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HOUSE OF REPRESENTATIVES
REPORT
110–285

PROVIDING FOR CONSIDERATION OF THE BILL (H.R. 3162) TO AMEND TITLES XVIII, XIX, AND XXI OF THE SOCIAL SECURITY ACT TO EXTEND AND IMPROVE THE CHILDREN'S HEALTH INSURANCE PROGRAM, TO IMPROVE BENEFICIARY PROTECTIONS UNDER THE MEDICARE, MEDICAID, AND THE CHIP PROGRAM, AND FOR OTHER PURPOSES

AUGUST 1, 2007 (legislative day of JULY 31, 2007).—Referred to the House Calendar and ordered to be printed

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Mr. CASTOR, from the Committee on Rules, submitted the following

R E P O R T

[To accompany H. Res. 594]

The Committee on Rules, having had under consideration House Resolution 594, by a record vote of 8 to 4, report the same to the House with the recommendation that the resolution be adopted.

SUMMARY OF PROVISIONS OF THE RESOLUTION

The resolution provides for consideration H.R. 3162, the Children's Health and Medicare Protection Act of 2007, under a closed rule providing two hours of general debate in the House, with one hour to be equally divided and controlled by the chairman and ranking minority member of the Committee on Ways & Means and one hour to be equally divided and controlled by the chairman and ranking minority member of the Committee on Energy and Commerce.

The rule waives all points of order against consideration of the bill except for clauses 9 and 10 of Rule XXI. The amendment in the nature of a substitute recommended by the Committee on Ways & Means now printed in the bill, modified by the amendment printed in this report, shall be considered as adopted. The rule waives all points of order against provisions in the bill as amended and provides that the bill, as amended, shall be considered as read. The rule provides one motion to recommit with or without instructions. Finally, the rule provides that the Chair may postpone further consideration of the bill to a time designated by the Speaker.

EXPLANATION OF WAIVERS

The waiver of all points of order against consideration of the bill (except for clauses 9 and 10 of Rule XXI) includes the following: a

waiver of Rule XIII, clause 4(a), requiring a three-day layover of the committee report and a waiver of Rule XIII, clause 3(e), requiring the inclusion of a comparative print of any part of the bill or joint resolution proposing to amend the statute and of the statute or part thereof proposed to be amended. Although the rule waives all points of order against provisions in the bill, as amended, the committee is not aware of any points of order against the bill, as amended. The waiver is prophylactic in nature.

COMMITTEE VOTES

The results of each record vote on an amendment or motion to report, together with the names of those voting for and against, are printed below:

Rules Committee record vote No. 273

Date: August 1, 2007 (legislative day of July 31, 2007).
Measure: H.R. 3162.
Motion by: Mr. Dreier.
Summary of motion: To grant an open rule.
Results: Defeated 4–8.
Vote by Members: McGovern—Nay; Hastings (FL)—Nay; Cardoza—Nay; Welch—Nay; Castor—Nay; Arcuri—Nay; Sutton—Nay; Dreier—Yea; Diaz-Balart—Yea; Hastings (WA)—Yea; Sessions—Yea; Slaughter—Nay.

Rules Committee record vote No. 274

Date: August 1, 2007 (legislative day of July 31, 2007).
Measure: H.R. 3162.
Motion by: Mr. Dreier.
Summary of motion: To grant a modified open rule.
Results: Defeated 4–8.
Vote by Members: McGovern—Nay; Hastings (FL)—Nay; Cardoza—Nay; Welch—Nay; Castor—Nay; Arcuri—Nay; Sutton—Nay; Dreier—Yea; Diaz-Balart—Yea; Hastings (WA)—Yea; Sessions—Yea; Slaughter—Nay.

Rules Committee record vote No. 275

Date: August 1, 2007 (legislative day of July 31, 2007).
Measure: H.R. 3162.
Motion by: Mr. Diaz-Balart.
Summary of motion: To make in order en bloc and provide appropriate waivers for all 43 amendments submitted to Rules on H.R. 3162.
Results: Defeated 4–8.
Vote by Members: McGovern—Nay; Hastings (FL)—Nay; Cardoza—Nay; Welch—Nay; Castor—Nay; Arcuri—Nay; Sutton—Nay; Dreier—Yea; Diaz-Balart—Yea; Hastings (WA)—Yea; Sessions—Yea; Slaughter—Nay.

Rules Committee record vote No. 276

Date: August 1, 2007 (legislative day of July 31, 2007).
Measure: H.R. 3162.
Motion by: Mr. Sessions.
Summary of motion: To make in order en bloc and provide appropriate waivers for amendments #8, 9, 10, and 11 by Rep. Burgess

to prohibit the Secretary of Health and Human Services from approving future state waivers that would cover adults other than pregnant adults under the State Children's Health Insurance Program; to modify Title III of HR 3162 that addresses Medicare physician reimbursement; to modify section 704 of HR 3162 that would require the Secretary of HHS to develop a plan to implement for never events; and to require a State submitting a SCHIP waiver request to the Secretary of Health and Human Services to certify that children in that state have access to an adequate level of pediatricians, pediatric specialists and pediatric sub-specialists for targeted low-income children covered under the State's child health plan.

Results: Defeated 4–8.

Vote by Members: McGovern—Nay; Hastings (FL)—Nay; Cardoza—Nay; Welch—Nay; Castor—Nay; Arcuri—Nay; Sutton—Nay; Dreier—Yea; Diaz-Balart—Yea; Hastings (WA)—Yea; Sessions—Yea; Slaughter—Nay.

Rules Committee record vote No. 277

Date: August 1, 2007 (legislative day of July 31, 2007).

Measure: H.R. 3162.

Motion by: Mr. Sessions.

Summary of motion: To make in order en bloc and provide appropriate waivers for amendments #25, 26, 27, and 28 by Rep. Blackburn, to strike Section 902 from the bill, which repeals the trigger provision; to prevent employers within a State from dropping the option to have employer-sponsored health insurance coverage for their employees' children; to prohibit SCHIP eligibility for adults for consecutive years; and to prohibit adults convicted of a "drug-related" crime from SCHIP eligibility.

