

# H.R.6111

**Tax Relief and Health Care Act of 2006 (Enrolled as Agreed to or Passed by Both House and Senate)**

***One Hundred Ninth Congress  
of the  
United States of America  
AT THE SECOND SESSION***

Begun and held at the City of Washington on Tuesday,  
the third day of January, two thousand and six

An Act

To amend the Internal Revenue Code of 1986 to extend expiring provisions,  
and for other purposes.

## **DIVISION B--MEDICARE AND OTHER HEALTH PROVISIONS**

### **SEC. 1. SHORT TITLE OF DIVISION.**

This division may be cited as the 'Medicare Improvements and Extension Act of 2006'.

## **TITLE I--MEDICARE IMPROVED QUALITY AND PROVIDER PAYMENTS**

### **SEC. 101. PHYSICIAN PAYMENT AND QUALITY IMPROVEMENT.**

(a) One-Year Increase in Medicare Physician Fee Schedule Conversion Factor- Section 1848(d) of the Social Security Act (42 U.S.C. 1395w-4(d)) is amended by adding at the end the following new paragraph:

    (7) CONVERSION FACTOR FOR 2007-

        (A) IN GENERAL- The conversion factor that would otherwise be applicable under this subsection for 2007 shall be the amount of such conversion factor divided by the product of--

            (i) 1 plus the Secretary's estimate of the percentage increase in the MEI (as defined in section 1842(i)(3)) for 2007 (divided by 100); and

` (ii) 1 plus the Secretary's estimate of the update adjustment factor under paragraph (4)(B) for 2007.

` (B) NO EFFECT ON COMPUTATION OF CONVERSION FACTOR FOR 2008- The conversion factor under this subsection shall be computed under paragraph (1)(A) for 2008 as if subparagraph (A) had never applied.'

(b) Quality Reporting System- Section 1848 of the Social Security Act (42 U.S.C. 1395w-4) is amended by adding at the end the following new subsection:

` (k) Quality Reporting System-

` (1) IN GENERAL- The Secretary shall implement a system for the reporting by eligible professionals of data on quality measures specified under paragraph (2). Such data shall be submitted in a form and manner specified by the Secretary (by program instruction or otherwise), which may include submission of such data on claims under this part.

` (2) USE OF CONSENSUS-BASED QUALITY MEASURES-

` (A) FOR 2007-

` (i) IN GENERAL- For purposes of applying this subsection for the reporting of data on quality measures for covered professional services furnished during the period beginning July 1, 2007, and ending December 31, 2007, the quality measures specified under this paragraph are the measures identified as 2007 physician quality measures under the Physician Voluntary Reporting Program as published on the public website of the Centers for Medicare & Medicaid Services as of the date of the enactment of this subsection, except as may be changed by the Secretary based on the results of a consensus-based process in January of 2007, if such change is published on such website by not later than April 1, 2007.

` (ii) SUBSEQUENT REFINEMENTS IN APPLICATION PERMITTED- The Secretary may, from time to time (but not later than July 1, 2007), publish on such website (without notice or opportunity for public comment) modifications or refinements (such as code additions, corrections, or revisions) for the application of quality measures previously published under clause (i), but may not, under this clause, change the quality measures under the reporting system.

` (iii) IMPLEMENTATION- Notwithstanding any other provision of law, the Secretary may implement by program instruction or otherwise this subsection for 2007.

` (B) FOR 2008-

` (i) IN GENERAL- For purposes of reporting data on quality measures for covered professional services furnished during 2008, the quality measures specified under this paragraph for covered professional services shall be measures that have been adopted or endorsed by a consensus organization (such as the National Quality Forum or AQA), that include measures that have been submitted by a physician specialty, and that the Secretary identifies as having used a consensus-based process for developing such measures. Such measures shall include structural measures, such as the use of electronic health records and electronic prescribing technology.

` (ii) PROPOSED SET OF MEASURES- Not later than August 15, 2007, the Secretary shall publish in the Federal Register a proposed set of quality measures that the Secretary determines are described in clause (i) and would be appropriate for eligible professionals to use to submit data to the Secretary in 2008. The Secretary shall provide for a period of public comment on such set of measures.

` (iii) FINAL SET OF MEASURES- Not later than November 15, 2007, the Secretary shall publish in the Federal Register a final set of quality measures that the Secretary determines are described in clause (i) and would be appropriate for eligible professionals to use to submit data to the Secretary in 2008.

` (3) COVERED PROFESSIONAL SERVICES AND ELIGIBLE PROFESSIONALS DEFINED- For purposes of this subsection:

` (A) COVERED PROFESSIONAL SERVICES- The term 'covered professional services' means services for which payment is made under, or is based on, the fee schedule established under this section and which are furnished by an eligible professional.

` (B) ELIGIBLE PROFESSIONAL- The term 'eligible professional' means any of the following:

` (i) A physician.

` (ii) A practitioner described in section 1842(b)(18)(C).

` (iii) A physical or occupational therapist or a qualified speech-language pathologist.

` (4) USE OF REGISTRY-BASED REPORTING- As part of the publication of proposed and final quality measures for 2008 under clauses (ii) and (iii) of paragraph (2)(B), the Secretary shall address a mechanism whereby an eligible professional may provide data on quality measures through an appropriate medical registry (such as the Society of Thoracic Surgeons National Database), as identified by the Secretary.

` (5) IDENTIFICATION UNITS- For purposes of applying this subsection, the Secretary may identify eligible professionals through billing units, which may include the use of the Provider Identification Number, the unique physician identification number (described in section 1833(q)(1)), the taxpayer identification number, or the National Provider Identifier. For purposes of applying this subsection for 2007, the Secretary shall use the taxpayer identification number as the billing unit.

