TITLE VI—COMMITTEE ON FINANCE

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

(a) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this title an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(b) REFERENCES TO THE SECRETARY.—In this title, the term ''Secretary'' means the Secretary of Health and Human Services.

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

Subtitle A—Medicaid

CHAPTER 1—PAYMENT FOR PRESCRIPTION DRUGS UNDER MEDICAID

SEC. 6001. PHARMACY REIMBURSEMENT.

(a) DEFINITION OF AVERAGE MANUFACTURER PRICE.—

(1) IN GENERAL.—Section 1927(k)(1) (42 U.S.C. 1396r–8(k)(1)) is amended—

(A) in the paragraph heading, by striking ''PRICE'' and inserting ''PRICE; WEIGHTED AVERAGE MANUFACTURER PRICE'';

(B) by striking ''The term'' and inserting the following:

''(A) IN GENERAL.—The term''; and

(C) by adding at the end the following:

"(B) CALCULATION REQUIREMENTS.—For purposes of subparagraph (A), the average manufacturer price shall be calculated according to the following:

"(i) SALES EXEMPTED FROM COMPUTATION.—Without regard to—

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

"(II) such other sales as the Secretary identifies as sales to an entity that are merely nominal in amount under subsection (c)(1)(C)(ii)(III); and

"(III) bona fide service fees (as defined in subparagraph (E)) that are paid by a manufacturer to an entity, that represent fair market value for a bona fide service, and that are not passed on in whole or in part to a client or customer of an entity.

"(ii) SALE PRICE NET OF DISCOUNTS.—By including the following:

"(I) Cash discounts and volume discounts.

''(II) Free goods that are contingent upon any purchase requirement or agreement.

''(III) Sales at a nominal price that are contingent upon any purchase requirement or agreement.

''(IV) Chargebacks, rebates provided to a pharmacy (including a mail order pharmacy but excluding a pharmacy benefit manager), or any other direct or indirect discounts.

''(V) Any other price concessions, which may be based on recommendations of the Inspector General of the Department of Health and Human Services, that would result in a reduction of the cost to the purchaser, but only if the Secretary provides notice of the Secretary's intent to include such price concessions in accordance with section 553 of title 5, United States Code.

''(C) WEIGHTED AVERAGE MANUFACTURER PRICE.—The term 'weighted average manufacturer price' means, with respect to a

rebate period and multiple source drug, the volume-weighted average of the average manufacturer prices reported under subsection (b)(3)(A)(i)(I) for all drug products described in paragraph (7)(A)(i) that are therapeutically equivalent and bioequivalent forms of the drug, determined by—

''(i) computing the sum of the products (for each National Drug Code assigned to such drug products) of—

''(I) the average manufacturer price; and

''(II) the total number of units reported sold under subsection (b)(3)(A)(i)(I); and

''(ii) dividing the sum determined under clause (i) by the sum of the total number of units under clause (i)(II) for all National Drug Codes assigned to such drug products.

''(D) LIMITATION ON SALES AT A NOMINAL PRICE.—

''(i) IN GENERAL.—For purposes of clauses (i)(II) and (ii)(III) of subparagraph (B), only sales by a manufacturer of

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

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

''(II) An intermediate care facility for the mentally retarded.

''(III) A State-owned or operated nursing facility.

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

''(aa) The type of facility.

''(bb) The services provided by the facility.

''(cc) The patient population served by the facility.

''(dd) The number of other facilities eligible to purchase at nominal prices in the same service area.

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

''(E) BONA FIDE SERVICE FEES.—For purposes of subparagraph (B)(i)(III), the term 'bona fide service fees' means expenses that are for an itemized service actually performed by an entity on behalf of a manufacturer that would have generally been paid for by the manufacturer at the same rate had these services been performed by another entity.''.

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

(A) in subclause (I)—

(i) by inserting ''and the total number of units sold'' after ''(as defined in subsection (k)(1))''; and

(ii) by striking ''and'' at the end;

(B) in subclause (II), by adding ''and'' at the end; and

(C) by adding at the end the following:

''(III) information and data on any sales that were made during such period at a nominal price, including, with respect to each such sale, the purchaser, the name of the product, the amount or number of units of the product sold at a nominal price, and the nominal price paid;''.

(3) EFFECTIVE DATE.—

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

(B) EXCEPTION.—Subparagraph (D) of section 1927(k)(1) of the Social Security Act (42 U.S.C. 1396r–8(k)(1)) (as added by paragraph (1)) shall not apply with respect to a contract in effect on the date of enactment of this

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

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

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

''(e) PHARMACY REIMBURSEMENT LIMITS.—

''(1) UPPER PAYMENT LIMIT FOR INGREDIENT COST OF COVERED OUTPATIENT DRUGS.—No Federal financial participation shall be available for payment for the ingredient cost of a covered outpatient drug that exceeds the upper payment limit for that drug established under paragraph (2).

''(2) UPPER PAYMENT LIMIT.—

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

''(i) single source drug, is 105 percent of the average manufacturer price for that drug; and

"(ii) multiple source drug, is 115 percent of the weighted average manufacturer price for that drug.

"(B) EXCEPTION FOR INITIAL SALES PERIODS.—

"(i) IN GENERAL.—In the case of a covered outpatient drug during an initial sales period (not to exceed 2 calendar quarters) in which data on sales for the drug is not sufficiently available from the manufacturer to compute the average manufacturer price or the weighted average manufacturer price, the Secretary shall establish the upper payment limit for the ingredient cost of such drug to apply only during such period based on the following:

"(I) In the case of a single source drug, such upper payment limit shall be the wholesale acquisition cost for the drug.

"(II) In the case of a first non-innovator multiple source drug, such upper payment limit shall be the average manufacturer price for the single source drug that is rated as thera-

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

''(III) In the case of a subsequent noninnovator multiple source drug—

''(aa) if the Secretary has sufficient data to determine the weighted average manufacturer price for the drug, such upper payment limit shall be the weighted average manufacturer price determined for the therapeutically equivalent and bioequivalent form of the drug; and

''(bb) if the Secretary does not have sufficient data to determine the weighted average manufacturer price for the drug, such upper payment limit shall be the average manufacturer price for the single source drug that is rated as therapeutically equivalent and bioequivalent to the drug, minus 10 percent.

"(ii) DEFINITION OF WHOLESALE ACQUISITION COST.—For purposes of clause (i), the term 'wholesale acquisition cost' means, with respect to a drug or biological, the manufacturer's list price for the drug or biological to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates, or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug or biological pricing data.

"(C) EXCEPTION FOR CERTAIN INNOVATOR MULTIPLE SOURCE DRUGS.—In the case of an innovator multiple source drug that a prescribing health care provider determines is necessary for treatment of a condition and that a noninnovator multiple source drug would not be as effective for the individual or would have adverse effects for the individual or both, and for which the provider obtains prior authorization in accordance with a program described in subsection (d)(5), the upper payment limit for the innovator multiple source drug shall be 105

percent of the average manufacturer price for such drug.

''(D) UPDATES; AVAILABILITY OF DATA.—

''(i) FREQUENCY OF DETERMINATION.—The Secretary shall update the upper payment limits applicable under this paragraph on a quarterly basis, taking into account the most recent data collected for purposes of determining such limits and the Food and Drug Administration's most recent publication of 'Approved Drug Products with Therapeutic Equivalence Evaluations'.

''(ii) COLLECTION OF DATA.—

''(I) IN GENERAL.—Beginning on January 1, 2006, the Secretary shall collect data with respect to the average manufacturer prices and volume of sales of covered outpatient drugs (or, in the case of covered outpatient drugs that are first marketed after such date, beginning with the first quarter during which the drugs are first marketed).

"(II) DATA REPORTED FOR PURPOSES OF DETERMINING WEIGHTED AVERAGE MANUFACTURER PRICE.—Insofar as there is a lag in the reporting of the information on rebates and chargebacks so that adequate data are not available on a timely basis to update the weighted average manufacturer price for a multiple source drug, the manufacturer of such drug shall apply a methodology based on a 12-month rolling average for the manufacturer to estimate costs attributable to rebates and charge backs for such drug. For years after 2006, the Secretary shall establish a uniform methodology to estimate and apply such costs.

"(iii) AVAILABILITY OF DATA TO STATES.—Notwithstanding subsection (b)(3)(D), beginning with the first quarter of fiscal year 2006 for which data is available, and for each fiscal year quarter thereafter, the Secretary shall make available to States the most recently reported

average manufacturer prices for single source drugs and weighted average manufacturer prices for multiple source drugs.

''(E) AUTHORITY TO ENTER CONTRACTS.—The Secretary may enter into contracts with appropriate entities to determine average manufacturer prices, volume, and other data necessary to calculate the upper payment limit for a covered outpatient drug established under this subsection and to calculate that payment limit.

''(3) STATE USE OF PRICE DATA.—

''(A) DISTRIBUTION OF DATA.—The Secretary shall devise and implement a means for electronic distribution of the most recently calculated weighted average manufacturer price and the average manufacturer price for all covered outpatient drugs to each State agency designated under section 1902(a)(5) with responsibility for the administration or supervision of the administration of the State plan under this title.

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

graph (A) in establishing payment rates for the ingredient costs and dispensing fees for covered outpatient drugs dispensed to individuals eligible for medical assistance under this title.

''(4) REASONABLE DISPENSING FEES REQUIRED.—

''(A) IN GENERAL.—A State which provides medical assistance for covered outpatient drugs shall pay a dispensing fee for each covered outpatient drug for which Federal financial participation is available in accordance with this section in accordance with the following:

''(i) The dispensing fee for a noninnovator multiple source drug shall be greater than the dispensing fee for an innovator multiple source drug that is rated as therapeutically equivalent and bioequivalent to such drug.

''(ii) In establishing such dispensing fees, the State takes into consideration such requirements as the Secretary shall, by regulation, establish, and which shall include consideration of the following:

''(I) Any reasonable costs associated with a pharmacist's time in

checking for information about an individual's coverage or performing quality assurance activities.

"(II) Costs associated with—

"(aa) the measurement or mixing of a covered outpatient drug;

"(bb) filling the container for the drug;

"(cc) physically providing the completed prescription to an individual enrolled in the program under this title;

"(dd) delivery;

"(ee) special packaging;

"(ff) overhead related to maintaining the facility and equipment necessary to operate the pharmacy, including the salaries of pharmacists and other pharmacy workers;

"(gg) geographic factors that impact operational costs;

"(hh) patient counseling; and

"(ii) the dispensing of drugs requiring specialty pharmacy care management services (as determined by the Secretary in accordance with subparagraph (B)).

"(B) DETERMINATION OF DRUGS REQUIRING SPECIALTY PHARMACY CARE MANAGEMENT SERVICES.—

"(i) IN GENERAL.—Not later than 15 months after the date of enactment of the Deficit Reduction Omnibus Reconciliation Act of 2005, the Secretary shall establish a list of covered outpatient drugs which require specialty pharmacy care management services that includes only those drugs for which the Secretary determines that access by individuals eligible for medical assistance under this title would be seriously impaired without the provision of specialty pharmacy care management services.

"(ii) SPECIALTY PHARMACY CARE MANAGEMENT SERVICES DEFINED.—For purposes of this paragraph, the term 'specialty pharmacy care management services'

means services provided in connection with the dispensing or administration of a covered outpatient drug which the Secretary determines requires—

''(I) significant caregiver and provider contact and education regarding the relevant disease state, prevention, treatment, drug indications, benefits, risks, complications, use, pharmacy counseling, and explanation of existing provider guidelines;

''(II) patient compliance services, including coordination of provider visits with drug delivery, compliance with a drug dosing regimen, mailing or telephone call reminders, compiling compliance data, and assisting providers in developing compliance programs; or

''(III) tracking services, including developing referral processes with providers, screening referrals, and tracking patient weight for dosing requirements.

''(iii) QUARTERLY UPDATES.—The Secretary shall update the list of covered outpatient drugs requiring specialty pharmacy management services on a quarterly basis.

(2) CONFORMING AMENDMENTS.—

(A) Section 1927(b)(3)(D)(i) (42 U.S.C. 1396r–8(b)(3)(D)(i)) is amended by inserting ''(including with respect to the determination of weighted average manufacturer prices under subsection (e)(2) and the distribution of weighted average manufacturer prices and average manufacturer prices for covered outpatient drugs to States under subsection (e)(3))'' after ''this section''.

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

(i) in subparagraph (A), by striking ''and'' at the end;

(ii) in subparagraph (B), by striking ''or'' at the end and inserting ''and''; and

(iii) by adding at the end the following:

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

exceeds the upper payment limit for that drug established under section 1927(e); or''.

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

(A) January 1, 2007; or

(B) the date that is 6 months after the close of the first regular session of the State legislature that begins after the date of enactment of this Act.

(c) INTERIM UPPER PAYMENT LIMIT.—

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

(A) apply the Federal upper payment limit established under section 447.332(b) of title 42, Code of Federal Regulations to the State by substituting ''125 percent'' for ''150 percent''; and

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

447.332 of title 42, Code of Federal Regulations, use average wholesale prices, direct prices, and wholesale acquisition costs for such drugs that do not exceed such prices and costs as of such date to determine the Federal upper payment limits that apply under section 447.332 of title 42, Code of Federal Regulations to such drugs during such period.

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

SEC. 6002. INCREASE IN REBATES FOR COVERED OUTPATIENT DRUGS.

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

(1) in subclause (IV), by striking ''and'' after the semicolon;

(2) in subclause (V)—

(A) by inserting ''and before January 1, 2006,'' after ''1995,''; and

(B) by striking the period and inserting ''; and''; and

(3) by adding at the end the following:

''(VI) after December 31, 2005, is 17 percent.''.

(b) INCREASE IN REBATE FOR OTHER DRUGS.—Section 1927(c)(3)(B) (42 U.S.C. 1396r–8(c)(3)(B)) is amended—

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

(2) in clause (ii)—

(A) by inserting ''and before January 1, 2006,'' after ''December 31, 1993,''; and

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

(3) by adding at the end the following:

''(iii) after December 31, 2005, is 17 percent.''.

SEC. 6003. IMPROVED REGULATION OF AUTHORIZED GENERIC DRUGS.

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

(1) by striking clause (i) and inserting the following:

''(i) not later than 30 days after the last day of each rebate period under the agreement—

''(I) on the average manufacturer price (as defined in subsection (k)(1)) for each covered outpatient drug for the rebate period under the agreement (including for each such drug that is an authorized generic drug or is any other drug sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act); and

''(II) for each single source drug, innovator multiple source drug, authorized generic drug, and any other drug sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act, on the manufacturer's best price (as defined in subsection (c)(1)(C)) for such drug for the rebate period under the agreement;''; and

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

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

(1) in subsection (c)(1)(C)—

(A) in clause (i), in the matter preceding subclause (I), by striking ''or innovator multiple source drug of a manufacturer'' and inserting '', innovator multiple source drug, or authorized generic drug of a manufacturer, or any other drug of a manufacturer that is sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act''; and

(B) in clause (ii)—

(i) in subclause (II), by striking ''and'' at the end;

(ii) in subclause (III), by striking the period at the end and inserting ''; and''; and

(iii) by adding at the end the following:

"(IV) in the case of a manufacturer that approves, allows, or otherwise permits an authorized generic drug or any other drug of the manufacturer to be sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act, shall be inclusive of the lowest price for such authorized generic or other drug available from the manufacturer during the rebate period to any wholesaler, retailer, provider, health maintenance organization, nonprofit entity, or governmental entity within the United States, excluding those prices described in subclauses (I) through (IV) of clause (i).''; and

(2) in subsection (k)—

(A) in paragraph (1), as amended by section 6001(a)(1)(B), by adding at the end the following:

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

thorized generic drug or any other drug of the manufacturer to be sold under a new drug application approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act, such term shall be inclusive of the average price paid for such authorized generic or other drug.''; and

(B) by adding at the end the following:

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

''(A) has been approved under section 505(c) of such Act; and

''(B) is marketed, sold, or distributed directly or indirectly to the retail class of trade under a different labeling, packaging (other than repackaging as the listed drug in blister packs, unit doses, or similar packaging for use in institutions), product code, labeler code, trade name, or trade mark than the listed drug.''.

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

SEC. 6004. COLLECTION OF REBATES FOR CERTAIN PHYSICIAN ADMINISTERED DRUGS.

(a) IN GENERAL.—Section 1927(a) (42 U.S.C. 1396r–8(a)) is amended by adding at the end the following:

''(7) REQUIREMENT FOR SUBMISSION OF UTILIZATION DATA FOR CERTAIN PHYSICIAN-ADMINISTERED DRUGS.—In order for payment to be available under section 1903(a) for a covered outpatient drug that is physician administered (as determined by the Secretary), and that is administered on or after January 1, 2006, the State shall provide for the submission of such utilization data and coding (including both J-codes and National Drug Code numbers) for each such drug as the Secretary may specify as necessary in order to secure rebates for payments made under this title.''.

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

(1) in subparagraph (B), by striking ''and'' at the end;

(2) in subparagraph (C), by striking ''; or'' at the end and inserting '', and''; and

(3) by adding at the end the following:

''(D) with respect to covered outpatient drugs described in section 1927(a)(7), unless information with respect to utilization data and coding on such drugs is submitted in accordance with that section; or''.

CHAPTER 2—LONG-TERM CARE UNDER MEDICAID

SEC. 6011. REFORM OF MEDICAID ASSET TRANSFER RULES.

(a) REQUIREMENT TO IMPOSE PARTIAL MONTHS OF INELIGIBILITY.—Section 1917(c)(1)(E) (42 U.S.C. 1396p(c)(1)(E)) is amended by adding at the end the following:

''(iv) A State shall not round down, or otherwise disregard any fractional period of ineligibility determined under clause (i) or (ii) with respect to the disposal of assets.''.

(b) AUTHORITY FOR STATES TO ACCUMULATE MULTIPLE TRANSFERS INTO 1 PENALTY PERIOD.—Section 1917(c)(1) (42 U.S.C. 1396p(c)(1)) is amended by adding at the end the following:

''(F) Notwithstanding the preceding provisions of this paragraph, in the case of an individual (or individual's spouse) who disposes of multiple assets in more than 1 month for less than fair market value on or after the applicable look-back date specified in subparagraph (B), a

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

''(i) treating the total, cumulative uncompensated value of all assets transferred by the individual (or individual's spouse) during all months on or after the look-back date specified in subparagraph (B) as 1 transfer for purposes of clause (i) or (ii) (as the case may be) of subparagraph (E); and

''(ii) beginning such period on the earliest date which would apply under subparagraph (D) to any of such transfers.''.

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

''(G) For purposes of this paragraph with respect to a transfer of assets, the term 'assets' includes funds used to purchase a promissory note, loan, or mortgage unless such note, loan, or mortgage—

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

''(ii) provides for payments to be made in equal amounts during the term of the loan, with no deferral and no balloon payments made; and

''(iii) prohibits the cancellation of the balance upon the death of the lender.

In the case of a promissory note, loan, or mortgage that does not satisfy the requirements of clauses (i) through (iii), the value of such note, loan, or mortgage shall be the outstanding balance due as of the date of the individual's application for medical assistance for services described in subparagraph (C).''.

(d) TREATMENT OF ANNUITIES.—

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

''(H) For purposes of this paragraph with respect to a transfer of assets, the term 'assets' includes an annuity purchased by or on behalf of an annuitant who has applied for medical assistance with respect to nursing facility services or other long-term care services under this title unless—

''(i) the annuity is—

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

''(II) purchased with proceeds from—

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

''(bb) a simplified employee pension (within the meaning of section 408(k) of such Code); or

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

''(ii) the annuity—

''(I) is irrevocable and nonassignable;

''(II) is actuarially sound (as determined in accordance with actuarial publications of the Office of the Chief Actuary of the Social Security Administration); and

''(III) provides for payments in equal amounts during the term of the annuity, with no deferral and no balloon payments made.''.

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

''(I) For purposes of this paragraph, the purchase of an annuity shall be treated as the disposal of an asset for less than fair market value unless the State is named as the remainder beneficiary in the first position for at least the total amount of medical assistance paid on behalf of the annuitant under this title or is named as such a beneficiary in the second position after the community spouse and such spouse does not dispose of any such remainder for less than fair market value.''.

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

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

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

(C) by adding at the end the following:

''(C) shall include an annuity unless the annuity was purchased from a financial institution or other business that sells annuities in the State as part of its regular business.''.

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

''(J) For purposes of this paragraph with respect to a transfer of assets, the term 'assets' includes the purchase of a life estate interest in another individual's home unless the purchaser resides in the home for a period of at least 1 year after the date of the purchase.

(f) PROTECTION AGAINST UNDUE HARDSHIP.—Section 1917(c) (42 U.S.C. 1396p(c)) is amended by adding at the end the following:

''(6) For purposes of paragraph (2)(D) and subsection (d)(5), the procedures established by the State in accordance with standards specified by the Secretary shall provide for—

''(A) notice, before application of the provisions of paragraph (1) or subsection (d), to an individual who is an applicant for medical assistance under this title who would be subject to such a penalty under such provisions that an undue hardship exception exists;

''(B) a timely process before the imposition of a penalty for determining whether an undue hardship waiver will be granted for the individual;

''(C) a process under which an adverse determination can be appealed; and

''(D) application of criteria that specifies that an undue hardship exists when application of the

provisions of paragraph (1) or subsection (d) would deprive the individual of medical care such that the individual's health or life would be endangered or when the application of such provisions would deprive the individual of food, clothing, shelter, or other necessities of life.''.

(g) EFFECTIVE DATES.—

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

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

(A) to medical assistance provided for services furnished before the date of enactment;

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

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

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

plan under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) which the Secretary of Health and Human Services determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by a provision of this section, the State plan shall not be regarded as failing to comply with the requirements of such title solely on the basis of its failure to meet these additional requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of the enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session is considered to be a separate regular session of the State legislature.

SEC. 6012. STATE LONG-TERM CARE PARTNERSHIPS.

(a) EXPANSION OF STATE LONG-TERM CARE PARTNERSHIPS.—

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

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

''(I) a Qualified State Long-Term Care Insurance Partnership (as defined in paragraph (5)); or

''(II) under a State plan of a State which—

''(aa) had a State plan amendment approved as of May 14, 1993, which provided for the disregard of any assets or resources to the extent that payments are made under a long-term care insurance policy or because an individual has received (or is entitled to receive) benefits under a long-term care insurance policy; and

''(bb) has a State plan amendment which satisfies the requirements of subparagraphs (B) through (G) of paragraph (5) in the case of any long-term care insurance policy sold under such plan amendment on or after the date that is 2 years after the date of enactment of such paragraph.

For purposes of this clause and paragraphs (5) and (6), the term 'long-term care insurance policy' includes a certificate issued under a group insurance contract.''.

(2) SATISFACTION OF MINIMUM FEDERAL STANDARDS, TAX QUALIFICATIONS, INFLATION PROTECTION, AND OTHER REQUIREMENTS FOR LONG-TERM CARE INSURANCE PARTNERSHIPS.—Section 1917(b) (42 U.S.C. 1396p(b)) is amended by inserting at the end the following:

''(5) The term 'Qualified State Long-Term Care Insurance Partnership' means a program offered in a State with an approved State plan amendment that provides for the following:

''(A) Subject to the limit specified in subparagraph (D), the disregard of any assets or resources in an amount equal to the amount of payments made to, or on behalf of, an individual who is a beneficiary under any long-term care insurance policy sold under such plan amendment.

''(B) A requirement that the State will treat benefits paid under any long-term care insurance policy sold under a plan amendment of another State that maintains a Qualified Long-Term Care Insurance Partnership or is described in subsection (b)(1)(C)(ii)(II) the same as the State treats benefits paid under such a policy sold under the State's plan amendment.

"(C) A requirement that any long-term care insurance policy sold under such plan amendment—

"(i) be a qualified long-term care insurance contract within the meaning of section 7702B(b) of the Internal Revenue Code of 1986; and

"(ii) meet the requirements described in paragraph (6).

"(D) A requirement that any such policy sold under the State plan amendment shall provide for—

"(i) compound annual inflation protection of at least 5 percent; and

"(ii) asset protection that does not exceed $250,000.

The dollar amount specified in the preceding sentence shall be increased, beginning with 2007, from year to year based on the percentage increase in the medical care expenditure category of the Consumer Price Index for All Urban Consumers (United States city average), published by the Bureau of Labor Statistics, rounded to the nearest $100.

''(E) A requirement that an insurer may rescind a long-term care insurance policy sold under such State plan amendment that has been in effect for at least 2 years or deny an otherwise valid long-term care insurance claim under such a policy only upon a showing of misrepresentation that is material to the acceptance of coverage, pertains to the claim made, and could not have been known by the insurer at the time the policy was sold.