Results: Defeated 4–8.

Vote by Members: McGovern—Nay; Hastings (FL)—Nay; Cardoza—Nay; Welch—Nay; Castor—Nay; Arcuri—Nay; Sutton—Nay; Dreier—Yea; Diaz-Balart—Yea; Hastings (WA)—Yea; Sessions—Yea; Slaughter—Nay.

Rules Committee record vote No. 278

Date: August 1, 2007 (legislative day of July 31, 2007).

Measure: H.R. 3162.

Motion by: Mr. Sessions.

Summary of motion: To strike Section 651 regarding specialty hospitals.

Results: Defeated 4–8.

Vote by Members: McGovern—Nay; Hastings (FL)—Nay; Cardoza—Nay; Welch—Nay; Castor—Nay; Arcuri—Nay; Sutton—Nay; Dreier—Yea; Diaz-Balart—Yea; Hastings (WA)—Yea; Sessions—Yea; Slaughter—Nay.

Rules Committee record vote No. 279

Date: August 1, 2007 (legislative day of July 31, 2007).

Measure: H.R. 3162.

Motion by: Mr. Hastings (WA).

Summary of motion: To make in order and provide appropriate waivers for an amendment offered by Rep. Hastings (WA) #29 to

strike clause (i) of subparagraph (D) in subsection (i)(l) added by section 651 (a)(3).

Results: Defeated 4–8.

Vote by Members: McGovern—Nay; Hastings (FL)—Nay; Cardoza—Nay; Welch—Nay; Castor—Nay; Arcuri—Nay; Sutton—Nay; Dreier—Yea; Diaz-Balart—Yea; Hastings (WA)—Yea; Sessions—Yea; Slaughter—Nay.

Rules Committee record vote No. 280

Date: August 1, 2007 (legislative day of July 31,2007).

Measure: H.R. 3162.

Motion by: Mr. Hastings (WA).

Summary of motion: To extend general debate to four hours.

Results: Defeated 4–8.

Vote by Members: McGovern—Nay; Hastings (FL)—Nay; Cardoza—Nay; Welch—Nay; Castor—Nay; Arcuri—Nay; Sutton—Nay; Dreier—Yea; Diaz-Balert—Yea; Hastings (WA)—Yea; Sessions—Yea; Slaughter—Nay.

Rules Committee record vote No. 281

Date: August 1, 2007 (legislative day of July 31, 2007).

Measure: H.R. 3162.

Motion by: Mr. McGovern.

Summary of motion: To report the rule.

Results: Adopted 8–4.

Vote by Members: McGovern—Yea; Hastings (FL)—Yea; Cardoza—Yea; Welch—Yea; Castor—Yea; Arcuri—Yea; Sutton—Yea; Dreier—Nay; Diaz-Balart—Nay; Hastings (WA)—Nay; Sessions—Nay; Slaughter—Yea.

SUMMARY OF AMENDMENT CONSIDERED AS ADOPTED

The following changes are reflected in the amendment.

Amendments to Title I—Children's Health Insurance Program

8. Amends Sec. 104 to increase the percentage of CHIP allotment "qualifying States" may spend from 30 percent to 100 percent.

9. Adds section 115 to require States with Separate State CHIP programs to provide 12 months of continuous eligibility for targeted low income children in families with incomes under 200% of the federal poverty level under XXI.

10. Amends section 111(a)(3)(A) to sunset the outreach performance bonus at the end of FY 2013 and require a GAO study of the effectiveness of the outreach bonus at enrolling eligible but uninsured children.

11. Amends section 131 to allow for coverage of children under CHIP to age 21.

12. Adds a new section 135 to make clear that nothing in the act allows Federal payment for individuals who are not legal residents.

13. Adds a new section 136 to require audits to enforce citizenship restrictions on eligibility for Medicaid and CHIP benefits. This replaces the previous audit requirement in section 143.

14. Amends 151(a)(2)(B) to require the new pediatric health quality measurement program to collect data on efforts to reduce hospitalization rate of premature infants.

Amendments to Title II—Medicare Beneficiary Improvements

8. Amends section 211(a)(2)(D) by changing the indexing of the asset test from $1000 and $2000 per year to the consumer price index.

9. Amends section 213(a) to clarify applicants' ability to self-certify income and resources for purposes of qualifying for the Part D low-income subsidy. Also clarifies that SSA can verify eligibility with existing data, but without the need for additional documentation from applicants, except in extraordinary circumstances. Also makes required technical changes to account for this clarification.

10. Amends section 213(d) to clarify that SSA will provide beneficiaries with a simplified application form and will accept and deliver these applications to the states.

11. Amends section 217 to increase the cost-sharing limitation from 2.5 percent of annual income to 5 percent of annual income.

12. Amends effective date of section 223.

13. Changes paragraph (c)(3) of section 231 to clarify the definition of future patient record systems; adds a new subparagraph (f)(2)(E) to facilitate the collection of racial and ethnicity data.

14. Amends section 233 to clarify the scope of the demonstration.

Amendments to Title III—Physicians' Service Payment Reform

Amends section 301 by clarifying the formula for excluding services not covered under the physician fee schedule from the target growth rates, changing the allowable growth rate for the primary care and preventive services category from three percent to two-and-a-half percent, and by freezing the update in years after 2012. Amends section 304 to clarify the definition of efficient areas; conforms language in section 309 to reflect changes made in the bill as reported by the Committee on Ways and Means; adds language in section 905 directing CMS to report on the specific needs of communities serving vulnerable populations;

Amendments to Title IV—Medicare Advantage Reform

4. Amends section 431 by adding authority for Severe and Disabling Chronic Condition Special Needs Plans (SDCC–SNPs). Provides that SDCC–SNPS must enroll 90% beneficiaries with specific chronic conditions as indicated by MA risk adjustment data; serve beneficiaries with one or more of six specific severe chronic conditions; have an average risk score of 1.35 or greater; manage a MA chronic care improvement program that excels such programs in regular MA plans; and maintain a network of providers to meet the needs of enrollees with severe and disabling conditions.