` (6) EDUCATION AND OUTREACH- The Secretary shall provide for education and outreach to eligible professionals on the operation of this subsection.

` (7) LIMITATIONS ON REVIEW- There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of the development and implementation of the reporting system under paragraph (1), including identification of quality measures under paragraph (2) and the application of paragraphs (4) and (5).

` (8) IMPLEMENTATION- The Secretary shall carry out this subsection acting through the Administrator of the Centers for Medicare & Medicaid Services.'.

(c) Transitional Bonus Incentive Payments for Quality Reporting in 2007-

(1) IN GENERAL- With respect to covered professional services furnished during a reporting period (as defined in paragraph (6)(C)) by an eligible professional, if--

(A) there are any quality measures that have been established under the physician reporting system that are applicable to any such services furnished by such professional for such period, and

(B) the eligible professional satisfactorily submits (as determined under paragraph (2)) to the Secretary data on such quality measures in accordance with such reporting system for such reporting period,

in addition to the amount otherwise paid under part B of title XVIII of the Social Security Act, subject to paragraph (3), there also shall be paid to the eligible professional (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6) of the Social Security Act (42 U.S.C. 1395u(b)(6))) from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t) an amount equal to 1.5 percent of the Secretary's estimate (based on claims submitted not later than two months after the end of the reporting period) of the allowed charges under such part for all such covered professional services furnished during the reporting period.

(2) SATISFACTORY REPORTING DESCRIBED- For purposes of paragraph (1), an eligible professional shall be treated as satisfactorily submitting data on quality measures for covered professional services for a reporting period if quality measures have been reported as follows:

(A) THREE OR FEWER QUALITY MEASURES APPLICABLE- If there are no more than 3 quality measures that are provided under the physician reporting system and that are applicable to such services of such professional furnished during the period, each such quality measure has been reported under such system in at least 80 percent of the cases in which such measure is reportable under the system.

(B) FOUR OR MORE QUALITY MEASURES APPLICABLE- If there are 4 or more quality measures that are provided under the physician reporting system and that are applicable to such services of such professional furnished during the period, at least 3 such quality measures have been reported under such system in at least 80 percent of the cases in which the respective measure is reportable under the system.

(3) PAYMENT LIMITATION-

(A) IN GENERAL- In no case shall the total payment made under this subsection to an eligible professional (or to an employer or facility in the cases described in clause (A) of section 1842(b)(6) of the Social Security Act) exceed the product of--

(i) the total number of quality measures for which data are submitted under the physician reporting system for covered professional services of such professional that are furnished during the reporting period; and

(ii) 300 percent of the average per measure payment amount specified in subparagraph (B).

(B) AVERAGE PER MEASURE PAYMENT AMOUNT

SPECIFIED- The average per measure payment amount specified in this subparagraph is an amount, estimated by the Secretary (based on claims submitted not later than two months after the end of the reporting period), equal to--

(i) the total of the amount of allowed charges under part B of title XVIII of the Social Security Act for all covered professional services furnished during the reporting period on claims for which quality measures are reported under the physician reporting system; divided by

(ii) the total number of quality measures for which data are reported under such system for covered professional services furnished during the reporting period.

(4) FORM OF PAYMENT- The payment under this subsection shall be in the form of a single consolidated payment.

(5) APPLICATION-

(A) PHYSICIAN REPORTING SYSTEM RULES- Paragraphs (5), (6), and (8) of section 1848(k) of the Social Security Act, as added by subsection (b), shall apply for purposes of this subsection in the same manner as they apply for purposes of such section.

(B) COORDINATION WITH OTHER BONUS PAYMENTS- The provisions of this subsection shall not be taken into account in applying subsections (m) and (u) of section 1833 of the Social Security Act (42 U.S.C. 1395I) and any payment under such subsections shall not be taken into account in computing allowable charges under this subsection.

(C) IMPLEMENTATION- Notwithstanding any other provision of law, the Secretary may implement by program instruction or otherwise this subsection.

(D) VALIDATION-

(i) IN GENERAL- Subject to the succeeding provisions of this subparagraph, for purposes of determining whether a measure is applicable to the covered professional services of an eligible professional under paragraph (2), the Secretary shall presume that if an eligible professional submits data

for a measure, such measure is applicable to such professional.

(ii) METHOD- The Secretary shall validate (by sampling or other means as the Secretary determines to be appropriate) whether measures applicable to covered professional services of an eligible professional have been reported.

(iii) DENIAL OF PAYMENT AUTHORITY- If the Secretary determines that an eligible professional has not reported measures applicable to covered professional services of such professional, the Secretary shall not pay the bonus incentive payment.

(E) LIMITATIONS ON REVIEW-

(i) IN GENERAL- There shall be no administrative or judicial review under section 1869 or 1878 of the Social Security Act or otherwise of--

(I) the determination of measures applicable to services furnished by eligible professionals under this subsection;

(II) the determination of satisfactory reporting under paragraph (2);

(III) the determination of the payment limitation under paragraph (3); and

(IV) the determination of the bonus incentive payment under this subsection.

(ii) TREATMENT OF DETERMINATIONS- A determination under this subsection shall not be treated as a determination for purposes of section 1869 of the Social Security Act.

(6) DEFINITIONS- For purposes of this subsection:

(A) ELIGIBLE PROFESSIONAL; COVERED PROFESSIONAL SERVICES- The terms `eligible professional' and `covered professional services' have the meanings given such terms in section 1848(k)(3) of the Social Security Act, as added by subsection (b).

(B) PHYSICIAN REPORTING SYSTEM- The term `physician reporting system' means the system established under section 1848(k) of the Social Security Act, as added by subsection (b).

(C) REPORTING PERIOD- The term `reporting period' means the period beginning on July 1, 2007, and ending on December 31, 2007.

