLIDATED BILLING.—The first sen-
20 tence of section 1842(b)(6)(F) (42 U.S.C.
21 1395u(b)(6)(F)) is amended—

22 (A) by striking “and (G)” and inserting
23 “(G)”; and

24 (B) by inserting before the period at the
25 end the following: “, and (H) in the case of

1 services described in section 1861(aa)(3) that
2 are furnished by a health care professional
3 under contract with a Federally qualified health
4 center, payment shall be made to the center”.

5 (b) TECHNICAL CORRECTIONS.—Clauses (i) and
6 (ii)(II) of section 1861(aa)(4)(A) (42 U.S.C.
7 1395x(aa)(4)(A)) are each amended by striking “(other
8 than subsection (h))”.

9 (c) EFFECTIVE DATES.—The amendments made by
10 this section shall apply to services furnished on or after
11 January 1, 2006.