5. Amends section 431 to clarify a provision referring to Medicare-Medicaid demonstration programs in Massachusetts, Minnesota and Wisconsin.

6. Amends section 411(h) to clarify a provision that provides financial support for State Health Insurance Assistance Programs.

Amendments to Title V—Provisions Relating to Medicare Part A

5. Amends section 503(c) to clarify the treatment of satellites facilities for long-stay cancer hospitals. Modifies the title for the section setting forth Medicare payments for long-stay cancer hospitals.

6. Amends section 504 to modify the formula for disproportionate share hospital payments for hospitals located in Puerto Rico.

7. Amends section 505(b) to streamline language pertaining to one PPS-exempt cancer hospital.

8. Amends section 508(c) to streamline language pertaining to geographic reclassifications and to allow for geographic reclassification of certain hospitals.

Amendments to Title VI—Other Provisions Relating to Medicare Part B

4. Amends sections 608(b) and 609(c) to extend the date by which contracts entered into under the competitive acquisition program are exempt from these sections. The date for the exemption is extended to October 1, 2007.

5. Amends section 612(c) to clarify that certain inhalation drugs are appropriately reimbursed. Specifically, the amendment clarifies that generic albuterol be reimbursed at the lower of its current or historic level, and that brand name levalbuterol be reimbursed at the lower of its current or historic level.

6. Amends section 612(b) to clarify that Competitive Acquisition Program vendors may deliver drugs to a main office or satellite office as designated by the prescribing physician, and that physicians may be allowed to transport drugs to the site of administration if all applicable laws and regulations are followed.

Amendments to Title VII—Provisions Relating to Medicare Parts A and B

4. Amends section 705 to modify criteria for reallocation of graduate medical education residency slots from hospital closures and provision of additional residency slots.

5. Adds section 706 providing for a study of the effect of home health remote monitoring on patient outcomes.

6. Adds section 707 providing for a demonstration project testing effectiveness of home health telemonitoring and other telehealth technologies.

Amendments to Title VIII—Medicaid

5. Amends section 801(a)(1) to extend the TMA program until 2011, rather than 2009.

6. Amends section 812(a) to change the applicable percentage to 22.1.

7. Strikes section 812(b).

8. Adds a new section 812 to extend the automated web-based asset verification demonstration to Medicaid, in the States in which the demonstration is operating.

Amendments to Title IX—Miscellaneous

5. Amends section 904(a) to clarify the number of members and their terms of appointment on the Comparative Effectiveness Research Commission, and to clarify the terms of appointment of the members of the Coordinating Council for Health Services Research.

6. Amends section 904(b) to clarify that the term 'specified health insurance policy' does not include any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

7. Adds a new section 909 to the act allowing Congressional Support Agencies (MedPAC, GAO, and CBO) to obtain from CMS necessary data about the Medicare Part D program.

8. Adds a new section 910 to reauthorize the Title V Social Security Act abstinence education programs with provisions to ensure that medically or scientifically accurate information is provided; that States have the flexibility to teach abstinence-only education programs OR abstinence-plus education programs; and that funded programs are proven effective at decreasing teen pregnancy rates and rates of STDs and HIV/AIDS.

TEXT OF AMENDMENTS CONSIDERED AS ADOPTED

In the matter inserted by section 104, strike "30 percent" and insert "100 percent".

Add at the end of subtitle B of title I the following:

SEC. 115. CONTINUOUS COVERAGE UNDER CHIP.

(a) IN GENERAL.—Section 2102(b) of the Social Security Act (42 U.S.C. 1397bb(b)) is amended by adding at the end the following new paragraph:

"(5) 12-MONTHS CONTINUOUS ELIGIBILITY.—In the case of a State child health plan that provides child health assistance under this title through a means other than described in section 2101(a)(2), the plan shall provide for implementation under this title of the 12-months continuous eligibility option described in section 1902(e)(12) for targeted low-income children whose family income is below 200 percent of the poverty line.".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to determinations (and redeterminations) of eligibility made on or after January 1, 2008.

In the paragraph (3)(A) added by section 111, insert "and ending with fiscal year 2013" after "beginning with fiscal year 2008".

In section 111, insert "(a) IN GENERAL.—" before "Section 2105(a)", and add at the end the following:

(b) GAO STUDY.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study on the effectiveness of the performance bonus payment program under the amendment made by subsection (a) on the enrollment and retention of eligible children under the Medicaid and CHIP programs and in reducing the rate of uninsurance among such children.

(2) REPORT.—Not later than January 1, 2013, the Comptroller General shall submit a report to Congress on such study and shall include in such report such recommendations for extending or modifying such program as the Comptroller General determines appropriate.

Amend section 131 to read as follows:

SEC. 131. OPTIONAL COVERAGE OF CHILDREN UP TO AGE 21 UNDER CHIP.

(a) IN GENERAL.—Section 2110(c)(1) of the Social Security Act (42 U.S.C. 1397jj(c)(1)) is amended by inserting "(or, at the option of the State, under 20 or 21 years of age)" after "19 years of age".

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2008.

Add at the end of subtitle D of title I the following (and in section 143(a), strike paragraph (2) and redesignate paragraph (3) as paragraph (2)):

SEC. 135. NO FEDERAL FUNDING FOR ILLEGAL ALIENS.

Nothing in this Act allows Federal payment for individuals who are not legal residents.

SEC. 136. AUDITING REQUIREMENT TO ENFORCE CITIZENSHIP RESTRICTIONS ON ELIGIBILITY FOR MEDICAID AND CHIP BENEFITS.