(D) SECRETARY- The term `Secretary' means the Secretary of Health and Human Services.

(d) Physician Assistance and Quality Initiative Fund- Section 1848 of the Social Security Act, as amended by subsection (b), is further amended by adding at the end the following new subsection:

`(I) Physician Assistance and Quality Initiative Fund-

`(1) ESTABLISHMENT- The Secretary shall establish under this subsection a Physician Assistance and Quality Initiative Fund (in this subsection referred to as the `Fund') which shall be available to the Secretary for physician payment and quality improvement initiatives, which may include application of an adjustment to the update of the conversion factor under subsection (d).

`(2) FUNDING-

`(A) AMOUNT AVAILABLE- There shall be available to the Fund for expenditures an amount equal to \$1,350,000,000.

`(B) TIMELY OBLIGATION OF ALL AVAILABLE FUNDS FOR SERVICES FURNISHED DURING 2008- The Secretary shall provide for expenditures from the Fund in a manner designed to provide (to the maximum extent feasible) for the obligation of the entire amount specified in subparagraph (A) for payment with respect to physicians' services furnished during 2008.

`(C) PAYMENT FROM TRUST FUND- The amount specified in subparagraph (A) shall be available to the Fund, as expenditures are made from the Fund, from the Federal Supplementary Medical Insurance Trust Fund under section 1841.

`(D) FUNDING LIMITATION- Amounts in the Fund shall be available in advance of appropriations in accordance with subparagraph (B) but only if the total amount obligated from the Fund does not exceed the amount available to the Fund under subparagraph (A). The Secretary may obligate funds from the Fund only if the Secretary determines (and the Chief Actuary of the Centers for Medicare & Medicaid Services and the appropriate budget officer certify) that there are available in the Fund sufficient amounts to cover all such obligations incurred consistent with the previous sentence.

`(E) CONSTRUCTION- In the case that expenditures from the Fund are applied to, or otherwise affect, a conversion factor under subsection (d) for a year, the conversion factor under such subsection shall be computed for a subsequent year as if such application or effect had never occurred.'.

(e) Implementation- For purposes of implementing the provisions of, and amendments made by, this section, the Secretary of Health and Human Services shall provide for the transfer, from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t), of \$60,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2007, 2008, and 2009.

## **SEC. 102. EXTENSION OF FLOOR ON MEDICARE WORK GEOGRAPHIC ADJUSTMENT.**

Section 1848(e)(1)(E) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)(E)) is amended by striking `before January 1, 2007' and inserting `before January 1, 2008'.

## **SEC. 103. UPDATE TO THE COMPOSITE RATE COMPONENT OF THE BASIC CASE-MIX ADJUSTED PROSPECTIVE PAYMENT SYSTEM FOR DIALYSIS SERVICES.**

(a) In General- Section 1881(b)(12)(G) of the Social Security Act (42 U.S.C. 1395rr(b)(12)(G)) is amended to read as follows:

`(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--

`(i) furnished on or after January 1, 2006, and before April 1, 2007, by 1.6 percent above the amount of such composite rate component for such services furnished on December 31, 2005; and

`(ii) furnished on or after April 1, 2007, by 1.6 percent above the amount of such composite rate component for such services furnished on March 31, 2007.'.

(b) GAO Report on Home Dialysis Payment- Not later than January 1, 2009, the Comptroller General of the United States shall submit to Congress a report on the costs for home hemodialysis treatment and patient training for both home hemodialysis and peritoneal dialysis. Such report shall also include recommendations for a payment methodology for payment under section 1881 of the Social Security Act (42 U.S.C. 1395rr) that measures, and is based on, the costs of providing such services and takes into account the case mix of patients.

## **SEC. 104. EXTENSION OF TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE.**

Section 542(c) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106-554), as amended by section 732 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173), is amended by striking `and 2006' and inserting `, 2006, and 2007'.

## **SEC. 105. EXTENSION OF MEDICARE REASONABLE COSTS PAYMENTS FOR CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED TO HOSPITAL PATIENTS IN CERTAIN RURAL AREAS.**

Effective as if included in the enactment of section 416 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (42 U.S.C. 1395l-4), subsection (b) of such section is amended by striking `2-year period' and inserting `3-year period'.

## **SEC. 106. HOSPITAL MEDICARE REPORTS AND CLARIFICATIONS.**

(a) Correction of Mid-Year Reclassification Expiration- Notwithstanding any other provision of law, in the case of a subsection (d) hospital (as defined for purposes of section 1886 of the Social Security Act (42 U.S.C. 1395ww)) with respect to which a reclassification of its wage index for purposes of such section would (but for this subsection) expire on March 31, 2007, such reclassification of such hospital shall be extended through September 30, 2007. The previous sentence shall not be effected in a budget-neutral manner.

(b) Revision of the Medicare Wage Index Classification System-

### **(1) MEDPAC REPORT-**

(A) IN GENERAL- The Medicare Payment Advisory Commission shall submit to Congress, by not later than June 30, 2007, a report on its study of the wage index classification system applied under Medicare prospective payment systems, including under section 1886(d)(3)(E) of the Social Security Act (42 U.S.C. 1395ww(d)(3)(E)). Such report shall include any alternatives the Commission recommends to the method to compute the wage index under such section.

(B) FUNDING- Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Medicare Payment Advisory Commission, \$2,000,000 for fiscal year 2007 to carry out this paragraph.

(2) PROPOSAL TO REVISE THE HOSPITAL WAGE INDEX CLASSIFICATION SYSTEM- The Secretary of Health and Human Services, taking into account the recommendations described in the report under paragraph (1), shall include in the proposed rule published under section 1886(e)(5)(A) of the Social Security Act (42 U.S.C. 1395ww(e)(5)(A)) for fiscal year 2009 one or more proposals to revise the wage index adjustment applied under section 1886(d)(3)(E) of such Act (42 U.S.C.