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

''(G) A requirement that the issuer of any such policy report—

''(i) to the Secretary, such information or data as the Secretary may require; and

''(ii) to the State, the information or data reported to the Secretary (if any), the information or data required under the minimum reporting requirements developed under section 6012(b)(2)(B) of the Deficit

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

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

''(6)(A) For purposes of subparagraph (C)(ii) of paragraph (5), the requirements of this paragraph are met if a long-term care insurance policy sold under a plan amendment described in that paragraph meets—

''(i) MODEL REGULATION.—The following requirements of the model regulation:

''(I) Section 6A (relating to guaranteed renewal or noncancellability), other than paragraph (5) thereof, and the requirements of section 6B of the model Act relating to such section 6A.

''(II) Section 6B (relating to prohibitions on limitations and exclusions) other than paragraph (7) thereof.

''(III) Section 6C (relating to extension of benefits).

''(IV) Section 6D (relating to continuation or conversion of coverage).

''(V) Section 6E (relating to discontinuance and replacement of policies).

''(VI) Section 7 (relating to unintentional lapse).

''(VII) Section 8 (relating to disclosure), other than sections 8F, 8G, 8H, and 8I thereof.

''(VIII) Section 9 (relating to required disclosure of rating practices to consumer).

''(IX) Section 11 (relating to prohibitions against post-claims underwriting).

''(X) Section 12 (relating to minimum standards).

''(XI) Section 14 (relating to application forms and replacement coverage).

''(XII) Section 15 (relating to reporting requirements).

''(XIII) Section 22 (relating to filing requirements for marketing).

''(XIV) Section 23 (relating to standards for marketing), including inaccurate completion of medical histories, other than

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

''(XV) Section 25 (relating to prohibition against preexisting conditions and probationary periods in replacement policies or certificates).

''(XVI) The provisions of section 26 relating to contingent nonforfeiture benefits, if the policyholder declines the offer of a nonforfeiture provision described in paragraph (4).

''(XVII) Section 29 (relating to standard format outline of coverage).

''(XVIII) Section 30 (relating to requirement to deliver shopper's guide).

''(ii) MODEL ACT.—The following requirements of the model Act:

''(I) Section 6C (relating to preexisting conditions).

''(II) Section 6D (relating to prior hospitalization).

''(III) The provisions of section 8 relating to contingent nonforfeiture benefits.

''(IV) Section 6F (relating to right to return).

''(V) Section 6G (relating to outline of coverage).

''(VI) Section 6H (relating to requirements for certificates under group plans).

''(VII) Section 6J (relating to policy summary).

''(VIII) Section 6K (relating to monthly reports on accelerated death benefits).

''(B) DEFINITIONS.—For purposes of this paragraph—

''(i) MODEL PROVISIONS.—The terms 'model regulation' and 'model Act' mean the long-term care insurance model regulation, and the long-term care insurance model Act, respectively, promulgated by the National Association of Insurance Commissioners (as adopted as of October 2000).

''(ii) COORDINATION.—Any provision of the model regulation or model Act listed under clause (i) or (ii) of subparagraph (A) shall be treated as including any other provision of such regulation or Act necessary to implement the provision.

"(iii) DETERMINATION.—For purposes of this paragraph, the determination of whether any requirement of a model regulation or the model Act has been met shall be made by the Secretary.".

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

(b) DEVELOPMENT OF UNIFORM STANDARDS AND RECOMMENDATIONS.—

(1) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Secretary, in consultation with the National Association of Insurance Commissioners, issuers of long-term care insurance policies, States with experience with long-term care insurance partnership plans, other States, and representatives of consumers of long-term care insurance policies shall develop the uniform standards described in paragraph (2) and submit recommendations to Congress with respect to the issues identified in paragraph (3).

(2) UNIFORM STANDARDS.—The uniform standards described in this paragraph are the following:

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

(B) MINIMUM REPORTING REQUIREMENTS.—Standards for minimum reporting requirements for issuers of long-term care insurance policies under such State long-term care insurance partnerships that shall specify the data and information that each such issuer shall report to the State with which it has such a partnership. The requirements developed in accordance with this subparagraph shall specify the type and format of the data and information to be reported and the frequency with which such reports are to be made.

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

Association of Insurance Commissioners regarding suitability.

(3) RECOMMENDATIONS.—The recommendations described in this paragraph are the following:

(A) INCONTESTABILITY.—Recommendations regarding whether the requirements relating to incontestability for long-term care insurance policies sold under a State long-term care insurance partnership program under section 1917(b)(1)(C)(ii) of the Social Security Act should be modified based on guidance of the National Association of Insurance Commissioners regarding incontestability.

(B) NONFORFEITURE.—Recommendations regarding whether requirements relating to nonforfeiture for issuers of long-term care insurance policies under a State long-term care insurance partnership program under section 1917(b)(1)(C)(ii) of such Act should be modified to reflect changes in an insured's financial circumstances.

(C) INDEPENDENT CERTIFICATION FOR BENEFITS ASSESSMENT.—Recommendations regarding whether uniform standards for requiring benefits assessment evaluations to be con-

ducted by independent entities should be established for issuers of long-term care insurance policies under such a State partnership program and, if so, what such standards should be.

(D) RATING REQUIREMENTS.—Recommendations regarding whether uniform standards for the establishment of, and annual increases in, premiums for long-term care insurance policies sold under such a State partnership program should be established and, if so, what such standards should be.

(E) DISPUTE RESOLUTION.—Recommendations regarding whether uniform standards are needed to ensure fair adjudication of coverage disputes under long-term care insurance policies sold under such a State partnership program and the delivery of the benefits promised under such policies.

(4) STATE REPORTING REQUIREMENTS.—Nothing in paragraph (2)(B) shall be construed as prohibiting a State from requiring an issuer of a long-term care insurance policy sold in the State (regardless of whether the policy is issued under a State long-term care insurance partnership under section 1917(b)(1)(C)(ii) of the Social Security Act) to re-

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

(c) ANNUAL REPORTS TO CONGRESS.—The Secretary of Health and Human Services shall annually report to Congress on the long-term care insurance partnerships established in accordance with section 1917(b)(1)(C)(ii) of the Social Security Act (42 U.S.C. 1396p(b)(1)(C)(ii)) (as amended by subsection (a)(1)). Such reports shall include analyses of the extent to which such partnerships expand or limit access of individuals to long-term care and the impact of such partnerships on Federal and State expenditures under the Medicare and Medicaid programs.

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

SEC. 6021. ENHANCING THIRD PARTY RECOVERY.

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

(1) in subparagraph (A), in the matter preceding clause (i)—

(A) by inserting ", including self-insured plans" after "health insurers"; and

(B) by striking "and health maintenance organizations" and inserting "health maintenance organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service"; and

(2) in subparagraph (G)—

(A) by inserting "a self-insured plan," after "1974,"; and

(B) by striking "and a health maintenance organization" and inserting "a health maintenance organization, a pharmacy benefit manager, or other party that is, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service".

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

(1) in subparagraph (G), by striking "and" at the end;

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

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

''(I) that the State shall provide assurances satisfactory to the Secretary that the State has in effect laws requiring health insurers, including self-insured plans, group health plans (as defined in section 607(1) of the Employee Retirement Income Security Act of 1974), service benefit plans, health maintenance organizations, pharmacy benefit managers, or other parties that are, by statute, contract, or agreement, legally responsible for payment of a claim for a health care item or service, as a condition of doing business in the State, to—

''(i) provide eligibility and claims payment data with respect to an individual who is eligible for, or is provided, medical assistance under the State plan, upon the request of the State;

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

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

''(iii) respond to any inquiry by the State regarding a claim for payment for any health care item or service submitted not later than 3 years after the date of the provision of such health care item or service; and

''(iv) agree not to deny a claim submitted by the State solely on the basis of the date of submission of the claim;''.

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

SEC. 6022. LIMITATION ON USE OF CONTINGENCY FEE ARRANGEMENTS.

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

(1) in paragraph (19), by adding ''or'' at the end;

(2) by striking the period at the end of paragraph (21) and inserting ''; or''; and

(3) by inserting after paragraph (21), the following:

''(22) with respect to any amount expended in connection with a contract or agreement (other than a risk contract under section 1903(m)) between the State agency under section 1902(a)(5) (or any State or local agency designated by such agency to administer any portion of the State plan under this title) and a consultant or other contractor if the terms of compensation for the consultant or other contractor do not meet the standards established by the Inspector General of the Department of Health and Human Services under section 6022(b) of the Deficit Reduction Omnibus Reconciliation Act of 2005.''.

(b) CONTINGENCY FEE ARRANGEMENT STANDARDS.—Not later than 6 months after the date of enactment of this Act, the Inspector General of the Department of Health and Human Services shall issue standards for the terms of compensation of consultants and other individuals or entities contracting with State agencies (or their designees) administering State Medicaid plans under title XIX of the Social Security Act that ensure prudent purchasing and program integrity with respect to Federal funds. The Inspector General shall annually review and,

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

(c) EFFECTIVE DATE.—Except as provided in section 6026(e), the amendments made by subsection (a) take effect on January 1, 2007.

SEC. 6023. ENCOURAGING THE ENACTMENT OF STATE FALSE CLAIMS ACTS.

(a) IN GENERAL.—Title XIX (42 U.S.C. 1396 et seq.) is amended by inserting after section 1908A the following:

''STATE FALSE CLAIMS ACT REQUIREMENTS FOR INCREASED STATE SHARE OF RECOVERIES

''SEC. 1909. (a) IN GENERAL.—Notwithstanding section 1905(b), if a State has in effect a law relating to false or fraudulent claims that meets the requirements of subsection (b), the Federal medical assistance percentage with respect to any amounts recovered under a State action brought under such law, shall be decreased by 10 percentage points.

''(b) REQUIREMENTS.—For purposes of subsection (a), the requirements of this subsection are that the Inspector General of the Department of Health and Human Services, in consultation with the Attorney General, determines that the State has in effect a law that meets the following requirements:

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

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

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

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

''(5) The law contains provisions that are designed to prevent a windfall recovery for a qui tam relator in the event that the relator files a Federal and State action for the same false or fraudulent claim.

''(c) DEEMED COMPLIANCE.—A State that, as of January 1, 2007, has a law in effect that meets the requirements of subsection (b) shall be deemed to be in compliance with such requirements for so long as the law continues to meet such requirements.

''(d) NO PRECLUSION OF BROADER LAWS.—Nothing in this section shall be construed as prohibiting a State that has in effect a law that establishes liability to the State for false or fraudulent claims described in section 3729 of title 31, United States Code, with respect to programs in addition to the State program under this title, or with respect to expenditures in addition to expenditures described in section 1903(a), from being considered to be in compliance with the requirements of subsection (a) so long as the law meets such requirements.''.

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

SEC. 6024. EMPLOYEE EDUCATION ABOUT FALSE CLAIMS RECOVERY.

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

(1) in paragraph (66), by striking ''and'' at the end;

(2) in paragraph (67) by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (67) the following:

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

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

"(A) establish written policies, procedures, and protocols for training of all employees of the entity (including management), and of any contractor or agent of the entity, that includes a detailed discussion of the False Claims Act established under sections 3729 through 3733 of title 31, United States Code, administrative remedies for false claims and statements established under chapter 38 of title 31, United States Code, any State laws pertaining to civil or criminal penalties for false claims and statements, and whistleblower protections under such laws, with respect to the role of such laws in preventing and detecting fraud, waste, and abuse in Federal health care programs (as defined in section 1128B(f));

"(B) include as part of such written policies, procedures, and protocols, detailed provisions and training regarding the entity's policies and procedures for detecting and preventing fraud, waste, and abuse;

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

scribed in subparagraph (A), the rights of employees to be protected as whistleblowers, and the entity's policies and procedures for detecting and preventing fraud, waste, and abuse; and

''(D) require mandatory training for all employees of the entity and of any contractor or agent of the entity, at the time of hiring, with respect to the laws described in subparagraph (A) (including the whistleblower protections under such laws) and the entity's policies and procedures for detecting fraud, waste, and abuse.''.

(b) EFFECTIVE DATE.—Except as provided in section 6026(e), the amendments made by subsection (a) take effect on January 1, 2007.

SEC. 6025. PROHIBITION ON RESTOCKING AND DOUBLE BILLING OF PRESCRIPTION DRUGS.

(a) IN GENERAL.—Section 1903(i)(10) (42 U.S.C. 1396b(i)), as amended by section 6004(b), is amended—

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

(2) in subparagraph (D), by striking ''; or'' at the end and inserting '', and''; and

(3) by adding at the end the following:

''(E) with respect to any amount expended for reimbursement to a pharmacy under this title for the ingredient cost of a covered outpatient drug for which the pharmacy has already received payment under this title (other than with respect to a reasonable restocking fee for such drug); or''.

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

SEC. 6026. MEDICAID INTEGRITY PROGRAM.

(a) ESTABLISHMENT OF MEDICAID INTEGRITY PROGRAM; MEDICAID CFO; MEDICAID PROGRAM INTEGRITY OVERSIGHT BOARD.—Title XIX (42 U.S.C. 1396 et seq.) is amended—

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

(2) by inserting after section 1935 the following:

''MEDICAID INTEGRITY PROGRAM

''SEC. 1936. (a) IN GENERAL.—There is hereby established the Medicaid Integrity Program (in this section referred to as the 'Program') under which the Secretary shall promote the integrity of the program under this title by entering into contracts in accordance with this section

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

''(b) ACTIVITIES DESCRIBED.—The activities described in this subsection are as follows:

''(1) Review of the actions of individuals or entities furnishing items or services (whether on a fee-for-service, risk, or other basis) for which payment may be made under a State plan approved under this title (or under any waiver of such plan approved under section 1115) to determine whether fraud, waste, or abuse has occurred, is likely to occur, or whether such actions have any potential for resulting in an expenditure of funds under this title in a manner which is not intended under the provisions of this title.

''(2) Audit of claims for payment for items or services furnished, or administrative services rendered, under a State plan under this title, including—

''(A) cost reports;

''(B) consulting contracts; and

''(C) risk contracts under section 1903(m).

''(3) Identification and recovery of overpayments to individuals or entities receiving Federal funds under this title.

''(4) Education of providers of services, managed care entities, beneficiaries, and other individuals with respect to payment integrity and benefit quality assurance issues.

''(c) ELIGIBLE ENTITY AND CONTRACTING REQUIREMENTS.—

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

''(2) ELIGIBILITY REQUIREMENTS.—The requirements of this paragraph are the following:

''(A) The entity has demonstrated capability to carry out the activities described in subsection (b).

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

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

"(D) The entity meets such other requirements as the Secretary may impose.

"(3) CONTRACTING REQUIREMENTS.—The entity has contracted with the Secretary in accordance with such procedures as the Secretary shall by regulation establish, except that such procedures shall include the following:

"(A) Procedures for identifying, evaluating, and resolving organizational conflicts of interest that are generally applicable to Federal acquisition and procurement.

"(B) Competitive procedures to be used—

"(i) when entering into new contracts under this section;

"(ii) when entering into contracts that may result in the elimination of responsibilities under section 202(b) of the Health Insurance Portability and Accountability Act of 1996; and

"(iii) at any other time considered appropriate by the Secretary.

"(C) Procedures under which a contract under this section may be renewed without regard to any provision of law requiring competition if the contractor has met or exceeded the performance requirements established in the current contract.

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

"(4) LIMITATION ON CONTRACTOR LIABILITY.—The Secretary shall by regulation provide for the limitation of a contractor's liability for actions taken to carry out a contract under the Program, and such regulation shall, to the extent the Secretary finds appropriate, employ the same or comparable standards and other substantive and procedural provisions as are contained in section 1157.

"(d) COMPREHENSIVE PLAN FOR PROGRAM INTEGRITY.—

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

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

''(e) APPROPRIATION.—

''(1) IN GENERAL.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to carry out the Medicaid Integrity Program under this section, without further appropriation—

''(A) for each of fiscal years 2006 through 2008, $50,000,000; and

''(B) for each fiscal year after fiscal year 2008, $75,000,000.

''(2) AVAILABILITY.—Amounts appropriated pursuant to paragraph (1) shall remain available until expended.

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

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

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

''(B) the effectiveness of the use of such funds.''.

''MEDICAID CHIEF FINANCIAL OFFICER; MEDICAID PROGRAM INTEGRITY OVERSIGHT BOARD

''SEC. 1937. (a) ESTABLISHMENT OF MEDICAID CFO.—

''(1) IN GENERAL.—There is established in the Centers for Medicare & Medicaid Services within the Office of Financial Management the position of Medicaid Chief Financial Officer. The Medicaid Chief Financial Officer shall be appointed by, and report directly to, the Administrator of such Centers. The Medicaid Chief Financial Officer may be removed only for cause.

''(2) DUTIES AND AUTHORITY.—The duties and authority of the Medicaid Chief Financial Officer with respect to the management and expenditure of Federal funds under this title shall be comparable to the duties and authority of other Chief Financial Officers with respect to the management and expenditure of Federal funds under Federal health care programs (as defined in section 1128B(f)).

''(b) PROGRAM INTEGRITY OVERSIGHT BOARD.—The Secretary shall establish a Medicaid Program Integrity Oversight Board. The duties and authority of the Medicaid Program Integrity Oversight Board shall be comparable to the duties and authority of other oversight boards established for purposes of Federal health care programs (as so defined) and shall include responsibility for identifying vulnerabilities in the State programs established under this title and developing strategies for minimizing integrity risks to such programs.''.

(b) STATE REQUIREMENT TO COOPERATE WITH INTEGRITY PROGRAM EFFORTS.—Section 1902(a) (42 U.S.C. 1396a(a)), as amended by section 6024(a), is amended—

(1) in paragraph (67), by striking ''and'' at the end;

(2) in paragraph (68), by striking the period at the end and inserting ''; and''; and

(3) by inserting after paragraph (68), the following:

''(69) provide that the State must comply with any requirements determined by the Secretary to be necessary for carrying out the Medicaid Integrity Program established under section 1936, or the duties of the Medicaid Chief Financial Officer and the

Medicaid Program Integrity Oversight Board established under section 1937.''.

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

(1) IN GENERAL.—Out of any money in the Treasury of the United States not otherwise appropriated, there are appropriated to the Office of the Inspector General of the Department of Health and Human Services, without further appropriation, $25,000,000 for each of fiscal years 2006 through 2010, for activities of such Office with respect to the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

(2) AVAILABILITY; AMOUNTS IN ADDITION TO OTHER AMOUNTS APPROPRIATED FOR SUCH ACTIVITIES.—Amounts appropriated pursuant to paragraph (1) shall—

(A) remain available until expended; and

(B) be in addition to any other amounts appropriated or made available to the Office of the Inspector General of the Department of Health and Human Services for activities of such Office with respect to the Medicaid program.

(3) ANNUAL REPORT.—Not later than 180 days after the end of each fiscal year (beginning with fiscal year 2006), the Inspector General of the Department of Health and Human Services shall submit a report to Congress which identifies—

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

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

(d) INCREASE IN CMS STAFFING DEVOTED TO ENSURING MEDICAID PROGRAM INTEGRITY.—The Secretary shall significantly increase the number of full-time equivalent employees whose duties consist solely of ensuring the integrity of the Medicaid program established under title XIX of the Social Security Act by providing effective support and assistance to States to combat provider fraud and abuse.

(e) DELAYED EFFECTIVE DATE FOR CHAPTER.—in the case of a State plan under title XIX of the Social Security Act which the Secretary determines requires State legislation in order for the plan to meet the additional requirements imposed by the amendments made by a provision of this chapter, the State plan shall not be regarded as failing to comply with the requirements of such Act solely on the basis of its failure to meet these additional

requirements before the first day of the first calendar quarter beginning after the close of the first regular session of the State legislature that begins after the date of enactment of this Act. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of the session shall be considered to be a separate regular session of the State legislature.

CHAPTER 4—STATE FINANCING UNDER MEDICAID

SEC. 6031. REFORMS OF TARGETED CASE MANAGEMENT.

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

''(2) For purposes of this subsection:

''(A)(i) The term 'case management services' means services which will assist individuals eligible under the plan in gaining access to needed medical, social, educational, and other services.

''(ii) Such term includes the following:

''(I) Assessment of an eligible individual to determine service needs, including activities that focus on needs identification, to determine the need for any medical, educational, social, or other services. Such assessment activities include the following:

''(aa) Taking client history.

''(bb) Identifying the needs of the individual, and completing related documentation.

''(cc) Gathering information from other sources such as family members, medical providers, social workers, and educators, if necessary, to form a complete assessment of the eligible individual.

''(II) Development of a specific care plan based on the information collected through an assessment, that specifies the goals and actions to address the medical, social, educational, and other services needed by the eligible individual, including activities such as ensuring the active participation of the eligible individual and working with the individual (or the individual's authorized health care decision maker) and others to develop such goals and identify a course of action to respond to the assessed needs of the eligible individual.

''(III) Referral and related activities to help an individual obtain needed services, including activities that help link eligible individuals with medical, social, educational providers

or other programs and services that are capable of providing needed services, such as making referrals to providers for needed services and scheduling appointments for the individual.

''(IV) Monitoring and followup activities, including activities and contacts that are necessary to ensure the care plan is effectively implemented and adequately addressing the needs of the eligible individual, and which may be with the individual, family members, providers, or other entities and conducted as frequently as necessary to help determine such matters as—

''(aa) whether services are being furnished in accordance with an individual's care plan;

''(bb) whether the services in the care plan are adequate; and

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

''(iii) Such term does not include the direct delivery of an underlying medical, educational, social, or other service to which an eligible individual has

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

"(I) Research gathering and completion of documentation required by the foster care program.

"(II) Assessing adoption placements.

"(III) Recruiting or interviewing potential foster care parents.

"(IV) Serving legal papers.

"(V) Home investigations.

"(VI) Providing transportation.

"(VII) Administering foster care subsidies.

"(VIII) Making placement arrangements.

"(B) The term 'targeted case management services' are case management services that are furnished without regard to the requirements of section 1902(a)(1) and section 1902(a)(10)(B) to specific classes of individuals or to individuals who reside in specified areas.

"(3) With respect to contacts with individuals who are not eligible for medical assistance under the State plan or, in the case of targeted case management services, individuals who are eligible for such assistance but are not

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

''(A) are considered an allowable case management activity, when the purpose of the contact is directly related to the management of the eligible individual's care; and

''(B) are not considered an allowable case management activity if such contacts relate directly to the identification and management of the noneligible or nontargeted individual's needs and care.

''(4)(A) In accordance with section 1902(a)(25), Federal financial participation only is available under this title for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program.

''(B) A State shall allocate the costs of any part of such services which are reimbursable under another federally funded program in accordance with OMB Circular A-87 (or any related or successor guidance or regulations regarding allocation of costs among federally funded programs) under an approved cost allocation program.''.

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

SEC. 6032. TEMPORARY FEDERAL MATCHING PAYMENTS FOR FEDERAL ASSISTANCE.

(a) 100 PERCENT FEDERAL MATCHING PAYMENTS FOR MEDICAL ASSISTANCE PROVIDED TO SPECIFIED INDIVIDUALS.—

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

(2) APPLICATION TO CHILD HEALTH ASSISTANCE.—Notwithstanding section 2105(b) of the Social Security Act (42 U.S.C. 1397ee(b)), for items and services furnished during the period described in paragraph (1), the Federal matching rate for providing child health assistance for such items and services under a State child health plan to a specified individual (as so defined), and for costs directly attributable to all administrative activities that re-

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

(b) SPECIFIED INDIVIDUAL.—

(1) IN GENERAL.—For purposes of subsection (a), the term ''specified individual'' means an individual who, on any day during the week preceding August 28, 2005, had a primary residence in a Louisiana parish described in paragraph (2), a Mississippi county described in paragraph (3), or an Alabama county described in paragraph (4).

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

(A) Acadia.

(B) Ascension.

(C) Assumption.

(D) Calcasieu.

(E) Cameron.

(F) East Baton Rouge.

(G) East Feliciana.

(H) Iberia.

(I) Iberville.

(J) Jefferson.

(K) Jefferson Davis.

(L) Lafayette.

(M) Lafourche.

(N) Livingston.

(O) Orleans.

(P) Pointe Coupee.

(Q) Plaquemines.

(R) St. Bernard.

(S) St. Charles.

(T) St. Helena.

(U) St. James.

(V) St. John.

(W) St. Mary.

(X) St. Martin.

(Y) St. Tammany.

(Z) Tangipahoa.

(AA) Terrebonne.

(BB) Vermilion.

(CC) Washington.

(DD) West Baton Rouge.

(EE) West Feliciana.

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

(A) Adams.

(B) Amite.

(C) Attala.

(D) Clairborne.

(E) Choctaw.

(F) Clarke.

(G) Copiah.

(H) Covington.

(I) Forrest.

(J) Franklin.

(K) George.

(L) Greene.

(M) Hancock.

(N) Harrison.

(O) Hinds.

(P) Jackson.

(Q) Jasper.

(R) Jefferson.

(S) Jefferson Davis.

(T) Jones.

(U) Kemper.

(V) Lamar.

(W) Lauderdale.