Section 1903(x) of the Social Security Act (as amended by section 405(c)(1)(A) of division B of the Tax Relief and Health Care Act of 2006 (Public Law 109–432)) is amended by adding at the end the following new paragraph:

"(4)(A) Each State shall audit a statistically-based sample of cases of individuals whose eligibility for medical assistance (or child health assistance) is determined under section 1902(a)(46)(B) or under subsection (v)(4)(A) in order to demonstrate to the satisfaction of the Secretary that Federal funds under this title or title XXI are not unlawfully spent for benefits for individuals who are not legal residents. In conducting such audits, a State may rely on case reviews regularly conducted pursuant to its Medicaid Quality Control or Payment Error Rate Measurement (PERM) eligibility reviews under subsection (u) and the provisions of subsection (e) of section 1137 shall apply under this paragraph in the same manner as they apply under subsection (b) of such section.

"(B) The State shall remit to the Secretary the Federal share of any unlawful expenditures for benefits, for aliens who are not legal residents, which are identified under an audit conducted under subparagraph (A).".

In section 151(a)(2)(B), insert after clause (vi) the following new clause:

> (vii) Data on State efforts to reduce hospitalization rate of premature infants under the age of 12 months who were born prior to 35 weeks.

In the subclause (IV) inserted by section 211(a)(2)(D), strike "increased by $1,000 (or $2,000 in the case of the combined value referred to in subclause (III))" and insert "increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year".

In section 211(a)(2), strike "and" at the end of subparagraph (C), strike the last period at the end of the matter inserted by subparagraph (D) and insert "; and", and add at the end the following:

> (E) in the last sentence, by inserting "or (IV)" after "subclause (II)".

Amend subsection (a) of section 213 to read as follows:

(a) ADMINISTRATIVE VERIFICATION OF INCOME AND RESOURCES UNDER THE LOW-INCOME SUBSIDY PROGRAM.—Clause (iii) of section

1860D–14(a)(3)(E) of the Social Security Act (42 U.S.C. 1395w–114(a)(3)(E)) is amended to read as follows:

"(iii) CERTIFICATION OF INCOME AND RESOURCES.—For purposes of applying this section—

"(I) an individual shall be permitted to apply on the basis of self-certification of income and resources; and

"(II) matters attested to in the application shall be subject to appropriate methods of verification without the need of the individual to provide additional documentation, except in extraordinary situations as determined by the Commissioner.".

In section 213(b), strike ", as amended by subsection (a), is further amended" and insert "is amended" and redesignate the subparagraph added by such section as subparagraph (G).

In the paragraph (7) added by section 213(c), strike "clauses (iii) and (iv) of section 1860D–14(a)(3)(C)" and inserting "subparagraphs (C)(iii) and (G) of section 1860D–14(a)(3)".

In the subsection (c)(1)(B) added by section 213(d), strike "an application form" and insert "a simplified application form".

In the subsection (c)(3) added by section 213(d), strike "COMPLETED" in the heading and "completed" in the text.

In the clause added by section 217(a)(1) and in the subparagraph added by section 217(a)(2), strike "2.5 percent" and insert "5 percent".

In section 223(b), strike "January 1, 2009" and insert "January 1, 2013".

In section 231(c)(3), insert after "systems" the following: ", including electronic health records, electronic medical records and patient health records,".

In section 231(f)(2), strike "and" at the end of subparagraph (C), strike the period at the end of subparagraph (D) and insert "; and", and add at the end the following new subparagraph:

(E) provide for the revision of existing HIPAA claims-related code sets to mandate the collection of racial and ethnicity data, and to provide a code set for primary language.

In section 233(a), strike "limited English proficient" and insert "living in communities where racial and ethnic minorities, including populations that face language barriers, are underserved with respect to such services".

In the matter inserted by section 301(c)(1), strike "and (8)" and insert "(8), and (9)".

In the paragraph (8) added by section 301(c)(4), in the heading insert "AND ENDING WITH 2012" after "BEGINNING WITH 2008" and in the matter in subparagraph (A) before clause (i), insert "and ending with 2012" after "beginning with 2008".

In the paragraph (8)(B) added by section 301(c)(4), amend clause (i) to read as follows:

"(i) FOR 2008.—For 2008:

"(I) TOTAL 2007 ALLOWED EXPENDITURES FOR ALL SERVICES INCLUDED IN SGR COMPUTATION.—Compute total allowed expenditures for physicians' services (as defined in subsection (f)(4)(A)) for 2007 that would otherwise be calculated under subsection (d) but for this paragraph.

"(II) TOTAL 2007 ALLOWED EXPENDITURES FOR PHYSICIAN FEE SCHEDULE SERVICES.—Compute total allowed expenditures for services furnished under the physician fee schedule for 2007 by subtracting, from the total allowed expenditures computed under subclause (I), the Secretary's estimate of the amount of the actual expenditures for 2007 for services included in such subclause for which payment is not made under the fee schedule established pursuant to this section.

"(III) ALLOCATION OF 2007 ALLOWED EXPENDITURES TO SERVICE CATEGORY.—Compute allowed expenditures for the service category involved for 2007 by multiplying the total allowed expenditures computed under subclause (II) by the overhang allocation factor for the service category (as defined in subparagraph (C)(iii)).

"(IV) INCREASE BY GROWTH RATE TO OBTAIN 2008 ALLOWED EXPENDITURES FOR SERVICE CATEGORY.—Compute allowed expenditures for the service category for 2008 by increasing the allowed expenditures for the service category for 2007 computed under subclause (III) by the target growth rate for such service category under subsection (f) for 2008.

In the paragraph (8)(D) added by section 301(c)(4), strike "FLOOR FOR UPDATES" and insert "UPDATES" and strike "not less than" and insert "equal to".

In the matter added by section 301(c)(4), add at the end the following:

"(9) NO UPDATE FOR SERVICE CATEGORIES BEGINNING WITH 2013.—The update to the conversion factor for each of the service categories established under paragraph (8) for 2013 and each succeeding year shall be 0 percent.".

In the paragraph (5)(B) added by section 301(d)(1), strike "0.03" and insert "0.025".