1395ww(d)(3)(E)) for purposes of the Medicare prospective payment system for inpatient hospital services. Such proposal (or proposals) shall consider each of the following:

- (A) Problems associated with the definition of labor markets for purposes of such wage index adjustment.
- (B) The modification or elimination of geographic reclassifications and other adjustments.
- (C) The use of Bureau of Labor Statistics data, or other data or methodologies, to calculate relative wages for each geographic area involved.
- (D) Minimizing variations in wage index adjustments between and within Metropolitan Statistical Areas and Statewide rural areas.
- (E) The feasibility of applying all components of the proposal to other settings, including home health agencies and skilled nursing facilities.
- (F) Methods to minimize the volatility of wage index adjustments, while maintaining the principle of budget neutrality in applying such adjustments.
- (G) The effect that the implementation of the proposal would have on health care providers and on each region of the country.
- (H) Methods for implementing the proposal, including methods to phase-in such implementation.
- (I) Issues relating to occupational mix, such as staffing practices and any evidence on the effect on quality of care and patient safety and any recommendations for alternative calculations.

(c) Elimination of Unnecessary Report- Section 1886 of the Social Security Act (42 U.S.C. 1395ww) is amended--

- (1) in subsection (d)(4)(C), by striking clause (iv); and
- (2) in subsection (e), by striking paragraph (3).

## **SEC. 107. PAYMENT FOR BRACHYTHERAPY.**

(a) Extension of Payment Rule- Section 1833(t)(16)(C) of the Social Security Act (42 U.S.C. 1395l(t)(16)(C)) is amended by striking `January 1, 2007' and inserting `January 1, 2008'.

(b) Establishment of Separate Payment Groups-

(1) IN GENERAL- Section 1833(t)(2)(H) of such Act (42 U.S.C. 1395l(t)(2)(H)) is amended by inserting `and for stranded and non-stranded devices furnished on or after July 1, 2007' before the period at the end.

(2) IMPLEMENTATION- The Secretary of Health and Human Services may implement the amendment made by paragraph (1) by program instruction or otherwise.

## **SEC. 108. PAYMENT PROCESS UNDER THE COMPETITIVE ACQUISITION PROGRAM (CAP).**

(a) In General- Section 1847B(a)(3) of the Social Security Act (42 U.S.C. 1395w-3b(a)(3)) is amended--

(1) in subparagraph (A)(iii), by striking `and biologicals' and all that follows and inserting `and biologicals shall be made only to such contractor upon receipt of a claim for a drug or biological supplied by the contractor for administration to a beneficiary.'; and

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

`(D) POST-PAYMENT REVIEW PROCESS- The Secretary shall establish (by program instruction or otherwise) a post-payment review process (which may include the use of statistical sampling) to assure that payment is made for a drug or biological under this section only if the drug or biological has been administered to a beneficiary. The Secretary shall recoup, offset, or collect any overpayments determined by the Secretary under such process.'.

(b) Construction- Nothing in this section shall be construed as--

(1) requiring the conduct of any additional competition under subsection (b)(1) of section 1847B of the Social Security Act (42 U.S.C. 1395w-3b); or

(2) requiring any additional process for elections by physicians under subsection (a)(1)(A)(ii) of such section or additional selection by a selecting physician of a contractor under subsection (a)(5) of such section.

(c) Effective Date- The amendments made by subsection (a) shall apply to payment for drugs and biologicals supplied under section 1847B of the Social Security Act (42 U.S.C. 1395w-3b)--

(1) on or after April 1, 2007; and

(2) on or after July 1, 2006, and before April 1, 2007, for claims that are unpaid as of April 1, 2007.

## **SEC. 109. QUALITY REPORTING FOR HOSPITAL OUTPATIENT SERVICES AND AMBULATORY SURGICAL CENTER SERVICES.**

(a) Outpatient Hospital Services-

(1) IN GENERAL- Section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)) is amended--

(A) in paragraph (3)(C)(iv), by inserting `subject to paragraph (17),' after `For purposes of this subparagraph,'; and

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

`(17) QUALITY REPORTING-

`(A) REDUCTION IN UPDATE FOR FAILURE TO REPORT-

`(i) IN GENERAL- For purposes of paragraph (3)(C)(iv) for 2009 and each subsequent year, in the case of a subsection (d) hospital (as defined in section 1886(d)(1)(B)) that does not submit, to the Secretary in accordance with this paragraph, data required to be submitted on measures selected under this paragraph with respect to such a year, the OPD fee schedule increase factor under paragraph (3)(C)(iv) for such year shall be reduced by 2.0 percentage points.

`(ii) NON-CUMULATIVE APPLICATION- A reduction under this subparagraph shall apply only with respect to the year involved and the Secretary shall not take into account such reduction in computing the OPD fee schedule increase factor for a subsequent year.

`(B) FORM AND MANNER OF SUBMISSION- Each subsection (d) hospital shall submit data on measures selected under this paragraph to the Secretary in a form and manner, and at a time, specified by the Secretary for purposes of this paragraph.

`(C) DEVELOPMENT OF OUTPATIENT MEASURES-

`(i) IN GENERAL- The Secretary shall develop measures that the Secretary determines to be appropriate for the measurement of the quality of care (including medication errors) furnished by hospitals in outpatient settings and that reflect consensus among affected parties and, to the extent feasible and practicable, shall include measures set

forth by one or more national consensus building entities.

`(ii) CONSTRUCTION- Nothing in this paragraph shall be construed as preventing the Secretary from selecting measures that are the same as (or a subset of) the measures for which data are required to be submitted under section 1886(b)(3)(B)(viii).