(X) Lawrence.

(Y) Leake.

(Z) Lincoln.

(AA) Lowndes.

(BB) Madison.

(CC) Marion.

(DD) Neshoba.

(EE) Newton.

(FF) Noxubee.

(GG) Oktibbeha.

(HH) Pearl River.

(II) Perry.

(JJ) Pike.

(KK) Rankin.

(LL) Scott.

(MM) Simpson.

(NN) Smith.

(OO) Stone.

(PP) Walthall.

(QQ) Warren.

(RR) Wayne.

(SS) Wilkinson.

(TT) Winston.

(UU) Yazoo.

(4) ALABAMA COUNTIES DESCRIBED.—For purposes of paragraph (1) the Alabama counties described in this paragraph are the following:

(A) Baldwin.

(B) Choctaw.

(C) Clarke.

(D) Greene.

(E) Hale.

(F) Marengo.

(G) Mobile.

(H) Pickens.

(I) Sumter.

(J) Tuscaloosa.

(K) Washington.

(c) FMAP ADJUSTMENT.—Notwithstanding the first sentence of section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)), if, for purposes of titles XIX and XXI of the Social Security Act (42 U.S.C. 1396 et seq., 1397aa et seq.), the Federal medical assistance percentage determined for Alaska for fiscal year 2006 or fiscal year 2007 is less than the Federal medical assistance percentage determined for Alaska for fiscal year 2005, the Federal medical assistance percentage determined for Alaska for fiscal year 2005 shall be substituted for the Federal medical assistance percentage otherwise determined for Alaska for fiscal year 2006 or fiscal year 2007, as the case may be.

SEC. 6033. MANAGED CARE ORGANIZATION PROVIDER TAX REFORM.

(a) IN GENERAL.—Section 1903(w)(7)(A)(viii) (42 U.S.C. 1396b(w)(7)(A)(viii)) is amended to read as follows:

''(viii) Services of managed care organizations (including health maintenance organizations, preferred provider organizations, and such other similar organizations as the Secretary may specify by regulation).''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by subsection (a) shall take effect on January 1, 2006.

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

SEC. 6034. INCLUSION OF PODIATRISTS AS PHYSICIANS.

(a) IN GENERAL.—Section 1905(a)(5)(A) (42 U.S.C. 1396d(a)(5)(A)) is amended by striking ''section 1861(r)(1)'' and inserting ''paragraphs (1) and (3) of section 1861(r)''.

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

SEC. 6035. DSH ALLOTMENT FOR THE DISTRICT OF COLUMBIA.

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

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

SEC. 6036. DEMONSTRATION PROJECT REGARDING MEDICAID REIMBURSEMENT FOR STABILIZATION OF EMERGENCY MEDICAL CONDITIONS BY NON-PUBLICLY OWNED OR OPERATED INSTITUTIONS FOR MENTAL DISEASES.

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

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

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

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

(b) ELIGIBLE STATE DEFINED.—

(1) APPLICATION.—Upon approval of an application submitted by a State described in paragraph (2), the State shall be an eligible State for purposes of conducting a demonstration project under this section.

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

(A) Arizona.

(B) Arkansas.

(C) Louisiana.

(D) Maine.

(E) North Dakota.

(F) Wyoming.

(G) Four other States selected by the Secretary to provide geographic diversity on the basis of the application to conduct a demonstration project under this section submitted by such States.

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

(d) LIMITATIONS ON FEDERAL FUNDING.—

(1) APPROPRIATION.—

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

(B) BUDGET AUTHORITY.—Subparagraph (A) constitutes budget authority in advance of appropriations Act and represents the obligation of the Federal Government to provide for the payment of the amounts appropriated under that subparagraph.

(2) 3-YEAR AVAILABILITY.—Funds appropriated under paragraph (1) shall remain available for obligation through December 31, 2008.

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

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

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

(4) FUNDS ALLOCATED TO STATES.—The Secretary shall allocate funds to eligible States based on their applications and the availability of funds.

(5) PAYMENTS TO STATES.—The Secretary shall pay to each eligible State, from its allocation under paragraph (4), an amount each quarter equal to the Federal medical assistance percentage of expenditures in the quarter for medical assistance described in subsection (a).

(e) REPORTS.—

(1) ANNUAL PROGRESS REPORTS.—The Secretary shall submit annual reports to Congress on the progress of the demonstration project conducted under this section.

(2) FINAL REPORT AND RECOMMENDATION.—Not later than March 31, 2009, the Secretary shall submit to Congress a final report on the demonstration project conducted under this section that shall include the following:

(A) A determination as to whether the demonstration project resulted in increased access to inpatient mental health services under the medicaid program.

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

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

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

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

(f) WAIVER AUTHORITY.—

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

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

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

(g) DEFINITIONS.—In this section:

(1) EMERGENCY MEDICAL CONDITION.—The term ''emergency medical condition'' has the meaning given that term in section 1867(e)(1) of the Social Security Act (42 U.S.C. 1395dd(e)(1)).

(2) FEDERAL MEDICAL ASSISTANCE PERCENTAGE.—The term ''Federal medical assistance percentage'' has the meaning given that term with respect to a State in section 1905(b) of the Social Security Act (42 U.S.C. 1396d(b)).

(3) INSTITUTION FOR MENTAL DISEASES.—The term ''institution for mental diseases'' has the meaning given that term in section 1905(i) of the Social Security Act (42 U.S.C. 1396d(i)).

(4) MEDICAL ASSISTANCE.—The term ''medical assistance'' has the meaning given that term in section 1905(a) of the Social Security Act (42 U.S.C. 1396d(a)).

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

(6) STATE.—The term ''State'' has the meaning given that term for purposes of title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).

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

Subchapter A—Family Opportunity Act

SEC. 6041. SHORT TITLE OF SUBCHAPTER.

This subchapter may be cited as the ''Family Opportunity Act of 2005'' or the ''Dylan Lee James Act''.

SEC. 6042. OPPORTUNITY FOR FAMILIES OF DISABLED CHILDREN TO PURCHASE MEDICAID COVERAGE FOR SUCH CHILDREN.

(a) STATE OPTION TO ALLOW FAMILIES OF DISABLED CHILDREN TO PURCHASE MEDICAID COVERAGE FOR SUCH CHILDREN.—

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

(A) in subsection (a)(10)(A)(ii)—

(i) by striking ''or'' at the end of subclause (XVII);

(ii) by adding ''or'' at the end of subclause (XVIII); and

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

"(XIX) who are disabled children described in subsection (cc)(1);"; and

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

"(cc)(1) Individuals described in this paragraph are individuals—

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

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

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

"(iii) after October 1, 1990, in the case of each quarter of fiscal year 2010 and each quarter of any fiscal year thereafter;

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

''(C) whose family income does not exceed such income level as the State establishes and does not exceed—

''(i) 300 percent of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved; or

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

''(I) any medical assistance provided to an individual whose family income exceeds 300 percent of such poverty line may only be provided with State funds; and

''(II) no Federal financial participation shall be provided under section 1903(a) for any medical assistance provided to such an individual.''.

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

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

''(i) require such parent to apply for, enroll in, and pay premiums for such coverage as a condition of such parent's child being or remaining eligible for medical assistance under subsection (a)(10)(A)(ii)(XIX) if the parent is determined eligible for such coverage and the employer contributes at least 50 percent of the total cost of annual premiums for such coverage; and

''(ii) if such coverage is obtained—

''(I) subject to paragraph (2) of section 1916(h), reduce the premium imposed by the State under that section in an amount that reasonably reflects the premium contribution made by the parent for private coverage on behalf of a child with a disability; and

''(II) treat such coverage as a third party liability under subsection (a)(25).

''(B) In the case of a parent to which subparagraph (A) applies, a State, subject to paragraph (1)(C)(ii), may provide for payment of any portion of the annual premium for such family coverage that the parent is required to pay. Any payments made by the State under this subparagraph shall be considered, for purposes of section 1903(a), to be payments for medical assistance.''.

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

(1) in subsection (a), by striking ''subsection (g)'' and inserting ''subsections (g) and (h)''; and

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

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

''(2) A premium requirement imposed under paragraph (1) may only apply to the extent that—

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

''(i) does not exceed 200 percent of the poverty line, the aggregate amount of such premium and any premium that the parent is required to pay for family coverage under section 1902(cc)(2)(A)(i) and other cost-sharing charges do not exceed 5 percent of the family's income; and

''(ii) exceeds 200, but does not exceed 300, percent of the poverty line, the aggregate amount of such premium and any premium that the parent is required to pay for family coverage under section 1902(cc)(2)(A)(i) and other cost-sharing charges do not exceed 7.5 percent of the family's income; and

''(B) the requirement is imposed consistent with section 1902(cc)(2)(A)(ii)(I).

''(3) A State shall not require prepayment of a premium imposed pursuant to paragraph (1) and shall not terminate eligibility of a child under section 1902(a)(10)(A)(ii)(XIX) for medical assistance under this title on the basis of failure to pay any such premium until such failure continues for a period of at least 60 days from the date on which the premium became past due. The State may waive payment of any such premium in any case where the State determines that requiring such payment would create an undue hardship.''.

(c) CONFORMING AMENDMENTS.—(1) Section 1903(f)(4) (42 U.S.C. 1396b(f)(4)) is amended in the matter preceding subparagraph (A), by inserting ''1902(a)(10)(A)(ii)(XIX),'' after ''1902(a)(10)(A)(ii)(XVIII),''.

(2) Section 1905(u)(2)(B) (42 U.S.C. 1396d(u)(2)(B)) is amended by adding at the end the following sentence: ''Such term excludes any child eligible for medical assistance only by reason of section 1902(a)(10)(A)(ii)(XIX).''.

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

SEC. 6043. DEMONSTRATION PROJECTS REGARDING HOME AND COMMUNITY-BASED ALTERNATIVES TO PSYCHIATRIC RESIDENTIAL TREATMENT FACILITIES FOR CHILDREN.

(a) IN GENERAL.—The Secretary is authorized to conduct, during each of fiscal years 2007 through 2011, demonstration projects (each in the section referred to as a ''demonstration project'') in accordance with this section under which up to 10 States (as defined for purposes of title XIX of the Social Security Act) are awarded grants, on a competitive basis, to test the effectiveness in improving or maintaining a child's functional level and cost-effectiveness of providing coverage of home and community-based alternatives to psychiatric residential treatment for children enrolled in the Medicaid program under title XIX of such Act.

(b) APPLICATION OF TERMS AND CONDITIONS.—

(1) IN GENERAL.—Subject to the provisions of this section, for the purposes of the demonstration projects, and only with respect to children enrolled under such demonstration projects, a psychiatric residential treatment facility (as defined in section 483.352 of title 42 of the Code of Federal Regulations) shall be deemed to be a facility specified in section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)), and to be included in each reference in such section 1915(c) to hospitals, nursing facilities, and intermediate care facilities for the mentally retarded.

(2) STATE OPTION TO ASSURE CONTINUITY OF MEDICAID COVERAGE.—Upon the termination of a demonstration project under this section, the State that conducted the project may elect, only with respect to a child who is enrolled in such project on the termination date, to continue to provide medical assistance for coverage of home and community-based alternatives to psychiatric residential treatment for the child in accordance with section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)), as modified through the application of paragraph (1). Expenditures incurred for providing such medical assistance shall be treated as a home

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

(c) TERMS OF DEMONSTRATION PROJECTS.—

(1) IN GENERAL.—Except as otherwise provided in this section, a demonstration project shall be subject to the same terms and conditions as apply to a waiver under section 1915(c) of the Social Security Act (42 U.S.C. 1396n(c)), including the waiver of certain requirements under the first sentence of paragraph (3) of such section but not applying the second sentence of such paragraph.

(2) BUDGET NEUTRALITY.—In conducting the demonstration projects under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.) do not exceed the amount which the Secretary estimates would have been paid under that title if the demonstration projects under this section had not been implemented.

(3) EVALUATION.—The application for a demonstration project shall include an assurance to provide for such interim and final evaluations of the

demonstration project by independent third parties, and for such interim and final reports to the Secretary, as the Secretary may require.

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

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

(2) LIMITATION.—In no case may the amount of payments made by the Secretary under this section for State demonstration projects for a fiscal year exceed the amount available under subsection (f)(2)(A) for such fiscal year.

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

(f) FUNDING.—

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

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

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

(2) FISCAL YEAR LIMIT.—

(A) IN GENERAL.—For purposes of paragraph (1), the amount specified in this paragraph for a fiscal year is the amount specified in subparagraph (B) for the fiscal year plus the difference, if any, between the total amount available under this paragraph for prior fiscal years and the total amount previously expended under paragraph (1)(A) for such prior fiscal years.

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

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

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

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

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

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

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

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

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

''(i) there is appropriated to the Secretary, out of any money in the Treasury not otherwise appropriated—

''(I) $3,000,000 for fiscal year 2007;

''(II) $4,000,000 for fiscal year 2008; and

''(III) $5,000,000 for fiscal year 2009; and

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

''(B) Funds appropriated or authorized to be appropriated under subparagraph (A) shall—

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

''(ii) remain available until expended.

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

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

''(B) provide information regarding the health care needs of, and resources available for, such children;

''(C) identify successful health delivery models for such children;

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

''(E) provide training and guidance regarding caring for such children;

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

''(G) are staffed—

''(i) by such families who have expertise in Federal and State public and private health care systems; and

''(ii) by health professionals.

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

''(A) With respect to fiscal year 2007, such centers shall be developed in not less than 25 States.

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

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

''(4) The provisions of this title that are applicable to the funds made available to the Secretary under section 502(a)(1) apply in the same manner to funds made available to the Secretary under paragraph (1)(A).

''(5) For purposes of this subsection, the term 'State' means each of the 50 States and the District of Columbia.''.

SEC. 6045. RESTORATION OF MEDICAID ELIGIBILITY FOR CERTAIN SSI BENEFICIARIES.

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

(1) by inserting ''(aa)'' after ''(II)'';

(2) by striking '') and'' and inserting ''and'';

(3) by striking ''section or who are'' and inserting ''section), (bb) who are''; and

(4) by inserting before the comma at the end the following: '', or (cc) who are under 21 years of age and with respect to whom supplemental security income benefits would be paid under title XVI if subparagraphs (A) and (B) of section 1611(e)(7) were applied without regard to the phrase 'the first day of the month following' ''.

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

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.

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

(1) by amending subsection (e) to read as follows:

''(e) AVAILABILITY OF AMOUNTS ALLOTTED.—

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

''(A) for each of fiscal years 1998 through 2003, and for fiscal year 2006 and each fiscal year thereafter, shall remain available for expenditure by the State through the end of the second succeeding fiscal year; and

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

''(2) AVAILABILITY OF REALLOTMENTS, REDISTRIBUTED AMOUNTS, AND EXTENDED AVAILABILITY.—

''(A) IN GENERAL.—Amounts reallotted to a State under subsection (f) shall be available for expenditure by the State through the end of the fiscal year in which they are reallotted.

''(B) AVAILABILITY OF REDISTRIBUTED FUNDS AND EXTENDED AVAILABILITY.—Amounts redistributed to a State under subsection (i)(3) or (j)(3) and unused allotments of a State extended under subsection (i)(4) or (j)(4) are available for expenditure by the State during the redistribution/extension period (as defined in paragraph (3)(B)).

''(3) PERIODS DEFINED.—For purposes of this section:

''(A) INITIAL AVAILABILITY PERIOD.—The term 'initial availability period' means, with respect to allotments for a fiscal year, the 2-fiscal year period beginning with that fiscal year.

''(B) REDISTRIBUTION/EXTENSION PERIOD.—The term 'redistribution/extension period' means, with respect to allotments for a

fiscal year, the second year following that fiscal year.''; and

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

''(h) RULE FOR REDISTRIBUTION OF FISCAL YEAR 2003 ALLOTMENTS.—

''(1) COMPUTATION OF UNEXPENDED ALLOTMENTS FOR FISCAL YEAR 2003.—The Secretary shall determine—

''(A) the amount of each State's allotment under this section for fiscal year 2003 that was not expended by the end of fiscal year 2005; and

''(B) the total of the unexpended allotments determined under subparagraph (A).

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

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

''(B) PROJECTED EXPENDITURES FOR FISCAL YEAR 2006.—The estimated expenditures

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

''(C) INITIAL PROJECTED SHORTFALL FOR FISCAL YEAR 2006.—The amount, if any, by which the projected expenditures determined under subparagraph (B) for the State for quarters in fiscal year 2006 exceeds the sum of the following:

''(i) FISCAL YEAR 2005 CARRYOVER.—The amount determined under subparagraph (A) for the State.

''(ii) FISCAL YEAR 2006 ALLOTMENT.—The amount of the State's allotment for fiscal year 2006.

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

''(i) the amount of such excess; to

''(ii) the total of such excesses determined for all States with such an excess.

''(3) REDISTRIBUTION OF UNEXPENDED ALLOTMENTS FOR FISCAL YEAR 2003.—From the total of the unexpended allotments for fiscal year 2003

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

"(A) STATES OTHER THAN TERRITORIES.—There shall be redistributed to each State for which there is an excess determined under paragraph (2)(C) an amount equal to the product of the following:

"(i) STATE REDISTRIBUTION POOL.—The amount determined under paragraph (1)(B), reduced by the total amount redistributed under subparagraph (B).

"(ii) STATE'S SHORTFALL PROPORTION.—The ratio described in paragraph (2)(D) for that State.

"(B) TERRITORIES.—There shall be redistributed to each commonwealth or territory described in subsection (c)(3) an amount equal to the product of the following:

"(i) TERRITORIAL REDISTRIBUTION POOL.—1.05 percent of the amount determined under paragraph (1)(B).

"(ii) TERRITORIAL PROPORTION.—The ratio of—

''(I) the allotment for fiscal year 2003 for such commonwealth or territory under subsection (c), to

''(II) the total of all such allotments for such fiscal year for such commonwealths or territories under such subsection.

''(4) DETERMINATION OF AMOUNTS.—For purposes of calculating the amounts described in—

''(A) paragraphs (1) and (2)(A), the Secretary shall use the amounts reported by the States not later than November 30, 2005, on Form CMS-64 or Form CMS-21, as the case may be, as approved by the Secretary; and

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

''(i) REDISTRIBUTION AND EXTENSION OF AVAILABILITY OF UNUSED ALLOTMENTS FOR FISCAL YEAR 2004.—Notwithstanding subsection (f):

''(1) COMPUTATION OF UNEXPENDED ALLOTMENTS FOR FISCAL YEAR 2004.—

"(A) IN GENERAL.—The Secretary shall determine with respect to each State that receives an allotment for fiscal year 2004 under subsection (b)—

"(i) the amount of the State's allotment for such fiscal year that was not expended by the end of fiscal year 2005; and

"(ii) the total of the unexpended allotments determined under clause (i).

"(B) REDUCTION OF UNEXPENDED ALLOTMENT BY NET FISCAL YEAR 2006 SHORTFALL.—

"(i) IN GENERAL.—In the case of a State described in clause (ii), the Secretary shall reduce, but not below 0, the amount determined for the State under subparagraph (A)(i) (relating to the State's unexpended allotment for fiscal year 2004) by the amount of the allotment of the State for which availability is extended under paragraph (4)(A).

"(ii) STATE DESCRIBED.—A State described in this clause is a State that meets the following requirements:

''(I) FULLY SPENT FISCAL YEAR 2003 ALLOTMENT.—The State's allotment under this section for fiscal year 2003 was fully expended by the end of fiscal year 2005.

''(II) DID NOT FULLY EXPEND FISCAL YEAR 2004 ALLOTMENT BY END OF FISCAL YEAR 2005.—The State's allotment under this section for fiscal year 2004 was not fully expended by the end of fiscal year 2005.

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

''(C) TOTALS AND RATIOS.—The Secretary shall determine the following:

''(i) REDISTRIBUTION POOL.—A redistribution pool equal to the total of the amounts determined under subparagraph (A)(i), as reduced (if applicable) under subparagraph (B)(i).

''(ii) STATE PROPORTION TOWARD REDISTRIBUTION POOL.—For each State in

which the amount determined under subparagraph (A)(i) (as reduced, if applicable, under subparagraph (B)(i)) exceeds 0, the ratio of—

"(I) such amount (as so reduced) for the State; to

"(II) the total determined under clause (i).

"(D) AMOUNT OF UNEXPENDED FISCAL YEAR 2004 ALLOTMENT APPLIED TO REDISTRIBUTIONS.—For each State described in subparagraph (C)(ii), the Secretary shall determine a redistribution/reduction amount equal to the product of the following:

"(i) TOTAL AMOUNT REDISTRIBUTED.—The total amount redistributed under paragraph (3).

"(ii) STATE'S PROPORTION OF UNEXPENDED ALLOTMENTS.—The ratio for the State determined under subparagraph (C)(ii).

"(2) DETERMINATION OF NET PROJECTED SHORTFALLS FOR FISCAL YEAR 2006.—For each State that has an excess determined under subsection (h)(2)(C) (relating to initial projected fiscal

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

"(A) the amount redistributed to the State under subsection (h)(3)(A), and

"(B) the amount of funds of the State for which availability is extended under paragraph (4)(A).

"(3) REDISTRIBUTION FROM REDISTRIBUTION POOL.—From the redistribution pool determined under paragraph (1)(C)(i)—

"(A) STATES OTHER THAN TERRITORIES.—There shall be redistributed to each State which has a net projected shortfall under paragraph (2) an amount determined under such paragraph for the State.

"(B) TERRITORIES.—There shall be redistributed to each commonwealth or territory described in subsection (c)(3) an amount equal to the product of the following:

"(i) TERRITORIAL REDISTRIBUTION POOL.—1.05 percent of the amount of such unexpended allotments determined under paragraph (1)(A)(ii).

"(ii) TERRITORIAL PROPORTION.—The ratio of—

"(I) the allotment under subsection (c) for such commonwealth or territory for fiscal year 2004, to

"(II) the total of all such allotments for such commonwealths and territories.

"(4) EXTENDED AVAILABILITY OF REMAINING UNEXPENDED ALLOTMENTS.—

"(A) TO MEET NET SHORTFALL FOR FISCAL YEAR 2006.—In the case of a State described in paragraph (1)(B)(ii), the Secretary shall extend the availability of funds from the State's allotment for fiscal year 2004 to the extent that—

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

"(ii) the amount redistributed to the State under subsection (h)(3)(A).

"(B) OTHER EXTENSIONS.—The Secretary shall extend the availability of funds from allotments for fiscal year 2004 for each State which has an unexpended allotment for fiscal year

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

''(i) the amount of such unexpended allotment (as so reduced) for the State, exceeds

''(ii) the redistribution/reduction amount determined under paragraph (1)(D) for the State (relating to the portion of the unexpended allotment applied to redistributions).

''(5) DETERMINATION OF AMOUNTS.—For purposes of calculating the amounts described in—

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

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

''(j) REDISTRIBUTION AND EXTENSION OF AVAILABILITY OF UNUSED ALLOTMENTS FOR FISCAL YEAR 2005.—Notwithstanding subsection (f):

''(1) COMPUTATION OF UNEXPENDED ALLOTMENTS FOR FISCAL YEAR 2005.—

''(A) IN GENERAL.—The Secretary shall determine with respect to each State that receives an allotment for fiscal year 2005 under subsection (b)—

''(i) the amount of the State's allotment for fiscal year 2005 that was not expended by the end of fiscal year 2006; and

''(ii) the total of the unexpended allotments determined under clause (i).

''(B) REDUCTION OF UNEXPENDED ALLOTMENT BY NET FISCAL YEAR 2007 SHORTFALL.—

''(i) IN GENERAL.—In the case of a State described in clause (ii), the Secretary shall reduce, but not below 0, the amount determined for the State under subparagraph (A)(i) (relating to the State's unexpended allotment for fiscal year 2005) by the amount of the allotment of the State

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

''(ii) STATE DESCRIBED.—A State described in this clause is a State that meets the following requirements:

''(I) DID NOT FULLY EXPEND FISCAL YEAR 2005 ALLOTMENT BY END OF FISCAL YEAR 2006.—The State's allotment under this section for fiscal year 2005 was not fully expended by the end of fiscal year 2006.

''(II) PROJECTED SHORTFALL FOR FISCAL YEAR 2007.—The State has an excess determined under paragraph (2)(C) for fiscal year 2007 (relating to initial projected fiscal year 2007 shortfall).

''(C) TOTALS AND RATIOS.—The Secretary shall determine the following:

''(i) REDISTRIBUTION POOL.—A redistribution pool equal to the total of the amounts determined under subparagraph (A)(i), as reduced (if applicable) under subparagraph (B)(i).

''(ii) STATE PROPORTION TOWARD REDISTRIBUTION POOL.—For each State in which the amount determined under subparagraph (A)(i) (as reduced, if applicable, under subparagraph (B)(i)) exceeds 0, the ratio of—

''(I) such amount (as so reduced) for the State; to

''(II) the total determined under clause (i).