In the subsection (v)(2)(A) added by section 304, insert before the period at the end the following: "as standardized to eliminate the effect of geographic adjustments in payment rates".

In the subsection (m)(4) inserted by section 309(a)(2), in subparagraph (F) strike "(n)(3)(G)" and insert "(n)" and strike subparagraph (B) and redesignate succeeding subparagraphs accordingly.

In section 411(h)(2), add "and" at the end of subparagraph (A), strike "; and" at the end of subparagraph (B) and insert a period, and strike subparagraph (C).

Amend the clause (ii) inserted by section 431(b)(1)(A) to read as follows:

"(ii) as of January 1, 2009—

"(I) at least 90 percent of the enrollees in which are described in subparagraph (B)(i), as determined under regulations in effect as of July 1, 2007;

"(II) at least 90 percent of the enrollees in which are described in subparagraph (B)(ii) and are full-benefit dual eligible individuals (as defined in sec-

tion 1935(c)(6)) or qualified medicare beneficiaries (as defined in section 1905(p)(1)); or

"(III) at least 90 percent of the enrollees in which have a severe or disabling chronic condition of the type that the plan is committed to serve as indicated by the data submitted for the risk-adjustment of plan payments; and".

In section 431(b)(1), add "and" at the end of subparagraph (A), strike subparagraph (B), and redesignate subparagraph (C) as subparagraph (B).

At the end of the paragraphs added by section 431(b)(1)(B)(iii), as so redesignated, add the following additional paragraph:

"(4) ADDITIONAL REQUIREMENTS FOR SEVERE OR DISABLING CHRONIC CONDITION SNPS.—In the case of a specialized MA plan for special needs individuals described in subsection (b)(6)(A)(ii)(III), the applicable requirements of this subsection are as follows:

"(A) The plan is designated to serve, and serves, Medicare beneficiaries with one or more of the following specific severe or disabling chronic conditions:

"(i) Cardiovascular.

"(ii) Cerebrovascular.

"(iii) Congestive health failure.

"(iv) Diabetes.

"(v) Chronic obstructive pulmonary disease.

"(vi) HIV/AIDS.

"(B) The plan has an average risk score under section 1853(a)(1)(C) of 1.35 or greater.

"(C) The plan has established and actively manages a chronic care improvement program under section 1852(e)(2) for each of the conditions that it serves under subparagraph (A) that significantly exceeds the features and results of such programs established and managed by Medicare Part C plans that are not specialized Medicare Part C plans for special needs individuals of the type described in this paragraph.

"(D) The plan has a network of a sufficient number of primary care and specialty physicians, hospitals, and other health care providers under contract to the plan so that the plan can clearly meet the routine and specialty needs of the severely ill and disabled enrollees of the plan throughout the service area of the plan.

"(E) The plan reports to the Secretary information on additional quality measures specified by the Secretary under section 1852(e)(3)(D)(iv)(III) for such plans.".

In the matter inserted by section 431(b)(2)(A), strike "or (3)" and insert ", (3), or (4)".

In the clause (iii) added by section 431(b)(2)(B), strike "and" at the end of subclause (I), strike the period at the end of subclause (II) and insert "; and", and add at the end the following new subclause:

"(III) beneficiaries enrolled in specialized Medicare Part C plans for special needs individuals (described in section 1859(b)(6)(A)(ii)(III)) that serve predominantly individuals with severe or

disabling chronic conditions by measuring the special needs for care of such individuals.".

Amend subparagraph (A) of section 431(b)(3) to read as follows:

(A) to a Medicare Advantage plan with a contract with a State Medicaid integrated Medicare-Medicaid plan program that had been approved by the Centers for Medicare & Medicaid Services as of January 1, 2004; and

Add at the end of section 431 the following:

(c) SUNSET OF ADDITIONAL DESIGNATION AUTHORITY.—

(1) IN GENERAL.—Subsection (d) of section 231 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108–173) is repealed.

(2) EFFECTIVE DATE.—The repeal made by paragraph (1) shall take effect on January 1, 2009, and shall apply to plans offered on or after such date.

In section 503(c)(4), strike "TRANSITION RULE" and insert "IN GENERAL".

In section 503(c)(5), insert "without regard to section 412.22(h)(2)(i) of title 42, Code of Federal Regulations," after "of this Act" and strike "of title 42, Code of Federal Regulations" and insert "of such title".

In section 504, insert "(a) IN GENERAL.—" before "Section 1886(d)(5)(F)(xiv)" and add at the end the following:

(b) SPECIAL RULE IN COMPUTING DISPROPORTIONATE PATIENT PERCENTAGE.—

(1) IN GENERAL.—Section 1886(d)(5)(F)(vi) of such Act (42 U.S.C. 1395ww(d)(5)(F)(vi)) is amended by adding at the end the following: "In applying this clause in the case of hospitals located in Puerto Rico, the Secretary shall substitute for the fraction described in subclause (I) one-half of the national average of such fraction for all subsection (d) hospitals, as estimated by the Secretary.".

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to discharges in cost reporting periods of hospitals beginning on or after January 1, 2008.

In the clause (vii) inserted by section 505(b)(1)(B), strike subclauses (I), (V), and (VIII) and redesignate subclauses (II), (III), (IV), (VI), and (VII) as subclauses (I) through (V), respectively, and in subclause (IV), as so redesignated, add "and" at the end and in subclause (V), as so redesignated, strike "and" at the end.

In section 508, strike subsections (c) and (d).

Redesignate subsection (e) of section 508 as subsection (c) and, in such subsection, in paragraph (3)(A), insert "greater" after "and no", in paragraph (4), strike "Notwithstanding paragraph (6), in" and insert "In" and strike "of this section" and insert "of this paragraph", and redesignate paragraph (8) as paragraph (13) and insert after paragraph (7) the following:

(8) For purposes of making payment under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), the Nashville-Davidson-Murfreesboro core based statistical area is deemed to include Cumberland County, Tennessee.