`(D) REPLACEMENT OF MEASURES- For purposes of this paragraph, the Secretary may replace any measures or indicators in appropriate cases, such as where all hospitals are effectively in compliance or the measures or indicators have been subsequently shown not to represent the best clinical practice.

`(E) AVAILABILITY OF DATA- The Secretary shall establish procedures for making data submitted under this paragraph available to the public. Such procedures shall ensure that a hospital has the opportunity to review the data that are to be made public with respect to the hospital prior to such data being made public. The Secretary shall report quality measures of process, structure, outcome, patients' perspectives on care, efficiency, and costs of care that relate to services furnished in outpatient settings in hospitals on the Internet website of the Centers for Medicare & Medicaid Services.'

(2) CONFORMING AMENDMENT- Section 1886(b)(3)(B)(viii)(III) of such Act (42 U.S.C. 1395ww(b)(3)(B)(viii)(III)) is amended by inserting `(including medication errors)' after `quality of care'.

(b) Application to Ambulatory Surgical Centers- Section 1833(i) of such Act (42 U.S.C. 1935l(i)) is amended--

(1) in paragraph (2)(D), by redesignating clause (iv) as clause (v) and by inserting after clause (iii) the following new clause:

`(iv) The Secretary may implement such system in a manner so as to provide for a reduction in any annual update for failure to report on quality measures in accordance with paragraph (7).'; and

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

`(7)(A) For purposes of paragraph (2)(D)(iv), the Secretary may provide, in the case of an ambulatory surgical center that does not submit, to the Secretary in accordance with this paragraph, data required to be submitted on measures selected under this paragraph with respect to a year, any annual increase provided under the system established under paragraph (2)(D) for such year shall be reduced by 2.0 percentage points. A reduction under this subparagraph shall apply only with respect to the year involved and the Secretary shall not take

into account such reduction in computing any annual increase factor for a subsequent year.

`(B) Except as the Secretary may otherwise provide, the provisions of subparagraphs (B), (C), (D), and (E) of paragraph (17) of section 1833(t) shall apply with respect to services of ambulatory surgical centers under this paragraph in a similar manner to the manner in which they apply under such paragraph and, for purposes of this subparagraph, any reference to a hospital, outpatient setting, or outpatient hospital services is deemed a reference to an ambulatory surgical center, the setting of such a center, or services of such a center, respectively.'

(c) Effective Date- The amendments made by this section shall apply to payment for services furnished on or after January 1, 2009.

## **SEC. 110. REPORTING OF ANEMIA QUALITY INDICATORS FOR MEDICARE PART B CANCER ANTI-ANEMIA DRUGS.**

(a) In General- Section 1842 of the Social Security Act (42 U.S.C. 1395u) is amended by adding at the end the following new subsection:

`(u) Each request for payment, or bill submitted, for a drug furnished to an individual for the treatment of anemia in connection with the treatment of cancer shall include (in a form and manner specified by the Secretary) information on the hemoglobin or hematocrit levels for the individual.'

(b) Effective Date- The amendment made by subsection (a) shall apply to drugs furnished on or after January 1, 2008. The Secretary of Health and Human Services shall address the implementation of such amendment in the rulemaking process under section 1848 of the Social Security Act (42 U.S.C. 1395w-4) for payment for physicians' services for 2008, consistent with the previous sentence.

## **SEC. 111. CLARIFICATION OF HOSPICE SATELLITE DESIGNATION.**

Notwithstanding any other provision of law, for purposes of calculating the hospice aggregate payment cap for 2004, 2005, and 2006 for a hospice program under section 1814(i)(2)(A) of the Social Security Act (42 U.S.C. 1395f(i)(2)(A)) for hospice care provided on or after November 1, 2003, and before December 27, 2005, Medicare provider number 29-1511 is deemed to be a multiple location of Medicare provider number 29-1500.

## **TITLE II--MEDICARE BENEFICIARY PROTECTIONS**

## **SEC. 201. EXTENSION OF EXCEPTIONS PROCESS FOR MEDICARE THERAPY CAPS.**

Section 1833(g)(5) of the Social Security Act (42 U.S.C. 1395l(g)(5)) is amended by striking `2006' and inserting `the period beginning on January 1, 2006, and ending on December 31, 2007,'.

## **SEC. 202. PAYMENT FOR ADMINISTRATION OF PART D VACCINES.**

(a) Transition for 2007- Notwithstanding any other provision of law, in the case of a vaccine that is a covered part D drug under section 1860D-2(e) of the Social Security Act (42 U.S.C. 1395w-102(e)) and that is administered during 2007, the administration of such vaccine shall be paid under part B of title XVIII of such Act as if it were the administration of a vaccine described in section 1861(s)(10)(B) of such Act (42 U.S.C. 1395w(s)(10)(B)).

(b) Administration Included in Coverage of Covered Part D Drugs Beginning in 2008- Section 1860D-2(e)(1) of the Social Security Act (42 U.S.C. 1395w-102(e)(1)) is amended, in the matter following subparagraph (B), by inserting `(and, for vaccines administered on or after January 1, 2008, its administration)' after `Public Health Service Act'.

## **SEC. 203. OIG STUDY OF NEVER EVENTS.**

(a) Study-

(1) IN GENERAL- The Inspector General in the Department of Health and Human Services shall conduct a study on--

(A) incidences of never events for Medicare beneficiaries, including types of such events and payments by any party for such events;

(B) the extent to which the Medicare program paid, denied payment, or recouped payment for services furnished in connection with such events and the extent to which beneficiaries paid for such services; and

(C) the administrative processes of the Centers for Medicare & Medicaid Services to detect such events and to deny or recoup payments for services furnished in connection with such an event.