''(D) AMOUNT OF UNEXPENDED FISCAL YEAR 2005 ALLOTMENT APPLIED TO REDISTRIBUTIONS.—For each State described in subparagraph (C)(ii), the Secretary shall determine a redistribution/reduction amount equal to the product of the following:

''(i) TOTAL AMOUNT REDISTRIBUTED.—The total amount redistributed under paragraph (3).

''(ii) STATE'S PROPORTION OF UNEXPENDED ALLOTMENTS.—The ratio for the State determined under subparagraph (C)(ii).

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

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

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

''(B) PROJECTED EXPENDITURES FOR FISCAL YEAR 2007.—The estimated expenditures for the State as would be reported as quarterly expenditures under section 2105(a) for quarters in fiscal year 2007.

''(C) INITIAL PROJECTED SHORTFALL FOR FISCAL YEAR 2007.—The amount, if any, by which the projected expenditures determined under subparagraph (B) for the State for quarters in fiscal year 2007 exceeds the sum of the following:

''(i) FISCAL YEAR 2006 CARRYOVER.—The amount determined under subparagraph (A) for the State.

''(ii) FISCAL YEAR 2007 ALLOTMENT.—The amount of the State's allotment for fiscal year 2007.

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

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

''(E) STATE'S PROPORTION OF NET AGGREGATE SHORTFALL.—For each State for which there is a net excess determined under subparagraph (D), the ratio of—

''(i) the amount of such net excess; to

''(ii) the total of such net excesses.

''(3) REDISTRIBUTION FROM REDISTRIBUTION POOL.—From the redistribution pool determined under paragraph (1)(C)(i)—

''(A) STATES OTHER THAN TERRITORIES.—There shall be redistributed to each State for which there is a net projected shortfall under paragraph (2)(D) an amount equal the lesser of the following:

''(i) NET FISCAL YEAR 2007 SHORTFALL.—The amount of the net excess described in paragraph (2)(D) for the State.

''(ii) PORTION OF UNEXPENDED FUNDS AVAILABLE.—The product of the following:

''(I) STATE REDISTRIBUTION POOL.—The amount determined under paragraph (1)(C)(i), reduced by the total amount redistributed under subparagraph (B).

''(II) STATE'S SHORTFALL PROPORTION.—The ratio described in paragraph (2)(E) for that State.

''(B) TERRITORIES.—There shall be redistributed to each commonwealth or territory described in subsection (c)(3) an amount equal to the product of the following:

''(i) TERRITORIAL REDISTRIBUTION POOL.—1.05 percent of the total amount of unexpended allotments determined under paragraph (1)(A)(ii).

''(ii) TERRITORIAL PROPORTION.—The ratio of—

''(I) the allotment under subsection (c) for such commonwealth or territory for fiscal year 2005, to

''(II) the total of all such allotments for such commonwealths and territories.

''(4) EXTENDED AVAILABILITY OF REMAINING UNEXPENDED ALLOTMENTS.—

''(A) TO MEET INITIAL PROJECTED SHORTFALL FOR FISCAL YEAR 2007.—In the case of a State that is described in paragraph (1)(B)(ii), the Secretary shall extend the availability of funds from the State's allotment for fiscal year 2005 to the extent of the amount described in paragraph (2)(C).

''(B) OTHER EXTENSIONS.—If the redistribution pool amount determined under paragraph (1)(C)(i) exceeds the total amount redistributed under paragraph (3), the Secretary shall extend the availability of funds from allotments for fiscal year 2005 for each State which has an unexpended allotment for that fiscal year determined under paragraph (1)(A) (as reduced, if applicable, under paragraph (1)(B)) by an amount equal to the amount (if any) by which—

''(i) the amount of the unexpended allotment (as so reduced) for the State, exceeds

''(ii) the redistribution/reduction amount determined under paragraph (1)(D) for the State (relating to the portion of the unexpended allotment applied to redistributions).

''(5) DETERMINATION OF AMOUNTS.—For purposes of calculating the amounts described in—

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

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

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

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

(2) by adding at the end the following:

''(3) USE OF REDISTRIBUTED FUNDS FOR CHILD HEALTH ASSISTANCE FOR TARGETED LOW-INCOME CHILDREN.—For purposes of paragraph (1), the expenditures described in this paragraph are expenditures that are not expenditures for child health assistance for targeted low-income children, but only if such expenditures are from any amounts redistributed under subparagraphs (A) or (B) of subsection (h)(3), (i)(3), or (j)(3) of section 2104.''.

SEC. 6052. AUTHORITY TO USE UP TO 10 PERCENT OF FISCAL YEAR 2006 AND 2007 ALLOTMENTS FOR OUTREACH.

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

''(C) USE OF UP TO 10 PERCENT OF 2006 AND 2007 ALLOTMENTS FOR OUTREACH ACTIVITIES.—Notwithstanding subparagraph (A), a State may use up to 10 percent of the allotment for the State for fiscal year 2006 and for fiscal year 2007 for expenditures incurred during the

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

SEC. 6053. PROHIBITION AGAINST COVERING NONPREGNANT CHILDLESS ADULTS WITH SCHIP FUNDS.

(a) PROHIBITION ON USE OF SCHIP FUNDS.—Section 2107 (42 U.S.C. 1397gg) is amended by adding at the end the following:

''(f) LIMITATION OF WAIVER AUTHORITY.—Notwithstanding subsection (e)(2)(A) and section 1115(a), on and after the date of enactment of this subsection, the Secretary may not approve a waiver, experimental, pilot, or demonstration project that would allow funds made available under this title to be used to provide child health assistance or other health benefits coverage to a nonpregnant childless adult. For purposes of the preceding sentence, a caretaker relative (as such term is defined for purposes of carrying out section 1931) shall not be considered a childless adult.''.

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

(1) by inserting ''and may not include coverage of a nonpregnant childless adult'' after ''section 2101)''; and

(2) by adding at the end the following: ''For purposes of the preceding sentence, a caretaker relative (as such term is defined for purposes of carrying out section 1931) shall not be considered a childless adult.''.

(c) RULE OF CONSTRUCTION.—Nothing in this section or the amendments made by this section shall be construed to—

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

(2) imply congressional approval of any waiver, experimental, pilot, or demonstration project affecting funds made available under the State children's health insurance program under title XXI of the Social Security Act (42 U.S.C. 1397aa et. seq.) or any amendment to such a waiver or project that has been approved as of such date of enactment; or

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

child health assistance or other health benefits coverage to a nonpregnant childless adult that is approved before the date of enactment of this Act or to any extension, renewal, or amendment of such a waiver or project that is approved on or after such date of enactment.

SEC. 6054. CONTINUED AUTHORITY FOR QUALIFYING STATES TO USE CERTAIN FUNDS FOR MEDICAID EXPENDITURES.

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

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

SEC. 6055. GRANTS TO PROMOTE INNOVATIVE OUTREACH AND ENROLLMENT UNDER MEDICAID AND SCHIP.

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

''SEC. 2111. EXPANDED OUTREACH ACTIVITIES.

''(a) GRANTS TO CONDUCT INNOVATIVE OUTREACH AND ENROLLMENT EFFORTS.—

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

''(A) conduct innovative outreach and enrollment efforts that are designed to increase the enrollment and participation of eligible children under this title and title XIX; and

''(B) promote understanding of the importance of health insurance coverage for prenatal care and children.

''(2) PERFORMANCE BONUSES.—The Secretary may reserve a portion of the funds appropriated under subsection (g) for a fiscal year for the purpose of awarding performance bonuses during the succeeding fiscal year to eligible entities that meet enrollment goals or other criteria established by the Secretary.

''(b) PRIORITY FOR AWARD OF GRANTS.—

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

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

''(i) eligible but unenrolled children, including such children who reside in rural areas; or

''(ii) racial and ethnic minorities and health disparity populations, including those proposals that address cultural and linguistic barriers to enrollment; and

''(B) eligible entities that plan to engage in outreach efforts with respect to individuals described in subparagraph (A) and that are—

''(i) Federal health safety net organizations; or

''(ii) faith-based organizations or consortia.

''(2) 10 PERCENT SET ASIDE FOR OUTREACH TO INDIAN CHILDREN.—An amount equal to 10 percent of the funds appropriated under subsection (g) for a fiscal year shall be used by the Secretary to award grants to Indian Health Service providers and urban Indian organizations receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.) for outreach to, and enrollment of, children who are Indians.

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

''(1) quality and outcomes performance measures to evaluate the effectiveness of activities funded by a grant awarded under this section to ensure that the activities are meeting their goals; and

''(2) an assurance that the entity shall—

''(A) conduct an assessment of the effectiveness of such activities against such performance measures; and

''(B) cooperate with the collection and reporting of enrollment data and other information determined as a result of conducting such assessments to the Secretary, in such form and manner as the Secretary shall require.

''(d) DISSEMINATION OF ENROLLMENT DATA AND INFORMATION DETERMINED FROM EFFECTIVENESS ASSESSMENTS; ANNUAL REPORT.—The Secretary shall—

''(1) disseminate to eligible entities and make publicly available the enrollment data and information collected and reported in accordance with subsection (c)(2)(B); and

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

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

not supplant, non-Federal funds that are otherwise available for activities funded under this section.

''(f) DEFINITIONS.—In this section:

''(1) ELIGIBLE ENTITY.—The term 'eligible entity' means any of the following:

''(A) A State or local government.

''(B) A Federal health safety net organization.

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

''(D) A faith-based organization or consortia, to the extent that a grant awarded to such an entity is consistent with the requirements of section 1955 of the Public Health Service Act (42 U.S.C. 300x–65) relating to a grant award to non-governmental entities.

''(E) An elementary or secondary school.

''(2) FEDERAL HEALTH SAFETY NET ORGANIZATION.—The term 'Federal health safety net organization' means—

''(A) an Indian tribe, tribal organization, or an urban Indian organization receiving funds under title V of the Indian Health Care Improvement Act (25 U.S.C. 1651 et seq.), or an Indian Health Service provider;

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

"(C) a hospital defined as a disproportionate share hospital for purposes of section 1923;

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

"(E) any other entity or a consortium that serves children under a federally-funded program, including the special supplemental nutrition program for women, infants, and children (WIC) established under section 17 of the Child Nutrition Act of 1966 (42 U.S.C. 1786), the head start and early head start programs under the Head Start Act (42 U.S.C. 9801 et seq.), the school lunch program established under the Richard B. Russell National School Lunch Act, and an elementary or secondary school.

"(3) INDIANS; INDIAN TRIBE; TRIBAL ORGANIZATION; URBAN INDIAN ORGANIZATION.—The terms 'Indian', 'Indian tribe', 'tribal organization', and 'urban Indian organization' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

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

''(1) be in addition to amounts appropriated under section 2104 and paid to States in accordance with section 2105; and

''(2) not be subject to the limitation on expenditures described in section 2105(c)(2)(A).''.

Subchapter C—Money Follows the Person Rebalancing Demonstration

SEC. 6061. MONEY FOLLOWS THE PERSON REBALANCING DEMONSTRATION.

(a) PROGRAM PURPOSE AND AUTHORITY.—The Secretary is authorized to award, on a competitive basis, grants to States in accordance with this section for demonstration projects (each in this section referred to as an ''MFP demonstration project'') designed to achieve the following objectives with respect to institutional and home and community-based long-term care services under State Medicaid programs:

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

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

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

(4) QUALITY ASSURANCE AND QUALITY IMPROVEMENT.—Ensure that procedures are in place (at least comparable to those required under the qualified HCB program) to provide quality assurance for eligible individuals receiving Medicaid home and community-based long-term care services and to provide for continuous quality improvement in such services.

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

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

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

(2) ELIGIBLE INDIVIDUAL.—The term ''eligible individual'' means, with respect to an MFP demonstration project of a State, an individual in the State—

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

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

(ii) is receiving Medicaid benefits for inpatient services furnished by such inpatient facility; and

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

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

(B) who resides in a qualified residence beginning on the initial date of participation in the demonstration project.

(3) INPATIENT FACILITY.—The term ''inpatient facility'' means a hospital, nursing facility, or intermediate care facility for the mentally retarded. Such term includes an institution for mental diseases, but only, with respect to a State, to the extent medical assistance is available under the State Medicaid plan for services provided by such institution.

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

(5) QUALIFIED HCB PROGRAM.—The term ''qualified HCB program'' means a program providing home and community-based long-term care services operating under Medicaid, whether or not operating under waiver authority.

(6) QUALIFIED RESIDENCE.—The term ''qualified residence'' means, with respect to an eligible individual—

(A) a home owned or leased by the individual or the individual's family member;

(B) an apartment with an individual lease, with lockable access and egress, and which includes living, sleeping, bathing, and cooking areas over which the individual or the individual's family has domain and control; and

(C) a residence, in a community-based residential setting, in which no more than 4 unrelated individuals reside.

(7) QUALIFIED EXPENDITURES.—The term ''qualified expenditures'' means expenditures by the State under its MFP demonstration project for home and community-based long-term care services for an eligible individual participating in the MFP demonstration project, but only with respect to services furnished during the 12-month period beginning on the date the individual is discharged from an inpatient facility referred to in paragraph (2)(A)(i).

(8) SELF-DIRECTED SERVICES.—The term ''self-directed'' means, with respect to home and community-based long-term care services for an eligible individual, such services for the individual which are planned and purchased under the direction and control of such individual or the individ-

ual's authorized representative (as defined by the Secretary), including the amount, duration, scope, provider, and location of such services, under the State Medicaid program consistent with the following requirements:

(A) ASSESSMENT.—There is an assessment of the needs, capabilities, and preferences of the individual with respect to such services.

(B) SERVICE PLAN.—Based on such assessment, there is developed jointly with such individual or the individual's authorized representative a plan for such services for such individual that is approved by the State and that—

(i) specifies those services, if any, which the individual or the individual's authorized representative would be responsible for directing;

(ii) identifies the methods by which the individual or the individual's authorized representative or an agency designated by an individual or representative will select, manage, and dismiss providers of such services;

(iii) specifies the role of family members and others whose participation is sought by the individual or the individual's authorized representative with respect to such services;

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

(I) is directed by the individual or the individual's authorized representative;

(II) builds upon the individual's capacity to engage in activities that promote community life and that respects the individual's preferences, choices, and abilities; and

(III) involves families, friends, and professionals as desired or required by the individual or the individual's authorized representative;

(v) includes appropriate risk management techniques that recognize the roles and sharing of responsibilities in obtaining services in a self-directed manner and assure the appropriateness of such plan based upon the resources and capabilities

of the individual or the individual's authorized representative; and

(vi) may include an individualized budget which identifies the dollar value of the services and supports under the control and direction of the individual or the individual's authorized representative.

(C) BUDGET PROCESS.—With respect to individualized budgets described in subparagraph (B)(vi), the State application under subsection (c)—

(i) describes the method for calculating the dollar values in such budgets based on reliable costs and service utilization;

(ii) defines a process for making adjustments in such dollar values to reflect changes in individual assessments and service plans; and

(iii) provides a procedure to evaluate expenditures under such budgets.

(9) STATE.—The term ''State'' has the meaning given such term for purposes of title XIX of the Social Security Act.

(c) STATE APPLICATION.—A State seeking approval of an MFP demonstration project shall submit to the Secretary, at such time and in such format as the Secretary requires, an application meeting the following requirements and containing such additional information, provisions, and assurances, as the Secretary may require:

(1) ASSURANCE OF A PUBLIC DEVELOPMENT PROCESS.—The application contains an assurance that the State has engaged, and will continue to engage, in a public process for the design, development, and evaluation of the MFP demonstration project that allows for input from eligible individuals, the families of such individuals, authorized representatives of such individuals, providers, and other interested parties.

(2) OPERATION IN CONNECTION WITH QUALIFIED HCB PROGRAM TO ASSURE CONTINUITY OF SERVICES.—The State will conduct the MFP demonstration project for eligible individuals in conjunction with the operation of a qualified HCB program that is in operation (or approved) in the State for such individuals in a manner that assures continuity of Medicaid coverage for such individuals so long as such individuals continue to be eligible for medical assistance.

(3) DEMONSTRATION PROJECT PERIOD.—The application shall specify the period of the MFP demonstration project, which shall include at least 2 consecutive fiscal years in the 5-fiscal-year period beginning with fiscal year 2009.

(4) SERVICE AREA.—The application shall specify the service area or areas of the MFP demonstration project, which may be a statewide area or one or more geographic areas of the State.

(5) TARGETED GROUPS AND NUMBERS OF INDIVIDUALS SERVED.—The application shall specify—

(A) the target groups of eligible individuals to be assisted to transition from an inpatient facility to a qualified residence during each fiscal year of the MFP demonstration project;

(B) the projected numbers of eligible individuals in each targeted group of eligible individuals to be so assisted during each such year; and

(C) the estimated total annual qualified expenditures for each fiscal year of the MFP demonstration project.

(6) INDIVIDUAL CHOICE, CONTINUITY OF CARE.—The application shall contain assurances that—

(A) each eligible individual or the individual's authorized representative will be provided the opportunity to make an informed choice regarding whether to participate in the MFP demonstration project;

(B) each eligible individual or the individual's authorized representative will choose the qualified residence in which the individual will reside and the setting in which the individual will receive home and community-based long-term care services;

(C) the State will continue to make available, so long as the State operates its qualified HCB program consistent with applicable requirements, home and community-based long-term care services to each individual who completes participation in the MFP demonstration project for as long as the individual remains eligible for medical assistance for such services under such qualified HCB program (including meeting a requirement relating to requiring a level of care provided in an inpatient facility and continuing to require such services).

(7) REBALANCING.—The application shall—

(A) provide such information as the Secretary may require concerning the dollar amounts of State Medicaid expenditures for the fiscal year, immediately preceding the first fiscal year of the State's MFP demonstration project, for long-term care services and the percentage of such expenditures that were for institutional long-term care services or were for home and community-based long-term care services;

(B)(i) specify the methods to be used by the State to increase, for each fiscal year during the MFP demonstration project, the dollar amount of such total expenditures for home and community-based long-term care services and the percentage of such total expenditures for long-term care services that are for home and community-based long-term care services; and

(ii) describe the extent to which the MFP demonstration project will contribute to accomplishment of objectives described in subsection (a).

(8) MONEY FOLLOWS THE PERSON.—The application shall describe the methods to be used by the State to eliminate any legal, budgetary, or other bar-

riers to flexibility in the availability of Medicaid funds to pay for long-term care services for eligible individuals participating in the project in the appropriate settings of their choice, including costs to transition from an institutional setting to a qualified residence.

(9) MAINTENANCE OF EFFORT AND COST-EFFECTIVENESS.—The application shall contain or be accompanied by such information and assurances as may be required to satisfy the Secretary that—

(A) total expenditures under the State Medicaid program for home and community-based long-term care services will not be less for any fiscal year during the MFP demonstration project than for the greater of such expenditures for—

(i) fiscal year 2005; or

(ii) any succeeding fiscal year before the first year of the MFP demonstration project; and

(B) in the case of a qualified HCB program operating under a waiver under subsection (c) or (d) of section 1915 of the Social Security Act (42 U.S.C. 1396n), but for the amount awarded under a grant under this sec-

tion, the State program would continue to meet the cost-effectiveness requirements of subsection (c)(2)(D) of such section or comparable requirements under subsection (d)(5) of such section, respectively.

(10) WAIVER REQUESTS.—The application shall contain or be accompanied by requests for any modification or adjustment of waivers of Medicaid requirements described in subsection (d)(3), including adjustments to the maximum numbers of individuals included and package of benefits, including one-time transitional services, provided.

(11) QUALITY ASSURANCE AND QUALITY IMPROVEMENT.—The application shall include—

(A) a plan satisfactory to the Secretary for quality assurance and quality improvement for home and community-based long-term care services under the State Medicaid program, including a plan to assure the health and welfare of individuals participating in the MFP demonstration project; and

(B) an assurance that the State will cooperate in carrying out activities under subsection (f) to develop and implement continuous quality assurance and quality improvement sys-

tems for home and community-based long-term care services.

(12) OPTIONAL PROGRAM FOR SELF-DIRECTED SERVICES.—If the State elects to provide for any home and community-based long-term care services as self-directed services (as defined in subsection (b)(8)) under the MFP demonstration project, the application shall provide the following:

(A) MEETING REQUIREMENTS.—A description of how the project will meet the applicable requirements of such subsection for the provision of self-directed services.

(B) VOLUNTARY ELECTION.—A description of how eligible individuals will be provided with the opportunity to make an informed election to receive self-directed services under the project and after the end of the project.

(C) STATE SUPPORT IN SERVICE PLAN DEVELOPMENT.—Satisfactory assurances that the State will provide support to eligible individuals who self-direct in developing and implementing their service plans.

(D) OVERSIGHT OF RECEIPT OF SERVICES.—Satisfactory assurances that the State will provide oversight of eligible individual's re-

ceipt of such self-directed services, including steps to assure the quality of services provided and that the provision of such services are consistent with the service plan under such subsection.

Nothing in this section shall be construed as requiring a State to make an election under the project to provide for home and community-based long-term care services as self-directed services, or as requiring an individual to elect to receive self-directed services under the project.

(13) REPORTS AND EVALUATION.—The application shall provide that—

(A) the State will furnish to the Secretary such reports concerning the MFP demonstration project, on such timetable, in such uniform format, and containing such information as the Secretary may require, as will allow for reliable comparisons of MFP demonstration projects across States; and

(B) the State will participate in and cooperate with the evaluation of the MFP demonstration project.

(d) SECRETARY'S AWARD OF COMPETITIVE GRANTS.—

(1) IN GENERAL.—The Secretary shall award grants under this section on a competitive basis to States selected from among those with applications meeting the requirements of subsection (c), in accordance with the provisions of this subsection.

(2) SELECTION AND MODIFICATION OF STATE APPLICATIONS.—In selecting State applications for the awarding of such a grant, the Secretary—

(A) shall take into consideration the manner in which, and extent to which, the State proposes to achieve the objectives specified in subsection (a);

(B) shall seek to achieve an appropriate national balance in the numbers of eligible individuals, within different target groups of eligible individuals, who are assisted to transition to qualified residences under MFP demonstration projects, and in the geographic distribution of States operating MFP demonstration projects;

(C) shall give preference to State applications proposing—

(i) to provide transition assistance to eligible individuals within multiple target groups; and

(ii) to provide eligible individuals with the opportunity to receive home and community-based long-term care services as self-directed services, as defined in subsection (b)(8); and

(D) shall take such objectives into consideration in setting the annual amounts of State grant awards under this section.

(3) WAIVER AUTHORITY.—The Secretary is authorized to waive the following provisions of title XIX of the Social Security Act, to the extent necessary to enable a State initiative to meet the requirements and accomplish the purposes of this section:

(A) STATEWIDENESS.—Section 1902(a)(1), in order to permit implementation of a State initiative in a selected area or areas of the State.

(B) COMPARABILITY.—Section 1902(a)(10)(B), in order to permit a State initiative to assist a selected category or categories of individuals described in subsection (b)(2)(A).

(C) INCOME AND RESOURCES ELIGIBILITY.—Section 1902(a)(10)(C)(i)(III), in order to permit a State to apply institutional

eligibility rules to individuals transitioning to community-based care.

(D) PROVIDER AGREEMENTS.—Section 1902(a)(27), in order to permit a State to implement self-directed services in a cost-effective manner.

(4) CONDITIONAL APPROVAL OF OUTYEAR GRANT.—In awarding grants under this section, the Secretary shall condition the grant for the second and any subsequent fiscal years of the grant period on the following:

(A) NUMERICAL BENCHMARKS.—The State must demonstrate to the satisfaction of the Secretary that it is meeting numerical benchmarks specified in the grant agreement for—

(i) increasing State Medicaid support for home and community-based long-term care services under subsection (c)(5); and

(ii) numbers of eligible individuals assisted to transition to qualified residences.

(B) QUALITY OF CARE.—The State must demonstrate to the satisfaction of the Secretary that it is meeting the requirements under sub-

section (c)(11) to assure the health and welfare of MFP demonstration project participants.

(e) PAYMENTS TO STATES; CARRYOVER OF UNUSED GRANT AMOUNTS.—

(1) PAYMENTS.—For each calendar quarter in a fiscal year during the period a State is awarded a grant under subsection (d), the Secretary shall pay to the State from its grant award for such fiscal year an amount equal to the lesser of—

(A) 90 percent of the amount of qualified expenditures made during such quarter; or

(B) the total amount remaining in such grant award for such fiscal year (taking into account the application of paragraph (2)).

(2) CARRYOVER OF UNUSED AMOUNTS.—Any portion of a State grant award for a fiscal year under this section remaining at the end of such fiscal year shall remain available to the State for the next 4 fiscal years, subject to paragraph (3).