(9) For purposes of making payment under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), any hospital that is co-located in Marinette, Wisconsin and the Menominee, Michigan is deemed to be located in Chicago, Illinois.

(10) In the case of a hospital located in Massachusetts or Clinton County, New York, that is reclassified based on wages under paragraph (8) or (10) of section 1886(d) of the Social Security Act into an area the area wage index for which is increased under section 4410(a) of the Balanced Budget Act of 1997 (Public Law 105–33), such increased area wage index shall also apply to such hospital under such section 1886(d).

(11) For purposes of applying the area wage index under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), hospital provider numbers 360112 and 23005 shall be treated as located in the same urban area as Ann Arbor, Michigan.

(12) For purposes of making payment under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)), any hospital that is located in Columbia County, New York, with less 250 beds is deemed to be located in the New York-White Plains-Wayne, NY–NJ core based statistical area.

In sections 608(b)(2) and 609(b)(3), strike "July 21, 2007" and insert "October 1, 2007".

In section 612(b), amend paragraph (2) to read as follows:

(2) PERMITTING APPROPRIATE DELIVERY AND TRANSPORT OF DRUGS.—Subsection (b)(4)(E) of such section is amended—

(A) by striking "or" at the end of clause (i);

(B) by striking the period at the end of clause (ii) and inserting a semicolon; and

(C) by adding at the end the following new clauses:

"(iii) prevent a contractor from delivering drugs to a satellite office designated by the prescribing physician; or

"(iv) prevent a contractor from allowing a selecting physician to transport drugs or biologicals to the site of administration consistent with State law and other applicable laws and regulations.".

In section 612(b)(4), insert before the period at the end the following: ", except in the case of a contractor terminated as a result of the application of section 1847B(b)(2)(B) of such Act".

Amend the paragraph (6) added by section 612(c)(2) to read as follows:

"(6) SPECIAL RULE.—Beginning with January 1, 2008, the payment amount for—

"(A) each single source drug or biological described in section 1842(o)(1)(G) (including a single source drug or biological that is treated as a multiple source drug because of the application of subsection (c)(6)(C)(ii)) is the lower of—

"(i) the payment amount that would be determined for such drug or biological applying such subsection; or

"(ii) the payment amount that would have been determined for such drug or biological if such subsection were not applied; and

"(B) a multiple source drug (excluding a drug or biological that is treated as a multiple source drug because of the application of such subsection) is the lower of—

"(i) the payment amount that would be determined for such drug or biological taking into account the application of such subsection; or

"(ii) the payment amount that would have been determined for such drug or biological if such subsection were not applied.".

In the clause (v) added by section 705(a)(1), strike "division of the core based" each place it appears before subclause (I) and insert after subclause (IV) the following:

"(V) The hospital maintains no more than 400 beds.

In section 705(a)(1), strike "the following new clause:" and insert "the following new clauses:" and add after clause (v) (as added by such section, and after "exceed 10.") the following new clause:

"(vi) INCREASE IN RESIDENCY SLOTS.—In the case of a hospital located in Peoria County, Illinois, that has more than 500 beds, the Secretary shall increase by two the otherwise applicable resident limit under subparagraph (F) for such hospital.".

At the end of title VII add the following:

SEC. 706. STUDIES RELATING TO HOME HEALTH.

(a) IN GENERAL.—The Medicare Payment Advisory Commission shall conduct a study of Medicare beneficiaries utilizing home health care services to determine—

(1) the impact that remote monitoring equipment and related services have on improving health care outcomes in the home health care setting for beneficiaries with chronic conditions;

(2) the differences in the percentage of inpatient hospital admissions and emergency room visits for beneficiaries with a similar health care risk profile who utilize remote monitoring equipment and services compared to those who do not use such equipment and services;

(3) the percentage of Medicare beneficiaries currently utilizing remote monitoring equipment and related services;

(4) the estimated reduction in aggregate expenditures under parts A and B of title XVIII of the Social Security Act expenditures if home health agencies increased their utilization of remote monitoring equipment and related services for patients with chronic disease conditions; and

(5) the variation of utilization of remote monitoring equipment and related services within geographic regions and by size of home health agency.

(b) DATA COLLECTION.—As a condition of a home health agency's participation in the program under title XVIII of the Social Security Act, beginning no later than January 1, 2008, the Secretary of Health and Human Services shall require such agencies to collect, in a form and manner determined by the Secretary, the following data:

(1) The extent of home health agency's usage of remote monitoring equipment and related services for beneficiaries with chronic conditions.

(2) Whether such equipment and services are used to monitor patients' with chronic conditions vital signs on a daily basis.

(3) Whether standing physician orders accompany the use of remote monitoring equipment and services.

(4) The costs of remote monitoring equipment and related services.

(c) REPORT TO CONGRESS.—Not later than June 1, 2010, the Commission shall report to Congress on its findings on the study conducted under subsection (a). Such report shall include recommendations regarding how Congress may enact reimbursement policies that increase the appropriate utilization of remote monitoring equipment and services under the home health program for Medicare beneficiaries with chronic conditions in a manner that facilitates health care outcomes and leads to the long-term reduction of aggregate expenditures under the Medicare program.

SEC. 707. RURAL HOME HEALTH QUALITY DEMONSTRATION PROJECTS.

(a) IN GENERAL.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Health and Human Services (in this section referred to as the "Secretary") shall make grants to eligible entities for demonstration projects to assist home health agencies to better serve their Medicare populations while aiming to reduce costs to the Medicare program through utilization of technologies, including telemonitoring and other telehealth technologies, health information technologies, and telecommunications technologies that—

(1) implement procedures and standards that reduce the need for inpatient hospital services and health center visits; and

(2) address the aims of safety, effectiveness, patient- or community-centeredness, timeliness, efficiency, and equity identified by the Institute of Medicine of the National Academies in its report entitled "Crossing the Quality Chasm: A New Health System for the 21st Century" released on March 1, 2001, when determining when and what care is needed.