(2) CONDUCT OF STUDY- In conducting the study under paragraph (1), the Inspector General--

(A) shall audit a representative sample of claims and medical records of Medicare beneficiaries to identify never

events and any payment (or recoupment) for services furnished in connection with such events;  
(B) may request access to such claims and records from any Medicare contractor; and  
(C) shall not release individually identifiable information or facility-specific information.

(b) Report- Not later than 2 years after the date of the enactment of this Act, the Inspector General shall submit a report to Congress on the study conducted under this section. Such report shall include recommendations for such legislation and administrative action, such as a noncoverage policy or denial of payments, as the Inspector General determines appropriate, including--

(1) recommendations on processes to identify never events and to deny or recoup payments for services furnished in connection with such events; and

(2) a recommendation on a potential process (or processes) for public disclosure of never events which--

(A) will ensure protection of patient privacy; and

(B) will permit the use of the disclosed information for a root cause analysis to inform the public and the medical community about safety issues involved.

(c) Funding- Out of any funds in the Treasury not otherwise appropriated, there are appropriated to the Inspector General of the Department of Health and Human Services \$3,000,000 to carry out this section, to be available until January 1, 2010.

(d) Never Events Defined- For purposes of this section, the term `never event' means an event that is listed and endorsed as a serious reportable event by the National Quality Forum as of November 16, 2006.

## **SEC. 204. MEDICARE MEDICAL HOME DEMONSTRATION PROJECT.**

(a) In General- The Secretary of Health and Human Services (in this section referred to as the `Secretary') shall establish under title XVIII of the Social Security Act a medical home demonstration project (in this section referred to as the `project') to redesign the health care delivery system to provide targeted, accessible, continuous and coordinated, family-centered care to high-need populations and under which--

(1) care management fees are paid to persons performing services as personal physicians; and

(2) incentive payments are paid to physicians participating in practices that provide services as a medical home under subsection (d).

For purposes of this subsection, the term `high-need population' means individuals with multiple chronic illnesses that require regular medical monitoring, advising, or treatment.

(b) Details-

(1) DURATION; SCOPE- The project shall operate during a period of three years and shall include urban, rural, and underserved areas in a total of no more than 8 States.

(2) ENCOURAGING PARTICIPATION OF SMALL PHYSICIAN PRACTICES- The project shall be designed to include the participation of physicians in practices with fewer than three full-time equivalent physicians, as well as physicians in larger practices particularly in rural and underserved areas.

(c) Personal Physician Defined-

(1) IN GENERAL- For purposes of this section, the term `personal physician' means a physician (as defined in section 1861(r)(1) of the Social Security Act (42 U.S.C. 1395x(r)(1)) who--

(A) meets the requirements described in paragraph (2); and

(B) performs the services described in paragraph (3).

Nothing in this paragraph shall be construed as preventing such a physician from being a specialist or subspecialist for an individual requiring ongoing care for a specific chronic condition or multiple chronic conditions (such as severe asthma, complex diabetes, cardiovascular disease, rheumatologic disorder) or for an individual with a prolonged illness.

(2) REQUIREMENTS- The requirements described in this paragraph for a personal physician are as follows:

(A) The physician is a board certified physician who provides first contact and continuous care for individuals under the physician's care.

(B) The physician has the staff and resources to manage the comprehensive and coordinated health care of each such individual.

(3) SERVICES PERFORMED- A personal physician shall perform or provide for the performance of at least the following services:

(A) Advocates for and provides ongoing support, oversight, and guidance to implement a plan of care that provides an integrated, coherent, cross-discipline plan for ongoing medical care developed in partnership with patients and including all other physicians furnishing care to the patient

involved and other appropriate medical personnel or agencies (such as home health agencies).

(B) Uses evidence-based medicine and clinical decision support tools to guide decision-making at the point-of-care based on patient-specific factors.

(C) Uses health information technology, that may include remote monitoring and patient registries, to monitor and track the health status of patients and to provide patients with enhanced and convenient access to health care services.

(D) Encourages patients to engage in the management of their own health through education and support systems.

(d) Medical Home Defined- For purposes of this section, the term 'medical home' means a physician practice that--

(1) is in charge of targeting beneficiaries for participation in the project; and

(2) is responsible for--

(A) providing safe and secure technology to promote patient access to personal health information;

(B) developing a health assessment tool for the individuals targeted; and

(C) providing training programs for personnel involved in the coordination of care.

(e) Payment Mechanisms-

(1) PERSONAL PHYSICIAN CARE MANAGEMENT FEE- Under the project, the Secretary shall provide for payment under section 1848 of the Social Security Act (42 U.S.C. 1395w-4) of a care management fee to personal physicians providing care management under the project. Under such section and using the relative value scale update committee (RUC) process under such section, the Secretary shall develop a care management fee code for such payments and a value for such code.

(2) MEDICAL HOME SHARING IN SAVINGS- The Secretary shall provide for payment under the project of a medical home based on the payment methodology applied to physician group practices under section 1866A of the Social Security Act (42 U.S.C. 1395cc-1). Under such methodology, 80 percent of the reductions in expenditures under title XVIII of the Social Security Act resulting from participation of individuals that are attributable to the medical home (as reduced by the total care managements fees paid to the medical home under the project) shall be paid to the medical home. The amount of such reductions in expenditures shall be determined by using assumptions with respect to reductions in the occurrence of

health complications, hospitalization rates, medical errors, and adverse drug reactions.

(3) SOURCE- Payments paid under the project shall be made from the Federal Supplementary Medical Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t).

(f) Evaluations and Reports-

(1) ANNUAL INTERIM EVALUATIONS AND REPORTS- For each year of the project, the Secretary shall provide for an evaluation of the project and shall submit to Congress, by a date specified by the Secretary, a report on the project and on the evaluation of the project for each such year.