(3) REAWARDING OF CERTAIN UNUSED AMOUNTS.—In the case of a State that the Secretary determines pursuant to subsection (d)(4) has failed to meet the conditions for continuation of a MFP demonstration project under this section in a succeeding year or years, the Secretary shall rescind

the grant awards for such succeeding year or years, together with any unspent portion of an award for prior years, and shall add such amounts to the appropriation for the immediately succeeding fiscal year for grants under this section.

(4) PREVENTING DUPLICATION OF PAYMENT.—The payment under a MFP demonstration project with respect to qualified expenditures shall be in lieu of any payment with respect to such expenditures that could otherwise be paid under Medicaid, including under section 1903(a) of the Social Security Act. Nothing in the previous sentence shall be construed as preventing the payment under Medicaid for such expenditures in a grant year after amounts available to pay for such expenditures under the MFP demonstration project have been exhausted.

(f) QUALITY ASSURANCE AND IMPROVEMENT; TECHNICAL ASSISTANCE; OVERSIGHT.—

(1) IN GENERAL.—The Secretary, either directly or by grant or contract, shall provide for technical assistance to, and oversight of, States for purposes of upgrading quality assurance and quality improvement systems under Medicaid home and community-based waivers, including—

(A) dissemination of information on promising practices;

(B) guidance on system design elements addressing the unique needs of participating beneficiaries;

(C) ongoing consultation on quality, including assistance in developing necessary tools, resources, and monitoring systems; and

(D) guidance on remedying programmatic and systemic problems.

(2) FUNDING.—From the amounts appropriated under subsection (h)(1) for the portion of fiscal year 2009 that begins on January 1, 2009, and ends on September 30, 2009, and for fiscal year 2010, not more than $2,400,000 shall be available to the Secretary to carry out this subsection during the period that begins on January 1, 2009, and ends on September 30, 2013.

(g) RESEARCH AND EVALUATION.—

(1) IN GENERAL.—The Secretary, directly or through grant or contract, shall provide for research on, and a national evaluation of, the program under this section, including assistance to the Secretary in preparing the final report required under paragraph (2). The evaluation shall include an analysis of pro-

jected and actual savings related to the transition of individuals to qualified residences in each State conducting an MFP demonstration project.

(2) FINAL REPORT.—The Secretary shall make a final report to the President and Congress, not later than September 30, 2013, reflecting the evaluation described in paragraph (1) and providing findings and conclusions on the conduct and effectiveness of MFP demonstration projects.

(3) FUNDING.—From the amounts appropriated under subsection (h)(1) for each of fiscal years 2010 through 2013, not more than $1,100,000 per year shall be available to the Secretary to carry out this subsection.

(h) APPROPRIATIONS.—

(1) IN GENERAL.—There are appropriated, from any funds in the Treasury not otherwise appropriated, for grants to carry out this section—

(A) $250,000,000 for the portion of fiscal year 2009 beginning on January 1, 2009, and ending on September 30, 2009;

(B) $300,000,000 for fiscal year 2010;

(C) $350,000,000 for fiscal year 2011;

(D) $400,000,000 for fiscal year 2012; and

(E) $450,000,000 for fiscal year 2013.

(2) AVAILABILITY.—Amounts made available under paragraph (1) for a fiscal year shall remain available for the awarding of grants to States by not later than September 30, 2013.

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

SEC. 6071. OPTION FOR HURRICANE KATRINA DISASTER STATES TO DELAY APPLICATION.

Notwithstanding any provision of this subtitle, or any amendment made by this subtitle, the State of Louisiana, Mississippi, or Alabama may elect to not have the provisions of this subtitle, or of any amendment made by this subtitle, apply with respect to the State during any period for which a major disaster declared in accordance with section 401 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (42 U.S.C. 5170) with respect to a parish, in the case of Louisiana, or a county, in the case of Mississippi or Alabama, as a result of Hurricane Katrina is in effect.

Subtitle B—Medicare

SEC. 6101. IMPROVEMENTS TO THE MEDICARE-DEPENDENT HOSPITAL (MDH) PROGRAM.

(a) 5-YEAR EXTENSION.—

(1) EXTENSION OF PAYMENT METHODOLOGY.—Section 1886(d)(5)(G) (42 U.S.C. 1395ww(d)(5)(G)) is amended—

(A) in clause (i), by striking ''October 1, 2006'' and inserting ''October 1, 2011''; and

(B) in clause (ii)(II)—

(i) by striking ''October 1, 2006'' and inserting ''October 1, 2011''; and

(ii) by inserting ''or for discharges in the fiscal year'' after ''for the cost reporting period''.

(2) CONFORMING AMENDMENTS.—

(A) EXTENSION OF TARGET AMOUNT.—Section 1886(b)(3)(D) (42 U.S.C. 1395ww(b)(3)(D)) is amended—

(i) in the matter preceding clause (i)—

(I) by striking ''beginning'' and inserting ''occurring''; and

(II) by striking ''October 1, 2006'' and inserting ''October 1, 2011''; and

(ii) in clause (iv), by striking ''through fiscal year 2005'' and inserting ''through fiscal year 2011''.

(B) PERMITTING HOSPITALS TO DECLINE RECLASSIFICATION.—Section 13501(e)(2) of the Omnibus Budget Reconciliation Act of 1993 (42 U.S.C. 1395ww note) is amended by striking ''through fiscal year 2005'' and inserting ''through fiscal year 2011''.

(b) OPTION TO USE OF 2002 AS BASE YEAR.—Section 1886(b)(3) (42 U.S.C. 1395ww(b)(3)) is amended—

(1) in subparagraph (D), by inserting ''subject to subparagraph (K),'' after ''(d)(5)(G)),''; and

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

''(K)(i) With respect to discharges occurring on or after October 1, 2006, in the case of a medicare-dependent, small rural hospital, for purposes of applying subparagraph (D)—

''(I) there shall be substituted for the base cost reporting period described in subparagraph (D)(i) the 12-month cost reporting period beginning during fiscal year 2002; and

''(II) any reference in such subparagraph to the 'first cost reporting period' described in such subparagraph is deemed a reference to the first cost reporting period beginning on or after October 1, 2006.

''(ii) This subparagraph shall only apply to a hospital if the substitution described in clause (i)(I) results in an increase in the target amount under subparagraph (D) for the hospital.''.

(c) ENHANCED PAYMENT FOR AMOUNT BY WHICH THE TARGET EXCEEDS THE PPS RATE.—Section 1886(d)(5)(G)(ii)(II) (42 U.S.C. 1395ww(d)(5)(G)(iv)(II)) is amended by inserting ''(or 75 percent in the case of discharges occurring on or after October 1, 2006)'' after ''50 percent''.

(d) ENHANCED DISPROPORTIONATE SHARE HOSPITAL (DSH) TREATMENT FOR MEDICARE DEPENDENT HOSPITALS.—Section 1886(d)(5)(F)(xiv)(II) (42 U.S.C. 1395ww(d)(5)(F)(xiv)(II)) is amended by inserting ''or, in the case of discharges occurring on or after October 1, 2006, as a medicare-dependent, small rural hospital under subparagraph (G)(iv)'' before the period at the end.

SEC. 6102. REDUCTION IN PAYMENTS TO SKILLED NURSING FACILITIES FOR BAD DEBT.

(a) IN GENERAL.—Section 1861(v)(1) (42 U.S.C. 1395x(v)(1)) is amended by adding at the end the following new subparagraph:

''(V) In determining such reasonable costs for skilled nursing facilities with respect to services furnished on or after October 1, 2005, the amount of bad debts otherwise

treated as allowed costs which are attributable to the deductibles and coinsurance amounts under this title shall be reduced by 30 percent of such amount otherwise allowable.''.

(b) TECHNICAL AMENDMENT.—Section 1861(v)(1)(T) (42 U.S.C. 1395x(v)(1)(T)) is amended by striking ''section 1833(t)(5)(B)'' and inserting ''section 1833(t)(8)(B)''.

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.

(a) EXTENSION.—

(1) IN GENERAL.—Effective as if enacted on June 30, 2005, notwithstanding section 412.23(b)(2) of title 42, Code of Federal Regulations, during the period beginning on July 1, 2005, and ending on June 30, 2007, the Secretary of Health and Human Services shall not—

(A) require a compliance rate, pursuant to the criterion (commonly known as the ''75 percent rule'') that is used to determine whether a hospital or unit of a hospital is an inpatient rehabilitation facility (as defined in the rule pub-

lished in the Federal Register on May 7, 2004, entitled ''Medicare Program; Final Rule; Changes to the Criteria for Being Classified as an Inpatient Rehabilitation Facility'' (69 Fed. Reg. 25752)), that is greater than the 50 percent compliance threshold that became effective on July 1, 2004; or

(B) change the designation of an inpatient rehabilitation facility that is in compliance with such 50 percent threshold.

(2) RETROACTIVE STATUS AS AN INPATIENT REHABILITATION FACILITY; PAYMENTS; EXPEDITED REVIEW.—The Secretary of Health and Human Services shall establish procedures for—

(A) making any necessary retroactive adjustment to restore the status of a facility as an inpatient rehabilitation facility as a result of subsection (a); and

(B) making any necessary payments to inpatient rehabilitation facilities based on such adjustment for discharges occurring on or after July 1, 2005, and before the date of enactment of this Act.

(b) SPECIAL RULE.—In the case of a hospital or unit of a hospital that failed to meet the 50 percent compliance

threshold described in subsection (a)(1)(A) with respect to the first cost reporting period of the hospital or unit that began on or after July 1, 2004, the following rules shall apply:

(1) Such hospital or unit shall be deemed to meet such 50 percent threshold for purposes of subsection (a).

(2) The Secretary shall examine all the claims of the hospital or unit under title XVIII of the Social Security Act submitted during the 6-month period beginning after the end of such first cost reporting period.

(3) If the Secretary determines after such review that the hospital or unit is still not in compliance with such 50 percent compliance threshold—

(A) the deemed status of the hospital or unit under paragraph (1) shall be revoked retroactive to the beginning of such 6-month period; and

(B) the Secretary shall provide for the collection of any necessary overpayments by reason of the revocation under subparagraph (A).

(c) STUDY AND REPORT BY THE HHS INSPECTOR GENERAL.—

(1) STUDY.—

(A) IN GENERAL.—The Inspector General of the Department of Health and Human Services shall conduct a study of hospitals and units of hospitals that—

(i) are designated as inpatient rehabilitation facilities under title XVIII of the Social Security Act; and

(ii) would not be so designated if this section had not been enacted because the hospital or unit has a compliance rate that is greater than the 50 percent compliance threshold described in subsection (a)(1)(A) but is less than the 60 percent compliance threshold that would have become effective on July 1, 2005, but for this section.

(B) REQUIREMENT.—In conducting the study under subparagraph (A), the Inspector General shall analyze the types of patients the hospitals and units are treating and issues relating to the medical conditions of such patients that do not meet the medical requirements for determining compliance with such threshold.

(2) REPORT.—Not later than January 1, 2007, the Inspector General shall submit to Congress and the Secretary a report on the study conducted under

paragraph (1), together with such recommendations as the Inspector General determines appropriate.

(d) REHABILITATION ADVISORY COUNCIL.—

(1) ESTABLISHMENT.—The Secretary shall establish an advisory council to be known as the ''Rehabilitation Advisory Council''.

(2) MEMBERSHIP.—The membership of the Rehabilitation Advisory Council shall include—

(A) physicians;

(B) medicare beneficiaries;

(C) representatives of inpatient rehabilitation facilities; and

(D) representatives of other entities and practitioners that provide rehabilitative care in settings other than in such facilities, such as skilled nursing facilities.

(3) DUTIES.—

(A) ADVICE AND RECOMMENDATIONS.—The Rehabilitation Advisory Council shall provide advice and recommendations to Congress and the Secretary concerning the coverage of rehabilitation services under the medicare program, including the appropriate medical criteria for determining the appropriateness of inpatient rehabilitation facility admissions.

(B) PERIODIC REPORTS.—The Rehabilitation Advisory Council shall provide Congress and the Secretary with periodic reports that summarize—

(i) the Council's activities; and

(ii) any recommendations for legislation or administrative action the Council considers to be appropriate.

(4) TERMINATION.—The Rehabilitation Advisory Council shall terminate on September 30, 2010.

SEC. 6104. PROHIBITION ON PHYSICIAN SELF REFERRALS TO PHYSICIAN OWNED, LIMITED SERVICE HOSPITALS.

(a) PROHIBITION.—Section 1877(d) (42 U.S.C. 1395nn(d)) is amended in each of paragraphs (2)(B) and (3)(B) by striking ''effective for the 18-month period beginning on the date of enactment of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003'' and inserting ''on and after December 8, 2003''.

(b) REVISIONS TO THE REQUIREMENTS TO QUALIFY FOR THE EXCEPTION TO THE DEFINITION OF SPECIALTY HOSPITAL.—Section 1877(h)(7)(B) (42 U.S.C. 1395nn(h)(7)(B)) is amended—

(1) by redesignating clauses (iii), (iv), and (v) as clauses (vi), (vii), and (viii), respectively;

(2) by inserting after clause (ii) the following new clauses:

"(iii) for which the percent of investment in the hospital by physician investors at any time on or after June 8, 2005, is no greater than the percent of such investment by physician investors as of such date;

"(iv) for which the percent of investment in the hospital by any physician investor at any time on or after June 8, 2005, is no greater than the percent of such investment by such physician as of such date;

"(v) for which the number of operating rooms at the hospital at any time on or after June 8, 2005, is no greater than the number of such rooms as of such date;"; and

(3) by striking clause (vii), as so redesignated, and inserting the following:

"(vii) for which—

''(I) during the period beginning on December 8, 2003, and ending on June 7, 2005, any increase in the number of beds occurs only in the facilities on the main campus of the hospital and does not exceed 50 percent of the number of beds in the hospital as of November 18, 2003, or 5 beds, whichever is greater; and

''(II) the number of beds at the hospital at any time on or after June 8, 2005, is no greater than the number of such beds as of such date; and''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on June 8, 2005.

SEC. 6105. MINIMUM UPDATE FOR PHYSICIANS' SERVICES FOR 2006.

(a) MINIMUM UPDATE FOR 2006.—Section 1848(d) (42 U.S.C. 1395w–4(d)), as amended by section 6110(c), is amended by adding at the end the following new paragraph:

''(7) UPDATE FOR 2006.—The update to the single conversion factor established in paragraph (1)(C) for 2006 shall be not less than 1 percent.''.

(b) CONFORMING AMENDMENT.—Section 1848(d)(4)(B) (42 U.S.C. 1395w–4(d)(4)(B)) is amended, in the matter preceding clause (i), by striking ''paragraph (5)'' and inserting ''paragraphs (5) and (7)''.

(c) NOT TREATED AS CHANGE IN LAW AND REGULATION IN SUSTAINABLE GROWTH RATE DETERMINATION.—The amendments made by this section shall not be treated as a change in law for purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)).

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.

Section 1833(t)(7)(D)(i) (42 U.S.C. 1395l(t)(7)(D)(i)) is amended by striking ''January 1, 2006'' and inserting ''January 1, 2007''.

SEC. 6107. UPDATE TO THE COMPOSITE RATE COMPONENT OF THE BASIC CASE-MIX ADJUSTED PROSPECTIVE PAYMENT SYSTEM FOR DIALYSIS SERVICES.

Section 1881(b)(12) (42 U.S.C. 1395rr(b)(12)) is amended—

(1) in subparagraph (F), in the flush matter at the end, by striking ''Nothing'' and inserting ''Except as provided in subparagraph (G), nothing'';

(2) by redesignating subparagraph (G) as subparagraph (H); and

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

''(G) The Secretary shall increase the amount of the composite rate component of the basic case-mix adjusted system under subparagraph (B) for dialysis services furnished on or after January 1, 2006, by 1.6 percent above the amount of such composite rate component for such services furnished on December 31, 2005.''.

SEC. 6108. ONE-YEAR EXTENSION OF MORATORIUM ON THERAPY CAPS.

Section 1833(g)(4) (42 U.S.C. 1395l(g)(4)) is amended by striking ''and 2005'' and inserting ''2005, and 2006''.

SEC. 6109. TRANSFER OF TITLE OF CERTAIN DME TO PATIENT AFTER 13-MONTH RENTAL.

(a) IN GENERAL.—Section 1834(a)(7)(A) (42 U.S.C. 1395m(a)(7)(A)) is amended to read as follows:

''(A) PAYMENT.—In the case of an item of durable medical equipment not described in

paragraphs (2) through (6), the following rules shall apply:

"(i) RENTAL.—

"(I) IN GENERAL.—Payment for the item shall be made on a monthly basis for the rental of the item during the period of medical need (but payments under this clause may not extend over a period of continuous use (as determined by the Secretary) of longer than 13 months).

"(II) PAYMENT AMOUNT.—Subject to subparagraph (B), the amount recognized for the item—

"(aa) for each of the first 3 months of such period is 10 percent of the purchase price recognized under paragraph (8) with respect to the item; and

"(bb) for each of the remaining months of such period is 7.5 percent of such purchase price.

"(ii) OWNERSHIP AFTER RENTAL.—

''(I) TRANSFER OF TITLE.—On the first day that begins after the 13th continuous month during which payment is made for the rental of an item under clause (i), the supplier of the item shall transfer title to the item to the individual.

''(II) MAINTENANCE AND SERVICING.—After the supplier transfers title to the item under subclause (I), maintenance and servicing payments shall, if the Secretary determines such payments are reasonable and necessary, be made (for parts and labor not covered by the supplier's or manufacturer's warranty, as determined by the Secretary to be appropriate for the particular type of durable medical equipment), and such payments shall be in an amount determined to be appropriate by the Secretary.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to items furnished for which the first rental month occurs on or after January 1, 2006.

SEC. 6110. ESTABLISHMENT OF MEDICARE VALUE-BASED PURCHASING PROGRAMS.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.) is amended—

(1) by redesignating part E as part F; and

(2) by inserting after part D the following new part:

''PART E—VALUE-BASED PURCHASING

''QUALITY MEASUREMENT SYSTEMS FOR VALUE-BASED PURCHASING PROGRAMS

''SEC. 1860E–1. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—The Secretary shall develop quality measurement systems in accordance with subsections (b), (c), (d), and (e), for purposes of providing value-based payments to—

''(A) hospitals pursuant to section 1860E–2;

''(B) physicians and practitioners pursuant to section 1860E–3;

''(C) plans pursuant to section 1860E–4;

''(D) end stage renal disease providers and facilities pursuant to section 1860E–5; and

''(E) home health agencies pursuant to section 1860E–6.

''(2) QUALITY.—The systems developed under paragraph (1) shall measure the quality of the care furnished by the provider involved.

''(3) HIGH QUALITY HEALTH CARE DEFINED.—In this part, the term 'high quality health care' means health care that is safe, effective, patient-centered, timely, equitable, efficient, necessary, and appropriate.

''(b) REQUIREMENTS FOR SYSTEMS.—Under each quality measurement system described in subsection (a)(1), the Secretary shall do the following:

''(1) MEASURES.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall select measures of quality to be used by the Secretary under each system.

''(B) REQUIREMENTS.—In selecting the measures to be used under each system pursuant to subparagraph (A), the Secretary shall, to the extent feasible and practicable, ensure that—

''(i) such measures are evidence-based, reliable and valid, actionable, and reasonable to collect and report;

''(ii) measures of process, structure, outcomes, and beneficiary experience of care are included;

''(iii) except for the system that is used to provide value-based payments to physicians and practitioners under section 1860E–3, measures of efficiency (where efficiency is improved quality care through the effective use of resources) are included;

''(iv) measures of overuse and underuse of health care items and services are included;

''(v)(I) at least 1 measure of health information technology infrastructure that enables the provision of high quality health care and facilitates the exchange of health information, such as the use of 1 or more elements of a qualified health information system (as defined in subparagraph (E)), is included during the first year each system is implemented; and

''(II) additional measures of health information technology infrastructure are included in subsequent years;

''(vi) in the case of the system that is used to provide value-based payments to hospitals under section 1860E–2, by not later than January 1, 2008, at least 5 measures that take into account the unique characteristics of small hospitals located in rural areas and frontier areas are included; and

''(vii) measures that assess the quality of care furnished to frail individuals over the age of 75 and to individuals with multiple complex chronic conditions are included.

''(C) REQUIREMENT FOR COLLECTION OF DATA ON A MEASURE FOR 1 YEAR PRIOR TO USE UNDER THE SYSTEMS.—Data on any measure selected by the Secretary under subparagraph (A) must be collected by the Secretary for at least a 12-month period before such measure may be used to determine whether a provider receives a value-based payment under a program described in subsection (a)(1).

''(D) AUTHORITY TO VARY MEASURES.—The Secretary may vary the measures selected under subparagraph (A) by the entity or indi-

vidual involved based on factors such as the type of, the size of, and the scope and volume of services provided by, the entity or individual. If the Secretary varies the measures for providers under the preceding sentence, the Secretary shall ensure that such measures are aligned to promote coordinated quality of care across provider settings.

''(E) QUALIFIED HEALTH INFORMATION SYSTEM DEFINED.—For purposes of subparagraph (B)(iv)(I), the term 'qualified health information system' means a computerized system (including hardware, software, and training) that—

''(i) protects the privacy and security of health information and properly encrypts such health information;

''(ii) maintains and provides access to patients' health records in an electronic format;

''(iii) incorporates decision support software to reduce medical errors and enhance health care quality;

''(iv) is consistent with data standards and certification processes recommended by the Secretary;

''(v) allows for the reporting of quality measures; and

''(vi) includes other features determined appropriate by the Secretary.

''(2) WEIGHTS OF MEASURES.—The Secretary shall assign weights to the measures used by the Secretary under each system. If the Secretary determines appropriate, in assigning the weights under the preceding sentence, some measures may be weighted more heavily than other measures.

''(3) RISK ADJUSTMENT.—The Secretary shall establish procedures, as appropriate, to control for differences in beneficiary health status and beneficiary characteristics. To the extent feasible, such procedures may be based on existing models for controlling for such differences.

''(4) MAINTENANCE.—

''(A) IN GENERAL.—The Secretary shall, as determined appropriate, but not more often than once each 12-month period, review and revise each system, including through—

''(i) the refinement of measures under the systems and the retirement of existing outdated measures under the system;

''(ii) the refinement of the weights assigned to measures under the system; and

''(iii) the refinement of the risk adjustment procedures established pursuant to paragraph (3) under the system.

''(B) REVISION SHALL ALLOW FOR COMPARISON OF DATA.—Each revision under subparagraph (A) of a quality measurement system shall allow for the comparison of data from one year to the next for purposes of providing value-based payments under the programs described in subsection (a)(1).

''(5) USE OF MOST RECENT QUALITY DATA.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the Secretary shall use the most recent quality data with respect to the provider involved that is available to the Secretary.

''(B) INSUFFICIENT DATA DUE TO LOW VOLUME.—If the Secretary determines that there is insufficient data with respect to a measure or measures because of a low number

of services provided, the Secretary may aggregate data across more than 1 fiscal or calendar year, as the case may be.

''(c) REQUIREMENTS FOR DEVELOPING AND REVIEWING AND REVISING THE SYSTEMS.—In developing and reviewing and revising each quality measurement system under this section, the Secretary shall—

''(1) consult with, and take into account the recommendations of, the entity that the Secretary has an arrangement with under subsection (e);

''(2) consult with provider-based groups, clinical specialty societies, and certification boards;

''(3) take into account existing quality measurement systems that have been developed through a rigorous process of validation and with the involvement of entities and persons described in subsection (e)(2)(B); and

''(4) take into account—

''(A) each of the reports by the Medicare Payment Advisory Commission that are required under section 1860E–3(a)(1);

''(B) the results of appropriate studies, reports, and demonstration programs; and

''(C) the report by the Institute of Medicine of the National Academy of Sciences under

section 238(b) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173).

''(d) REQUIREMENTS FOR IMPLEMENTING THE SYSTEMS.—In implementing each quality measurement system under this section, the Secretary shall consult with entities—

''(1) that have joined together to develop strategies for quality measurement and reporting, including the feasibility of collecting and reporting meaningful data on quality measures; and

''(2) that involve representatives of health care providers, health plans, consumers, employers, purchasers, quality experts, government agencies, and other individuals and groups that are interested in quality of care.

''(e) ARRANGEMENT WITH AN ENTITY TO PROVIDE ADVICE AND RECOMMENDATIONS.—

''(1) ARRANGEMENT.—On and after July 1, 2006, the Secretary shall have in place an arrangement with an entity that meets the requirements described in paragraph (2) under which such entity provides the Secretary with advice on, and recommendations with respect to, the development and review and revision of the quality measurement sys-

tems under this section, including the assigning of weights to the measures under subsection (b)(2).

''(2) REQUIREMENTS DESCRIBED.—The requirements described in this paragraph are the following:

''(A) The entity is a private nonprofit entity governed by an executive director and a board.