(b) ELIGIBLE ENTITIES.—In this section, the term "eligible entity" means a State that includes—

(1) a rural academic medical center;

(2) no urban regional medical center; and

(3) a Medicare population whose enrollees in the Medicare Part C program is less than 3 percent.

(c) CONSULTATION.—In developing the program for awarding grants under this section, the Secretary shall consult with the Administrator of the Centers for Medicare & Medicaid Services, home health agencies, rural health care researchers, and private and non-profit groups (including national associations) which are undertaking similar efforts.

(d) DURATION.—Each demonstration project under this section shall be for a period of 2 years.

(e) REPORT.—Not later than one year after the conclusion of all of the demonstration projects funded under this section, the Secretary shall submit a report to the Congress on the results of such projects. The report shall include—

(1) an evaluation of technologies utilized and effects on patient access to home health care, patient outcomes, and an analysis of the cost effectiveness of each such project; and

(2) recommendations on Federal legislation, regulations, or administrative policies to enhance rural home health quality and outcomes.

(f) FUNDING.—Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary for fiscal year

2008, $3,000,000 to carry out this section. Funds appropriated under this subsection shall remain available until expended.

In section 801(a), strike "TWO-YEAR" and insert "FOUR-YEAR" and in the matter inserted by section 801(a)(1) strike "September 30, 2009" and insert "September 30, 2011".

In the subclause (VI) added by section 812(a)(3), strike "20.1 percent" and insert "22.1 percent".

In section 812, strike "(a) BRAND.—" and strike subsection (b).

At the end of subtitle B of title VIII, add the following:

SEC. 817. EXTENSION OF SSI WEB-BASED ASSET DEMONSTRATION PROJECT TO THE MEDICAID PROGRAM.

(a) IN GENERAL.—The Secretary of Health and Human Services shall provide for the application to asset eligibility determinations under the Medicaid program under title XIX of the Social Security Act of the automated, secure, web-based asset verification request and response process being applied for determining eligibility for benefits under the Supplemental Security Income (SSI) program under title XVI of such Act under a demonstration project conducted under the authority of section 1631(e)(1)(B)(ii) of such Act (42 U.S.C. 1383(e)(1)(B)(ii)).

(b) LIMITATION.—Such application shall only extend to those States in which such demonstration project is operating and only for the period in which such project is otherwise provided.

(c) RULES OF APPLICATION.—For purposes of carrying out subsection (a), notwithstanding any other provision of law, information obtained from a financial institution that is used for purposes of eligibility determinations under such demonstration project with respect to the Secretary of Health and Human Services under the SSI program may also be shared and used by States for purposes of eligibility determinations under the Medicaid program. In applying section 1631(e)(1)(B)(ii) of the Social Security Act under this subsection, references to the Commissioner of Social Security and benefits under title XVI of such Act shall be treated as including a reference to a State described in subsection (b) and medical assistance under title XIX of such Act provided by such a State.

In the section 1822 added by section 904(a), in subsection (b)(3)(A)(iii) strike "up to 15" and insert "15"; in subsection (b)(6)(B) strike "10" and "9" and insert "8" and "7", respectively; and in subsection (g)(2)(B)(ii) strike "8" and "7" and insert "10" and "9", respectively.

Amend paragraph (2) of the section 4375(c) added by section 904(b)(2)(A) to read as follows:

> "(2) EXEMPTION FOR CERTAIN POLICIES.—The term 'specified health insurance policy' does not include any insurance if substantially all of its coverage is of excepted benefits described in section 9832(c).

At the end of title IX add the following:

SEC. 909. ACCESS TO DATA ON PRESCRIPTION DRUG PLANS AND MEDICARE ADVANTAGE PLANS.

(a) IN GENERAL.—Section 1875 of the Social Security Act (42 U.S.C. 1395ll) is amended—

> (1) in the heading, by inserting "TO CONGRESS; PROVIDING INFORMATION TO CONGRESSIONAL SUPPORT AGENCIES" after "AND RECOMMENDATIONS"; and
>
> (2) by adding at the end the following new subsection:

"(c) PROVIDING INFORMATION TO CONGRESSIONAL SUPPORT AGENCIES.—

"(1) IN GENERAL.—Notwithstanding any provision under part D that limits the use of prescription drug data collected under such part, upon the request of a Congressional support agency, the Secretary shall provide such agency with information submitted to, or compiled by, the Secretary under part D (subject to the restriction on disclosure under paragraph (2)), including—

"(A) only with respect to Congressional support agencies that make official baseline spending projections, conduct oversight studies mandated by Congress, or make official recommendations on the program under this title to Congress—

"(i) aggregate negotiated prices for drugs covered under prescription drug plans and MA–PD plans;

"(ii) negotiated rebates, discounts, and other price concessions by drug and by contract or plan (as reported under section 1860D–2(d)(2));

"(iii) bid information (described in section 1860D–11(b)(2)(C)) submitted by such plans;

"(iv) data or a representative sample of data regarding drug claims and other data submitted under section 1860D–15(c)(1)(C) (as determined necessary and appropriate by the Congressional support agency to carry out the legislatively mandated duties of the agency);

"(v) the amount of reinsurance payments paid under section 1860D–15(a)(2), provided at the plan level; and

"(vi) the amount of any adjustments of payments made under subparagraph (B) or (C) of section 1860D–15(e)(2), provided at the plan level aggregate negotiated prices for drugs covered under prescription drug plans and MA–PD plans; and

"(B) access to drug event data submitted by such plans under section 1860D–15(d)(2)(A), except, with respect to data that reveals prices negotiated with drug manufacturers, such data shall only be available to Congressional support agencies that make official baseline spending projections, conduct oversight studies mandated by Congress, or make official recommendations on the program under this title to Congress.

"(2) RESTRICTION ON DATA DISCLOSURE.—

"(A) IN GENERAL.—Data provided to a Congressional support agency under this subsection shall not be disclosed, reported, or released in identifiable form.