(2) FINAL EVALUATION AND REPORT- The Secretary shall provide for an evaluation of the project and shall submit to Congress, not later than one year after completion of the project, a report on the project and on the evaluation of the project.

## **SEC. 205. MEDICARE DRA TECHNICAL CORRECTIONS.**

(a) PACE Clarification- Paragraph (7) of section 5302(c) of the Deficit Reduction Act of 2005 (42 U.S.C. 1395eee note) is amended to read as follows:

    ` (7) APPROPRIATION-

        ` (A) IN GENERAL- Out of funds in the Treasury not otherwise appropriated, there are appropriated to the Secretary \$10,000,000 to carry out this subsection for the period of fiscal years 2006 through 2010.

        ` (B) AVAILABILITY- Funds appropriated under subparagraph (A) shall remain available for obligation through fiscal year 2010.'.

(b) Miscellaneous Technical Corrections-

(1) CORRECTION OF MARGIN (SECTION 5001)- Section 1886(b)(3)(B) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)), as amended by section 5001(a) of the Deficit Reduction Act of 2005 (Public Law 109-171), is amended by moving clause (viii) (including subclauses (I) through (VII) of such clause) 6 ems to the left.

(2) REFERENCE CORRECTION (SECTION 5114)- Section 5114(a)(2) of the Deficit Reduction Act of 2005 (Public Law 109-171), in the matter preceding subparagraph (A), is amended by striking `1842(b)(6)(F) of such Act (42 U.S.C. 1395u(b)(6)(F))' and inserting `1842(b)(6) of such Act (42 U.S.C. 1395u(b)(6))'.

(c) Effective Date- The amendments made by this section shall take effect as if included in the enactment of the Deficit Reduction Act of 2005 (Public Law 109-171).

## **SEC. 206. LIMITED CONTINUOUS OPEN ENROLLMENT OF ORIGINAL MEDICARE FEE-FOR-SERVICE ENROLLEES INTO MEDICARE ADVANTAGE NON-PRESCRIPTION DRUG PLANS.**

(a) In General- Section 1851(e)(2) of the Social Security Act (42 U.S.C. 1395w-21(e)(2)) is amended by adding at the end the following new subparagraph:

“(E) LIMITED CONTINUOUS OPEN ENROLLMENT OF ORIGINAL FEE-FOR-SERVICE ENROLLEES IN MEDICARE ADVANTAGE NON-PRESCRIPTION DRUG PLANS-

“(i) IN GENERAL- On any date during 2007 or 2008 on which a Medicare Advantage eligible individual is an unenrolled fee-for-service individual (as defined in clause (ii)), the individual may elect under subsection (a)(1) to enroll in a Medicare Advantage plan that is not an MA-PD plan.

“(ii) UNENROLLED FEE-FOR-SERVICE INDIVIDUAL DEFINED- In this subparagraph, the term ‘unenrolled fee-for-service individual’ means, with respect to a date, a Medicare Advantage eligible individual who--

“(I) is receiving benefits under this title through enrollment in the original medicare fee-for-service program under parts A and B;

“(II) is not enrolled in an MA plan on such date; and

“(III) as of such date is not otherwise eligible to elect to enroll in an MA plan.

“(iii) LIMITATION OF ONE CHANGE DURING YEAR- An individual may exercise the right under clause (i) only once during the year.

“(iv) NO EFFECT ON COVERAGE UNDER A PRESCRIPTION DRUG PLAN- Nothing in this subparagraph shall be construed as permitting an individual exercising the right under clause (i)--

“(I) who is enrolled in a prescription drug plan under part D, to disenroll from such plan or to enroll in a different prescription drug plan; or

“(II) who is not enrolled in a prescription drug plan, to enroll in such a plan.’.

(b) Conforming Amendment- Section 1860D-1(b)(1)(B)(iii) of the Social Security Act (42 U.S.C. 1395w-101(b)(1)(B)(iii)) is amended by striking ` subparagraphs (B) and (C)' and inserting ` subparagraphs (B), (C), and (E)'.

### **TITLE III--MEDICARE PROGRAM INTEGRITY EFFORTS**

#### **SEC. 301. OFFSETTING ADJUSTMENT IN MEDICARE ADVANTAGE STABILIZATION FUND.**

Section 1858(e)(2)(A)(i) of the Social Security Act (42 U.S.C. 1395w-27a(e)(2)(A)(i)) is amended by striking ` 2007,' and ` \$10,000,000,000' and inserting ` 2012,' and ` \$3,500,000,000', respectively.

#### **SEC. 302. EXTENSION AND EXPANSION OF RECOVERY AUDIT CONTRACTOR PROGRAM UNDER THE MEDICARE INTEGRITY PROGRAM.**

(a) In General- Section 1893 of the Social Security Act (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

` (h) Use of Recovery Audit Contractors-

` (1) IN GENERAL- Under the Program, the Secretary shall enter into contracts with recovery audit contractors in accordance with this subsection for the purpose of identifying underpayments and overpayments and recouping overpayments under this title with respect to all services for which payment is made under part A or B. Under the contracts--

` (A) payment shall be made to such a contractor only from amounts recovered;

` (B) from such amounts recovered, payment--

` (i) shall be made on a contingent basis for collecting overpayments; and

` (ii) may be made in such amounts as the Secretary may specify for identifying underpayments; and

` (C) the Secretary shall retain a portion of the amounts recovered which shall be available to the program management account of the Centers for Medicare & Medicaid Services for purposes of activities conducted under the recovery audit program under this subsection.

` (2) DISPOSITION OF REMAINING RECOVERIES- The amounts recovered under such contracts that are not paid to the contractor under paragraph (1) or retained by the Secretary

under paragraph (1)(C) shall be applied to reduce expenditures under parts A and B.