''(B) The members of the entity include representatives of—

''(i)(I) health plans and providers receiving reimbursement under this title for the provision of items and services, including health plans and providers with experience in the care of the frail elderly and individuals with multiple complex chronic conditions; or

''(II) groups representing such health plans and providers;

''(ii) groups representing individuals receiving benefits under this title;

''(iii) purchasers and employers or groups representing purchasers or employers;

''(iv) organizations that focus on quality improvement as well as the measurement and reporting of quality measures;

''(vi) organizations that certify and license such providers;

''(vi) State government health programs;

''(vii) persons skilled in the conduct and interpretation of biomedical, health services, and health economics research and with expertise in outcomes and effectiveness research and technology assessment; and

''(viii) persons or entities involved in the development and establishment of standards and certification for health information technology systems and clinical data.

''(C) The membership of the entity is representative of individuals with experience with—

''(i) urban health care issues;

''(ii) safety net health care issues; and

''(iii) rural and frontier health care issues.

''(D) The entity does not charge a fee for membership for participation in the work of the entity related to the arrangement with the Secretary under paragraph (1). If the entity does require a fee for membership for participation in other functions of the entity, there shall be no linkage between such fee and participation in the work of the entity related to such arrangement with the Secretary.

''(E) The entity—

''(i) permits members described in subparagraph (B) to vote on matters of the entity related to the arrangement with the Secretary under paragraph (1); and

''(ii) ensures that such members have an equal vote on such matters.

''(F) With respect to matters related to the arrangement with the Secretary under paragraph (1), the entity conducts its business in an open and transparent manner and provides the opportunity for public comment.

''(G) The entity operates as a voluntary consensus standards setting organization as defined for purposes of section 12(d) of the National Technology Transfer and Advancement

Act of 1995 (Public Law 104–113) and Office of Management and Budget Revised Circular A–119 (published in the Federal Register on February 10, 1998).

''(3) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out the provisions of this subsection, there are authorized to be appropriated—

''(A) for each of the fiscal years 2006 and 2007, $3,000,000; and

''(B) for fiscal year 2008 and each subsequent fiscal year, an amount equal to the sum of—

''(i) $3,000,000; and

''(ii) such amount multiplied by the percentage (if any) by which the average of the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with June of the calendar year in which such fiscal year begins exceeds such average for the 12-month period ending with June 2006.

''PPS HOSPITAL VALUE-BASED PURCHASING PROGRAM

''SEC. 1860E–2. (a) PROGRAM.—

''(1) IN GENERAL.—The Secretary shall establish a program under which value-based payments

are provided each fiscal year to hospitals that demonstrate the provision of high quality health care to individuals who are entitled to benefits under part A and are inpatients of the hospital.

''(2) PROGRAM TO BEGIN IN FISCAL YEAR 2007.—The Secretary shall establish the program under this section so that value-based payments described in subsection (b) are made with respect to fiscal year 2007 and each subsequent fiscal year.

''(3) APPLICABILITY OF PROGRAM TO HOSPITALS.—For purposes of this section, the term 'hospital' means a subsection (d) hospital (as defined in section 1886(d)(1)(B)).

''(b) VALUE-BASED PAYMENTS.—

''(1) IN GENERAL.—Subject to paragraph (4), the Secretary shall make a value-based payment to a hospital with respect to a fiscal year if the Secretary determines that the quality of the care provided in that year to individuals who are entitled to benefits under part A and are inpatients of the hospital—

''(A) has substantially improved (as determined by the Secretary) over the prior year; or

''(B) exceeds a threshold established by the Secretary.

''(2) USE OF SYSTEM.—In determining which hospitals qualify for a value-based payment under paragraph (1), the Secretary shall use the quality measurement system developed for this section pursuant to section 1860E–1(a).

''(3) DETERMINATION OF AMOUNT OF AWARD AND ALLOCATION OF AWARDS.—

''(A) IN GENERAL.—The Secretary shall determine—

''(i) the amount of a value-based payment under paragraph (1) provided to a hospital; and

''(ii) subject to subparagraph (B), the allocation of the total amount available under subsection (d) for value-based payments for any fiscal year between payments with respect to hospitals that meet the requirement under subparagraph (A) of paragraph (1) and hospitals that meet the requirement under subparagraph (B) of such paragraph.

''(B) REQUIREMENTS REGARDING THE AMOUNT OF FUNDING AVAILABLE FOR VALUE-BASED PAYMENTS FOR HOSPITALS EXCEEDING

A THRESHOLD.—The Secretary shall ensure that—

''(i) a majority of the total amount available under subsection (d) for value-based payments for any fiscal year is provided to hospitals that are receiving such payments because they meet the requirement under paragraph (1)(B); and

''(ii) with respect to fiscal year 2008 and each subsequent fiscal year, the percentage of the total amount available under subsection (d) for value-based payments for any fiscal year that is used to make payments to hospitals that meet such requirement is greater than such percentage in the previous fiscal year.

''(4) REQUIREMENTS.—

''(A) REQUIRED SUBMISSION OF DATA.—In order for a hospital to be eligible for a value-based payment for a fiscal year, the hospital must have complied with the requirements under section 1886(b)(3)(B)(viii)(II) with respect to that fiscal year.

''(B) ATTESTATION REGARDING DATA.—In order for a hospital to be eligible for a value-

based payment for a fiscal year, the hospital must have provided the Secretary (under procedures established by the Secretary) with an attestation that the data submitted under section 1886(b)(3)(B)(viii)(II) for the fiscal year is complete and accurate.

''(5) TOTAL AMOUNT OF VALUE-BASED PAYMENTS EQUAL TO TOTAL AMOUNT OF AVAILABLE FUNDING.—The Secretary shall establish payment amounts under paragraph (3)(A) so that, as estimated by the Secretary, the total amount of value-based payments made in a fiscal year under paragraph (1) is equal to the total amount available under subsection (d) for such payments for the year.

''(6) PAYMENT METHODS AND TIMING OF PAYMENTS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the payment of value-based payments under paragraph (1) shall be based on such a method as the Secretary determines appropriate.

''(B) TIMING.—The Secretary shall ensure that value-based payments under paragraph (1) with respect to a fiscal year are made by not later than the close of the following fiscal year.

''(c) DESCRIPTION OF HOW HOSPITALS WOULD HAVE FARED UNDER PROGRAM.—Not later than January 1, 2007, the Secretary shall provide each hospital with a description of the Secretary's estimate of how payments to the hospital under this title would have been affected with respect to items and services furnished during a period, as determined by the Secretary, if the program under this section (and the amendments made by paragraphs (1) and (2) of section 6110(b) of the Deficit Reduction Omnibus Reconciliation Act of 2005) had been in effect with respect to that period.

''(d) FUNDING.—

''(1) AMOUNT.—The amount available for value-based payments under this section with respect to a fiscal year shall be equal to the amount of the reduction in expenditures under the Federal Hospital Insurance Trust Fund under section 1817 in the year as a result of the amendments made by section 6110(b)(2) of the Deficit Reduction Omnibus Reconciliation Act of 2005, as estimated by the Secretary.

''(2) PAYMENTS FROM TRUST FUND.—Payments to hospitals under this section shall be made from the Federal Hospital Insurance Trust Fund.

''PHYSICIAN AND PRACTITIONER VALUE-BASED PURCHASING PROGRAM

''SEC. 1860E–3. (a) PROGRAM.—

''(1) IN GENERAL.—The Secretary shall establish a program under which value-based payments are provided each year to physicians and practitioners that demonstrate the provision of high quality health care to individuals enrolled under part B and the Medicare Payment Advisory Commission shall (A) conduct a study, and submit to Congress and the Secretary an initial report by not later than March 1, 2008, and a final report by not later than June 1, 2012, on how the medicare value-based purchasing programs under this part will impact medicare beneficiaries, medicare providers, and medicare financing, including how such programs will impact the access of such beneficiaries to items and services under this title, the volume and utilization of such items and services, and low-volume providers; and (B) conduct a study, and submit to Congress and the Secretary a report by not later than March 1, 2007, on the advisability and feasibility of establishing a value-based purchasing program under the this title for critical access hospitals (as defined in section 1861(mm)(1)); and (C) conduct a study, and

submit to Congress and the Secretary a report by not later than June 1, 2007, on the advisability and feasibility of including renal dialysis facilities described in subsection (a)(3)(A) of section 1860E–5 in the value-based purchasing program under such section 1860E–5 or establishing a value-based purchasing program under this title for such facilities; (D) taking into account the results to date of the demonstration of bundled case-mix adjusted payment system for ESRD services under section 623(e) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, conduct a study, and submit to Congress and the Secretary a report by not later than June 1, 2008, on the implementation of the ESRD provider and facility value-based purchasing program under section 1860E–5, including issues for the Secretary to consider in operating the ESRD provider and facility value-based purchasing program and recommendations on such issues; and (E) conduct a study, and submit to Congress and the Secretary a report by not later than June 1, 2007, on the advisability and feasibility of establishing a value-based purchasing program under this title for skilled nursing facilities (as defined in section 1819(a)).

''(2) PROGRAM TO BEGIN IN 2009.—The Secretary shall establish the program under this section so that value-based payments described in subsection (b) are made with respect to 2009 and each subsequent year.

''(3) DEFINITION OF PHYSICIAN AND PRACTITIONER.—In this section:

''(A) PHYSICIAN.—The term 'physician' has the meaning given that term in section 1861(r).

''(B) PRACTITIONER.—The term 'practitioner' means—

''(i) a practitioner described in section 1842(b)(18)(C);

''(ii) a physical therapist (as described in section 1861(p));

''(iii) an occupational therapist (as so described); and

''(iv) a qualified speech-language pathologist (as defined in section 1861(ll)(3)(A)).

''(4) IDENTIFICATION OF PHYSICIANS AND PRACTITIONERS.—For purposes of applying this section and paragraphs (4)(G) and (6) of section 1848(d), the Secretary shall establish procedures for

the identification of physicians and practitioners, such as through physician or practitioner billing units or other units, provider identification numbers, taxpayer identification numbers, the National Provider Identifier, and unique physician identifier numbers.

''(b) VALUE-BASED PAYMENTS.—

''(1) IN GENERAL.—Subject to paragraph (4), the Secretary shall make a value-based payment to a physician or a practitioner with respect to a year if the Secretary determines that both the quality of the care and the efficiency of the care provided in that year by the physician or practitioner to individuals enrolled under part B—

''(A) has substantially improved (as determined by the Secretary) over the prior year; or

''(B) exceeds a threshold established by the Secretary.

''(2) USE OF SYSTEMS AND DATA.—

''(A) IN GENERAL.—In determining which physicians and practitioners qualify for a value-based payment under paragraph (1), the Secretary shall use—

''(i) the quality measurement system developed for this section pursuant to sec-

tion 1860E–1(a) with respect to the quality of the care provided by the physician or practitioner; and

''(ii) the comparative utilization system developed under subsection (e) with respect to the efficiency and appropriateness of such care.

''(3) DETERMINATION OF AMOUNT OF AWARD AND ALLOCATION OF AWARDS.—

''(A) IN GENERAL.—The Secretary shall determine—

''(i) the amount of a value-based payment under paragraph (1) provided to a physician or a practitioner; and

''(ii) subject to subparagraph (B), the allocation of the total amount available under subsection (e) for value-based payments for any year between payments with respect to physicians and practitioners that meet the requirement under subparagraph (A) of paragraph (1) and physicians and practitioners that meet the requirement under subparagraph (B) of such paragraph.

''(B) REQUIREMENTS REGARDING THE AMOUNT OF FUNDING AVAILABLE FOR VALUE-BASED PAYMENTS FOR PHYSICIANS AND PRACTITIONERS EXCEEDING A THRESHOLD.—The Secretary shall ensure that—

''(i) a majority of the total amount available under subsection (e) for value-based payments for any year is provided to physicians and practitioners that are receiving such payments because they meet the requirement under paragraph (1)(B); and

''(ii) with respect to 2010 and each subsequent year, the percentage of the total amount available under subsection (e) for value-based payments for any year that is used to make payments to physicians and practitioners that meet such requirement is greater than such percentage in the previous year.

''(4) REQUIREMENTS.—

''(A) REQUIRED SUBMISSION OF DATA.—In order for a physician or a practitioner to be eligible for a value-based payment for a year, the physician or practitioner must have com-

plied with the requirements under section 1848(d)(6)(B)(ii) with respect to that year.

''(B) ATTESTATION REGARDING DATA.—In order for a physician or a practitioner to be eligible for a value-based payment for a year, the physician or practitioner must have provided the Secretary (under procedures established by the Secretary) with an attestation that the data submitted under section 1848(d)(6)(B)(ii) with respect to that year is complete and accurate.

''(5) TOTAL AMOUNT OF VALUE-BASED PAYMENTS EQUAL TO TOTAL AMOUNT OF AVAILABLE FUNDING.—The Secretary shall establish payment amounts under paragraph (3)(A) so that, as estimated by the Secretary, the total amount of value-based payments made in a year under paragraph (1) is equal to the total amount available under subsection (e) for such payments for the year.

''(6) PAYMENT METHODS AND TIMING OF PAYMENTS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the payment of value-based payments under paragraph (1) shall be based on such a method as the Secretary determines appropriate.

''(B) TIMING.—The Secretary shall ensure that value-based payments under paragraph (1) with respect to a year are made by not later than December 31 of the subsequent year.

''(c) COMPARATIVE UTILIZATION SYSTEM.—

''(1) DEVELOPMENT.—The Secretary, in consultation with relevant stakeholders, shall develop a comparative utilization system for purposes of providing value-based payments under subsection (b).

''(2) MEASURES OF EFFICIENCY AND APPROPRIATENESS OF CARE.—The comparative utilization system developed under paragraph (1) shall measure the efficiency and appropriateness of the care provided by a physician or practitioner.

''(3) REQUIREMENTS FOR SYSTEM.—Under the comparative utilization system described in paragraph (1), the Secretary shall do the following:

''(A) MEASURES.—The Secretary shall select measures of efficiency appropriateness to be used by the Secretary under the system. The Secretary may vary the measures selected under the preceding sentence by the type or specialty of the physician or practitioner. If the Secretary varies the measures for providers under the preceding sentence, the Secretary shall ensure that

such measures are aligned to promote coordinated quality of care across provider settings.

''(B) USE OF CLAIMS DATA FOR UTILIZATION PATTERNS.—

''(i) REVIEW OF CLAIMS DATA.—The Secretary shall review claims data with respect to services furnished or ordered by physicians and practitioners.

''(ii) USE OF MOST RECENT CLAIMS DATA.—The Secretary shall use the most recent claims data with respect to the physician or practitioner that is available to the Secretary.

''(C) RISK ADJUSTMENT.—The Secretary shall establish procedures, as appropriate, to control for differences in beneficiary health status and beneficiary characteristics.

''(4) ANNUAL REPORTS.—Beginning in 2007, the Secretary shall provide physicians and practitioners with annual reports on the utilization of items and services under this title based upon the review of claims data under paragraph (3)(B). With respect to reports provided in 2007 and 2008, such reports are confidential and the Secretary shall not make such reports available to the public.

"(d) DESCRIPTION OF HOW PHYSICIANS AND PRACTITIONERS WOULD HAVE FARED UNDER PROGRAM.—NOT LATER THAN MARCH 1, 2009, THE SECRETARY SHALL PROVIDE EACH PHYSICIAN AND PRACTITIONER WITH A DESCRIPTION OF THE SECRETARY'S ESTIMATE OF HOW PAYMENTS TO THE PHYSICIAN OR PRACTITIONER UNDER THIS TITLE WOULD HAVE BEEN AFFECTED WITH RESPECT TO ITEMS AND SERVICES FURNISHED DURING A PERIOD, AS DETERMINED BY THE SECRETARY, IF THE PROGRAM UNDER THIS SECTION (AND THE AMENDMENTS MADE BY PARAGRAPHS (1) AND (2) OF SECTION 6110(C) OF THE DEFICIT REDUCTION OMNIBUS RECONCILIATION ACT OF 2005) HAD BEEN IN EFFECT WITH RESPECT TO THAT PERIOD.

"(e) FUNDING.—

"(1) AMOUNT.—The amount available for value-based payments under this section with respect to a year shall be equal to the amount of the reduction in expenditures under the Federal Supplementary Medical Insurance Trust Fund under section 1841 in the year as a result of the amendments made by section 6110(c)(2) of the Deficit Reduction Omnibus Reconciliation Act of 2005, as estimated by the Secretary.

''(2) PAYMENTS FROM TRUST FUND.—Payments to physicians and practitioners under this section shall be made from the Federal Supplementary Medical Insurance Trust Fund.

''PLAN VALUE-BASED PURCHASING PROGRAM

''SEC. 1860E–4. (a) PROGRAM.—

''(1) IN GENERAL.—The Secretary shall establish a program under which value-based payments are provided each year to Medicare Advantage organizations offering Medicare Advantage plans under part C that demonstrate the provision of high quality health care to enrollees under the plan.

''(2) PROGRAM TO BEGIN IN 2009.—The Secretary shall establish the program under this section so that value-based payments under subsection (b) are made with respect to 2009 and each subsequent year.

''(3) DEFINITIONS OF MEDICARE ADVANTAGE ORGANIZATION AND PLAN.—

''(A) IN GENERAL.—In this section:

''(i) MEDICARE ADVANTAGE ORGANIZATION.—The term 'Medicare Advantage organization' has the meaning given such term in section 1859(a)(1).

''(ii) MEDICARE ADVANTAGE PLAN.—The term 'Medicare Advantage plan' has

the meaning given such term in section 1859(b)(1).

''(B) APPLICABILITY OF PROGRAM TO MEDICARE ADVANTAGE REGIONAL AND LOCAL PLANS.—For purposes of this section, the term 'Medicare Advantage plan' shall include both Medicare Advantage regional plans (as defined in section 1859(b)(4)) and Medicare Advantage local plans (as defined in section 1859(b)(5)).

''(C) APPLICABILITY OF PROGRAM TO REASONABLE COST CONTRACTS.—Except for paragraphs (5) and (6) of subsection (b), for purposes of this section, the terms—

''(i) 'Medicare Advantage organization' and 'organization' include an organization that is providing benefits under a reasonable cost reimbursement contract under section 1876(h); and

''(ii) 'Medicare Advantage plan' and 'plan' include such a contract.

''(b) VALUE-BASED PAYMENTS.—

''(1) IN GENERAL.—Subject to paragraph (4), the Secretary shall make value-based payments to Medicare Advantage organizations with respect to each Medicare Advantage plan offered by the organi-

zation during a year if the Secretary determines that the quality of the care provided under the plan—

"(A) has substantially improved (as determined by the Secretary) over the prior year; or

"(B) exceeds a threshold established by the Secretary.

"(2) USE OF SYSTEM.—In determining which organizations offering Medicare Advantage plans qualify for a value-based payment under paragraph (1), the Secretary shall—

"(A) use the quality measurement system developed for this section pursuant to section 1860E–1(a); and

"(B) ensure that awards are based on data from a full 12-month period (or 24-month period in the case of an award described in paragraph (1)(A)), such periods determined without regard to calendar year periods.

"(3) DETERMINATION OF AMOUNT OF AWARD AND ALLOCATION OF AWARDS.—

"(A) IN GENERAL.—The Secretary shall determine—

"(i) the amount of a value-based payment under paragraph (1) provided to an organization with respect to a plan; and

"(ii) subject to subparagraph (B), the allocation of the total amount available under subsection (d) for value-based payments for any year between payments with respect to plans that meet the requirement under subparagraph (A) of paragraph (1) and plans that meet the requirement under subparagraph (B) of such paragraph.

"(B) REQUIREMENT REGARDING THE AMOUNT OF FUNDING AVAILABLE FOR VALUE-BASED PAYMENTS FOR PLANS EXCEEDING A THRESHOLD.—The Secretary shall ensure that—

"(i) a majority of the total amount available under subsection (d) for value-based payments for any year is provided to organizations, with respect to plans offered by such organizations, that are receiving such payments because they meet the requirement under paragraph (1)(B); and

"(ii) with respect to 2010 and each subsequent year, the percentage of the total amount available under subsection (d) for value-based payments for any year that is used to make payments to organizations,

with respect to plans offered by such organizations, that meet such requirement is greater than such percentage in the previous year.

''(4) USE OF PAYMENTS.—Value-based payments received under this section may only be used for the following purposes:

''(A) To invest in quality improvement programs operated by the organization with respect to the plan.

''(B) To enhance beneficiary benefits under the plan.

''(5) REQUIRED SUBMISSION OF DATA.—In order for an organization to be eligible for a value-based payment for a year with respect to a Medicare Advantage plan or a reasonable cost contract, the organization must have provided for the collection, analysis, and reporting of data pursuant to sections 1852(e)(3) (or submitted the data under section 1876(h)(6) in the case of a reasonable cost contract) with respect to the plan or contract for the 2 years preceding that year.

''(6) NO EFFECT ON MEDICARE ADVANTAGE PLAN BIDS.—In order for a Medicare Advantage organization to be eligible for a value-based payment

for a year with respect to a Medicare Advantage plan, the organization must have provided the Secretary with an attestation that the program under this section, including the payment adjustments made by reason of the amendments made by section 6110(d)(2)(A) of the Deficit Reduction Omnibus Reconciliation Act of 2005, had no effect on the integrity and actuarial soundness of the bid submitted under section 1854 for the plan for the year.

''(7) TOTAL AMOUNT OF VALUE-BASED PAYMENTS EQUAL TO TOTAL AMOUNT OF REDUCTION IN PAYMENTS.—The Secretary shall establish payment amounts under paragraph (3)(A) so that, as estimated by the Secretary, the total amount of value-based payments made in a year under paragraph (1) is equal to the total amount available under subsection (d) for such payments for the year.

''(8) PAYMENT METHODS AND TIMING OF PAYMENTS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the payment of value-based payments under paragraph (1) shall be based on such a method as the Secretary determines appropriate.

"(B) TIMING.—The Secretary shall ensure that value-based payments under paragraph (1) with respect to a year are made by not later than March 1 of the subsequent year.

"(c) DESCRIPTION OF HOW PLANS WOULD HAVE FARED UNDER PROGRAM.—NOT LATER THAN MARCH 1, 2009, THE SECRETARY SHALL PROVIDE EACH MEDICARE ADVANTAGE ORGANIZATION OFFERING A MEDICARE ADVANTAGE PLAN WITH A DESCRIPTION OF THE SECRETARY'S ESTIMATE OF HOW PAYMENTS UNDER THIS TITLE TO SUCH ORGANIZATION WITH RESPECT TO THE PLAN FOR A PERIOD, AS DETERMINED BY THE SECRETARY, WOULD HAVE BEEN AFFECTED IF THE PROGRAM UNDER THIS SECTION (AND THE AMENDMENTS MADE BY SECTION 6110(D) OF THE DEFICIT REDUCTION OMNIBUS RECONCILIATION ACT OF 2005) HAD BEEN IN EFFECT WITH RESPECT TO THAT PERIOD.

"(d) FUNDING.—

"(1) AMOUNT.—The amount available for value-based payments under this section with respect to a year shall be equal to the amount of the reduction in expenditures under the Federal Hospital Insurance Trust Fund under section 1817 and the Federal Supplementary Medical Insurance Trust Fund under section 1841 in the year as a result of

the amendments made by section 6110(d)(2) of the Deficit Reduction Omnibus Reconciliation Act of 2005, as estimated by the Secretary.

''(2) PAYMENTS FROM TRUST FUNDS.—Payments to organizations under this section shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in the same proportion as payments to Medicare Advantage organizations are made from such Trust Funds under the first sentence of section 1853(f).

''ESRD PROVIDER AND FACILITY VALUE-BASED PURCHASING PROGRAM

''SEC. 1860E–5. (a) PROGRAM.—

''(1) IN GENERAL.—The Secretary shall establish a program under which value-based payments are provided each year to providers of services and renal dialysis facilities that—

''(A) provide items and services to individuals with end stage renal disease who are enrolled under part B; and

''(B) demonstrate the provision of high quality health care to such individuals.

''(2) PROGRAM TO BEGIN IN 2007.—The Secretary shall establish the program under this section so that value-based payments described in subsection

(b) are made with respect to 2007 and each subsequent year.

''(3) EXCLUSIONS FROM PROGRAM.—

''(A) PEDIATRIC FACILITIES.—Any renal dialysis facility at least 50 percent of whose patients are individuals under 18 years of age shall not be included in the program under this section.

''(B) PROVIDERS AND FACILITIES CURRENTLY PARTICIPATING IN BUNDLED CASE-MIX DEMONSTRATION NOT INCLUDED IN PROGRAM.—Any provider of services or renal dialysis facility that is currently participating in the bundled case-mix adjusted payment system for ESRD services demonstration project under section 623(e) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) shall not be included in the program under this section, but only for so long as the provider or facility is so participating.