"(B) IDENTIFIABLE FORM.—For purposes of subparagraph (A), the term 'identifiable form' means any representation of information that permits identification of a specific prescription drug plan, MA–PD plan, pharmacy benefit manager, drug manufacturer, drug wholesaler, or individual enrolled in a prescription drug plan or an MA–PD plan under part D.

"(3) TIMING.—The Secretary shall release data under this subsection in a timeframe that enables Congressional support agencies to complete congressional requests.

"(4) USE OF THE DATA PROVIDED.—Data provided to a Congressional support agency under this subsection shall only be used by such agency for carrying out the functions and activities of the agency mandated by Congress.

"(5) CONFIDENTIALITY.—The Secretary shall establish safeguards to protect the confidentiality of data released under this subsection. Such safeguards shall not provide for greater disclosure than is permitted under any of the following:

"(A) The Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

"(B) Sections 552 or 552a of title 5, United States Code, with regard to the privacy of individually identifiable beneficiary health information.

"(6) DEFINITIONS.—In this subsection:

"(A) CONGRESSIONAL SUPPORT AGENCY.—The term 'Congressional support agency' means—

"(i) the Medicare Payment Advisory Commission;

"(ii) the Government Accountability Office; and

"(iii) the Congressional Budget Office.

"(B) MA-PD PLAN.—The term 'MA–PD plan' has the meaning given such term in section 1860D–1(a)(3)(C).

"(C) PRESCRIPTION DRUG PLAN.—The term 'prescription drug plan' has the meaning given such term in section 1860D–41(a)(14).".

(b) CONFORMING AMENDMENT.—Section 1805(b)(2) of the Social Security Act (42 U.S.C. 1395b–6(b)(2)) is amended by adding at the end the following new subparagraph:

"(D) PART D.—Specifically, the Commission shall review payment policies with respect to the Voluntary Prescription Drug Benefit Program under part D, including—

"(i) the factors affecting expenditures;

"(ii) payment methodologies; and

"(iii) their relationship to access and quality of care for Medicare beneficiaries.".

SEC. 910. ABSTINENCE EDUCATION.

Section 510 of the Social Security Act (42 U.S.C. 710) is amended to read as follows:

"SEC. 510. SEPARATE PROGRAM FOR ABSTINENCE EDUCATION.

"(a) IN GENERAL.—For the purpose described in subsection (b), the Secretary shall, for fiscal year 2008 and fiscal year 2009, allot to each State which has transmitted an application for the fiscal year under section 505(a) an amount equal to the product of—

"(1) the amount appropriated in subsection (d) for the fiscal year; and

"(2) the percentage determined for the State under section 502(c)(1)(B)(ii).

"(b) PURPOSE OF ALLOTMENT.—

"(1) PURPOSE.—The purpose of an allotment under subsection (a) to a State is to enable the State to provide absti-

nence education, and where appropriate, mentoring, counseling, and adult supervision to promote abstinence from sexual activity, with a focus on those groups which are most likely to bear children out-of-wedlock.

"(2) DEFINITION; STATE OPTION.—For purposes of this section, the term 'abstinence education' has, at the option of each State receiving an allotment under subsection (a), the meaning given such term in subparagraph (A), or the meaning given such term in subparagraph (B), as follows:

"(A) Such term means a medically and scientifically accurate educational or motivational program which—

"(i) has as its exclusive purpose, teaching the social, psychological, and health gains to be realized by abstaining from sexual activity;

"(ii) teaches abstinence from sexual activity outside marriage as the expected standard for all school age children;

"(iii) teaches that abstinence from sexual activity is the only certain way to avoid out-of-wedlock pregnancy, sexually transmitted diseases, and other associated health problems;

"(iv) teaches that a mutually faithful monogamous relationship in context of marriage is the expected standard of human sexual activity;

"(v) teaches that sexual activity outside of the context of marriage is likely to have harmful psychological and physical effects;

"(vi) teaches that bearing children out-of-wedlock is likely to have harmful consequences for the child, the child's parents, and society;

"(vii) teaches young people how to reject sexual advances and how alcohol and drug use increases vulnerability to sexual advances; and

"(viii) teaches the importance of attaining self-sufficiency before engaging in sexual activity.

"(B) Such term means a medically and scientifically accurate educational or motivational program which promotes abstinence and educates those who are currently sexually active or at risk of sexual activity about additional methods to prevent unintended pregnancy or reduce other health risks.

"(3) CERTAIN REQUIREMENTS.—

"(A) LIMITATION REGARDING INACCURATE INFORMATION.—None of the funds made available under this section may be used to provide abstinence education that includes information that is medically and scientifically inaccurate. For purposes of this section, the term 'medically and scientifically inaccurate' means information that is unsupported or contradicted by a preponderance of peer-reviewed research by leading medical, psychological, psychiatric, and public health publications, organizations and agencies.

"(B) EFFECTIVENESS REGARDING CERTAIN MATTERS.—None of the funds made available under this section may be used for a program unless the program is based on a model that has been demonstrated to be effective in pre-

venting unintended pregnancy, or in reducing the transmission of a sexually transmitted disease, including the human immunodeficiency virus. The preceding sentence does not apply to any program that was approved and funded under this section on or before September 30, 2007.

"(c) APPLICABILITY OF CERTAIN SECTIONS.—

"(1) REQUIREMENTS.—Sections 503, 507, and 508 apply to allotments under subsection (a) to the same extent and in the same manner as such sections apply to allotments under section 502(c).

"(2) DISCRETION OF SECRETARY.—Sections 505 and 506 apply to allotments under subsection (a) to the extent determined by the Secretary to be appropriate.

"(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of allotments under subsection (a), there is authorized to be appropriated $50,000,000 for each of fiscal years 2008 and 2009.".

In the matter proposed to be inserted by section 1001(d)(1), strike "44.63 percent" and insert "40 percent (33 percent on cigars removed after December 31, 2007, and before October 1, 2013)".

Conform the table of contents accordingly.

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