` (3) NATIONWIDE COVERAGE- The Secretary shall enter into contracts under paragraph (1) in a manner so as to provide for activities in all States under such a contract by not later than January 1, 2010.

` (4) AUDIT AND RECOVERY PERIODS- Each such contract shall provide that audit and recovery activities may be conducted during a fiscal year with respect to payments made under part A or B--

    ` (A) during such fiscal year; and

    ` (B) retrospectively (for a period of not more than 4 fiscal years prior to such fiscal year).

` (5) WAIVER- The Secretary shall waive such provisions of this title as may be necessary to provide for payment of recovery audit contractors under this subsection in accordance with paragraph (1).

` (6) QUALIFICATIONS OF CONTRACTORS-

    ` (A) IN GENERAL- The Secretary may not enter into a contract under paragraph (1) with a recovery audit contractor unless the contractor has staff that has the appropriate clinical knowledge of, and experience with, the payment rules and regulations under this title or the contractor has, or will contract with, another entity that has such knowledgeable and experienced staff.

    ` (B) INELIGIBILITY OF CERTAIN CONTRACTORS- The Secretary may not enter into a contract under paragraph (1) with a recovery audit contractor to the extent the contractor is a fiscal intermediary under section 1816, a carrier under section 1842, or a medicare administrative contractor under section 1874A.

    ` (C) PREFERENCE FOR ENTITIES WITH DEMONSTRATED PROFICIENCY- In awarding contracts to recovery audit contractors under paragraph (1), the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated more than 3 years direct management experience and a proficiency for cost control or recovery audits with private insurers, health care providers, health plans, under the Medicaid program under title XIX, or under this title.

` (7) CONSTRUCTION RELATING TO CONDUCT OF INVESTIGATION OF FRAUD- A recovery of an overpayment to a individual or entity by a recovery audit contractor under this subsection shall not be construed to prohibit the Secretary or the

Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.

`(8) ANNUAL REPORT- The Secretary shall annually submit to Congress a report on the use of recovery audit contractors under this subsection. Each such report shall include information on the performance of such contractors in identifying underpayments and overpayments and recouping overpayments, including an evaluation of the comparative performance of such contractors and savings to the program under this title.'

(b) Access to Coordination of Benefits Contractor Database- The Secretary of Health and Human Services shall provide for access by recovery audit contractors conducting audit and recovery activities under section 1893(h) of the Social Security Act, as added by subsection (a), to the database of the Coordination of Benefits Contractor of the Centers for Medicare & Medicaid Services with respect to the audit and recovery periods described in paragraph (4) of such section 1893(h).

(c) Conforming Amendments to Current Demonstration Project- Section 306 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (Public Law 108-173; 117 Stat. 2256) is amended--

(1) in subsection (b)(2), by striking `last for not longer than 3 years' and inserting `continue until contracts are entered into under section 1893(h) of the Social Security Act'; and

(2) by striking subsection (f).

### **SEC. 303. FUNDING FOR THE HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.**

(a) Departments of Health and Human Services and Justice-

(1) IN GENERAL- Section 1817(k)(3)(A)(i) of the Social Security Act (42 U.S.C. 1395i(k)(3)(A)(i)) is amended--

(A) in the matter preceding subclause (I), by inserting `until expended' after `without further appropriation';

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

(C) in subclause (III)--

(i) by striking `for each fiscal year after fiscal year 2003' and inserting `for each of fiscal years 2004, 2005, and 2006'; and

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

(D) by adding at the end the following new subclauses:

`(IV) for each of fiscal years 2007, 2008, 2009, and 2010, the limit under this clause for the preceding fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year; and  
` (V) for each fiscal year after fiscal year 2010, the limit under this clause for fiscal year 2010.'

(2) OFFICE OF THE INSPECTOR GENERAL OF THE DEPARTMENT OF HEALTH AND HUMAN SERVICES- Section 1817(k)(3)(A)(ii) of such Act (42 U.S.C. 1395i(k)(3)(A)(ii)) is amended--

(A) in subclause (VI), by striking `and' at the end;

(B) in subclause (VII)--

(i) by striking `for each fiscal year after fiscal year 2002' and inserting `for each of fiscal years 2003, 2004, 2005, and 2006'; and

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

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

`(VIII) for fiscal year 2007, not less than \$160,000,000, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year;

`(IX) for each of fiscal years 2008, 2009, and 2010, not less than the amount required under this clause for the preceding fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year; and

`(X) for each fiscal year after fiscal year 2010, not less than the amount required under this clause for fiscal year 2010.'

(b) Federal Bureau of Investigation- Section 1817(k)(3)(B) of the Social Security Act (42 U.S.C. 1395i(k)(3)(B)) is amended--

(1) in the matter preceding clause (i), by inserting `until expended' after `without further appropriation';

(2) in clause (vi), by striking `and' at the end;

(3) in clause (vii)--

(A) by striking ` for each fiscal year after fiscal year 2002' and inserting ` for each of fiscal years 2003, 2004, 2005, and 2006'; and

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

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

`(viii) for each of fiscal years 2007, 2008, 2009, and 2010, the amount to be appropriated under this subparagraph for the preceding fiscal year, increased by the percentage increase in the consumer price index for all urban consumers (all items; United States city average) over the previous year; and  
`(ix) for each fiscal year after fiscal year 2010, the amount to be appropriated under this subparagraph for fiscal year 2010.'.

## **SEC. 304. IMPLEMENTATION FUNDING.**

For purposes of implementing the provisions of, and amendments made by, this title and titles I and II of this division, other than section 203, the Secretary of Health and Human Services shall provide for the transfer, in appropriate part from the Federal Hospital Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), of \$45,000,000 to the Centers for Medicare & Medicaid Services Program Management Account for the period of fiscal years 2007 and 2008.