''(b) VALUE-BASED PAYMENTS.—

''(1) IN GENERAL.—Subject to paragraph (4), the Secretary shall make a value-based payment to a provider of services or a renal dialysis facility with

respect to a year if the Secretary determines that the quality of the care provided in that year by the provider or facility to individuals with end stage renal disease who are enrolled under part B—

"(A) has substantially improved (as determined by the Secretary) over the prior year; or

"(B) exceeds a threshold established by the Secretary.

"(2) USE OF SYSTEM.—In determining which providers of services and renal dialysis facilities qualify for a value-based payment under paragraph (1), the Secretary shall use the quality measurement system developed for this section pursuant to section 1860E–1(a).

"(3) DETERMINATION OF AMOUNT OF AWARD AND ALLOCATION OF AWARDS.—

"(A) IN GENERAL.—The Secretary shall determine—

"(i) the amount of a value-based payment under paragraph (1) provided to a provider of services or a renal dialysis facility; and

"(ii) subject to subparagraphs (B) and (C), the allocation of the total amount available under subsection (c) for value-

based payments for any year between payments with respect to providers and facilities that meet the requirement under subparagraph (A) of paragraph (1) and providers and facilities that meet the requirement under subparagraph (B) of such paragraph.

''(B) REQUIREMENT REGARDING AMOUNT OF FUNDING AVAILABLE FOR VALUE-BASED PAYMENTS FOR PROVIDERS AND FACILITIES EXCEEDING A THRESHOLD.—The Secretary shall ensure that—

''(i) a majority of the total amount available under subsection (c) for value-based payments for any year is provided to providers of services and renal dialysis facilities that are receiving such payments because they meet the requirement under paragraph (1)(B); and

''(ii) with respect to 2009 and each subsequent year, the percentage of the total amount available under subsection (c) for value-based payments for any year that is used to make payments to providers and facilities that meet such requirement is

greater than such percentage in the previous year.

''(C) ONLY VALUE-BASED PAYMENTS FOR PROVIDERS AND FACILITIES EXCEEDING A THRESHOLD IN 2007.—With respect to 2007, the entire amount available under subsection (c) for value-based payments for that year shall be used to make payments to providers of services and renal dialysis facilities that meet the requirement under paragraph (1)(B).

''(4) REQUIREMENTS.—

''(A) REQUIRED SUBMISSION OF DATA.—

''(i) IN GENERAL.—In order for a provider of services or a renal dialysis facility to be eligible for a value-based payment for a year, the provider or facility must have provided for the submission of data in accordance with clause (ii) with respect to that year.

''(ii) SUBMISSION OF DATA.—For 2007 and each subsequent year, each provider of services and renal dialysis facility that receives payments under paragraph (12) shall submit to the Secretary such data that the Secretary determines is ap-

propriate for the measurement of health outcomes and other indices of quality, including data necessary for the operation of the program under this section. Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this clause.

''(iii) AVAILABILITY TO THE PUBLIC.—The Secretary shall establish procedures for making data submitted under clause (ii) available to the public in a clear and understandable form. Such procedures shall ensure that a provider or facility has the opportunity to review the data that is to be made public with respect to the provider or facility prior to such data being made public.

''(B) ATTESTATION REGARDING DATA.—In order for a provider of services or a renal dialysis facility to be eligible for a value-based payment for a year, the provider or facility must have provided the Secretary (under procedures established by the Secretary) with an attestation that the data submitted under subpara-

graph (A)(ii) for the year is complete and accurate.

''(5) TOTAL AMOUNT OF VALUE-BASED PAYMENTS EQUAL TO TOTAL AMOUNT OF AVAILABLE FUNDING.—The Secretary shall establish payment amounts under paragraph (3)(A) so that, as estimated by the Secretary, the total amount of value-based payments made in a year under paragraph (1) is equal to the total amount available under subsection (c) for such payments for the year.

''(6) PAYMENT METHODS AND TIMING OF PAYMENTS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the payment of value-based payments under paragraph (1) shall be based on such a method as the Secretary determines appropriate.

''(B) TIMING.—The Secretary shall ensure that value-based payments under paragraph (1) with respect to a year are made by not later than December 31 of the subsequent year.

''(c) FUNDING.—

''(1) AMOUNT.—The amount available for value-based payments under this section with respect to a year shall be equal to the amount of the reduc-

tion in expenditures under the Federal Supplementary Medical Insurance Trust Fund under section 1841 in the year by reason of the application of section 1881(b)(12)(G), as estimated by the Secretary.

''(2) PAYMENTS FROM TRUST FUND.—Payments to providers of services and renal dialysis facilities under this section shall be made from the Federal Supplementary Medical Insurance Trust Fund.

''HOME HEALTH AGENCY VALUE-BASED PURCHASING PROGRAM

''SEC. 1860E–6. (a) PROGRAM.—

''(1) IN GENERAL.—The Secretary shall establish a program under which value-based payments are provided each year to home health agencies that demonstrate the provision of high quality health care to individuals entitled to benefits under part A or enrolled under part B.

''(2) PROGRAM TO BEGIN IN 2008.—The Secretary shall establish the program under this section so that value-based payments described in subsection (b) are made with respect to 2008 and each subsequent year.

''(3) HOME HEALTH AGENCY DEFINED.—In this section, the term ''home health agency'' has the meaning given that term in section 1861(o).

''(b) VALUE-BASED PAYMENTS.—

''(1) IN GENERAL.—Subject to paragraph (4), the Secretary shall make a value-based payment to a home health agency with respect to a year if the Secretary determines that the quality of the care provided in that year by the agency to individuals entitled to benefits under part A or enrolled under part B—

''(A) has substantially improved (as determined by the Secretary) over the prior year; or

''(B) exceeds a threshold established by the Secretary.

''(2) USE OF SYSTEM.—In determining which home health agencies qualify for a value-based payment under paragraph (1), the Secretary shall use the quality measurement system developed for this section pursuant to section 1860E–1(a).

''(3) DETERMINATION OF AMOUNT OF AWARD AND ALLOCATION OF AWARDS.—

''(A) IN GENERAL.—The Secretary shall determine—

''(i) the amount of a value-based payment under paragraph (1) provided to a home health agency; and

''(ii) subject to subparagraph (B), the allocation of the total amount available under subsection (d) for value-based payments for any year between payments with respect to agencies that meet the requirement under subparagraph (A) of paragraph (1) and agencies that meet the requirement under subparagraph (B) of such paragraph.

''(B) REQUIREMENTS REGARDING THE AMOUNT OF FUNDING AVAILABLE FOR VALUE-BASED PAYMENTS FOR AGENCIES EXCEEDING A THRESHOLD.—The Secretary shall ensure that—

''(i) a majority of the total amount available under subsection (d) for value-based payments for any year is provided to home health agencies that are receiving such payments because they meet the requirement under paragraph (1)(B); and

''(ii) with respect to 2009 and each subsequent year, the percentage of the

total amount available under subsection (d) for value-based payments for any year that is used to make payments to agencies that meet such requirement is greater than such percentage in the previous year.

''(4) REQUIREMENTS.—

''(A) REQUIRED SUBMISSION OF DATA.—In order for a home health agency to be eligible for a value-based payment for a year, the agency must have complied with the requirements under section 1895(b)(3)(B)(v)(II) with respect to that year.

''(B) ATTESTATION REGARDING DATA.—In order for a home health agency to be eligible for a value-based payment for a year, the agency must have provided the Secretary (under procedures established by the Secretary) with an attestation that the data submitted under section 1895(b)(3)(B)(v)(II) with respect to that year is complete and accurate.

''(5) TOTAL AMOUNT OF VALUE-BASED PAYMENTS EQUAL TO TOTAL AMOUNT OF AVAILABLE FUNDING.—The Secretary shall establish payment amounts under paragraph (3)(A) so that, as estimated by the Secretary, the total amount of value-

based payments made in a year under paragraph (1) is equal to the total amount available under subsection (d) for such payments for the year.

''(6) PAYMENT METHODS AND TIMING OF PAYMENTS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the payment of value-based payments under paragraph (1) shall be based on such a method as the Secretary determines appropriate.

''(B) TIMING.—The Secretary shall ensure that value-based payments under paragraph (1) with respect to a year are made by not later than December 31 of the subsequent year.

''(c) DESCRIPTION OF HOW AGENCIES WOULD HAVE FARED UNDER PROGRAM.—NOT LATER THAN JANUARY 1, 2008, THE SECRETARY SHALL PROVIDE EACH HOME HEALTH AGENCY WITH A DESCRIPTION OF THE SECRETARY'S ESTIMATE OF HOW PAYMENTS TO THE AGENCY UNDER THIS TITLE WOULD HAVE BEEN AFFECTED WITH RESPECT TO ITEMS AND SERVICES FURNISHED DURING A PERIOD, AS DETERMINED BY THE SECRETARY, IF THE PROGRAM UNDER THIS SECTION (AND THE AMENDMENTS MADE BY SECTION 6110(F) OF THE DEFICIT REDUCTION

OMNIBUS RECONCILIATION ACT OF 2005) HAD BEEN IN EFFECT WITH RESPECT TO THAT PERIOD.

''(d) FUNDING.—

''(1) AMOUNT.—The amount available for value-based payments under this section with respect to a year shall be equal to the amount of the reduction in expenditures under the Federal Hospital Insurance Trust Fund under section 1817 and Federal Supplementary Medical Insurance Trust Fund under section 1841 in the year as a result of the application of section 1895(b)(3)(D), as estimated by the Secretary.

''(2) PAYMENTS FROM TRUST FUND.—Payments to home health agencies under this section shall be made from the Federal Hospital Insurance Trust Fund and Federal Supplementary Medical Insurance Trust Fund, in the same proportion as payments for home health services are made from such trust funds.''.

(b) HOSPITALS.—

(1) VOLUNTARY SUBMISSION OF HOSPITAL QUALITY DATA.—

(A) UPDATE FOR HOSPITALS THAT SUBMIT QUALITY DATA.—Section 1886(b)(3)(B) (42 U.S.C. 1395ww(b)(3)(B)) is amended—

(i) in clause (vii)—

(I) in subclause (I), by striking ''for each of fiscal years 2005 through 2007'' and inserting ''for fiscal years 2005 and 2006''; and

(II) in subclause (II), by striking ''Each'' and inserting ''For fiscal years 2005 and 2006, each''; and

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

''(viii)(I) For purposes of clause (i)(XX), for fiscal year 2007 and each subsequent fiscal year, in the case of a subsection (d) hospital that does not submit data in accordance with subclause (II) with respect to such a fiscal year, the applicable percentage increase under such clause for such fiscal year shall be reduced by 2 percentage points. Such reduction shall apply only with respect to the fiscal year involved, and the Secretary shall not take into account such reduction in computing the applicable percentage increase under clause (i)(XX) for a subsequent fiscal year.

''(II) For fiscal year 2007 and each subsequent fiscal year, each subsection (d) hospital shall submit to the Secretary such data that the Secretary determines is appropriate for the measurement of health care quality, including data necessary for the operation of the PPS hospital value-based purchasing program under section 1860E–2. Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this clause.

''(III) The Secretary shall establish procedures for making data submitted under subclause (II) available to the public in a clear and understandable form. Such procedures shall ensure that a subsection (d) hospital has the opportunity to review the data that is to be made public with respect to the hospital prior to such data being made public.''.

(B) CONFORMING AMENDMENTS.—Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

(i) in subclause (XIX), by striking ''2007'' and inserting ''2006''; and

(ii) in subclause (XX)—

(I) by striking ''2008'' and inserting ''2007''; and

(II) by inserting ''subject to clause (viii),'' after ''fiscal year,''.

(2) REDUCTION IN PAYMENTS IN ORDER TO FUND PROGRAM.—

(A) REDUCTION IN PAYMENTS.—Section 1886(d)(5)(A) (42 U.S.C. 1395ww(d)(5)(A)) is amended—

(i) in clause (iv), by striking ''5 percent nor more than 6 percent'' and inserting ''the applicable lower percent nor more than the applicable upper percent''; and

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

''(vii) For purposes of clause (iv)—

''(I) for fiscal years prior to 2007, the 'lower percent' is 5.0 percent and the 'upper percent' is 6.0 percent;

''(II) for fiscal year 2007, the 'lower percent' is 4.0 percent and the 'upper percent' is 5.0 percent;

''(III) for fiscal year 2008, the 'lower percent' is 3.75 percent and the 'upper percent' is 4.75 percent;

''(IV) for fiscal year 2009, the 'lower percent' is 3.5 percent and the 'upper percent' is 4.5 percent;

''(V) for fiscal year 2010, the 'lower percent' is 3.25 percent and the 'upper percent' is 4.25 percent; and

''(VI) for fiscal year 2011 and each subsequent fiscal year, the 'lower percent' is 3.0 percent and the 'upper percent' is 4.0 percent.''.

(B) CONTINUATION OF CURRENT LEVEL OF REDUCTIONS TO THE AVERAGE STANDARDIZED AMOUNT.—Section 1886(d)(3)(B) (42 U.S.C. 1395ww(d)(3)(B)) is amended to read as follows:

''(B) REDUCING FOR VALUE OF OUTLIER PAYMENTS AND FOR FUNDING OF HOSPITAL VALUE-BASED PURCHASING PROGRAM.—

''(i) IN GENERAL.—The Secretary shall reduce each of the average standardized amounts determined under subparagraph (A) by a factor equal to a fraction—

''(I) the numerator of which is the sum of—

''(aa) the additional payments described in paragraph (5)(A) (relating to outlier payments); and

''(bb) the applicable percent of the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year; and

''(II) the denominator of which is the total payments projected or estimated to be made based on DRG prospective payment rates for discharges in that year.

''(ii) APPLICABLE PERCENT.—For purposes of clause (i)(I)(bb), the term 'applicable percent' means—

''(I) for fiscal years prior to fiscal year 2007, 0 percent;

''(II) for fiscal year 2007, 1.0 percent;

''(III) for fiscal year 2008, 1.25 percent;

''(IV) for fiscal year 2009, 1.5 percent;

''(V) for fiscal year 2010, 1.75 percent; and

''(VI) for fiscal year 2011 and each subsequent year, 2.0 percent.''.

(3) VALUE-BASED PURCHASING DEMONSTRATION PROGRAM FOR CRITICAL ACCESS HOSPITALS.—

(A) ESTABLISHMENT.—Not later than 6 months after the date of enactment of this Act, the Secretary shall establish a 2-year demonstration program under which the Secretary establishes a value-based purchasing program under the medicare program under title XVIII of the Social Security Act for critical access hospitals (as defined in section 1861(mm)(1) of such Act (42 U.S.C. 1395x(mm)(1)) in order to test innovative methods of measuring and rewarding quality health care furnished by such hospitals.

(B) SITES.—The Secretary shall conduct the demonstration program at 6 critical access hospitals. The Secretary shall ensure that such hospitals are representative of the spectrum of such hospitals that participate in the medicare program.

(C) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and

XVIII of the Social Security Act as may be necessary to carry out the demonstration program.

(D) FUNDING.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) of such funds as are necessary for the costs of carrying out the demonstration program.

(E) REPORT.—Not later than 6 months after the demonstration program is completed, the Secretary shall submit to Congress a report on the demonstration program together with recommendations on the establishment of a permanent value-based purchasing program under the medicare program for critical access hospitals and recommendations for such other legislation or administrative action as the Secretary determines appropriate.

(c) PHYSICIANS AND PRACTITIONERS.—

(1) VOLUNTARY SUBMISSION OF PHYSICIAN AND PRACTITIONER QUALITY DATA.—

(A) UPDATE FOR PHYSICIANS AND PRACTITIONERS THAT SUBMIT QUALITY DATA.—Section 1848(d)(4) (42 U.S.C. 1395w–4(d)(4)) is

amended by adding at the end the following new subparagraph:

"(G) ADJUSTMENT IF QUALITY DATA NOT SUBMITTED.—

"(i) ADJUSTMENT.—For 2007 and each subsequent year, in the case of services furnished by a physician or a practitioner (as defined in section 1860E–3(a)(3)) that does not submit data in accordance with clause (ii) with respect to such a year, the update otherwise determined under subparagraph (A) shall be reduced by 2 percentage points. Such reduction shall apply only with respect to the year involved, and the Secretary shall not take into account such reduction in computing the conversion factor for a subsequent year.

"(ii) SUBMISSION OF QUALITY DATA.—For 2007 and each subsequent year, each physician and practitioner (as defined in section 1860E–3(a)(3)) shall submit to the Secretary such data that the Secretary determines is appropriate for the measurement of health outcomes and other

indices of quality, including data necessary for the operation of the physician and practitioner value-based purchasing program under section 1860E–3. Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

''(iii) AVAILABLE TO THE PUBLIC.—

''(I) IN GENERAL.—Subject to subclauses (II) and (III), the Secretary shall establish procedures for making data submitted under clause (ii), with respect to items and services furnished on or after January 1, 2008, available to the public in 3 phases as follows:

''(aa) PHASE I.—During phase I, the Secretary shall make available to the public the identity of physicians and practitioners that are submitting such data.

''(bb) PHASE II.—During phase II, the Secretary shall make available to the public the

identity of physicians and practitioners that are receiving a value-based payment under section 1860E–3.

''(cc) PHASE III.—During phase III, the Secretary shall make data submitted under clause (ii) available to the public in a clear and understandable form.

''(II) REVIEW.—The procedures established under subclause (I) shall ensure that a physician or practitioner has the opportunity to review the data that is to be made public with respect to the physician or practitioner under subclause (I)(cc) prior to such data being made public.

''(III) EXCEPTIONS.—The Secretary shall establish exceptions to the requirement for making data available to the public under subclause (I). In providing for such exceptions, the Secretary shall take into account the size

and specialty representation of the practice involved.''.

(B) CONFORMING AMENDMENT.—Section 1848(d)(4)(A) (42 U.S.C. 1395w–4(d)(4)(A)) is amended, in the matter preceding clause (i), by striking ''subparagraph (F)'' and inserting ''subparagraphs (F) and (G)''.

(2) REDUCTION IN CONVERSION FACTOR FOR PHYSICIANS AND PRACTITIONERS THAT SUBMIT QUALITY DATA IN ORDER TO FUND PROGRAM.—

(A) IN GENERAL.—Section 1848(d) (42 U.S.C. 1395w–4(d)) is amended by adding at the end the following new paragraph:

''(6) REDUCTION IN CONVERSION FACTOR FOR PHYSICIANS AND PRACTITIONERS IN ORDER TO FUND VALUE-BASED PURCHASING PROGRAM.—

''(A) IN GENERAL.—For 2009 and each subsequent year, the single conversion factor otherwise applicable under this subsection to services furnished in the year by a physician or a practitioner (as defined in section 1860E–3(a)(3)) that complies with the requirements under paragraph (4)(G)(ii) for the year (determined after application of the update under

paragraph (4)) shall be reduced by the applicable percent.

''(B) APPLICABLE PERCENT.—For purposes of subparagraph (A), the term 'applicable percent' means—

''(i) for 2009, 1.0 percent;

''(ii) for 2010, 1.25 percent;

''(iii) for 2011, 1.5 percent;

''(iv) for 2012, 1.75 percent; and

''(v) for 2013 and each subsequent year, 2.0 percent.''.

(B) CONFORMING AMENDMENT.—Section 1848(d)(1)(A) (42 U.S.C. 1395w–4(d)(1)(A)) is amended by striking ''The conversion factor'' and inserting ''Subject to paragraph (6), the conversion factor''.

(d) PLANS.—

(1) SUBMISSION OF QUALITY DATA.—

(A) MEDICARE ADVANTAGE ORGANIZATIONS.—Section 1852(e) (42 U.S.C. 1395w–22(e)), as amended by section 722 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2347), is amended—

(i) in paragraph (1), by striking ''an MA private fee-for-service plan or''; and

(ii) in paragraph (3)—

(I) in subparagraph (A)—

(aa) in clause (i), by adding at the end the following new sentence: ''Such data shall include data necessary for the operation of the plan value-based purchasing program under section 1860E–4.'';

(bb) by redesignating clause (iv) as clause (vi); and

(cc) by inserting after clause (iii) the following new clauses:

''(iv) APPLICATION TO MA PRIVATE FEE-FOR-SERVICE PLANS.—The Secretary shall establish as appropriate by regulation requirements for the collection, analysis, and reporting of data that permits the measurement of health outcomes and other indices of quality for MA organizations with respect to MA private fee-for-service plans.''.

''(v) AVAILABILITY TO THE PUBLIC.—The Secretary shall establish procedures for making data reported under this subparagraph available to the public in a clear and understandable form. Such procedures shall ensure that an MA organization has the opportunity to review the data that is to be made public with respect to the plan offered by the organization prior to such data being made public.''; and

(II) in subparagraph (B)—

(aa) in clause (i), by striking ''The'' and inserting ''Subject to clause (ii), the''; and

(bb) by striking clause (ii) and inserting the following new clause:

''(ii) CHANGES IN TYPES OF DATA.—Subject to clause (iii), the Secretary may only change the types of data that are required to be submitted under subparagraph (A) after submitting to Congress a report on the reasons for such changes that was prepared—

"(I) in the case of data necessary for the operation of the plan value-based purchasing program under section 1860E–4, after the requirements under subsections (c) and (d) of section 1860E–1 have been complied with; and

"(II) in the case of any other data, in consultation with MA organizations and private accrediting bodies.".

(B) ELIGIBLE ENTITIES WITH REASONABLE COST CONTRACTS.—Section 1876(h) (42 U.S.C. 1395mm(h)) is amended by adding at the end the following new paragraph:

"(6)(A) With respect to plan years beginning on or after January 1, 2006, an eligible entity with a reasonable cost reimbursement contract under this subsection shall submit to the Secretary such data that the Secretary determines is appropriate for the measurement of health outcomes and other indices of quality, including data necessary for the operation of the plan value-based purchasing program under section 1860E–4. Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this subparagraph.

''(B) The Secretary shall establish procedures for making data reported under subparagraph (A) available to the public in a clear and understandable form. Such procedures shall ensure that an eligible entity has the opportunity to review the data that is to be made public with respect to the contract prior to such data being made public.''.

(C) EFFECTIVE DATE.—The amendments made by this subsection shall apply to plan years beginning on or after January 1, 2006.

(D) SENSE OF THE SENATE.—It is the sense of the Senate that, in establishing the timeframes for Medicare Advantage organizations and entities with a reasonable cost reimbursement contract under section 1876(h) of the Social Security Act (42 U.S.C. 1395mm(h)) to report quality data under sections 1852(e)(3) and 1876(h)(6), respectively, of such Act, as added by this section, the Secretary should take into account other timeframes for reporting quality data that such organizations and entities are subject to under other Federal and State programs and in the commercial market.

(2) REDUCTION IN PAYMENTS TO ORGANIZATIONS IN ORDER TO FUND PROGRAM.—

(A) MEDICARE ADVANTAGE PAYMENTS.—

(i) IN GENERAL.—Section 1853(a)(1) (42 U.S.C. 1395w–23(a)(1)), as amended by section 222(e) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2200), is amended—

(I) in clauses (i) and (ii) of subparagraph (B), by inserting ''and, for 2009 and each subsequent year, except in the case of an MSA plan or an MA plan for which there was no contract under section 1857 during either of the preceding 2 years, reduced by the applicable percent (as defined in subparagraph (I))'' after ''(G)''; and

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

''(I) APPLICABLE PERCENT.—For purposes of clauses (i) and (ii) of subparagraph (B), the term 'applicable percent' means—

''(i) for 2009, 1.0 percent;

''(ii) for 2010, 1.25 percent;

''(iii) for 2011, 1.5 percent;

''(iv) for 2012, 1.75 percent; and

"(v) for 2013 and each subsequent year, 2.0 percent.".

(iii) REDUCTIONS IN PAYMENTS DO NOT AFFECT THE REBATE FOR BIDS BELOW THE BENCHMARK.—The amendments made by subparagraph (A) shall not be construed to have any effect on—

(I) the determination of whether a Medicare Advantage plan has average per capita monthly savings described in paragraph (3)(C) or (4)(C) of section 1854(b) of the Social Security Act (42 U.S.C. 1395w–24(b)); or

(II) the amount of such savings.

(A) REASONABLE COST CONTRACT PAYMENTS.—Section 1876(h) (42 U.S.C. 1395mm(h)), as amended by subsection (a)(2), is amended by adding at the end the following new paragraph:

"(7) Notwithstanding the preceding provisions of this subsection, the Secretary shall reduce each payment to an eligible organization under this subsection with respect to benefits provided on or after January 1, 2009, by an amount equal to the applicable percent (as defined in section 1853(a)(1)(I)) of the payment amount.".

(3) REQUIREMENT FOR REPORTING ON USE OF VALUE-BASED PAYMENTS.—

(A) MA PLANS.—Section 1854(a) (42 U.S.C. 1395w–24(a)), as amended by section 222(a) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2193), is amended—

(i) in paragraph (1)(A)(i), by striking ''or (6)(A)'' and inserting ''(6)(A), or (7)''; and

(ii) by adding at the end the following:

''(7) SUBMISSION OF INFORMATION OF HOW VALUE-BASED PAYMENTS WILL BE USED.—For an MA plan for a plan year beginning on or after January 1, 2011, the information described in this paragraph is a description of how the organization offering the plan will use any value-based payments that the organization received under section 1860E–4 with respect to the plan for the year preceding the year in which such information is submitted.''.

(B) REASONABLE COST CONTRACTS.—Section 1876(h) (42 U.S.C. 1395mm(h)), as

amended by subsection (c)(2), is amended by adding at the end the following new paragraph:

''(8) Not later than July 1 of each year (beginning in 2010), any eligible entity with a reasonable cost reimbursement contract under this subsection that received a value-based payment under section 1860E–4 with respect to the contract for the preceding year shall submit to the Secretary a report containing a description of how the organization will use such payments under the contract.''.

(e) ESRD PROVIDERS AND FACILITIES.—

(1) VOLUNTARY SUBMISSION OF QUALITY DATA.—Section 1881(b) (42 U.S.C. 1395rr(b)) is amended by adding at the end the following new paragraph:

''(14) By not later than July 31, 2006, the Secretary shall establish procedures under which providers of services and renal dialysis facilities that receive payments under paragraph (12) or (13) may submit to the Secretary data that permits the measurement of health outcomes and other indices of quality.''.

(2) REDUCTION IN CASE-MIX ADJUSTED PROSPECTIVE PAYMENT AMOUNT IN ORDER TO FUND PROGRAM.—Section 1881(b)(12) (42 U.S.C. 1395rr(b)(12)) is amended—

(A) by redesignating subparagraph (G) as subparagraph (H); and

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

''(G)(i) In the case of any payment made under this paragraph for an item or service furnished on or after January 1, 2007, such payment shall be reduced by the applicable percent. The preceding sentence shall not apply to a payment for an item or service furnished by a provider of services or a renal dialysis facility that is excluded from the program under section 1860E–5 by reason of subsection (a)(3) of such section at the time the item or service is furnished.

''(ii) For purposes of clause (i), the term 'applicable percent' means—

''(I) for 2007, 1.0 percent;

''(II) for 2008, 1.25 percent;

''(III) for 2009, 1.5 percent;

''(IV) for 2010, 1.75 percent; and

''(V) for 2011 and each subsequent year, 2.0 percent.''.

(3) VALUE-BASED PURCHASING UNDER THE DEMONSTRATION OF BUNDLED CASE-MIX ADJUSTED PAYMENT SYSTEM FOR ESRD SERVICES.—Section

623(e) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395rr note) is amended by adding at the end the following new paragraph:

''(7) VALUE-BASED PURCHASING PROGRAM.—As part of the demonstration project under this subsection, the Secretary shall, beginning January 1, 2007, implement a value-based purchasing program for providers and facilities participating in the demonstration project. The Secretary shall implement such value-based purchasing program in a similar manner as the ESRD provider and facility value-based purchasing program is implemented under section 1860E–5 of the Social Security Act, including the funding of such program.''.

(f) HOME HEALTH AGENCIES.—

(1) UPDATE FOR HOME HEALTH AGENCIES THAT SUBMIT QUALITY DATA.—Section 1895(b)(3)(B) (42 U.S.C.fff(b)(3)(B)) is amended—

(A) in clause (ii)(IV), by inserting ''subject to clause (v),'' after ''subsequent year,''; and

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

''(v) ADJUSTMENT IF QUALITY DATA NOT SUBMITTED.—

''(I) ADJUSTMENT.—For purposes of clause (ii)(IV), for 2007 and each subsequent year, in the case of a home health agency that does not submit data in accordance with subclause (II) with respect to such a year, the home health market basket percentage increase applicable under such clause for such year shall be reduced by 2 percentage points. Such reduction shall apply only with respect to the year involved, and the Secretary shall not take into account such reduction in computing the prospective payment amount under this section for a subsequent year.

''(II) SUBMISSION OF QUALITY DATA.—For 2007 and each subsequent year, each home health agency shall submit to the Secretary such data that the Secretary determines is appropriate for the measurement of health care quality, including data necessary for the operation of the home health agency value-based pur-

chasing program under section 1860E–6. Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this clause.

''(III) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subclause (II) available to the public in a clear and understandable form. Such procedures shall ensure that a home health agency has the opportunity to review the data that is to be made public with respect to the agency prior to such data being made public.''.

(2) REDUCTION IN STANDARD PROSPECTIVE PAYMENT AMOUNT FOR AGENCIES THAT SUBMIT QUALITY DATA IN ORDER TO FUND PROGRAM.—Section 1895(b)(3) (42 U.S.C. 1395fff(b)(3)) is amended by adding at the end the following new subparagraph:

''(D) REDUCTION IN ORDER TO FUND VALUE-BASED PURCHASING PROGRAM.—

''(i) IN GENERAL.—For 2008 and each subsequent year, in the case of a home health agency that complies with the submission requirements under section 1895(b)(3)(B)(v)(II) for the year, the standard prospective payment amount (or amounts) otherwise applicable under this paragraph for the year shall be reduced by the applicable percent.

''(ii) APPLICABLE PERCENT.—For purposes of clause (i), the term 'applicable percent' means—

''(I) for 2008, 1.0 percent;

''(II) for 2009, 1.25 percent;

''(III) for 2010, 1.5 percent;

''(IV) for 2011, 1.75 percent; and

''(V) for 2012 and each subsequent year, 2.0 percent.''.

(g) SKILLED NURSING FACILITIES.—

(1) REQUIREMENT FOR SKILLED NURSING FACILITIES TO REPORT FUNCTIONAL CAPACITY OF MEDICARE RESIDENTS UPON ADMISSION AND DISCHARGE.—Section 1819(b) (42 U.S.C. 1395i–3(b))

is amended by adding at the end the following new paragraph:

''(9) REPORTING FUNCTIONAL CAPACITY AT ADMISSION AND DISCHARGE.—

''(A) IN GENERAL.—On and after October 1, 2006, a skilled nursing facility must submit a report to the Secretary on the functional capacity of each resident who is entitled to benefits under this part at the time of—

''(i) the admission of such resident; and

''(ii) the discharge of such resident.

''(B) TIMEFRAME.—A report required under subparagraph (A) shall be submitted within 10 days of the admission or discharge, as the case may be.''.

(2) VOLUNTARY SUBMISSION OF SKILLED NURSING FACILITY QUALITY DATA.—Section 1888(e)(4)(E) (42 U.S.C. 1395yy(e)(4)(E)) is amended—

(A) in clause (ii)(IV), by inserting ''subject to clause (iii),'' after ''subsequent fiscal year,''; and

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

''(iii) ADJUSTMENT IF QUALITY DATA NOT SUBMITTED.—

''(I) ADJUSTMENT.—For purposes of clause (ii)(IV), for fiscal year 2009 and each subsequent fiscal year, in the case of a skilled nursing facility that does not submit data in accordance with subclause (II) with respect to such a fiscal year, the skilled nursing facility market basket percentage change applicable under such clause for such fiscal year shall be reduced by 2 percentage points. Such reduction shall apply only with respect to the fiscal year involved, and the Secretary shall not take into account such reduction in computing the Federal per diem rate under this section for a subsequent fiscal year.

''(II) SUBMISSION OF QUALITY DATA.—For fiscal year 2008 and each subsequent fiscal year, each skilled nursing facility shall submit to the Secretary such data that the Secretary determines, after conducting a

study in consultation with the entities described in subsections (c)(1), (c)(2), and (d) of section 1860E–1, is appropriate for the measurement of health outcomes and other indices of quality. Such data shall be submitted in a form and manner, and at a time, specified by the Secretary for purposes of this clause.

"(III) PUBLIC AVAILABILITY OF DATA SUBMITTED.—The Secretary shall establish procedures for making data submitted under subclause (II) available to the public in a clear and understandable form. Such procedures shall ensure that a facility has the opportunity to review the data that is to be made public with respect to the facility prior to such data being made public.".

(h) CONFORMING REFERENCES TO PREVIOUS PART E.—Any reference in law (in effect before the date of the enactment of this Act) to part E of title XVIII of the Social Security Act is deemed a reference to part F of such title (as in effect after such date).

SEC. 6111. PHASE-OUT OF RISK ADJUSTMENT BUDGET NEUTRALITY IN DETERMINING THE AMOUNT OF PAYMENTS TO MEDICARE ADVANTAGE ORGANIZATIONS.

(a) IN GENERAL.—Section 1853 (42 U.S.C. 1395w–23) is amended—

(1) in subsection (j)(1)—

(A) in subparagraph (A)—

(i) by inserting ''(or, beginning with 2007, 1/12 of the applicable amount determined under subsection (k)(1))'' after ''1853(c)(1)''; and

(ii) by inserting ''(for years before 2007)'' after ''adjusted as appropriate'';

(B) in subparagraph (B), by inserting ''(for years before 2007)'' after ''adjusted as appropriate''; and

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

''(k) DETERMINATION OF APPLICABLE AMOUNT FOR PURPOSES OF CALCULATING THE BENCHMARK AMOUNTS.—

''(1) APPLICABLE AMOUNT DEFINED.—For purposes of subsection (j), subject to paragraph (2), the term 'applicable amount' means for an area—

''(A) for 2007—

''(i) if such year is not specified under subsection (c)(1)(D)(ii), an amount equal to the amount specified in subsection (c)(1)(C) for the area for 2006—

''(I) first adjusted by the re-scaling factor for 2006 for the area (as made available by the Secretary in the announcement of the rates on April 4, 2005, under subsection (b)(1), but excluding any national adjustment factors for coding intensity and risk adjustment budget neutrality that were included in such factor); and

''(II) then increased by the national per capita MA growth percentage, described in subsection (c)(6) for that succeeding year, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004;

''(ii) if such year is specified under subsection (c)(1)(D)(ii), an amount equal to the greater of—

"(I) the amount determined under clause (i) for the area for the year; or

"(II) the amount specified in subsection (c)(1)(D) for the area for the year; and

"(B) for a subsequent year—

"(i) if such year is not specified under subsection (c)(1)(D)(ii), an amount equal to the amount determined under this paragraph for the area for the previous year, increased by the national per capita MA growth percentage, described in subsection (c)(6) for that succeeding year, but not taking into account any adjustment under subparagraph (C) of such subsection for a year before 2004; and

"(ii) if such year is specified under subsection (c)(1)(D)(ii), an amount equal to the greater of—

"(I) the amount determined under clause (i) for the area for the year; or

''(II) the amount specified in subsection (c)(1)(D) for the area for the year.

''(2) ADJUSTMENT.—

''(A) IN GENERAL.—Except as provided in subparagraph (D), in the case of 2007 through 2010, the applicable amount determined under paragraph (1) shall be increased by a factor equal to 1 plus the product of—

''(i) the percent determined under subparagraph (B) for the year; and

''(ii) the applicable percent for the year under subparagraph (C).

''(B) PERCENT DETERMINED.—

''(i) IN GENERAL.—For purposes of subparagraph (A)(i), subject to clause (ii), the percent determined under this subparagraph for a year is a percent equal to a fraction—

''(I) the numerator of which is an amount equal to—

''(aa) the Secretary's estimate of the total payments that would have been made under this part in the year if all the month-

ly payment amounts for all MA plans were equal to 1/12 of the annual MA capitation rate under subsection (c)(1) for the area and year; minus

"(bb) the Secretary's estimate of the total payments that would have been made under this part in the year if all the monthly payment amounts for all MA plans were equal to 1/12 of the MA area-specific non-drug monthly benchmark amount under subsection (j) for the area and year; and

"(II) the denominator of which is equal to the total amount estimated for the year under subclause (I)(bb).

"(ii) REQUIREMENTS.—In estimating the amounts under clause (i), the Secretary—

"(I) shall—

"(aa) use a complete set of the most recent and representative Medicare Advantage risk

scores under subsection (a)(3) that are available from the risk adjustment model announced for the year;

"(bb) adjust the risk scores to reflect changes in treatment and coding practices in the fee-for-service sector;

"(cc) adjust the risk scores for differences in coding patterns between Medicare Advantage plans and providers under part A and B to the extent that the Secretary has identified such differences;

"(dd) as necessary, adjust the risk scores for late data submitted by Medicare Advantage organizations;

"(ee) as necessary, adjust the risk scores for lagged cohorts; and

"(ff) as necessary, adjust the risk scores for changes in en-

rollment in Medicare Advantage plans during the year; and

"(II) may take into account the estimated health risk of enrollees in preferred provider organization plans (including MA regional plans) for the year.

In order to make the adjustment required under item (cc) and to ensure payment accuracy, the Secretary shall conduct an analysis of the differences described in such item. The Secretary shall complete such analysis by a date necessary to ensure that the results of such analysis are incorporated into the payment rates for a year not later than 2008. In conducting such analysis, the Secretary shall use data submitted with respect to 2004 and subsequent years, as available.

"(C) APPLICABLE PERCENT.—For purposes of subparagraph (A)(ii), the term 'applicable percent' means—

"(i) for 2007, 55 percent;

"(ii) for 2008, 40 percent;

"(iii) for 2009, 25 percent; and

"(iv) for 2010, 5 percent.

"(D) TERMINATION OF ADJUSTMENT.—The Secretary shall not make any adjustment under subparagraph (A) in a year if the amount estimated under subparagraph (B)(i)(I)(bb) for the year is equal to or greater than the amount estimated under subparagraph (B)(i)(I)(aa) for the year.

"(3) NO ADDITIONAL ADJUSTMENTS.—

"(A) IN GENERAL.—Except for the adjustment provided for in paragraph (2), the Secretary may not make any adjustment to the applicable amount determined in paragraph (1) for any year.

"(B) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to limit the authority of the Secretary to risk adjust the amount under subsection (c)(1)(D) pursuant to clause (i) of such subsection.".

(b) REFINEMENTS TO HEALTH STATUS ADJUSTMENT.—Section 1853(a)(1)(C) (42 U.S.C. 1395w–23) is amended by inserting after the first sentence the following new sentence: "In applying such adjustment for health status to such payment amounts, the Secretary shall ensure that such adjustment reflects changes in treatment

and coding practices in the fee-for-service sector and reflects differences in coding patterns between Medicare Advantage plans and providers under part A and B to the extent that the Secretary has identified such differences.''.

SEC. 6112. ELIMINATION OF MEDICARE ADVANTAGE REGIONAL PLAN STABILIZATION FUND.

(a) ELIMINATION.—

(1) IN GENERAL.—Subsection (e) of section 1858 (42 U.S.C. 1395w–27a) is repealed.

(2) CONFORMING AMENDMENT.—Section 1858(f)(1) (42 U.S.C. 1395w–27a(f)(1)) is amended by striking ''subject to subsection (e),''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect as if included in the enactment of section 221(c) of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173; 117 Stat. 2181).

(b) TIMEFRAME FOR PART A AND B PAYMENTS.—Notwithstanding sections 1816(c) and 1842(c)(2) of the Social Security Act or any other provision of law—

(1) any payment from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) or from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t)

for claims submitted under part A or B of title XVIII of such Act for items and services furnished under such part A or B, respectively, that would otherwise be payable during the period beginning on September 22, 2006, and ending on September 30, 2006, shall be paid on the first business day of October 2006; and

(2) no interest or late penalty shall be paid to an entity or individual for any delay in a payment by reason of the application of paragraph (1).

SEC. 6113. RURAL PACE PROVIDER GRANT PROGRAM.

(a) DEFINITIONS.—In this section:

(1) CMS.—The term ''CMS'' means the Centers for Medicare & Medicaid Services.

(2) ELIGIBLE PARTICIPANT.—The term ''eligible participant'' means a PACE program eligible individual (as defined in sections 1894(a)(5) and 1934(a)(5) of the Social Security Act (42 U.S.C. 1395eee(a)(5); 1396u–4(a)(5))).

(3) PACE PROGRAM.—The term ''PACE program'' has the meaning given that term in sections 1894(a)(2) and 1934(a)(2) of the Social Security Act (42 U.S.C. 1395eee(a)(2); 1396u–4(a)(2)).

(4) PACE PROVIDER.—The term ''PACE provider'' has the meaning given that term in section

1894(a)(3) or 1934(a)(3) of the Social Security Act (42 U.S.C. 1395eee(a)(3); 1396u–4(a)(3)).

(5) RURAL AREA.—The term ''rural area'' has the meaning given that term in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)).

(6) RURAL PACE PILOT SITE.—The term ''rural PACE pilot site'' means a PACE provider that has been approved to provide services in a geographic service area that is, in whole or in part, a rural area, and that has received a site development grant under this section.

(7) SECRETARY.—The term ''Secretary'' means the Secretary of Health and Human Services.

(b) SITE DEVELOPMENT GRANTS AND TECHNICAL ASSISTANCE PROGRAM.—

(1) SITE DEVELOPMENT GRANTS.—

(A) IN GENERAL.—The Secretary shall establish a process and criteria to award site development grants to qualified PACE providers that have been approved to serve a geographic service area that is, in whole or in part, a rural area.

(B) AMOUNT PER AWARD.—A site development grant awarded under subparagraph (A) to

any individual rural PACE pilot site shall not exceed $750,000.

(C) NUMBER OF AWARDS.—Not more than 15 rural PACE pilot sites shall be awarded a site development grant under subparagraph (A).

(D) USE OF FUNDS.—Funds made available under a site development grant awarded under subparagraph (A) may be used for the following expenses only to the extent such expenses are incurred in relation to establishing or delivering PACE program services in a rural area:

(i) Feasibility analysis and planning.

(ii) Interdisciplinary team development.

(iii) Development of a provider network, including contract development.

(iv) Development or adaptation of claims processing systems.

(v) Preparation of special education and outreach efforts required for the PACE program.

(vi) Development of expense reporting required for calculation of outlier payments or reconciliation processes.

(vii) Development of any special quality of care or patient satisfaction data collection efforts.

(viii) Establishment of a working capital fund to sustain fixed administrative, facility, or other fixed costs until the provider reaches sufficient enrollment size.

(ix) Startup and development costs incurred prior to the approval of the rural PACE pilot site's PACE provider application by CMS.

(x) Any other efforts determined by the rural PACE pilot site to be critical to its successful startup, as approved by the Secretary.

(E) APPROPRIATION.—

(i) IN GENERAL.—Out of funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this subsection for the period of fiscal years 2006 through 2007, $7,500,000.

(ii) AVAILABILITY.—Funds appropriated under clause (i) shall remain available for expenditure through fiscal year 2010.

(2) TECHNICAL ASSISTANCE PROGRAM.—The Secretary shall establish a technical assistance program to provide—

(A) outreach and education to State agencies and provider organizations interested in establishing PACE programs in rural areas; and

(B) technical assistance necessary to support rural PACE pilot sites.

(c) COST OUTLIER PROTECTION FOR RURAL PACE PILOT SITES.—

(1) ESTABLISHMENT OF FUND FOR REIMBURSEMENT OF OUTLIER COSTS.—

(A) IN GENERAL.—Notwithstanding any other provision of law, the Secretary shall establish an outlier fund to reimburse rural PACE pilot sites for outlier costs (as defined in subparagraph (B)) incurred for eligible participants who reside in a rural area in accordance with the expense payment specified in subparagraph (C).

(B) OUTLIER COSTS DEFINED.—

(i) IN GENERAL.—In subparagraph (A), the term ''outlier costs'' means the inpatient and related physician and ancillary costs in excess of $50,000 incurred within a given 12-month period for an eligible participant who resides in a rural area.

(ii) INCLUSION IN ONLY 1 PERIOD.—Outlier costs may not be included in more than one 12-month period for purposes of calculating an outlier expense payment under subparagraph (C).

(C) OUTLIER EXPENSE PAYMENT.—

(i) PAYMENT FOR OUTLIER COSTS.—Subject to clause (ii), in the case of a rural PACE pilot site that has incurred outlier costs for an eligible participant, the rural PACE pilot site shall receive an outlier expense payment equal to 80 percent of such costs.

(ii) LIMITATIONS.—

(I) COSTS INCURRED PER ELIGIBLE PARTICIPANT.—The total amount of outlier expense payments made under clause (i) to a rural PACE pilot site for outlier costs incurred with re-

spect to an eligible participant shall not exceed $100,000 for the 12-month period used to calculate the payment.

(II) COSTS INCURRED PER PROVIDER.—No rural PACE pilot site may receive more than $500,000 in total outlier expense payments in a 12-month period.

(III) LIMITATION OF OUTLIER COST REIMBURSEMENT PERIOD.—A rural PACE pilot site shall only receive outlier expense payments under this subparagraph with respect to outlier costs incurred during the first 3 years of the site's operation.

(D) REQUIREMENT TO ACCESS RISK RESERVES PRIOR TO PAYMENT.—A rural PACE pilot site shall access and exhaust any risk reserves held or arranged for the provider (other than revenue or reserves maintained to satisfy the requirements of section 460.80(c) of title 42, Code of Federal Regulations) and any working capital established through a site development grant awarded under subsection (b)(1),

prior to receiving any payment from the outlier fund.

(E) APPROPRIATION.—

(i) IN GENERAL.—Out of funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary to carry out this subsection for the period of fiscal years 2006 through 2007, $10,000,000.

(ii) AVAILABILITY.—Funds appropriated under clause (i) shall remain available for expenditure through fiscal year 2010.

(d) EVALUATION OF PACE PROVIDERS SERVING RURAL SERVICE AREAS.—Not later than 60 months after the date of enactment of this Act, the Secretary shall submit a report to Congress containing an evaluation of the experience of rural PACE pilot sites.

(e) AMOUNTS IN ADDITION TO PAYMENTS UNDER SOCIAL SECURITY ACT.—Any amounts paid under the authority of this section to a PACE provider shall be in addition to payments made to the provider under section 1894 or 1934 of the Social Security Act (42 U.S.C. 1395eee; 1396u–4).

SEC. 6114. WAIVER OF PART B LATE ENROLLMENT PENALTY FOR CERTAIN INTERNATIONAL VOLUNTEERS.

(a) IN GENERAL.—

(1) WAIVER OF PENALTY.—Section 1839(b)(42 U.S.C. 1395r(b)) is amended in the second sentence by inserting the following before the period at the end: ''or months for which the individual can demonstrate that the individual was an individual described in section 1837(k)(3)''.

(2) SPECIAL ENROLLMENT PERIOD.—

(A) IN GENERAL.—Section 1837 (42 U.S.C. 1395p) is amended by adding at the end the following new subsection:

''(k)(1) In the case of an individual who—

''(A) at the time the individual first satisfies paragraph (1) or (2) of section 1836, is described in paragraph (3), and has elected not to enroll (or to be deemed enrolled) under this section during the individual's initial enrollment period; or

''(B) has terminated enrollment under this section during a month in which the individual is described in paragraph (3),

there shall be a special enrollment period described in paragraph (2).

''(2) The special enrollment period referred to in paragraph (1) is the 6-month period beginning on the first day of the month which includes the date that the individual is no longer described in paragraph (3).

''(3) For purposes of paragraph (1), an individual described in this paragraph is an individual that is serving as a volunteer outside of the United States through a program—

''(A) that covers at least a 12-month period; and

''(B) that is sponsored by an organization described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from taxation under section 501(a) of such Code.''.

(B) COVERAGE PERIOD.—Section 1838 (42 U.S.C. 1395q) is amended by adding at the end the following new subsection:

''(f) Notwithstanding subsection (a), in the case of an individual who enrolls during a special enrollment period pursuant to section 1837(k), the coverage period shall begin on the first day of the month following the month in which the individual so enrolls.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a)(1) shall apply to months beginning with

January 2007 and the amendments made by subsection (a)(2) shall take effect on January 1, 2007.

SEC. 6115. DELIVERY OF SERVICES AT FEDERALLY QUALIFIED HEALTH CENTERS.

(a) COVERAGE.—

(1) IN GENERAL.—Section 1861(aa)(3) (42 U.S.C. 1395x(aa)(3)) is amended—

(A) in subparagraph (A), by striking ", and" and inserting "and services described in subsections (qq) and (vv); and";

(B) in subparagraph (B), by striking "sections 329, 330, and 340" and inserting "section 330"; and

(C) in the flush matter at the end, by inserting "by the center or by a health care professional under contract with the center" after "outpatient of a Federally qualified health center".

(2) CONSOLIDATED BILLING.—The first sentence of section 1842(b)(6)(F) (42 U.S.C. 1395u(b)(6)(F)) is amended—

(A) by striking "and (G)" and inserting "(G)"; and

(B) by inserting before the period at the end the following: ", and (H) in the case of

services described in section 1861(aa)(3) that are furnished by a health care professional under contract with a Federally qualified health center, payment shall be made to the center''.

(b) TECHNICAL CORRECTIONS.—Clauses (i) and (ii)(II) of section 1861(aa)(4)(A) (42 U.S.C. 1395x(aa)(4)(A)) are each amended by striking ''(other than subsection (h))''.

(c) EFFECTIVE DATES.—The amendments made by this section shall apply to services furnished on or after January 1, 2006.